



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

October 21, 2013

COPY

Jeff Morrell, Administrator
Intermountain Hospital
303 North Allumbaugh Street
Boise, ID 83704

RE: Intermountain Hospital, Provider #134002

Dear Mr. Morrell:

This is to advise you of the findings of the complaint investigation, which was concluded at your facility on October 17, 2013.

Enclosed is a Statement of Deficiencies/Plan of Correction form, CMS-2567, listing Medicare deficiencies. The hospital is under no obligation to provide a plan of correction for Medicare deficiencies. If you do choose to submit a plan of correction, provide it in the spaces provided on the right side of each sheet.

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

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the PoC is effective in bringing the HOSPITAL into compliance, and that the HOSPITAL remains in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
- The administrator's signature and the date signed on page 1 of the Form CMS-2567.

Jeff Morrell, Administrator
October 21, 2013
Page 2 of 2

Whether you choose to provide a plan of correction or not, please sign and date the form and return it to our office by **November 3, 2013**. Keep a copy for your records. For your information, the Statement of Deficiencies is disclosable to the public under the disclosure of survey information provisions.

Thank you for the courtesies extended to us during our visit. If you have any questions, please write or call this office at (208) 334-6626.

Sincerely,

Handwritten signature of Libby Doane in cursive, followed by the word "for" in a smaller font.

LIBBY DOANE
Health Facility Surveyor
Non-Long Term Care

Handwritten signature of Sylvia Creswell in cursive.

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

LD/pmt
Enclosures

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FACILITY STANDARDS

November 1, 2013

Department of Health and Welfare
Bureau of Facility Standards
Sylvia Creswell, Supervisor
Non-long Term Care

Libby Doane, BSN, BA, HFS
Health Facility Surveyor
Non-long Term Care

HAND DELIVERED

Dear Sylvia and Libby,

Enclosed please find our Plan of Correction for Medical Record Services (A-450). The Bureau of Facility Standard form and Plan of Correction response form is attached and identifies the standard, deficiency, action plan, educational program and monitoring plan for the deficiency.

Upon review of our Plan of Correction, if you have any questions, don't hesitate to contact me.

Sincerely,

A handwritten signature in black ink, appearing to read "Jeff Morrell".

Jeff Morrell
CEO

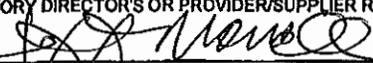
Attachments: CMS - 2567, Attachments A-C (Loop, QAPI Tool and SR Checklist)

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

PRINTED: 10/18/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134002	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/17/2013
NAME OF PROVIDER OR SUPPLIER INTERMOUNTAIN HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 303 NORTH ALLUMBAUGH STREET BOISE, ID 83704	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS The following deficiencies were cited during the complaint investigation survey of your hospital on 10/15/13 through 10/17/13. Surveyors conducting the investigation were: Libby Doane, BSN, RN, HFS- Team Lead Don Sylvester, BSN, RN, HFS Acronyms used in this report include: DON - Director of Nursing IM - Intramuscular injection mg - milligram	A 000	By submitting this Plan of Correction, the Facility does not admit that it violated the regulations. The Facility also reserves the right to amend the Plan of Correction as necessary and to contest the deficiencies, findings, conclusions and actions of the agency.	
A 450	482.24(c)(1) MEDICAL RECORD SERVICES All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures. This STANDARD is not met as evidenced by: Based on review of medical records, review of policies and staff interview, it was determined the hospital failed to ensure verbal orders were signed within 24 hours for 3 of 5 patients (#7, #8 and #12) whose records were reviewed and contained restraint or seclusion orders. This failure resulted in a lack of authentication of physician orders. Findings include: The hospital's "Medical Staff Rules and Regulations," revised July 2010, stated orders for restraint or seclusion would "be signed by the physician within 24 hours of initiation...." In addition, the "SECLUSION/PHYSICAL	A 450	482.24(c)(1) Medical Records Services Actions Taken: 1.) A meeting was scheduled and held on October 22, 2013 (Medical Executive Committee) for all active medical staff members at the facility. During this meeting, requirements for MD authentication of the medical record was discussed including the requirement for seclusion and restraint authentication within 24 hours of the event. Each physician acknowledged the requirement and understood the authentication for these procedures and will complete the necessary documentation requirements for each patient identified. A follow-up discussion of Seclusion/Restraint authentication requirements will be added to the Peer Review MD meeting scheduled for November 12, 2013.	10/22/2013 Target Date: 11/12/2013

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FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE CEO (X6) DATE 11/1/13

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 450	<p>Continued From page 1</p> <p>RESTRAINT/EMERGENCY USE OF MEDICATION PHYSICIAN ORDER FORM included a line for the physician to sign and documented "Must be signed within 24 hours of order given." The hospital failed to adhere to the medical staff rules as follows:</p> <p>1. Patient #8 was 47 year old female admitted to the hospital on 1/17/13 for alcohol detoxification. She was discharged from the hospital on 1/24/13.</p> <p>Her medical record contained a "SECLUSION/PHYSICAL RESTRAINT/EMERGENCY USE OF MEDICATION PHYSICIAN ORDER FORM," which documented a telephone order was received from the physician on 1/24/13 at 3:30 AM, for the use of physical restraint, seclusion, Haldol 10 mg IM and Benadryl 50 mg IM. The physician authenticated the order on 2/16/13 at 1:43 PM, 23 days later.</p> <p>The DON reviewed the record and was interviewed on 10/16/13 beginning at 1:35 PM. She confirmed the physician had not authenticated the orders within 24 hours in accordance with medical staff rules.</p> <p>2. Patient #12 was a 22 year old male admitted to the hospital on 4/05/13 with a diagnosis of schizoaffective disorder. He was discharged from the hospital on 5/03/13. His medical record contained the following:</p> <p>a. A "SECLUSION/PHYSICAL RESTRAINT/EMERGENCY USE OF MEDICATION PHYSICIAN ORDER FORM" documented a telephone order was received from the physician on 4/15/13 at 10:50 AM, for the use</p>	A 450	<p>482.24(c)(1) Medical Records Services (Continued)</p> <p>2.) The Director of Nursing provided immediate staff education to the RN Supervisors verbally and will be followed up with a specific QAPI monitoring tool (Checklist and flow sheet) education component for each RN Supervisor/Manager. The initial staff education included the review and requirements for MD authentication with the RN Managers and on-shift RN Supervisors. The follow-up RN Supervisor/Manager Team education will be completed by all available Supervisors/Managers by November 4, 2013 – with PRN RN Supervisors completing the education based upon PRN utilization in the RN Supervisor role. All education of these staff members will reflect these monitoring requirements and will be documented in their Human Resource Personnel file.</p> <p>3.) The CEO wrote a specific written article for "In the Loop" the hospitals' internal communication tool for all Charge Nurses on November 1, 2013. In this written educational section in the newsletter, Charge Nurses are required to document ALL/EVERY episode of seclusion/restraint on the 24-hour report sheet and verbally contact the RN Supervisor/Manager of the event. The newsletter written educational component also addresses the follow-up authentication requirement review for the RN Supervisor/Manager AND the MD requirements and responsibilities for the completion of the authentication. (see attachment A)</p>	<p>Initiated: 10/18/13</p> <p>Target Date: 11/4/2013</p> <p>11/1/2013</p>

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A 450	<p>Continued From page 2 of physical restraint and 50 mg of Benadryl to be given IM. The physician authenticated the order on 4/17/13 at 9:00 AM.</p> <p>b. A "SECLUSION/PHYSICAL RESTRAINT/EMERGENCY USE OF MEDICATION PHYSICIAN ORDER FORM" documented a telephone order was received from the physician on 4/15/13 at 7:29 PM, for the use of seclusion and Geodon 20 mg IM for psychosis. The physician authenticated the order on 4/17/13 at 9:00 AM.</p> <p>The DON reviewed the record and was interviewed on 10/16/13 beginning at 1:35 PM. She confirmed the physician had not authenticated the orders within 24 hours in accordance with medical staff rules.</p> <p>3. Patient #7 was a 77 year old female admitted to the hospital on 7/23/13 with diagnoses of episodic mood disorder, dementia and suicidal ideation. She was discharged from the hospital on 8/28/13. Her medical record contained the following:</p> <p>a. A "SECLUSION/PHYSICAL RESTRAINT/EMERGENCY USE OF MEDICATION PHYSICIAN ORDER FORM" documented a telephone order was received from the physician on 7/24/13 at 3:10 PM, for the use of physical restraint. The physician authenticated the order on 7/26/13 at 12:24 PM.</p> <p>b. A "SECLUSION/PHYSICAL RESTRAINT/EMERGENCY USE OF MEDICATION PHYSICIAN ORDER FORM" documented a telephone order was received from the physician on 8/08/13 at 8:00 PM, for the use</p>	A 450	<p>482.24(c)(1) Medical Records Services (Continued)</p> <p>4.) The Director of Nursing revised the QAPI Seclusion/Restraint tool to add the MD authentication review and completion to the tool. The tool was revised on October 31, 2013 and identified the MD authentication review and completion requirement for this standard. The Director of Nursing will complete the analysis of the QAPI results.</p> <p>5.) The Director of Nursing developed an informational flowsheet to provide a visual clinical decision pathway for authentication completion for all Seclusion/Restraint episodes. This flowsheet addresses the process flow for completion of all requirements for seclusion/restraint including the authentication of the original MD order. The flowsheet was revised on October 31, 2013. The flowsheet was posted in the RN Supervisor Office for reference as well a copy located in the RN Supervisor master binder for ease of access and review. (see Attachment B and C)</p> <p>Monitoring:</p> <p>1.)The DON/RN Manager will review 100% of all seclusion/restraint episodes for completion of the requirement for documentation of MD authentication of the original MD order. The Seclusion/Restraint QAPI tool will be reviewed and the outcome for MD authentication will be assessed.</p>	10/31/2013	10/31/2013

Initiated:
11/1/2013
Target Date:
1/31/2014

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

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A 450	Continued From page 3 of physical restraint and Haldol Decanoate 50 mg IM. The physician authenticated the order on 8/12/13, untimed. The DON reviewed the record and was interviewed on 10/16/13 beginning at 1:35 PM. She confirmed the physician had not authenticated the orders within 24 hours in accordance with medical staff rules. Verbal orders for restraint or seclusion were not authenticated.	A 450	482.24(c)(1) Medical Records Services (Continued) The DON will trend the QAPI tool results including a MD specific review of authentication of seclusion/restraint MD orders and present these findings in the MD Peer Review meeting which will occur monthly. 2.)The DON or Supervisor/Manager finding seclusion/restraint MD Orders not authenticated within 24 hours, will immediately contact the ordering MD/Attending MD or MD on-call for completion of the MD order. 3.)Trending of the seclusion/restraint authentication QAPI review will be presented and reviewed at the Quality Council Committee meetings and presented at Peer Review/MEC meetings on a monthly basis. The Board of Governors will review the data during the 2014 First Quarter meeting in January 2014.	Initiated: 11/1/2013 Target Date: 1/31/2014 Initiated: 11/1/2013 Target Date: 1/31/2014	



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November 4, 2013

COPY

Jeff Morrell, Administrator
Intermountain Hospital
303 North Allumbaugh Street
Boise, ID 83704

RE: Intermountain Hospital, Provider #134002

Dear Mr. Morrell:

On **October 17, 2013**, a complaint survey was conducted at Intermountain Hospital. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00006028

Allegation #1: A patient was moved to a seclusion room without cause, and staff did not respond to his gestures for help.

Findings #1: An unannounced visit was made to the hospital on 10/15/13 through 10/17/13. During the survey, hospital policies and patient records were reviewed, and staff interviews were conducted.

One medical record documented a 44 year old male admitted to the hospital for detoxification from opiates on 3/19/13 and discharged 3/21/13.

A Nursing Flow Sheet dated 3/20/13 stated, "The patient had increased detox signs and symptoms, restlessness, anxiety, agitation, sweats, and tremors. Patient medicated with Robaxin, Ibuprofen, Clonidine, Phenergan and Bentyl."

On 3/20/13 at 2:00 PM, a Physician's Order sheet stated, "Transfer to ICU".

Beginning at 2:10 PM on 3/20/13, the RN documented on the Nursing Flow Sheet "Patient transferred to ICU for closer observation." On 3/20/13, untimed, the RN's PM nursing reassessment reported, "Patient is pale, miserable, Ativan 1 mg PO administered X 2 no reportable relief." The night shift RN reassessment for 3/20/13, documented at 5:30 AM, stated, "Slept through the night."

A Patient Observation Record dated 3/20/13, documented patient's behavior and location every 15 minutes. While in the ICU, the patient was documented as at the nurses' station at 5:30 and 5:45 PM. The night shift RN documented, "The patient slept throughout the night."

The policy "Level of Observation Orders", dated March 2000, stated, "All patients will be closely observed in compliance with physician orders and prescribed protocols". The policy also stated "...minimum level of observation for all patients and staff will observe patients and document on the Patient Observation Record q 15 minutes."

An RN was interviewed on 10/17/13 beginning at 10:10 AM. She confirmed her assessment that the patient's detox signs and symptoms were in need of closer observation. She got a physician's order to move the patient to the ICU. She also stated while a patient is in an observation room, the door is unlocked and the door opens to the nursing station. She also confirmed a staff member is always at the nursing station, observing and documenting every 15 minutes.

There was no evidence that the patient was moved without cause or his needs not responded to.

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: A patient received only 1 juice and 1 yogurt and was not provided an opportunity to use the bathroom, while in seclusion.

Findings #2: An unannounced visit was made to the hospital on 10/15/13 through 10/17/13. During the survey, a hospital tour was completed and patient records were reviewed, and staff interviews were conducted.

One medical record documented a 44 year old male admitted to the hospital for detoxification from opiates on 3/19/13 and was discharged 3/21/13.

A Nursing Flow Sheet dated 3/20/13, stated, "Patient had increased detox signs and symptoms, restlessness, anxiety, agitation, sweats, and tremors, patient is tossing and turning in bed. Patient medicated with Robaxin, Ibuprofen, Clonidine, Phenergan and Bentyl."

On 3/20/13 at 2:00 PM, a Physician's Order sheet stated, "Transfer to ICU".

At 2:10 PM on 3/20/13, the RN documented on the Nursing Flow Sheet, "Patient transferred to ICU for closer observation, patient ate half of his soup for lunch and a glass of water, and encouraged patient to increase fluid intake." The night shift RN reassessment, documented at 5:30 AM on 3/21/13, stated, "Slept through the night."

A Patient Observation Record dated 3/20/13, documented the patient's behavior and location every 15 minutes. While in ICU observation, the patient was documented as at the nurses' station at, 5:30 and, 5:45 PM. The night shift RN documented "Patient slept throughout the night".

Also noted, at 7:15 AM on 3/21/13, the patient was in the bathroom.

The policy "Level of Observation Orders", dated March 2000, stated, "All patients will be closely observed in compliance with physician orders and prescribed protocols." The policy also stated, "...minimum level of observation for all patients and staff, will observe patients' and document on the Patient Observation Record q (every) 15 minutes."

An RN was interviewed on 10/17/13 beginning at 10:10 AM. She stated when the patient is awake and checked on they are asked if they need to use the bathroom or want anything to eat or drink.

There was no evidence that staff did not provide the patient an opportunity for food, drinks or the use of the bathroom while in the observation room.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: Upon discharge the hospital did not return a patient's medications he brought on admission.

Findings #3: An unannounced visit was made to the hospital on 10/15/13 through 10/17/13. During the survey, hospital policies and patient records were reviewed, and staff interviews were conducted.

One medical record documented a 44 year old male admitted to the hospital for detoxification from opiates on 3/19/13, and was discharged 3/21/13.

The patient's medical record documented a hospital form titled "Return of patient's medications." The document stated, "I acknowledge that my receipt of my outpatient prescription drugs may not be consistent or compliant with my discharging physician's medication orders. I grant (Name Hospital) the authority to destroy any prescription medications I do NOT take in return."

The patient's medical record documented a hospital form titled "Return of patient's medications". It stated on 3/21/13, the patient signed and printed his name acknowledging the hospital's receipt of his outpatient prescription drugs. The type, dosage, and number of the medications documented on the form included 50 Soma 350 mg., 66 Norco 10/325, 51 Oxcontin 40 mg., and 10 Ambien 10 mg. Two RN's cosigned verifying the patient's signature on 3/21/13.

It could not be determined through the investigative process, the hospital withheld medications upon discharge without the patient's written acknowledgement.

Conclusion #3: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: A patient called the hospital after discharge to file a complaint, but did not receive a response.

Findings #4: An unannounced visit was made to the hospital on 10/15/13 through 10/17/13. During the survey, hospital policies and patient records were reviewed, and staff interviews were conducted. Grievance documents and logs were reviewed.

One medical record documented a 44 year old male admitted to the hospital for detoxification from opiates on 3/19/13 and was discharged 3/21/13.

The policy "Patient Grievance" dated November 2008 stated, "...patient grievance is those issues presented by patients, family members, staff and/or visitors that due to their very nature require the attention of staff members to resolve the issue. Issues that cannot be resolved on an immediate basis and need further review/and administrative staff involvement will be considered a grievance. All patient grievances will be investigated in the specified time frame and results of the investigation reported back to the complainant."

The Patient Advocate was interviewed on 10/17/13 at 8:40 AM. She stated, all complaint calls are forwarded to her during regular business hours and when a call is received, it is documented in the Patient Advocate log book. After business hours, the nursing supervisor takes all complaint calls. If a complaint cannot be resolved, it is forwarded to the Director Performance Improvement/Risk Management. The Patient Advocate log book was reviewed for grievances, and the patient's grievance was not found.

An interview with the Director of Performance Improvement/Risk Management was completed on 10/17/13 at 9:30 AM. She stated that upon admission, patients receive a complaint hotline number and these calls are fielded by the patient advocate or nursing supervisor. She said they try to resolve the problem at their level. If the issues are not resolved, it will be forwarded to administration.

The Director of Social Services was interviewed on 10/17/13 at 11:05 AM, and stated, all patients are called for a follow up after discharge. She provided documentation of a telephone log showing the patient was called on 3/22/13, with no answer and, twice on 3/25/13 with no answer.

Additional patient grievances reviewed were appropriately documented and responded to by the facility.

It could not be verified through the investigative process that the patient filed a complaint and did not receive a response.

Conclusion #4: Unsubstantiated. Lack of sufficient evidence.

Jeff Morrell, Administrator
November 4, 2013
Page 5 of 5

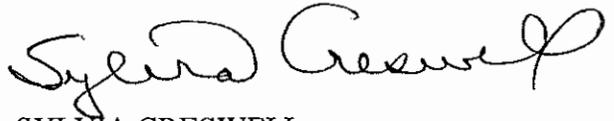
As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

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

Sincerely,



LIBBY DOANE
Health Facility Surveyor
Non-Long Term Care



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

LD/pt