

FILE COPY



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

CERTIFIED MAIL: 7007 3020 0001 4038 9772

November 5, 2014

Judy Moore, Administrator
Safe Haven Hospital Of Treasure Valley
8050 Northview Street
Boise, ID 83704

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

Dear Ms. Moore:

Based on the survey completed at Safe Haven Hospital Of Treasure Valley, on October 17, 2014, by our staff, we have determined Safe Haven Hospital Of Treasure Valley, is out of compliance with the Medicare Hospital Conditions of Participation of **Governing Body (42 CFR 482.12)**, **Nursing Services (42 CFR 482.23)** and **Infection Control (42 CFR 482.42)**. 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 these conditions to be unmet, substantially limit the capacity of Safe Haven Hospital Of Treasure Valley, 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;

Judy Moore, Administrator
November 5, 2014
Page 2 of 2

- 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 each form.

Such corrections must be achieved and compliance verified by this office, before December 1, 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 November 23, 2014.

Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **November 18, 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/pmt

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



November 18, 2014

Sylvia Creswell
Health Facility Surveyor
Non-Long Term Care
Bureau of Facility Standards
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009

RECEIVED
NOV 18 2014
FACILITY STANDARDS

Dear Ms. Creswell,

Enclosed please find our Plan of Correction for the survey conducted on October 17, 2014. The Bureau of Facility Standard form and Plan of Correction response form is attached and identifies the standard, deficiency, action plan, education and monitoring process for each deficiency.

If you have any questions regarding this Plan of Correction, please do not hesitate to contact me.

Sincerely,

A handwritten signature in cursive script that reads "C Freeman".

Coty Freeman

RN, Chief Administrative Officer

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

PRINTED: 11/04/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134009	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/17/2014
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN HOSPITAL OF TREASURE VALLEY			STREET ADDRESS, CITY, STATE, ZIP CODE 8060 WEST NORTHVIEW STREET BOISE, ID 83704	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the complaint investigation of your Psychiatric Hospital completed 10/14/14 through 10/17/14. The surveyors conducting the survey were:</p> <p>Don Sylvester, RN, HFS, Team Leader Laura Thompson, RN, HFS Rebecca Lara, RN, HFS Susan Costa, RN, HFS</p> <p>The following acronyms were used in this report:</p> <p>CAO- Chief Administrative Officer CPT- Certified Psychiatric Technician DNS- Director of Nursing H.S.- at bedtime IM- Intramuscular LOC- Level of Consciousness LOS - Line of Sight LPN-Licensed Practical Nurse MAR- Medication Administration Record MD- Medical Doctor NP-Nurse Practitioner PRN- as needed Pt - Patient RBTO - Read Back Telephone Order RN-Registered Nurse TO - Telephone Order VO- Verbal Order</p>	A 000	<p>A000 Preparation and execution of this Plan of Correction is not an admission of denial or guilt nor does the provider agree with the conclusions set forth in the Statement of Deficiencies rendered by the Bureau. The Plan of Correction is prepared and executed simply as a requirement of federal and state law. We maintain that alleged deficiencies do not individually, or collectively, jeopardize the health and safety of our patients, nor are they of such character as to limit this provider's capacity to render adequate patient care. Furthermore, the provider asserts that it is in substantial compliance with regulations governing the operation and licensure of an acute psychiatric hospital, and this document, in its entirety, constitutes this providers claim of compliance.</p> <p>Completion dates are provided for the procedural procession purposes to comply with the state and federal regulations, and correlate with the most recent contemplated or accomplished corrective action. These dates do not necessarily correspond chronologically to the date the provider is under the opinion it was in compliance with the requirements of participation or that corrective actions were necessary.</p>	<p style="writing-mode: vertical-rl; transform: rotate(180deg);">RECEIVED NOV 18 2014 FACILITY STANDARDS</p>
A 043	<p>482.12 GOVERNING BODY</p> <p>There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the</p>	A 043	<p>A043 Safe Haven Hospital of Treasure Valley does have an effective governing body that is legally responsible for the conduct of the hospital. The hospital does have an organized governing body; the persons legally responsible for the conduct of the hospital carry out the functions specified in the part that pertains to the governing body.</p>	

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

C Freeman

TITLE

RN, CAO

(X6) DATE

11/18/14

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 043	<p>Continued From page 1 governing body ...</p> <p>This CONDITION is not met as evidenced by: Based on staff interview, review of medical records, Medical Staff Bylaws, policies, and Idaho Statutes and Administrative Rules it was determined the hospital's Governing Body failed to provide sufficient oversight to ensure patients were admitted by and under the care of a physician as required in Idaho; nursing services were provided consistent with patients' needs, and an ongoing comprehensive infection control program was developed and implemented. This resulted in the potential for significant adverse patient outcomes. Findings include:</p> <p>1. Refer to A064 as it relates to the Governing Body's failure to ensure medical staff bylaws were followed in order to provide quality healthcare to patients.</p> <p>2. Refer to A065 as it relates to the failure of the Governing Body to ensure all patients were under the care of a physician as required by Idaho Statutes, Idaho Administrative Rules, and Medical Staff Bylaws.</p> <p>3. Refer to A385 Condition of Participation of Nursing Services and associated standard level deficiencies as they relate to failure the Governing Body to ensure nursing services were provided and monitored consistent with patients' needs.</p> <p>4. Refer to A747 Condition of Participation of Infection Control as it relates to the failure of the Governing Body to ensure a hospital-wide infection control program was developed and implemented.</p>	A 043	<ol style="list-style-type: none"> 1. Refer to A064 2. Refer to A065 3. Refer to A0385 4. Refer to A0747 	

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A 043	Continued From page 2	A 043		
A 064	<p>These systemic negative practices seriously impede the ability of the hospital to provide safe and effective services.</p> <p>482.12(c)(1) CARE OF PATIENTS - PRACTITIONERS</p> <p>{ ...the governing body must ensure that the following requirements are met:}</p> <p>Every Medicare patient is under the care of:</p> <p>(i) A doctor of medicine or osteopathy (This provision is not to be construed to limit the authority of a doctor of medicine or osteopathy to delegate tasks to other qualified health care personnel to the extent recognized under State law or a State's regulatory mechanism);</p> <p>(ii) A doctor of dental surgery or dental medicine who is legally authorized to practice dentistry by the State and who is acting within the scope of his or her license;</p> <p>(iii) A doctor of podiatric medicine, but only with respect to functions which he or she is legally authorized by the State to perform;</p> <p>(iv) A doctor of optometry who is legally authorized to practice optometry by the State in which he or she practices;</p> <p>(v) A chiropractor who is licensed by the State or legally authorized to perform the services of a chiropractor, but only with respect to treatment by means of manual manipulation of the spine to correct a subluxation demonstrated on x-ray to exist; or</p> <p>(vi) A clinical psychologist as defined in §410.71 of this chapter, but only with respect to clinical psychologist services as defined in §410.71 of this chapter and only to the extent permitted by State law.</p>	A 064	<p>A064 Patient Specific: 1 of 4 Medicare patients (Patient # 11) were affected by this citation. This patient was discharged.</p> <p>Other Patients: The governing body will ensure that all Medicare patients admitted to Safe Haven Hospital of Treasure Valley are under the care of a doctor of medicine or clinical psychologist. All Medicare patients admitted by NPs or Allied Health Professionals that participate directly in the management and care of patients under the general supervision or direction of an active or associate appointee of the Medical Staff, furthermore, NPs and Allied Health Professionals cannot admit or discharge patients at the hospital solely by themselves. The governing body will ensure that all Medicare patients admitted, overseeing the care and discharged from the hospital will include supervision of the supervisory physician, which will include: Admission Orders, Factsheets, Initial Psychiatric Evaluation, Medical Consultation, Progress Notes, Master Treatment Plans and discharge orders.</p> <p>Hospital Systems: Safe Haven Hospital will continue to utilize and abide by the Medical Staff Bylaws that are currently in place. A Med Exce Meeting will be held on 11/21/2014 to discuss the current Medical Staff Bylaws and ensure that the NPs, Allied Health Professionals and all active and associate appointees of the Medical Staff understand the current bylaws, and what is</p>	

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A 064	<p>Continued From page 3</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of medical records and Medical Staff Bylaws It was determined the hospital's governing body failed to ensure 1 of 4 Medicare patients (Patient #11) whose records were reviewed, was under the care of a physician. This resulted in an NP admitting, overseeing the care of, and discharging a Medicare patient without evidence of physician oversight. Findings include:</p> <p>The hospital's Medical Staff Bylaws, undated, Article VII Section I: Exercise of Privileges stated, "In every case, a licensed physician will be responsible for the diagnosis and all medical care and treatment rendered to patients at this facility."</p> <p>The Medical Staff Bylaws classified NPs as Allied Health Professionals. The bylaws stated at Article VIII Allied Health Professionals, "...participate directly in the management and care of patients under the general supervision or direction of an active or associate appointee of the Medical Staff." The same section further stated Allied Health Professionals could not "admit or discharge patients at the hospital."</p> <p>The above Medical Staff Bylaws were not adhered to for Patient #11, as follows:</p> <p>Patient #11 was a 51 year old male admitted to the facility on 10/09/14, related to schizo affective disorder. The face sheet in his medical record stated his primary insurance was Medicare. The face sheet also listed the NP as the attending physician.</p> <p>Additionally, his medical record included the following forms, signed by the NP, which did not</p>	A 064	<p>expected of them. All medical staff unable to attend will receive individual education regarding these specific standards. On 11/18/2014 through 11/20/2014 the Chief Administrative Officer will meet with all Nursing Staff, Ward Clerks, Social Services Staff, Medical Records and Business Office staff to ensure that they understand the Medical Staff Bylaws in regards to admitting patients, overseeing the care of patients and discharging patients.</p> <p>Updated admission orders and discharge orders have been approved for use effective 11/18/2014. All nursing staff were educated and trained by the Chief Administrative Officer on these new orders that coincide with the above education related to the active and associate appointees of the Medical Staff overseeing the care of provided to patients by NPs and Allied Health Professionals.</p> <p>Monitoring: All admission charts will be audited at 24-hours and then again at 48-hours, by a member of the administrative nursing team to ensure proper admission processes and Medical Staff oversight. This will be standard practice and not just a monitoring process. We will maintain a monitoring log on all charts for this practice to document compliance. In addition, all admission charts will be audited on a weekly basis to ensure that all active and associate appointees of the Medical Staff are overseeing the care of NPs and Allied Health Professionals by auditing: Admission Orders, Factsheets, Initial Psychiatric Evaluations, Medical Consultations, Progress Notes, Treatment Plans, Treatment Team Meetings and Discharge Orders. These weekly audits will be completed for</p>		

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A 064	<p>Continued From page 4 included the signature of the supervisory physician:</p> <ul style="list-style-type: none"> - Initial Psychiatric Assessment dated 10/09/14. - Admission Orders-"Admit to the services of Dr: (name of NP), dated 10/09/14. - Medical Consultation-history and physical dated 10/10/14. - Progress Notes dated 10/10/14, 10/11/14, 10/12/14, 10/13/14, 10/14/14 and 10/15/14. - Master Treatment Plan dated 10/14/14. <p>Documentation of physician oversight of Patient #11's care was not found in his medical record.</p> <p>During an interview on 10/17/14 beginning at 12:00 PM, the Psychiatrist who was also the Medical Director confirmed the NP admitted patients and followed them through their hospitalization. He stated he indirectly provided oversight, as each patient is discussed during the Interdisciplinary Rounds on Wednesday mornings. He confirmed that he had no knowledge of Patient #11's admission to date. The Psychiatrist confirmed the bylaws specifically stated NP's cannot admit patients, and stated he would be able to adapt the bylaws to allow that activity.</p> <p>During an interview on 10/17/14 beginning at 3:30 PM, the NP confirmed she admitted patients and followed them through to discharge. She stated the Medical Director provided indirect oversight, however, she was unable to provide documentation in the patients' records to support</p>	A 064	<p>three months, by medical records. If there are any findings that do not abide by the Medical Staff Bylaws, the active and/or associate appointee of the Medical Staff that is responsible for overseeing the care of the NPs and/or Allied Health Professionals will be immediately notified for appropriate follow up. In addition, the Medical Director and the Chief Administrative Officer will receive notification of this breach, so that immediate corrective action can be put into place.</p>		

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A 064	Continued From page 5 her statement.	A 064	A065 Patient Specific: 2 of 12 patients (#9 and #11) These patients have been discharged.		
A 065	<p>The Governing Body did not ensure the care of Patient #11, whose primary insurance was Medicare, was under the care of a physician.</p> <p>482.12(c)(2) CARE OF PATIENTS - ADMISSION</p> <p>[...the governing body must ensure that the following requirements are met:] Patients are admitted to the hospital only on the recommendation of a licensed practitioner permitted by the State to admit patients to a hospital.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of medical records, Idaho Statutes and Administrative Code, and Medical Staff Bylaws, it was determined the hospital's governing body failed to provide the oversight necessary to ensure 2 of 12 patients (#9 and #11) whose records were reviewed, were admitted to the hospital by a licensed practitioner permitted by the State to admit patients to hospitals. The lack of oversight resulted in patients being admitted by the NP. Findings include:</p> <p>Idaho Code at 39-1301, includes a definition of a hospital. One section of the definition states a hospital is defined, in part, as a facility "...which is primarily engaged in providing, by or under the supervision of physicians, concentrated medical and nursing care ..." The same section of the Idaho Code defines a physician as "...an individual licensed to practice medicine and surgery by the Idaho state board of medicine or the Idaho state board of podiatry." The Idaho administrative rules for hospitals at IDAPA</p>	A 065	<p>Other Patients: The governing body will ensure that patients admitted to Safe Haven Hospital of Treasure Valley are admitted to the hospital only on the recommendation of a licensed practitioner permitted by the State of Idaho to admit patients to the hospital. NPs in Idaho are licensed consistent with IDAPA 23.01.01 Rules of the Idaho State Board of Nursing. Based on the above statutes and administrative rules, NPs may not independently admit patients to hospitals in Idaho. The governing body will ensure that all Medicare patients admitted to Safe Haven Hospital of Treasure Valley are under the care of a doctor of medicine or clinical psychologist. All Medicare patients admitted by NPs as Allied Health Professionals that participate directly in the management and care of patients under the general supervision or direction of an active or associate appointee of the Medical Staff, furthermore, NPs and Allied Health Professionals cannot admit or discharge patients at the hospital. The governing body will ensure that all Medicare patients admitted, overseeing the care and discharged from the hospital will include supervision of the supervisory physician, which will include: Admission Orders, Factsheets, Initial Psychiatric Evaluation, Medical Consultation, Progress Notes, Master Treatment Plans and discharge orders.</p> <p>All of the above statutes, administrative rules are currently addressed in Safe Haven's Medical Staff Bylaws and Safe Haven Governing Board will assure adherence to these bylaws through</p>		

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A 065	<p>Continued From page 6</p> <p>16.03.14.200.01.h. state: "The (Medical Staff) bylaws shall specify that every patient be under the care of a physician licensed by the Idaho State Board of Medicine." IDAPA 16.03.14.200.01.m, states "Patients being treated by nonphysician practitioners shall be under the general care of a physician." NPs in Idaho are licensed consistent with IDAPA 23.01.01 Rules of the Idaho State Board of Nursing. Based on the above statutes and administrative rules, NPs may not independently admit patients to hospitals in Idaho.</p> <p>The hospital's Medical Staff Bylaws, undated, Article VII Section I: Exercise of Privileges stated, "In every case, a licensed physician will be responsible for the diagnosis and all medical care and treatment rendered to patients at this facility."</p> <p>The Medical Staff Bylaws classified NPs as Allied Health Professionals. The bylaws stated at Article VIII Allied Health Professionals, "...participate directly in the management and care of patients under the general supervision or direction of an active or associate appointee of the Medical Staff." The same section further stated Allied Health Professionals could not "admit or discharge patients at the hospital."</p> <p>The above statutes, administrative rules, and Medical Staff Bylaws were not followed. Examples Include:</p> <p>1. Patient #9 was a 23 year old male admitted to the facility on 10/09/14, related to suicidal ideation. His discharge was ordered on 10/17/14.</p> <p>Patient #9's record included a face sheet which listed the attending physician as the NP.</p>	A 065	<p>continuing education and monitoring processes.</p> <p>The Chief Administrative Officer will meet with the Medical Staff at minimum of quarterly to assure understanding of the Admission guidelines and rules. This dialogue will be documented in the minutes of the meeting.</p> <p>Monitoring: All admission charts will be audited at 24-hours and then again at 48-hours, by a member of the administrative nursing team to ensure proper admission process and Medical Staff oversight. This will be standard of practice and not just a monitoring process. We will maintain a monitoring log on all charts for this practice to document compliance. In addition, all charts will be audited on a weekly basis to ensure that all active and associate appointees of the Medical Staff are overseeing the care of NPs and Allied Health Professionals by auditing: Admission Orders, Factsheets, Initial Psychiatric Evaluations, Medical Consultations, Progress Notes, Treatment Plans, Treatment Team Meetings and Discharge Orders. These weekly audits will be completed for three months, by medical records. If there are any findings that do not abide by the Medical Staff Bylaws, the active and/or associate appointee of the Medical Staff that is responsible for overseeing the care of the NPs and/or Allied Health Professionals will be immediately notified for appropriate follow up.</p> <p>Updated admission orders and discharge orders have been approved for use effective 11/18/2014. All nursing staff were educated and trained, by the Chief Administrative Officer, on these new orders that coincide</p>		

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A 065	<p>Continued From page 7</p> <p>Additionally, his record included forms titled Discharge Orders, Discharge Medication Orders, and Discharge Instructions, dated 10/17/14. They each indicated the NP was Patient #9's physician. Patient #9's record did not include documentation by the psychiatrist.</p> <p>During an interview on 10/17/14 beginning at 12:00 PM, the Psychiatrist who was also the Medical Director confirmed he was aware the NP admitted patients and continued to follow them through their hospitalization. He stated he indirectly provided oversight, as each patient is discussed during the Interdisciplinary Rounds on Wednesday mornings. Additionally, when asked if he knew the details of Patient #9's admission and course of treatment, he stated "No, I have never seen him." The Psychiatrist confirmed the Bylaws specifically stated NP's cannot admit patients.</p> <p>During an interview on 10/17/14 beginning at 3:30 PM, the NP confirmed she admitted patients and followed them through to discharge. She stated the Medical Director provided indirect oversight, however, she was unable to provide documentation in the patients' records to support her statement.</p> <p>The governing body did not ensure Patient #9 was admitted by a physician as required by Idaho Statutes, Idaho Administrative Rules, and hospital Medical Staff Bylaws.</p> <p>2. Patient #11 was a 51 year old male admitted to the facility on 10/09/14, related to schizoaffective disorder.</p>	A 065	with the above education related to the active and associate appointees of the Medical Staff overseeing the care of provided to patients by NPs and Allied Health Professionals.		

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A 065	<p>Continued From page 8</p> <p>Patient #11's medical record included a face sheet, which listed the attending physician as the NP.</p> <p>Additionally, his medical record included forms, which the NP had signed, but there were no supervisory physician signatures as follows:</p> <ul style="list-style-type: none"> - Initial Psychiatric Assessment dated 10/09/14. -Admission Orders-"Admit to the services of Dr: {name of NP}, dated 10/09/14. -Medical Consultation-history and physical dated 10/10/14. -Progress Notes dated 10/10/14, 10/11/14, 10/12/14, 10, /13/14, 10/14/14 and 10/15/14. -Master Treatment Plan dated 10/14/14. <p>Documentation of physician oversight of Patient #11's care was not found in his medical record.</p> <p>During an interview on 10/17/14 beginning at 12:00 PM, the Psychiatrist who was also the Medical Director confirmed the NP admitted patients and followed them through their hospitalization. He stated he indirectly provided oversight, as each patient is discussed during the Interdisciplinary Rounds on Wednesday mornings. He confirmed that he had no knowledge of Patient #11's admission to date. The Psychiatrist confirmed the Bylaws specifically stated NP's could admit patients, and stated he would be able to adapt the bylaws to allow that activity.</p> <p>During an interview on 10/17/14 beginning at 3:30</p>	A 065			

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A 065	Continued From page 9 PM, the NP confirmed she admitted patients and followed them through to discharge. She stated the Medical Director provided indirect oversight, however, she was unable to provide documentation in the patients' records to support her statement.	A 065			
A 123	The Governing Body did not ensure Patient #11 was admitted by a physician. 482.13(a)(2)(iii) PATIENT RIGHTS: NOTICE OF GRIEVANCE DECISION At a minimum: In its resolution of the grievance, the hospital must provide the patient with written notice of its decision that contains the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion. This STANDARD is not met as evidenced by: Based on review of hospital policies, medical records, and grievance information, and staff interviews, it was determined the hospital failed to ensure the hospital's grievance process included the expectation the hospital would provide written notice to patients that included required elements. This impacted 1 of 1 patient (#1) whose grievance was reviewed and had the potential to impact the clarity of resolution of grievances for all patients who filed grievances. Findings include: On 10/14/14, surveyors requested to view the grievance log for all grievances filed from 3/01/13 until 10/14/14.	A 123	A123 Safe Haven Hospital of Treasure Valley does provide patient's written notice of its decision that contains the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of the completion. Patient Specific: 1 of 1 patient (#1) This patient has been discharged. Other Patients: All new admissions to Safe Haven Hospital of Treasure Valley will ensure our hospital's current grievance process which expects a written notice to the patient within the allotted time, which includes the required elements. Per Safe Haven Hospital's policy this also includes another person filing the grievance or complaint on behalf of the patient. Hospital Systems: Upon receiving a grievance, written or verbal, Safe Haven Policy is followed. This policy includes: an immediate investigation is implemented. If a patient is at risk, the patient is protected, by the provision of privacy, 1:1 if necessary, room changes, placing employees on suspension pending investigation outcomes, etc. Once the investigation is complete, the		

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A 123	<p>Continued From page 10</p> <p>The grievance/complaint log was reviewed and included a grievance that was forwarded to the facility on 9/09/13, on behalf of Patient #1.</p> <p>Patient #1 was a 26 year old female admitted to the hospital on 8/20/13, and discharged on 9/20/13. The grievance log contained a summary of Patient #1's hospital stay, however, there was no evidence of contact with Patient #1. Additionally, the log did not include documentation an investigation was conducted or if Patient #1 was informed regarding resolution of the grievance.</p> <p>A "GRIEVANCE/COMPLAINTS" policy dated 4/2013, stated "The patient, or person filing the grievance complaint on behalf of the patient, will be informed of the investigation and the actions that will be taken to correct any identified problems. Such reports may be making orally by the Administrator or designee, within three working days of the filing of the grievance or complaint with the facility. A written summary of the report will also be provided to the patient, and a copy will be secured in the office of the Administrator."</p> <p>The CAO was interviewed on 10/16/14 at 2:00 PM. She stated the prior CAO should have taken responsibility for conducting an investigation and of responding to the complainant. She confirmed the grievance log for Patient #1 did not include documentation of a written response, and that Patient #1 or the complainant did not get a response.</p> <p>The facility did not respond in writing to a patient grievance.</p>	A 123	<p>patient is brought in for a discussion regarding outcomes, a formal letter is written, necessary discipline is handled, any legal, police, or governmental oversight matters are dealt with and reported accordingly.</p> <p>Each grievance will be reviewed in the monthly Med Exce Meeting and the monthly QAPI meeting. The grievances will also be shared in the quarterly Governing Board Meeting the information presented will include the grievance, action taken, including the date the follow up letter was sent or personally given to the patient or the person filing the grievance or complaint on behalf of the patient.</p> <p>Monitoring: All patient grievances will be reviewed in the monthly Med Exce Meeting and the monthly QAPI meeting to ensure that the current policy regarding patient grievances is followed and the appropriate follow up is met.</p> <p>All patient grievances will be forwarded to the Chief Administrative Officer or designee. The Chief Administrative Officer or designee will then forward the grievance to the QAPI Director to ensure that all policies and timelines are followed via the monitoring tool developed. This monitoring tool will be used to audit the grievances received for the next six months. Additional trends and analysis will be conducted by the QAPI committee as well as determination of further Quality Assurance activity as appropriate.</p>		

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A 385 A 385	Continued From page 11 482.23 NURSING SERVICES The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse. This CONDITION is not met as evidenced by: Based on staff interview and review of policies and clinical records, it was determined the hospital failed to ensure RN's appropriately monitored the care provided to patients to ensure their needs were met and practitioners were alerted to negative changes in patients' health status. This resulted in a lack of monitoring of medications administered, lack of assessment and reassessment of patients' conditions, and patients receiving more medications than ordered. Findings include: 1. Refer to A395 as it relates to the failure of the facility to ensure an RN provided sufficient supervision and oversight to ensure appropriate care was provided. 2. Refer to A457 as it relates to the failure of the facility to ensure nursing staff transcribed standing orders correctly. These systemic failures significantly impede the ability of the hospital to provide nursing services of sufficient scope and quality.	A 385 A 385	A385 Safe Haven Hospital of Treasure Valley does have an organized nursing service that provides 24-hour nursing services. The nursing services are furnished and supervised by a registered nurse. Safe Haven Hospital of Treasure Valley has hired a Chief Nursing Officer, Gretchen Gayle RN that will work fulltime, under the direction of the Chief Administrative Officer. This new CNO begins her fulltime position December 1, 2014. Monitoring: The new CNO will have weekly, documented meetings with the CAO to review her progress. The CNO and CAO will meet every two weeks with the COO, Judy L. Moore, RN, MSN/MBA/HC to discuss the transition of this new model, discuss development of the new processes, and further advance the hospital's best practice.		
A 395	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient.	A 395	A 395 Safe Haven Hospital of Treasure Valley does ensure an RN provides sufficient supervision and oversight to ensure appropriate care is provided. Safe Haven Hospital of Treasure Valley has hired a Chief Nursing Officer, Gretchen Gayle RN that will work fulltime, under the direction		

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A 395	<p>Continued From page 12</p> <p>This STANDARD is not met as evidenced by: Based on review of clinical records, hospital policies, and staff interviews, it was determined the facility failed to ensure an RN provided sufficient supervision and oversight to ensure appropriate patient care was provided for 7 of 12 patients (#3, #4, #6, #7, #9, #10, and #11) whose records were reviewed. This resulted in the potential for medication errors and deterioration in patients' medical conditions without interventions to occur. Findings include:</p> <p>1. A facility policy, titled "Charting," revised 5/01/13, stated all observations, medications given, and services performed must be recorded in the patient's record. The follow up of all observations, medications given, and services performed must also be documented in the record. The policy also stated all incidents, accidents, or changes in the patient's condition must be recorded. It further stated, all pertinent information must be relayed to the attending provider or on-call provider, and documentation of all communication must be noted in the record.</p> <p>A nursing services policy for nursing services titled "Daily Nursing Flow Sheets," revised 5/01/13, was reviewed. The policy stated the purpose of the nursing flow sheet was to provide a concise record of physical and psychological interventions and assessments. These policies were not followed. Examples include:</p> <p>a. Patient #10 was a 41 year old male admitted on 10/10/14. His diagnoses included schizoaffective disorder (a combination of hallucinations or delusions, and mood disorder symptoms, such as mania or depression), bipolar disorder (mood swings that range from the lows</p>	A 395	<p>of the Chief Administrative Officer. This new CNO begins her fulltime position December 1, 2014.</p> <p>Patient Specific: 7 of 12 patients (#3, #4, #6, #7, #9, #10, and #11) These patients have been discharged.</p> <p>Other Patients: Safe Haven Hospital of Treasure will ensure that all new admission are provided sufficient supervision and oversight from an RN, to ensure appropriate patient care is provided.</p> <p>Safe Haven Hospital has updated several of its nursing forms (see attachments) and nursing documentation practices to support the actual documentation from the RN and oversight signatures when LPNs are documenting.</p> <p>Hospital Systems: Safe Haven Hospital of Treasure Valley has updated The Daily Nursing Flow Sheet to coincide with the current policy and procedure titled, "Charting", and "Daily Nursing Flow Sheet".</p> <p>Safe Haven Hospital of Treasure Valley has updated the "Vital Signs Flow Sheet" which includes a section to ensure that the RN has followed up with Vital Signs that are out of parameters.</p> <p>Safe Haven Hospital of Treasure Valley has updated the PRN Medication Administration Form which includes sections for a summary for PRN administration of medications and a summary for the effectiveness of the PRN medication administered. This form will be utilized during treatment teams and nursing report to the physician to update them on the use of PRN medications.</p>		

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A 395	<p>Continued From page 13 of depression to the highs of mania), and alcohol and opiate detoxification.</p> <p>Patient #10's record contained a vital sign flow sheet. The flow sheet included instructions for staff to notify the RN immediately if vital signs fall outside of the listed parameters, which were at the top of the flow sheet. A systolic blood pressure lower than 90 or greater than 160 or a diastolic blood pressure lower than 50 or greater than 100 were two of the parameters listed. The flow sheet instructions noted that abnormal vital signs were to be reassessed and documented on the back of the flow sheet. The physician was to be notified if the repeated vital signs were also out of parameter.</p> <p>Patient #10's vital sign flow sheet contained the following entries:</p> <ul style="list-style-type: none"> - 10/12/14 at 10:20 AM, blood pressure of 86/49, (both out of parameter). - 10/13/14 at 8:30 AM, blood pressure of 87/59, (systolic below parameter). - 10/13/14 at 12:30 PM, blood pressure of 86/59, (systolic below parameter). <p>The vital sign flow sheet also had a column for the staff to indicate the RN was notified for vital signs that went outside the listed parameters. There was no documentation the RN was notified of the low blood pressure on 10/13/14 at 8:30 AM.</p> <p>A facility policy titled "Nursing Process- Vital Signs," revised 4/24/2014, stated "A daily assessment of vital signs is completed on every patient, unless there is reason to complete the vital signs more frequently. The RN assesses the</p>	A 395	<p>Safe Haven Hospital of Treasure Valley's updated Daily Nursing Flow Sheet now has a section for each assessment per shift for the RN to cosign if an LPN does complete a shift assessment.</p> <p>Education to all RN's and LPN's occurred on 11/18/2014 through 11/20/2014, the Chief Administrative Officer reviewed the current policies regarding, "Charting" and "Daily Nursing Flow Sheet" and the Daily Nursing Flow Sheet. The education also included the responsibilities of the nurse and what documentation is expected when providing and charting patient care.</p> <p>Education to all RN's, LPN's and psychiatric technicians occurred on 11/18/2014 through 11/20/2014, the Chief Administrative Officer reviewed all of the changes regarding the Vital Signs Flow Sheet and the nursing teams responsibilities and expectations regarding charting, proper notification of the physician after vital sign reassessment and patient care.</p> <p>Education to all RN's, LPN's and psychiatric technicians occurred on 11/18/2014 through 11/20/2014 by the Chief Administrative Officer reviewing respiratory status, respiratory rate, and proper documentation of patients that are on oxygen and the appropriate terms regarding nasal cannula and face mask.</p> <p>Education to all RN's occurred on 11/18/2014 through 11/20/2014 by the Chief Administrative Officer reviewing the importance of the RN's signature on documentation.</p> <p>Education to the RN's and LPN's occurred on 11/18/2014 through 11/20/2014</p>		

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A 395	<p>Continued From page 14</p> <p>patients' vital signs and refers significant problems to the MD or mid-level provider for follow-up, evaluation, and treatment if needed."</p> <p>Patient #10's vital sign flow sheet did not indicate his vital signs were reassessed. His record did not include documentation the physician or mid-level provider was notified regarding the low blood pressure measurements noted above on 10/12/14 and 10/13/14.</p> <p>During an interview on 10/17/14 beginning at 10:55 AM, the CAO reviewed Patient #10's record. She confirmed the low blood pressure measurements, as well as, the failure to reassess according to policy. The CAO also confirmed Patient #10's record did not include documentation the physician or mid-level provider were notified.</p> <p>Patient #10's low blood pressure was not reassessed, nor were the RN and physician notified as required by facility policies.</p> <p>b. Patient #7 was a 65 year old female admitted 10/08/14. Her diagnoses included schizoaffective disorder, pneumonia, and sleep apnea.</p> <p>On admission to the facility on 10/08/14, Patient #7's medical physician completed an H&P which included plans to continue antibiotic treatment, treatment with an Inhaler every 6 hours, and oxygen at 2 liters per minute to ease shortness of breath for her diagnosis of pneumonia. The physician also included a plan for Patient #7 to use her CPAP machine (a small machine that supplies a constant and steady air pressure through the nose or mouth) while sleeping for her sleep apnea.</p>	A 395	<p>introducing the new PRN medication administration form and the expectations of charting PRN medications that are administered. This information will be utilized in treatment team and report to the physicians to update them on PRN medications given to patients.</p> <p>Education was provided to all RN's and LPN's regarding the scope of practice for both RN's and LPN's and the RN's responsibility of providing oversight to LPN patient assessments.</p> <p>Monitoring: All charts will be audited weekly by a member of the administrative nursing team for accuracy and documentation with all charting. This will be an ongoing auditing process as part of QAPI.</p>		

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A 395	Continued From page 15 Patient #7's record also contained a physician order, dated 10/08/14, which stated she may use her own CPAP machine and to use oxygen at 2 liters by nasal cannula to keep oxygen saturation measurements greater than 93%. - A nursing assessment by an RN, dated 10/09/14 at 12:40 PM, documented Patient #7's respiratory status was not within normal limits. A section titled "Physical Assessment," on the nursing flow sheet, contained a checked box which indicated abnormal findings, and that further information about the assessment would be in the progress notes/treatment plan. The progress notes did not include what was abnormal regarding Patient #7's respiratory status. The RN's entry did not include an assessment of breath sounds, or if Patient #7 was experiencing shortness of breath at the time of the assessment. - A subsequent reassessment by an LPN, dated 10/09/14 at 1:20 AM, documented Patient #7 was not using the oxygen. Her oxygen saturation was measured at 92%. The LPN documented she assisted Patient #7 with resuming oxygen at 2 liters, but did not reassess her oxygen saturation or document if Patient #7's respiratory status had changed or improved. - A nursing assessment by an RN, dated 10/10/14 at 12:30 PM, documented Patient #7's respiratory status was not within normal limits. A section titled "Physical Assessment," on the nursing flow sheet, contained a checked box which indicated abnormal findings, and that further information about the assessment would be in the progress notes/treatment plan. The progress notes did not include what was abnormal regarding Patient #7's	A 395			

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A 395	<p>Continued From page 16 respiratory status.</p> <p>- A nursing assessment by an RN, dated 10/11/14 at 3:15 PM documented Patient #7's respiratory status was not within normal limits. A section titled "Physical Assessment," on the nursing flow sheet, contained a checked box which indicated abnormal findings, and that further information about the assessment would be in the progress notes/treatment plan. The progress notes did not include what was abnormal regarding Patient #7's respiratory status.</p> <p>- A reassessment by an RN, dated 10/12/14 at 3:30 AM, documented Patient #7's status had no changes. At 3:40 AM the RN documented Patient #7 was very congested and treated with medication. The RN documented at 4:00 AM, Patient #7's oxygen measurement was 88% and she continued to have nasal congestion. Patient #7 was again placed on oxygen at 2 liters by mask, and not nasal cannula, as ordered. At 4:10 AM the RN documented Patient #7's oxygen measurement was 91%. There was no documentation by the RN of further interventions or that the physician or mid-level provider was notified of Patient #7's respiratory changes.</p> <p>- A nursing assessment by an RN, dated 10/12/14 at 8:20 AM, documented Patient #7's respiratory status was not within normal limits. A section titled "Physical Assessment," on the nursing flow sheet, contained a checked box which indicated abnormal findings, and that further information about the assessment would be in the progress notes/treatment plan. The progress notes did not include what was abnormal regarding Patient #7's respiratory status.</p>	A 395			

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A 395	<p>Continued From page 17</p> <p>- A reassessment by an LPN, dated 10/13/14 at 3:15 AM, documented Patient #7 was restless and making grunting noises both while awake and asleep. Patient #7 was documented as using her CPAP machine. The LPN also documented Patient #7 was coughing, producing mucus. The note included that staff would continue to monitor for changes in her status. There was no further reassessment by nursing staff during that shift which ended at 7:00 AM 10/11/14.</p> <p>During an interview on 10/16/14 beginning at 3:30 PM, the CAO reviewed Patient #7's record. She confirmed Patient #7 was not reassessed by the nursing staff, per facility policy, after noting changes in her status. The CAO also confirmed Patient #7 was noted to receive oxygen by mask, rather than by nasal cannula as ordered. She stated she thought Patient #7 was placed back on oxygen per nasal cannula, and the LPN wrote mask by mistake.</p> <p>Patient #7 was not further assessed by nursing staff according to her changing needs.</p> <p>c. Patient #4's medical record documented a 58 year old female who was admitted to the facility on 9/01/13. Diagnoses included psychotic disorder and generalized anxiety disorder.</p> <p>- Patient #4's record included a form titled "FACE-TO-FACE ASSESSMENT FOR THE USE OF HOLD AND RESTRAINT" unsigned, undated and unlined. It documented Patient #4's behaviors of increased agitation, anxiety, paranoia, non-redirectable behavior, yelling out, and medication non-compliance. It could not be determined when the assessment was completed.</p>	A 395			

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A 395	<p>Continued From page 18</p> <ul style="list-style-type: none"> - Patient #4's MAR noted Klonopin, a PRN medication for anxiety, was administered 10/15/13 at 5:00 PM. The nursing flow sheet dated 10/15/13, did not include documentation of her anxiety, or of a reassessment of her anxiety after the Klonopin was administered. - Patient #4's MAR noted Klonopin was administered at 3:00 PM on 10/16/13. The nursing flow sheet dated 10/16/13, did not include documentation of her anxiety, or of a reassessment of her anxiety after the Klonopin was administered. - Patient #4's MAR noted Prolixin, a PRN medication for psychosis/agitation, was administered 10/16/13 at 3:30 PM. The nursing flow sheet dated 10/16/13, did not include documentation of her agitation or psychosis, or of a reassessment after the Prolixin was administered. <p>During an interview on 10/16/14 beginning at 3:45 PM, the CAO reviewed Patient #4's record. She confirmed the nurse did not sign, date or time Patient #4's face-to-face assessment for the use of a hold and restraint. She also confirmed reassessments were not documented after PRN medication administration.</p> <p>The facility failed to ensure an RN provided effective oversight of Patient #4's care.</p> <p>d. Patient #3 was a 27 year old male admitted to the facility on 11/09/13, for psychiatric care related to schizophrenia and autism.</p> <ul style="list-style-type: none"> - A nursing flow sheet, dated 11/09/13, did not 	A 395			

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A 395	<p>Continued From page 19</p> <p>include day shift assessment, evening reassessment, or night shift assessment notes or nursing signatures. The nursing narrative for 11/09/13 included a single entry timed at 8:20 PM, "Pt was placed on 1:1 LOS after receiving IM injection while awake. Will continue to monitor Pt." The narrative charting from 11/09/13 from 8:20 PM until 11:00 AM 11/10/13, did not include further indication of his condition after the chemical restraint was administered. There was no documented nursing assessment of Patient #3 from the time of his admission at 5:50 PM on 11/09/13 through 11:00 AM on 11/10/13.</p> <p>- A nursing flow sheet dated 11/10/13, did not include a pain assessment, or documentation of his bowel habits. The flow sheet included a section titled "PM Reassessment," which was blank. The section titled "Night Shift Assessment," included a single entry of "Pt is in his bed sleeping comfortably." The narrative section on the back of the flowsheet included an entry at 7:30 PM, "Pt had his mom and dad here to visit. Went well. Pt had 1:1 as ordered while awake. No negative behaviors."</p> <p>- A nursing flow sheet dated 11/12/13, did not include documentation of his bowel habits, or of a reassessment after Haldol was administered at 9:15 PM.</p> <p>- A nursing flow sheet dated 11/13/13, did not include documentation of his bowel habits, or reassessment after he received Klonopin at 7:00 PM, and Zyprexa at 7:10 PM for agitation. The flow sheet included a narrative note at 8:00 PM, which indicated Patient #3 continued to experience visual hallucinations, and he was given "multiple PRN medications for</p>	A 395			

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A 395	Continued From page 20 hallucinations and anxiety." There was no further documentation in Patient #3's record until the following day 11/14/13 at 9:45 AM. - A nursing flow sheet dated 11/14/13, did not include documentation of his bowel habits, or of reassessment after Klonopin was administered at 4:15 PM on that date. His medication sheet documented he received a dose of Klonopin at 10:00 PM the same day for anxiety, however the nursing progress notes did not indicate he was experiencing increased anxiety. There was no entry in the progress notes that Patient #3 was reassessed after the above PRN medications were administered. The progress notes did not include an entry from 11/14/13 at 4:15 PM until the following day 11/15/13 at 7:45 AM. - A nursing flow sheet dated 11/16/13, did not include documentation of a pain assessment, bowel habits and hydration status. His medication sheet indicated he received PRN Haldol on 11/16/13 at 11:00 AM, however, there was no indication of the reason for administration or of a reassessment in the progress notes. A progress note entry at 4:30 PM, noted PRN Zyprexa was administered for hallucinations and agitation, but there were no further entries in the progress notes until 11/16/13 at 12:30 PM. - A nursing flow sheet dated 11/17/13, did not include documentation of a pain assessment, bowel habits and hydration status. His medication sheet indicated he received Klonopin on 11/17/13 at 9:00 PM, for agitation. However, the progress notes did not include documentation or reassessment after the PRN was administered.	A 395			

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A 395	<p>Continued From page 21</p> <p>- A nursing flow sheet dated 11/18/13, did not include documentation of a pain assessment, bowel habits and hydration status. His medication sheet indicated he received Klonopin on 11/18/13 at 9:00 PM, for agitation. However, the progress notes did not include documentation or of a reassessment after the PRN was administered. Patient #3's progress notes for 11/18/13 included brief narrative notes timed at 11:00 AM and 12:00 PM. There was no further documentation until 11/19/13 at 1:15 PM.</p> <p>- A nursing flow sheet dated 11/19/13, did not include documentation of a pain assessment, bowel habits and hydration status. His medication sheet indicated he received Zyprexa on the same day at 11:25 AM, for agitation but the progress notes did not include documentation or of a reassessment after the prn was administered. His progress notes included a brief narrative note on 11/19/13 at 1:15 PM, and no further documentation until 11/20/14 at 11:45 AM.</p> <p>- A nursing flow sheet dated 11/20/13, included a narrative note at 11:45 AM. The nurse documented Patient #3 had a flat affect, and was attending group meetings. The nurse further noted he denied suicidal ideation or hallucinations. The progress notes did not include further assessments or documentation until 11/21/14 at 9:20 AM. Patient #3's medication sheet for 11/20/13 indicated he received Haldol at 8:00 AM, Zyprexa at 8:00 AM, Klonopin at 9:00 AM, and again at 1:30 PM, and Zyprexa at 6:00 PM. There was no indication why the medications were administered, and there were no reassessments after these PRN medications were administered.</p>	A 395			

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A 395	<p>Continued From page 22</p> <p>During an interview on 10/16/14 beginning at 4:30 PM, the VP of Operations reviewed Patient #3's record and confirmed the flow sheets did not include documentation by the nursing staff as related to pain, reassessments after PRN medications, and other assessment information that was left incomplete on the nursing flow sheets. She confirmed the medication sheets documented administration of PRN medications without further reassessments as to how effective the medications were.</p> <p>An RN did not ensure Patient #3 received care and services consistent with his needs.</p> <p>e. Patient #9 was a 23 year old male admitted to the facility on 10/09/14 for psychiatric care related to suicidal ideation.</p> <p>- A nursing flow sheet dated 10/10/14, included a single narrative note at 11:00 AM. The note described Patient #9 as being suicidal with a plan. The nurse reported Patient #9 had increased paranoia, was avoidant with staff and peers and felt like he would explode with anger. There was no further narrative documentation that day to indicate if Patient #9 demonstrated improvement or if further interventions were implemented.</p> <p>- A nursing flow sheet dated 10/11/14, included a single narrative note at 11:00 AM. The note included documentation that Patient #9 remained suicidal and depressed. There was no further narrative documentation that day by nursing staff.</p> <p>- A nursing flow sheet dated 10/12/14, included a single narrative note at 2:45 PM. The note included documentation that Patient #9 denied suicidal ideation, hallucinations, and was</p>	A 395			

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A 395	<p>Continued From page 23</p> <p>cooperative with staff. There were no further entries for that day, however, his medication sheet indicated he requested multiple prn medications. The MAR noted he was administered PRN medications three times on 10/12/14; Ativan at 4:16 PM, and 8:25 PM, for anxiety, and Trazodone at 8:25 PM for sleep. There was no documentation of reassessment after the medications were administered.</p> <p>- A nursing flow sheet dated 10/13/14, included a single narrative note at 1:40 PM. The note included documentation that Patient #9 denied suicidal ideation, hallucinations, and was oppositional with staff. There were no further entries for that day, however, his medication sheet indicated he received Ativan at 7:10 PM for anxiety. There was no documentation of reassessment after the PRN Ativan was administered.</p> <p>- A nursing flow sheet dated 10/14/14, included a single narrative note at 1:55 PM. The note included documentation that Patient #9 was oppositional during his assessment, but did become more cooperative during the shift. There were no further entries for that day, however, his medication sheet indicated he received Ativan at 11:35 PM, and at 8:30 PM, for anxiety. There was no documentation of reassessments after the PRN Ativan doses were administered.</p> <p>- A nursing flow sheet dated 10/15/14, included narrative entries at 10:00 AM and 12:00 PM. There were no further entries for that day, however, his medication sheet indicated he received multiple PRN medications. The MAR noted he was administered Ativan at 8:30 PM, and 8:50 PM, for anxiety, as well as, Trazodone</p>	A 395			

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A 395	<p>Continued From page 24 at 8:50 PM for sleep. There was no documentation of reassessments after the Ativan and Trazodone doses were administered.</p> <p>- A nursing flow sheet dated 10/16/14, included one narrative entry at 2:20 PM. His medication sheet indicated that on 10/16/14 he received Trazodone at 9:00 PM, and at 10:00 PM. There was no narrative to indicate a reassessment of Patient #9 was performed to evaluate the effectiveness of the PRN medications.</p> <p>During an interview on 10/17/14 beginning at 3:30 PM, the CAO reviewed Patient #9's record and confirmed reassessments after PRN medications were not documented. Additionally, she stated each shift was to document in the narrative section regarding patients' assessments and activities during the shift, and confirmed the record did not indicate that was happening.</p> <p>An RN did not ensure Patient #9 was assessed, reassessed, and monitored consistent with his needs.</p> <p>2. The facility staffing shifts were 7:00 AM - 7:00 PM and 7:00 PM - 7:00 AM. A policy titled "Daily Nursing Flow Sheets", effective 5/01/13, stated the RN will complete the required 12 hour assessment each shift. It further stated the RN will delegate appropriate tasks and interventions, and will ensure that pertinent sections of the flow sheet are completed.</p> <p>This policy was not followed. Examples include:</p> <p>a. Patient #11 was a 51 year old male, admitted to the facility on 10/09/14. His diagnoses included schizoaffective and audio hallucinations.</p>	A 395			

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A 395	<p>Continued From page 25</p> <ul style="list-style-type: none"> - On a nursing flow sheet dated 10/16/14, an RN signed the bottom of the flow sheet at 12:00 PM. However, an additional reassessment was signed by an LPN at 9:15 PM, and 10/17/14 at 5:00 AM. There was no documentation of an RN assessment on the 7:00 PM - 7:00 AM shift. - On a nursing flow sheet dated 10/12/14, an RN signed the bottom of the flow sheet at 9:25 AM, and reassessments were signed by an LPN at 9:30 PM, and 10/13/14 at 3:45 AM. There was no documentation of an RN assessment on the 7:00 PM - 7:00 AM shift. - On a nursing flow sheet dated 10/10/14, an RN signed the bottom of the flow sheet at 11:30 AM, and a PM reassessment was signed by an LPN at 9:30 PM. There was no documentation of an RN assessment on the 7:00 PM - 7:00 AM shift. <p>During an interview on 10/16/14 beginning at 3:30 PM, the CAO reviewed Patient #11's medical record and confirmed the assessments were not reviewed or co-signed by an RN as the policy indicated. She stated the RN must sign the patient assessment sheets every shift to indicate oversight.</p> <p>The facility did not ensure RNs provided oversight of LPN patient assessments.</p> <p>b. Patient #6 was a 50 year old female admitted to the facility on 10/07/14 for psychiatric care related to suicidal ideation.</p> <ul style="list-style-type: none"> - A nursing flow sheet dated 10/07/14, included assessments at 11:35 PM and 10/08/14 at 5:00 AM. Both assessments were signed by an LPN. 	A 395			

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A 395	<p>Continued From page 26</p> <p>The admission assessment on 10/07/14 was signed by an LPN, and did not include an RN countersignature. Patient #6's record did not include documentation of RN oversight or assessments during the 7:00 PM - 7:00 AM shift.</p> <p>- A nursing flow sheet dated 10/09/14, an RN signed the assessment at 12:40 PM, an LPN assessment was signed at 11:00 PM, and 10/10/14 at 5:00 AM. There was no documentation of an RN assessment on the 7:00 PM - 7:00 AM shift.</p> <p>- A nursing flow sheet dated 10/12/14, an RN signed the assessment at 7:30 AM, an LPN signed the assessment at 10:00 PM and 10/13/14 at 3:00 AM. There was no documentation of an RN assessment on the 7:00 PM - 7:00 AM shift.</p> <p>- A nursing flow sheet dated 10/13/14, an RN signed the assessment at 7:40 AM, an LPN signed the assessment 11:00 PM and on 10/14/14 at 5:00 AM. There was no documentation of an RN assessment on the 7:00 PM - 7:00 AM shift.</p> <p>- A nursing flow sheet dated 10/14/14, an RN signed the assessment at 9:10 AM, an LPN signed the assessment at 11:00 PM and on 10/15/14 at 5:00 AM. There was no documentation of an RN assessment on the 7:00 PM - 7:00 AM shift.</p> <p>During an interview on 10/16/14 beginning at 3:30 PM, the CAO reviewed Patient #6's record and confirmed the flow sheets did not include an RN assessment each shift. She reviewed the policy, and stated an RN is to sign each shift assessment for all patients.</p>	A 395		

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A 395	Continued From page 27 Patient #6's record did not include RN oversight as per facility policy. c. Patient #9 was a 23 year old male admitted to the facility on 10/09/14 for psychiatric care related to suicidal ideation. - A nursing flow sheet dated 10/13/14, an RN signed the assessment at 8:10 AM, and an LPN signed the assessment at 11:00 PM and on 10/14/14 at 5:00 AM. There was no documentation of an RN assessment on the 7:00 PM - 7:00 AM shift. - A nursing flow sheet dated 10/14/14, an RN signed the assessment at 10:25 AM, and an LPN signed the assessment at 11:00 PM and on 10/15/14 at 5:00 AM. There was no documentation of an RN assessment on the 7:00 PM - 7:00 AM shift. - A nursing flow sheet dated 10/15/14, an RN signed the assessment at 12:00 PM, and an LPN signed the assessment at 9:55 PM and on 10/16/14 at 6:00 AM. There was no documentation of RN assessments for each 12 hour shift. - A nursing flow sheet dated 10/16/14, an RN signed the assessment at 12:00 PM, and an LPN signed the assessment at 11:00 PM and on 10/15/14 at 5:00 AM. There was no documentation of RN assessments for each 12 hour shift. During an interview on 10/16/14 beginning at 3:30 PM, the CAO reviewed Patient #9's record and confirmed the flow sheets did not include an RN	A 395			

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A 395	<p>Continued From page 28</p> <p>assessment each shift. She reviewed the policy, and stated an RN is to sign each shift assessment for all patients.</p> <p>Patient #9's record did not include RN oversight as per facility policy.</p> <p>d. Patient #7 was a 65 year old female admitted 10/08/14. Her diagnoses included schizoaffective disorder, pneumonia, and sleep apnea (breathing periodically stops and starts while sleeping).</p> <p>- A nursing flow sheet dated 10/09/14, an RN signed the assessment at 1:00 PM, and an LPN signed the assessment at 11:00 PM and on 10/10/14 at 5:00 AM. There was no documentation of an RN assessment on the 7:00 PM - 7:00 AM shift.</p> <p>- A nursing flow sheet dated 10/12/14, an RN signed the assessment at 8:20 AM, and an LPN signed the assessment at 10:10 PM and on 10/13/14 at 3:15 AM. There was no documentation of an RN assessment on the 7:00 PM - 7:00 AM shift.</p> <p>- A nursing flow sheet dated 10/13/14, an RN signed the assessment at 12:20 PM, and an LPN signed the assessment at 11:00 PM and on 10/14/14 at 5:00 AM. There was no documentation of an RN assessment on the 7:00 PM - 7:00 AM shift.</p> <p>- A nursing flow sheet dated 10/14/14, an RN signed the assessment but did not include the time, and an LPN signed the assessment at 11:00 PM and on 10/15/14 at 5:00 AM. There was no documentation of an RN assessment on the 7:00 PM - 7:00 AM shift.</p>	A 395		

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NAME OF PROVIDER OR SUPPLIER SAFE HAVEN HOSPITAL OF TREASURE VALLEY		STREET ADDRESS, CITY, STATE, ZIP CODE 8050 WEST NORTHVIEW STREET BOISE, ID 83704		
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A 395	<p>Continued From page 29</p> <p>During an interview on 10/16/14 beginning at 3:50 PM, the CAO reviewed Patient #7's record and confirmed the flow sheets did not include an RN assessment each shift. She reviewed the policy, and stated an RN is to sign each shift assessment for all patients.</p> <p>Patient #7's record did not include RN oversight as per facility policy.</p> <p>e. Patient #10 was a 41 year old male admitted on 10/10/14. His diagnoses included schizoaffective disorder (a combination of hallucinations or delusions, and mood disorder symptoms, such as mania or depression), bipolar disorder (mood swings that range from the lows of depression to the highs of mania), and alcohol and opiate detoxification.</p> <p>- A nursing flow sheet dated 10/12/14, an RN signed the assessment at 9:05 AM, and an LPN signed the assessment at 11:00 PM and on 10/13/14 at 5:00 AM. There was no documentation of an RN assessment on the 7:00 PM - 7:00 AM shift.</p> <p>- A nursing flow sheet dated 10/13/14, an RN signed the assessment at 10:30 AM, and an LPN signed the assessment at 8:05 PM and on 10/14/14 at 5:00 AM. There was no documentation of an RN assessment on the 7:00 PM - 7:00 AM shift.</p> <p>During an interview on 10/16/14 beginning at 3:50 PM, the CAO reviewed Patient #10's record and confirmed the flow sheets did not include an RN assessment each shift. She reviewed the policy, and stated an RN is to sign each shift</p>	A 395		

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NAME OF PROVIDER OR SUPPLIER SAFE HAVEN HOSPITAL OF TREASURE VALLEY			STREET ADDRESS, CITY, STATE, ZIP CODE 8050 WEST NORTHVIEW STREET BOISE, ID 83704	
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A 395	Continued From page 30 assessment for all patients.	A 395		
A 457	<p>Patient #10's record did not include RN oversight as per facility policy.</p> <p>482.24(c)(1)(iii) CONTENT OF RECORD: STANDING ORDERS</p> <p>(3) Hospitals may use pre-printed and electronic standing orders, order sets, and protocols for patient orders only if the hospital:</p> <p>(i) Establishes that such orders and protocols have been reviewed and approved by the medical staff and the hospital's nursing and pharmacy leadership;</p> <p>(ii) Demonstrates that such orders and protocols are consistent with nationally recognized and evidence-based guidelines;</p> <p>(iii) Ensures that the periodic and regular review of such orders and protocols is conducted by the medical staff and the hospital's nursing and pharmacy leadership to determine the continuing usefulness and safety of the orders and protocols; and</p> <p>(iv) Ensures that such orders and protocols are dated, timed, and authenticated promptly in the patient's medical record by the ordering practitioner or another practitioner 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.</p> <p>This STANDARD is not met as evidenced by: Based on review of facility policies, record review, and staff interview, it was determined the facility failed to ensure nursing staff transcribed and processed standing orders correctly. This resulted in medication administration errors and</p>	A 457	<p>A 457 Safe Haven Hospital has established guidelines for all standing orders that are consistent with nationally recognized and evidenced-based guidelines. These orders have been approved by the medical staff, pharmacy and nursing leadership. All nursing staff have been educated on the correct process for using such orders.</p> <p>Patient Specific: 3 of 12 patients (#6, #9, and #10) These patients have been discharged.</p> <p>Other Patients: All new admission to Safe Haven Hospital of Treasure Valley will receive pre-printed standing orders to deviate medication administration errors and transcription/documentation errors. The pre-printed orders are now located directly on the physician orders to deviate medication administration errors and transcription/documentation errors.</p> <p>Hospital Systems: Safe Haven Hospital of Treasure Valley has updated the Physician Admission Orders to include the standing medication orders.</p> <p>Updated Detoxification Orders were updated with the appropriate verbage to deviate medication administration errors and transcription/documentation errors.</p> <p>Education to all RN's and LPN's occurred on 11/18/2014, the Chief Administrative Officer reviewed the form change with the</p>	

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A 457	<p>Continued From page 31</p> <p>transcription/documentation errors for 3 of 12 (#6, #9, and #10) patients whose records were reviewed. Findings include:</p> <p>A facility policy "Standing Orders," revised 10/2014, noted that standing orders are to be discouraged. The policy further stated each item from the standing order list must be ordered in writing and be identified as an order from the approved standing order list.</p> <p>During an interview on 10/17/14 beginning at 11:15 AM, the CAO described the facility's practice of using standing orders. She reviewed the hospital's standing orders. The CAO indicated patient records included a form titled "PHYSICIAN ORDERS AND MEDICATION RECONCILIATION," which she described as admission orders. The form included a section with a check box to indicate if standing orders were authorized. It also included space for the physician to state standing order medications that were not authorized.</p> <p>During the same interview, the CAO also provided a copy of what she described as "Standing Orders." The printed paper included a title "Standing Order Medications." The form was undated and not signed. The form stated "The list below are the standing order medications for Safe Haven Hospital of Treasure Valley. Please note that these are not listed on the admission orders. If a patient needs an order for one of the standing order medications, you must also write an order on the Physician Orders."</p> <p>The form included an example of how the nursing staff was to write the order. The example included instructions to write the selected order</p>	A 457	<p>nurses including their responsibilities when admitting patients and utilizing standing order medications.</p> <p>Monitoring: All admission orders will be audited within 24 hours by a member of the administrative nursing team to ensure accuracy of documentation and to deviate medication administration errors and transcription/documentation errors.</p>		

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A 457	<p>Continued From page 32</p> <p>as a TORB (telephone order read back), followed by the practitioner's name and then the name of the nurse who was transcribing the order. During the interview with the CAO, she confirmed the standing orders were transcribed as telephone orders, although no telephone call from the practitioner would have occurred.</p> <p>The standing order practices at the facility resulted in medication errors and the potential for additional errors to occur. Examples include:</p> <p>1. Patient #9 was a 23 year old male, admitted on 10/09/14, for care related to suicidal ideation. His admission orders included a check mark beside the words "Standing Order Medications," indicating the use of standing orders were authorized.</p> <p>Patient #9's admission orders included Trazodone, 50 mg to be taken each night as needed, for sleep. The record indicated the dose could be given once, but not to be repeated.</p> <p>Patient #9's MAR documented Trazodone was administered on 10/12/14 at 10:25 PM, and on 10/16/14 at 8:00 PM.</p> <p>A second MAR, with PRN medication administration documentation written in a different format, stated Patient #9 received Trazodone on 10/12/14 at 10:25 PM, 10/15/14 at 8:00 PM, and again at 8:50 PM, and 10/16/14 at 9:00 PM and 10:00 PM.</p> <p>When the MAR and the additional MAR with PRN medication administration were reviewed together, the documentation indicated that on 10/15/14, Patient #9 received 2 doses of</p>	A 457			

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A 457	<p>Continued From page 33</p> <p>Trazodone - at 8:00 PM, and again at 8:50 PM. Additionally, on 10/16/14, Patient #9 recieved Trazodone at 8:00 PM, 9:00 PM, and at 10:00 PM, a total of 3 doses.</p> <p>The hospital's standing orders stated Trazodone could be given PRN for insomnia and if the first dose was ineffective, a second dose could be given one hour after the first one. Patient #9's record did not include documentation the standing orders were implemented. His record included only the initial order for Trazadone 50 mg (once, not to be repeated).</p> <p>The CAO reviewed Patient #9's record on 10/17/14 at 11:15, and confirmed the standing order for trazodone was not transcribed. She also confirmed the first MAR was incorrect and that since the standing order was not transcribed and authenticated, the extra doses of Trazodone on 10/15/14 and 10/16/14 were administered without an order.</p> <p>Patient #9's record indicated standing orders were not transcribed and authenticated, therefore, he received medications without an order.</p> <p>2. Patient #6 was a 50 year old female admitted to the facility on 10/07/14 for psychiatric care related to suicidal ideation. Her admission orders included a check mark beside the words "Standing Order Medications, with the Exception of Trazodone- it is scheduled."</p> <p>Patient #6's admission orders dated 10/07/14, included Trazodone, 150 mg to be taken every night for sleep. It was written as a routine order, not as a prn.</p>	A 457			

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A 457	<p>Continued From page 34</p> <p>However, Patient #6's medication tracking record indicated Trazodone 50 mg was transcribed from the standing orders list in error, and placed on the PRN medication list to be given nightly with an additional dose given if needed. The additional doses of Trazodone, if given, would result in a total of 250 mg nightly.</p> <p>During an interview on 10/16/14 beginning at 3:30 PM, the CAO reviewed Patient #9's record and confirmed the standing orders for Trazodone were transcribed in error.</p> <p>Trazodone was transcribed to Patient #6's medication sheet in error, creating the potential for the medication to be given without an order.</p> <p>3. Patient #10 was a 41 year old male admitted on 10/10/14. His diagnoses included schizoaffective disorder, bipolar disorder, and alcohol and opiate detoxification.</p> <p>A pre-printed physician order form for opioid detoxification was in Patient #10's record. The form contained orders for medications to be administered as needed, if Patient #10 was observed with symptoms of withdrawal. The form was signed by the psychiatrist on 10/10/14 at 2:05 PM. It was also signed by the RN, but no date or time was documented.</p> <p>The pre-printed orders contained an order for Trazodone with a possible error in how it was written. The order read "Trazodone 50 mg by mouth h.s. prn insomnia, M/Respirations x1 in 1 hour if the first dose is ineffective."</p> <p>Patient #10's MAR included Trazodone, which</p>	A 457			

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A 457	Continued From page 35 was transcribed as "50 mg (PO) QHS PRN. May repeat X 1 (after) 1 (hour) if needed." The MAR indicated he received Trazadone 50 mg by mouth on 10/10/14 at 9:05 PM and again on 10/10/14 at 10:05 PM. His record did not include documentation to indicate the Tradodone order was clarified before transcription and administration. During an interview on 10/17/14 beginning at 10:55 AM, the CAO reviewed Patient #10's record, including the pre-printed order form for opioid detoxification. She stated the word "Respirations" was a typo, and the order should have read as "May repeat once in 1 hour if the first dose is ineffective." Additionally, the CAO confirmed the record did not indicate the order was clarified before transcription or administration.	A 457			
A 747	482.42 INFECTION CONTROL The facility failed to ensure orders were clearly written, and if not, the orders clarified by nursing staff prior to administration of the medication. The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active program for the prevention, control, and investigation of Infections and communicable diseases. This CONDITION Is not met as evidenced by: Based on staff interview and review of infection control documents and personnel files, it was determined the facility failed to ensure an active program for the prevention, control, and investigation of infections and communicable	A 747	A747 Safe Haven Hospital of Treasure Valley does provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There is an active program for prevention, control and investigation of infections and communicable diseases. This program has been fully implemented and all staff have been reeducated on the process. This education took place 11/18/2014 and 11/20/2014 by the QAPI/Infection Control Nurse. 1. Refer to A748 2. Refer to A749		

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A 747	Continued From page 36 diseases, was developed and implemented. This resulted in the inability of the hospital to protect patients and personnel from infections and communicable diseases. Findings include: 1. Refer to A748 as it relates to the failure of the facility to appoint a trained infection control officer. 2. Refer to A749 as it relate to the failure of the facility to develop and implement a hospital-wide infection control program for the prevention, identification, investigation, and control of infections and communicable diseases of patients and personnel. This systemic failure seriously impedes the ability of the hospital to provide care of sufficient scope and quality.	A 747			
A 748	482.42(a) INFECTION CONTROL OFFICER(S) A person or persons must be designated as infection control officer or officers to develop and implement policies governing control of infections and communicable diseases. This STANDARD is not met as evidenced by: Based on staff interview and review of personnel files, it was determined the hospital failed to ensure the appointment of a trained infection control officer. This resulted in the failure of the facility to 1) to perform surveillance activities, 2) evaluate and trend results of infections occurring in the facility, and 3) implement education and training to staff. Findings include: During an interview on 10/17/14 beginning at 3:00	A 748	A748 Safe Haven Hospital of Treasure Valley does have a person designated as an Infection Control Officer to develop and implement policies governing control of infections and communicable diseases. Safe Haven Hospital of Treasure Valley does ensure the appointment of a trained Infection Control Officer. Our hospital does 1) perform surveillance activities 2) evaluates and trends results of infections occurring in the hospital, and 3) implements education and training to staff. Hospital Systems: The Chief Administrative Officer has created a log of training, including all education/training provided to the Infection Control Officer. The Infection Control Officer accepted the position October 1, 2014 and was in training at the time of the survey that was conducted at Safe Haven Hospital of Treasure Valley.		

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A 748	Continued From page 37 PM the CAO identified the RN who was the infection control officer. The RN's personnel file was reviewed and contained no evidence of specialized training in infection control. During the same interview, the CAO confirmed the facility did not have a trained infection control officer.	A 748	The Infection Control Officer will continue to receive further training and education throughout his employment at Safe Haven Hospital of Treasure Valley, to remain current with updates regarding both infection control and QAPI.	
A 749	The facility did not have a trained infection control officer. 482.42(a)(1) INFECTION CONTROL PROGRAM The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel. This STANDARD is not met as evidenced by: Based on observation, staff interview, and infection control logs, it was determined the facility failed to ensure an active program was in place for the prevention, control, and investigation of infections and communicable diseases. This resulted in the failure to investigate, identify trends, and educate staff regarding infection control practices. Findings include: The facility did not maintain an active program for the prevention, control, and investigation of infections and communicable diseases. During an interview on 10/17/14 beginning at 2:10 PM the CAO was asked about the facility's infection control program. A request was made to view any staff training, infection logs, or QAPI data related to the infection control program for	A 749	Training and Education for all staff will include: the hospital's current surveillance activities, evaluation of trends and results of infections occurring in the hospital, and specific educational series regarding best practice methods regarding infection control. Education: All staff were reeducated on the Infection Control Program and QAPI by the QAPI/Infection Control Nurse on 11/18/2014 through 11/20/2014. Monitoring: All in-services held by the QAPI/Infection Control Nurse are submitted to the QAPI committee for review. Recommendations for additional training for the staff or additional surveillance will be made at that time by the committee. A749 Safe Haven Hospital has a system for identifying, reporting, investigating and controlling infections and communicable diseases of patients and personnel. This system is carried out at the direction of the Infection Control Nurse and reported through the QAPI process to QAPI committee members monthly and to the Governing Board on a quarterly basis for review.	

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A 749	Continued From page 38 August and September of 2014. The CAO brought in an infection control log book which contained no data for August and September of 2014. The CAO was asked to bring the data she was working on for August and September. The CAO returned with blank audit tool forms which she stated were to be revised and used for the program eventually. The CAO confirmed nothing had been done with infection control since 8/01/14. The hospital failed to develop and implement processes to protect patients and personnel from infections.	A 749	Safe Haven Hospital of Treasure Valley does maintain an active program for the prevention, control, and investigation of infections and communicable diseases. Safe Haven Hospital does develop and implements processes to protect patients and personnel from infections. Hospital Systems: Safe Haven Hospital of Treasure Valley at the time of survey and currently has policy and procedures in place regarding systems utilized for identifying, reporting, investigating and controlling infections and communicable diseases of patients and personnel. Our hospital currently has an active program for prevention, control and investigation of infections and communicable diseases. Our hospital currently develops and implements processes to protect patients and personnel from infections. At the time of survey a new QAPI/Infection Control Nurse had been put into place to replace the previous nurse that had been in the position. The new QAPI/Infection Control Nurse was in training and had not yet implemented any of the policies he had been trained on. He has now moved forward with the program and has the Infection Control Program in place and up to date. Monitoring: The administrative nursing team will validate policy and procedures are followed by reviewing patient records. Any concerns will be addressed immediately and discussed with the QAPI committee as indicated per policy. Audits of patient records will be conducted by the administrative nursing team weekly for two months then monthly for two months,		

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER
SAFE HAVEN HOSPITAL OF TREASURE VALLEY

STREET ADDRESS, CITY, STATE, ZIP CODE
8050 WEST NORTHVIEW STREET
BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
B 000	16.03.14 Initial Comments The following deficiencies were cited during the complaint investigation of your Psychiatric Hospital. The surveyors conducting the survey were: Don Sylvester, RN, HFS, Team Leader Laura Thompson, RN, HFS Susan Costa, RN, HFS Rebecca Lara, RN, HFS The following acronyms were used in this report: CAO- Chief Administrative Officer CPT- Certified Psychiatric Technician DNS- Director of Nursing H.S.- at bedside IM- Intramuscular LOC- Level of Consciousness LOS - Line of Sight LPN- Licenced Practical Nurse MAR- Medication Administration Record MD- Medical Doctor NP- Nurse Practitioner PRN- as needed PI - Patient RN- Registered Nurse	B 000	ensuring existing policy and procedure are met. Results of the audits will be reviewed by QAPI committee. The administrative nursing team may be instructed to adjust the frequency of monitoring as deemed necessary.	
BB116	16.03.14.200.01 Governing Body and Administration 200. GOVERNING BODY AND ADMINISTRATION. There shall be an organized governing body, or equivalent, that has ultimate authority and responsibility for the operation of the hospital. (10-14-88) 01. Bylaws. The governing body shall adopt bylaws in accordance with Idaho Code,	BB116		

RECEIVED
NOV 18 2014
FACILITY STANDARDS

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
CF Freeman RN, CAO 11/26/14

TITLE

(X6) DATE

STATE FORM 642 RX7711 If continuation sheet 1 of 0

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ID5ENT	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/17/2014
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STREET ADDRESS, CITY, STATE, ZIP CODE
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BOISE, ID 83704

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BB115	<p>16.03.14.200.01 Governing Body and Administration</p> <p>200. GOVERNING BODY AND ADMINISTRATION. There shall be an organized governing body, or equivalent, that has ultimate authority and responsibility for the operation of the hospital. (10-14-88)</p> <p>01. Bylaws. The governing body shall adopt bylaws in accordance with Idaho Code,</p>	BB115		

Bureau of Facility Standards
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BB115	<p>Continued From page 1</p> <p>community responsibility, and identify the purposes of the hospital and which specify at least the following: (10-14-88)</p> <p>a. Membership of Governing Body, which consist of: (12-31-91)</p> <p>i. Basis of selecting members, term of office, and duties; and. (10-14-88)</p> <p>ii. Designation of officers, terms of office, and duties. (10-14-88)</p> <p>b. Meetings, (12-31-91)</p> <p>i. Specify frequency of meetings. (10-14-88)</p> <p>ii. Meet at regular intervals, and there is an attendance requirement. (10-14-88)</p> <p>iii. Minutes of all governing body meetings shall be maintained. (10-14-88)</p> <p>c. Committees, (12-31-91)</p> <p>i. The governing body officers shall appoint committees as appropriate for the size and scope of activities in the hospitals. (10-14-88)</p> <p>ii. Minutes of all committee meetings shall be maintained, and reflect all pertinent business. (10-14-88)</p> <p>d. Medical Staff Appointments and Reappointments; (12-31-91)</p> <p>i. A formal written procedure shall be established for appointment to the medical staff. (10-14-88)</p>	BB115		

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BB115	<p>Continued From page 2</p> <p>ii. Medical staff appointments shall include an application for privileges, signature of applicant to abide by hospital bylaws, rules, and regulations, and delineation of privileges as recommended by the medical staff. The same procedure shall apply to nonphysician practitioners who are granted clinical privileges. (10-14-88)</p> <p>iii. The procedure for appointment and reappointment to the medical staff shall involve the administrator, medical staff, and the governing body. Reappointments shall be made at least biannually. (10-14-88)</p> <p>iv. The governing body bylaws shall approve medical staff authority to evaluate the professional competence of applicants, appointments and reappointments, curtailment of privileges, and delineation of privileges. (10-14-88)</p> <p>v. Applicants for appointment, reappointment or applicants denied to the medical staff privileges shall be notified in writing. (10-14-88)</p> <p>vi. There shall be a formal appeal and hearing mechanism adopted by the governing body for medical staff applicants who are denied privileges, or whose privileges are reduced. (10-14-88)</p> <p>e. The bylaws shall provide a mechanism for adoption, and approval of the organization bylaws, rules and regulations of the medical staff. (10-14-88)</p> <p>f. The bylaws shall specify an appropriate and regular means of communication with the medical</p>	BB115		

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BB115	<p>Continued From page 3 staff. (10-14-88)</p> <p>g. The bylaws shall specify departments to be established through the medical staff, if appropriate. (10-14-88)</p> <p>h. The bylaws shall specify that every patient be under the care of a physician licensed by the Idaho State Board of Medicine. (10-14-88)</p> <p>i. The bylaws shall specify that a physician be on duty or on call at all times. (10-14-88)</p> <p>j. The bylaws shall specify to whom responsibility for operations, maintenance, and hospital practices can be delegated and how accountability is established. (10-14-88)</p> <p>k. The governing body shall appoint a chief executive officer or administrator, and shall designate in writing who will be responsible for the operation of the hospital in the absence of the administrator. (10-14-88)</p> <p>l. Bylaws shall be dated and signed by the current governing body. (10-14-88)</p> <p>m. Patients being treated by nonphysician practitioners shall be under the general care of a physician. (10-14-88)</p> <p>This Rule is not met as evidenced by: Based on staff interview and review of medical records and Medical Staff Bylaws, it was determined the hospital's governing body failed to provide the oversight necessary to maintain the hospital in for compliance with Idaho statutes, administrative rules, and Medical Staff Bylaws.</p>	BB115		

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BB115	<p>Continued From page 4</p> <p>This had the potential to negatively impact the care of 2 of 12 patients (#9 and #11) whose records were reviewed. The lack of oversight had the potential to allow patients to be treated by unqualified personnel. Findings include:</p> <p>Idaho Code at 39-1301, includes a definition of a hospital. One section of the definition states a hospital is defined, in part, as a facility "...which is primarily engaged in providing, by or under the supervision of physicians, concentrated medical and nursing care ..." The same section of the Idaho Code defines a physician as "...an individual licensed to practice medicine and surgery by the Idaho state board of medicine or the Idaho state board of podiatry."</p> <p>The Idaho administrative rules for hospitals at IDAPA 16.03.14.200.01.h. state: "The (Medical Staff) bylaws shall specify that every patient be under the care of a physician licensed by the Idaho State Board of Medicine." IDAPA 16.03.14.200.01.m, states "Patients being treated by nonphysician practitioners shall be under the general care of a physician."</p> <p>The hospital's Medical Staff Bylaws, undated, Article VII Section I: Exercise of Privileges stated, "In every case, a licensed physician will be responsible for the diagnosis and all medical care and treatment rendered to patients at this facility."</p> <p>The Medical Staff Bylaws classified NPs as Allied Health Professionals. The bylaws stated at Article VIII Allied Health Professionals, "...participate directly in the management and care of patients under the general supervision or direction of an active or associate appointee of the Medical Staff." The same section further stated Allied Health Professionals could not "admit or discharge patients at the hospital."</p>	BB115		

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BB115	<p>Continued From page 5</p> <p>The above Statutes, Administrative Rules, and Medical Staff Bylaws were not followed. Examples include:</p> <p>1. Patient #9 was a 23 year old male admitted to the facility on 10/09/14, related to suicidal ideation. His discharge was ordered on 10/17/14.</p> <p>Patient #9's record included a face sheet which listed the attending physician as the NP.</p> <p>Additionally, his record included forms filled Discharge Orders, Discharge Medication Orders, and Discharge Instructions, dated 10/17/14. They each indicated the NP was Patient #9's physician. Patient #9's record did not include any documentation by the psychiatrist.</p> <p>During an interview on 10/17/14 beginning at 12:00 PM, the Psychiatrist who was also the Medical Director confirmed he was aware the NP admitted patients and continued to follow them through their hospitalization. He stated he indirectly provided oversight, as each patient is discussed during the Interdisciplinary Rounds on Wednesday mornings. Additionally, when asked if he knew the details of Patient #9's admission and course of treatment, he stated "No, I have never seen him." The Psychiatrist confirmed the bylaws specifically stated NP's cannot admit patients.</p> <p>During an interview on 10/17/14 beginning at 3:30 PM, the NP confirmed she admitted patients and followed them through to discharge. She stated the Medical Director provided indirect oversight, however, she was unable to provide documentation in the patients' records to support her statement.</p>	BB115		

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BB115	<p>Continued From page 6</p> <p>The governing body did not ensure Patient #9 was under the care of a physician.</p> <p>2. Patient #11 was a 51 year old male admitted to the facility on 10/09/14, related to schizoaffective disorder.</p> <p>Patient #11's medical record included a face sheet, which listed the attending physician as the NP.</p> <p>Additionally, his medical record included forms, which the NP had signed, but there were no supervisory physician signatures as follows:</p> <ul style="list-style-type: none"> - Initial Psychiatric Assessment dated 10/09/14. - Admission Orders-"Admit to the services of Dr: (name of NP), dated 10/09/14. - Medical Consultation-history and physical dated 10/10/14. - Progress Notes dated 10/10/14, 10/11/14, 10/12/14, 10/13/14, 10/14/14 and 10/15/14. - Master Treatment Plan dated 10/14/14. <p>During an interview on 10/17/14 beginning at 12:00 PM, the Psychiatrist who was also the Medical Director confirmed the NP admitted patients and followed them through their hospitalization. He stated he indirectly provided oversight, as each patient is discussed during the Interdisciplinary Rounds on Wednesday mornings. He confirmed that he had no knowledge of Patient #11's admission to date. The Psychiatrist confirmed the bylaws specifically stated NP's cannot admit patients, and stated he</p>	BB115		

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BB115	Continued From page 7 would be able to adapt the bylaws to allow that actively. During an interview on 10/17/14 beginning at 3:30 PM, the NP confirmed she admitted patients and followed them through to discharge. She stated the Medical Director provided indirect oversight, however, she was unable to provide documentation in the patients' records to support her statement. The Governing Body did not ensure Patient #11 was under the care of a physician.	BB115	Refer to A064 Refer to A065 Refer to A0385 Refer to A0747	
BB287	16.03.14.360.16 Standing Orders 16. Standing Orders. There shall be an annual review and approval of standing orders, and a current signed and dated copy of approved orders shall be available. This review shall be done by the medical staff or appropriate staff committee and there shall be evidence of the review, signed and dated by the designated authority. (10-14-88) This Rule is not met as evidenced by: Refer to A457.	BB287	Refer to A457	
BB539	16.03.14.540.02 Infection Control Program 02. Infection Control Program. The program shall include at least the following elements: (10-14-88) a. Definition of nosocomial infection, as opposed to community acquired infections; and (10-14-88) b. A procedure for hospital surveillance of and for nosocomial infections; and (10-14-88)	BB539	Refer to A749	

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BB539	Continued From page 8 c. A procedure for reporting and evaluating nosocomial infections. The procedure must enable the hospital to establish the following on at least a quarterly basis: (10-14-88) i. Level or rate of nosocomial infections; and (10-14-88) ii. Site of infection; and (10-14-88) iii. Microorganism involved. (10-14-88) This Rule is not met as evidenced by: Refer to A749.	BB539		



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
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November 14, 2014

Judy Moore, Administrator
Safe Haven Hospital Of Treasure Valley
8050 Northview Street
Boise, ID 83704

Provider #134009

Dear Ms. Moore:

On **October 17, 2014**, a complaint survey was conducted at Safe Haven Hospital Of Treasure Valley. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00006196

Allegation #1: The facility did not provide a written response to complaints.

Finding #1: An unannounced survey of the facility was conducted from 10/14/14 through 10/17/14. The grievance/complaint log and policies were reviewed, and staff was interviewed.

On 10/14/14, surveyors requested to view the grievance log for all grievances filed from 3/01/13 until 10/14/14.

The grievance/complaint log was reviewed and included a grievance that was forwarded to the facility on 9/09/13, on behalf of a patient.

The patient was a 26 year old female admitted to the hospital on 8/20/13, and discharged on 9/20/13. The grievance log contained a summary of Patient #1's hospital stay, however, there was no evidence of contact with the patient. Additionally, the log did not include documentation an investigation was conducted or if the patient was informed regarding resolution of the grievance.

Judy Moore, Administrator
November 14, 2014
Page 2 of 4

A "GRIEVANCE/COMPLAINTS" policy dated 4/2013, stated "The patient, or person filing the grievance complaint on behalf of the patient, will be informed of the investigation and the actions that will be taken to correct any identified problems.

Such reports may be made orally by the Administrator or designee, within three working days of the filing of the grievance or complaint with the facility. A written summary of the report will also be provided to the patient, and a copy will be secured in the office of the Administrator."

The Chief Administrative Officer (CAO) was interviewed on 10/16/14 at 2:00 PM. She stated the prior CAO should have taken responsibility for conducting an investigation and of responding to the complainant. She confirmed the grievance log for related to the patient did not include documentation of a written response, and that the patient and the complainant did not get a response.

The hospital's grievance process was incomplete and the hospital did not respond in writing to a patient grievance.

The allegation was substantiated. The facility was cited at CFR 482.13(a)(2)(iii) for failing to ensure grievances were investigated and the results of the investigations provided in writing to the patient and/or complainants.

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

Allegation #2: Patients were injured during physical restraint holds.

Findings #2: An unannounced survey of the facility was conducted from 10/14/14 through 10/17/14. Medical records, incident reports, and policies were reviewed, and staff were interviewed.

One patient's behavioral nursing treatment plan, dated 8/24/13, included interventions related to the potential for the patient to harm herself or others.

Six physical holds were documented in the patient's record. Each hold was initiated to prevent the patient from further harming herself or others. The patient was assessed for injuries after each hold. The injuries identified during the assessments were documented as being self-inflicted or a result of the patient's behavior prior to the hold.

The CAO was interviewed on 10/16/14 at 2:00 PM. She stated the patient's care plan was developed to address her behaviors. She confirmed all incidents were self-inflicted and the patient was assessed for injuries.

None of the other records reviewed showed injuries related to physical holds.

It could not be verified through the investigation process that patients' were injured during physical restraint hold.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: The Durable Power of Attorney (DPOA) of a patient was not allowed to participate in care planning and discharge planning.

Findings #3: An unannounced survey of the facility was conducted from 10/14/14 through 10/17/14. Medical records and transfer logs were reviewed and staff were interviewed.

One patient's record documented she was admitted on 8/20/13 and discharged from the hospital on 9/20/13.

Social Service progress notes documented discussions between the CEO and Medical Social Worker (MSW). One progress note, dated 9/07/13 at 6:30 PM, stated, "MSW spoke with CEO of Safe Haven regarding patient's husband acting as a medical DPOA to the patient. Patient's husband believes that regardless if the patient denies to give consent to inform him of how she is doing, due to the DPOA standards he is able to still receive that information. MSW and CEO concluded that while patient is lucid enough to make her own decisions, she is able to deny information regardless of the DPOA. MSW spoke with patients husband and informed him of this."

During an interview with the CAO on 10/16/14 at 2:00 PM, she confirmed the patient did choose not to involve her husband at times. She stated hospital staff communicated with the patient's husband when the patient allowed it.

No concerns related to information sharing was identified in the other patient records reviewed.

It could not be determined that hospital staff inappropriately withheld patient information.

Conclusion #3: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: Facility staff falsely claimed a visitor went behind the nursing station and took medications.

Findings #4: An unannounced survey of the facility was conducted from 10/14/14 through 10/17/14. Incident reports were reviewed and staff were interviewed.

Judy Moore, Administrator
November 14, 2014
Page 4 of 4

An Incident Report dated 8/23/13 at 9:45 PM was reviewed. It stated a visitor of a patient was on the inpatient unit. The RN gave the patient 3 medications and walked to the nursing station and disposed of the empty medication containers. The RN then went to the chart room and when she returned, she saw the visitor behind the nurses' station where he took the empty medication containers from the trash and put them in his pocket.

The RN explained to him that he needed to immediately leave from behind the nurses' station and put the empty medication containers back in the garbage. The visitor acted as if he could not understand what the RN had told him by stating "No Habra ingles", although the RN had spoken to him earlier. The visitor said goodnight to the patient and left the building.

An observation of the nurses' station was completed by a surveyor on 10/15/14 at 9:00 AM. There are two entrances to the nurses' station. They both contain swinging doors that do not lock.

During an interview with the CAO on 10/16/14 at 2:00 PM, she confirmed the incident report and its findings. She was the RN that had witnessed the incident and fill out the report. She stated the visitor did not remove the medication containers from his pocket before leaving the building.

It could not be verified through the investigation process that visitors were accused of stealing medications.

Conclusion #4: 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,



DON SYLVESTER
Health Facility Surveyor
Non-Long Term Care



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

DS/pmt



IDAHO DEPARTMENT OF
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November 14, 2014

Judy Moore, Administrator
Safe Haven Hospital Of Treasure Valley
8050 Northview Street
Boise, ID 83704

Provider #134009

Dear Ms. Moore:

On **October 17, 2014**, a complaint survey was conducted at Safe Haven Hospital Of Treasure Valley. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00006124

Allegation: A graduate RN, who failed the Idaho State Board of Nursing exam, was still working as a charge nurse at the facility.

Findings: An unannounced, on-site complaint survey was conducted from 10/14/14 to 10/17/14. Personnel records, facility policies, staff schedules, and time cards were reviewed. Staff were also interviewed.

Personnel records and hospital policies were reviewed, as well as, staff schedules and time cards for July 2013 to August 2013.

A "Graduate Nurses/Student" policy effective 5/01/13, stated "Safe Haven Hospital abides by the Idaho State Board of Nursing rules and regulations regarding graduate nurses and student nurses. All graduate nurses and student nurses work under the direct supervision of a licensed registered nurse and does not assume charge nurse responsibilities. The registered nurse that is directly supervising the graduate or student nurse must be physically present and immediately accessible to designate or prescribe a course of action or to give procedural guidance, directions, and periodic evaluation."

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Personnel files of all graduate nurses for the past 24 months were reviewed. One personnel file included a temporary license issued by the Idaho State Board of Nursing on 7/22/13.

Additionally, an RN license was issued to that individual by the Idaho State Board of Nursing on 8/19/13. The individual worked as a graduate nurse at the facility for one month, prior to receiving an RN license. The staff schedules were reviewed for that one month time period, and did not indicate the individual was working independently or in a charge nurse role.

During an interview on 10/16/14 at 5:30 PM, the CAO reviewed the individual's personnel record and stated the graduate nurse never worked independently without a preceptor. She stated that after the graduate nurse passed boards and obtained an RN license, she then allowed the individual to work as a charge nurse.

There was no documentation in the personnel records that were reviewed to indicate any of the graduate nurses had failed the Idaho State Board of Nursing exam. It could not be verified graduate nurses acted independently.

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,



DON SYLVESTER
Health Facility Surveyor
Non-Long Term Care



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

DS/pmt