



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

October 29, 2013

Chris Roth
St Luke's Regional Medical Center
PO Box 2577
Boise, ID 83701-2577

RE: St Luke's Regional Medical Center, Provider #130006

Dear Mr. Roth:

This is to advise you of the findings of the complaint investigation, which was concluded at your facility on October 21, 2013.

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

Also enclosed is a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction.

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

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the PoC is effective in bringing the Hospital into compliance, and that the Hospital remains in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable

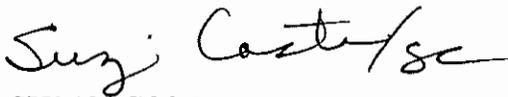
Chris Roth, Administrator
October 29, 2013
Page 2 of 2

- plan of correction; and
- The administrator's signature and the date signed on page 1 of the Form CMS-2567.

Please sign and date both of the forms and return them to our office by November 10, 2013.
Keep a copy for your records. For your information, the Statement of Deficiencies is disclosable to the public under the disclosure of survey information provisions.

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

Sincerely,



SUSAN COSTA
Health Facility Surveyor
Non-Long Term Care



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/pt
Enclosures



November 12, 2013

Sent via facsimile to (208) 364-1888

Sylvia Creswell
Idaho Department of Health and Welfare
Bureau of Facility Standards
3232 Elder Street
PO Box 83720
Boise, ID 83720

Re: CMS Certification Number: 13-7028

Dear Ms. Creswell:

This letter is in follow-up to your correspondence and Statement of Deficiencies dated October 29, 2013, advising us of your findings relative to the Complaint Survey completed at St. Luke's Treasure Valley, Boise Medical Center.

Enclosed is the Plan of Correction describing process improvement plans and integration of monitoring activities within our Quality and Performance Improvement framework.

Thank you for the opportunity to respond to the findings. If you have any questions or concerns, please feel free to contact me at (208) 381-9288.

Sincerely,

Danika A. Severe, RN, HACP
Director, Accreditation and Patient Relations

Enclosures

RECEIVED
NOV 12 2013
FACILITY STANDARDS

PRINTED: 10/26/2013
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/21/2013
NAME OF PROVIDER OR SUPPLIER ST LUKE'S REGIONAL MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 190 EAST BANNOCK STREET BOISE, ID 83712		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
A 000	INITIAL COMMENTS A complaint investigation survey was completed at your hospital from 10/15/13 through 10/21/13. The Condition of Participation for Patient Rights, Nursing Services, Pharmacy Services, and Dietary Services were reviewed. Surveyors conducting the investigation were: Susan Costa, RN, HFS, Team Lead Gary Guiles, RN, HFS Acronyms used in this report include: CVA- cerebral vascular accident hrs - hours ICMP - Interdisciplinary Care Management Plan, the hospital's plan of care mg - milligram ml - milliliter q - every prn - as needed SLP - speech and language pathologist SNF - Skilled Nursing Facility	A 000			
A 131	The following deficiencies were cited. 482.13(b)(2) PATIENT RIGHTS: INFORMED CONSENT The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care. The patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed	A 131	Tag A 131 - 482.13 (b)(2) Patient Rights: Informed Consent Responsible Parties: Cynthia Gearhard, Interim CNO, Dawn Lombardo, Senior Director Heart, Liz Jorgensen, Director of Nursing , Marylynn Hippe, Clinical Nurse Specialist. Process Improvements: Streamline communication and documentation to include patient's verbal consent for treatment with medications that may be listed as allergy/intolerances.		

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NOV 12 2013
FACILITY STANDARDS

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

TITLE

(X6) DATE

CEO

11/12/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 131	<p>Continued From page 1</p> <p>medically unnecessary or inappropriate.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of medical records and hospital policies, it was determined the hospital failed to ensure 3 of 8 patients (#12, #14, and #17), whose records were reviewed for allergies, were involved in planning their care and had the opportunity to refuse treatment. This interfered with patients' ability to make informed decisions. Findings include:</p> <p>1. Patient #14's medical record documented a 53 year old female who was hospitalized from 4/03/13 to 4/05/13 for abdominal surgery. Her "HISTORY AND PHYSICAL," dated 3/21/13, stated "ALLERGIES: VICODIN CAUSING NAUSEA AND PRURITUS." Vicodin contains hydrocodone and acetaminophen. Untimed orders dated 4/04/13, called for Patient #14 to receive "Lortab elixir (Hydrocodone 7.5 mg/acetaminophen 500 mg per 15 ml) give 10-15 ml q 4 hrs pm pain."</p> <p>Patient #14's medical record documented she received the Lortab on 4/04/13 at 3:49 PM and 11:20 PM. She also received Lortab at 6:37 AM on 4/05/13. An order, dated 4/05/13 at 7:20 AM, called for Patient #14 to receive Benadryl 50 mg "now." The progress note by the PA that was written with the order stated "Benadryl for likely allergic [reaction] to Hydrocodone."</p> <p>No documentation was present in the medical record that Patient #14 was informed of the order for Lortab and told it was the same medication she had reported she was allergic to. No documentation was present in the medical record that Patient #14 was afforded the opportunity to</p>	A 131	<p>Action Plan Implementation / Training & Education</p> <p>1. Update policy to reflect the clinician having a conversation with patient regarding administration of a medication that has been listed as an allergy. 1/8/2014</p> <p>2. Add to EMR a documentation screen that will provide for standardized conversation of necessary information in regards to allergy/intolerance and treatment with said medication. 1/8/2014</p> <p>3. Educate staff on the policy and required information prior to administering a medication that is listed as an allergy, the first time. 1/8/2014</p> <p>4. Pharmacist to use the intervention tool in the Siemens pharmacy information system to document pharmacist-patient or pharmacist-clinician conversations prior to approving prescriptions for medications which the patient has reported as a known allergy/intolerance. 1/6/2014</p>	

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NAME OF PROVIDER OR SUPPLIER ST LUKE'S REGIONAL MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 190 EAST BANNOCK STREET BOISE, ID 83712	1/6/2014	
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A 131	<p>Continued From page 2 refuse the medication.</p> <p>The Department Director for the telemetry unit was interviewed on 10/21/13 beginning at 2:15 PM. She confirmed Patient #14 received medication that was listed as an allergen. She confirmed there was no documentation stating Patient #14 was informed about the medication and given an opportunity to refuse it.</p> <p>Patient #14 was not informed medication had been ordered that she believed she was allergic to.</p> <p>2. Patient #12's medical record documented a 68 year old male who was hospitalized from 5/05/13 to 5/20/13 for sepsis. His "HISTORY AND PHYSICAL," dated 5/05/13, stated he was allergic to Morphine.</p> <p>The form "St. Lukes Admission and Discharge Medication Reconciliation Orders," dated 5/05/13 at 3:20 PM, stated Patient #12 was allergic to Morphine which caused "Mental Changes." The form "ADULT CRITICAL CARE INTENSIVIST PATIENT ADMIT ORDERS," dated 5/05/13 at 4:20 AM, stated he was allergic to Morphine. An order, dated 5/06/13 at 9:50 AM, stated Patient #12 was to receive Morphine IV every 4 hours as needed for pain. Patient #12's medical record documented he received the Morphine on 5/06/13 at 10:45 AM. An order dated 5/06/13 at 11:40 AM discontinued the Morphine.</p> <p>No documentation was present in the medical record that Patient #12 was informed of the order for Morphine and told it was a medication he had reported he was allergic to. No documentation was present in the medical record that Patient</p>	A 131	<p>QAPI Integration:</p> <ol style="list-style-type: none"> 1. Build report from Siemens to identify patients who received medications that were on the patient's known allergy/intolerance list. 2. Monthly audit x 4 of identified patient records for documentation of education and consent. 3. Results to be reported to Quality and Patient Safety Committee. 	<p>1/6/2014</p> <p>1/6/2014</p> <p>1/6/2014</p>

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A 131	<p>Continued From page 3</p> <p>#12 was afforded the opportunity to refuse medication.</p> <p>The Medication Safety Coordinator, a pharmacist, was interviewed on 10/18/13 beginning at 8:05 AM. She stated the hospital had a system for pharmacists to evaluate reported allergies to determine whether they were true allergies prior to administration of the medication. She stated Patient #12 did not have a true allergy to Morphine.</p> <p>The Department Director for the telemetry unit was interviewed on 10/21/13 beginning at 2:15 PM. She confirmed Patient #12 received medication that was listed as an allergen. She confirmed there was no documentation stating Patient #12 was informed about the medication and given an opportunity to refuse it.</p> <p>Patient #12 was not informed medication had been ordered that he believed he was allergic to.</p> <p>3. Patient #17's medical record documented an 80 year old female who was hospitalized from 5/13/13 to 5/23/13 for leg ulcers. Her "HISTORY AND PHYSICAL," dated 5/13/13, stated she was allergic to Morphine which caused gastrointestinal disturbances.</p> <p>An order dated 5/18/13 at 6:00 PM called for Patient #17 to receive oral Morphine every 12 hours. No documentation was present that the medication was administered to Patient #17. The Morphine order was discontinued on 5/19/13 at 11:46 AM. A physician progress note, written at the same time, stated "Treating [Patient #17's] pain adequately with opioids will [(increase)] her risk of falls, constipation, and anorexia."</p>	A 131		

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A 131	<p>Continued From page 4</p> <p>An addendum to the "DISCHARGE SUMMARY," dated 5/24/13, stated Patient #17 was discharged to a rehabilitation facility on 5/23/13. A "DISCHARGE PRESCRIPTION" form, dated 5/21/13 at 2:45 PM, stated Patient #17 was to receive oral Morphine 2 times a day for pain after she was discharged. No explanation was documented why the medication was ordered. No documentation was present in the medical record that Patient #17 was informed of the order for Morphine prior to discharge and given the opportunity to refuse the medication and request that another be ordered.</p> <p>Patient #17 was readmitted to the hospital from 5/28/13 to 6/05/13, after a fall. Her history and physical, dated 5/28/13, again listed she was allergic to Morphine which it stated caused nausea and vomiting. Morphine was ordered 2 times a day on admission on 5/28/13 at 10:16 AM. The medical record stated she received the Morphine on 5/28/13, 5/29/13, and 5/30/13.</p> <p>The Department Director for the telemetry unit was interviewed on 10/21/13 beginning at 2:15 PM. She confirmed the Morphine was ordered twice for Patient #17. She confirmed there was no documentation stating Patient #17 was informed about the medication and given an opportunity to refuse it.</p> <p>Patient #17 was not informed a medication had been ordered that she believed she was allergic to.</p> <p>4. The policy "Allergy, Intolerance, and Side Effect Assessment," revised 10/01/13, outlined a procedure to determine whether reported</p>	A 131			

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A 131	Continued From page 5 allergies were true allergies or side effects. The policy stated "If the patient identifies that they have an allergy, sensitivity or intolerance, the clinician is responsible for acknowledging the patient's concern, seek clarification and determine if true allergy, provide education and determine if an alternative is required." The Clinical Nurse Specialist for the Medical/Surgical units and the Director of Accreditation and Patient Relations were interviewed together on 10/24/13 beginning at 9:55 AM. They stated the term clinician was broadly defined at the hospital. They confirmed the policy did not specify which staff should inform the patient that a medication was being ordered for which the patient had reported a prior problem to allow the patient to refuse the medication and discuss alternatives. The policy did not promote informing patients about treatment options for medications to which they had known reactions.	A 131			
A 396	482.23(b)(4) NURSING CARE PLAN The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. The nursing care plan may be part of an interdisciplinary care plan This STANDARD is not met as evidenced by: Based on review of facility policies, medical record review and staff interview, it was determined the hospital failed to ensure a plan of care was developed and updated for 1 of 10 patients (#5) whose records were reviewed. This resulted in a lack of direction to interdisciplinary staff in the delivery of care to the patient and had	A 396	Tag A 396 - 482.23 (b)(4) Nursing Care Plan Responsible Parties: Cynthia Gearhard, Interim CNO, Dawn Lombardo, Sr, Director Heart, Liz Jorgensen, Director of Nursing , Marylynn Hippe, Clinical Nurse Specialist.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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NAME OF PROVIDER OR SUPPLIER ST LUKE'S REGIONAL MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 180 EAST BANNOCK STREET BOISE, ID 83712		
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A 396	Continued From page 7 2/24/13 (night shift) - turned 1 time in 12 hours 2/26/13 (night shift) - turned 1 time in 12 hours 2/26/13 (night shift) - turned 4 times in 12 hours 2/28/13 (night shift) - turned 2 times in 12 hours 3/01/13 (night shift) - turned 4 times in 12 hours 3/02/13 (day shift) - turned 4 times in 12 hours 3/02/13 (night shift) - turned 1 time in 12 hours 3/04/13 (day shift) - turned 4 times in 12 hours 3/04/13 (night shift) - turned 3 times in 12 hours During an interview on 10/21/13 beginning at 1:45 PM, Nurse A, who had been assigned to care for Patient #5 on 3/05/13, reviewed the medical record. She confirmed the ICMP did not include frequency of position changes or mobility needs specific to Patient #5's needs. She stated the standard of care on her nursing unit was to ensure patients who had mobility deficits were repositioned every 2 hours around the clock. She stated a patient or family member may refuse repositioning, but usually that would be documented. Nurse A stated when a patient was placed on "Comfort Care," many patient care activities such as vital signs, monitoring blood sugars and labs would be discontinued. She stated the goal would be to keep the patient comfortable and the family would usually decide what and when patient care activities would be done, which included repositioning. She stated if the family member was not present, she would decide if the patient needed to be repositioned, but it was not on the every 2 hour schedule as the routine for the other patients. 3. Patient #5 had a SLP evaluation on the day of her admission, with additional assessments and dietary modifications on 2/25/13, 2/26/13, and 2/27/13 as noted:	A 396			

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A 396	Continued From page 8 - 2/24/13 at 1400 a "Dysphagia Evaluation" was completed by a Speech Language Pathologist (SLP). Physician's orders were written as pre-approved diet texture protocol orders and signed by a physician on 3/14/13. The diet orders included a general diet texture with any liquid and 1:1 assistance during meals because of Patient #5's fractured right arm. - 2/25/13 at 11:05 AM, a SLP follow up visit progress note documented a decline in Patient #5's swallow function. Orders per "Swallow Protocol" were written for a Dysphagia 2 mechanically altered diet with liquids thickened to nectar consistency and signed by a physician on 2/25/13 at 1:45 PM. - 2/26/13 at 10:30 AM, a SLP follow up visit progress note documented Patient #5 did not tolerate thin liquids, and her diet orders were changed. Orders per "Swallow Protocol" were written for a Dysphagia 2 mechanically altered diet with liquids thickened to honey consistency. The 1:1 assistance was continued to ensure oral clearing between bites. The order was authenticated by a physician on 2/26/13 at 10:43 AM. - 2/27/13 at 12:20 PM, a SLP progress note documented Patient #5 had no difficulty with any viscosity of liquids. Orders were written for ADA (American Diabetic Association) dysphagia 2 mech-soft (mechanical soft), with any liquids. The order was authenticated by a physician on 2/27/13 at 2:00 PM. - 2/28/13 at 9:15 AM, a SLP progress note recommended Patient #5 continue with the	A 396			

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A 396	Continued From page 9 dysphagia 2 diet. The dietary modifications were not continued when Patient #5 was placed on Comfort Care on 3/01/13, at which time all her previous orders were discontinued and a "General Diet" was ordered. The ICMP dated 3/02/13 to 3/06/13 documented Patient #5 was to have a general diet and did not include dysphagia precautions and mechanical soft texture. During an interview on 10/21/13 beginning at 2:10 PM, Nurse B, who had been assigned to care for Patient #5 on 3/04/13, stated the ICMP indicated a "General Diet." Nurse B stated a general diet included foods without restrictions such as low sodium, no concentrated sweets, etc. She was not aware of the texture requirements that Patient #5 had prior to being placed on "Comfort Care" and stated she was unaware she had been on a dysphagia 2 diet and 1:1 assistance with meals was required. She stated multiple family members were with Patient #5 throughout that day and she had assumed they had fed their mother lunch and dinner. Nurse B stated when a family member told her the food was not appropriate, she thought they had meant Patient #5 did not want to eat and had refused the meal. The hospital did not ensure Patient #5's plan of care was individualized and revised according to her needs.	A 396			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ID1LGZ	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/21/2013
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NAME OF PROVIDER OR SUPPLIER ST LUKE'S REGIONAL MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 190 EAST BANNOCK STREET BOISE, ID 83712
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B 000	16.03.14 Initial Comments A complaint investigation survey was completed at your hospital from 10/15/13 through 10/21/13. Surveyors conducting the investigation were: Susan Costa, RN, HFS, Team Lead Gary Gulles, RN, HFS The following deficiencies were cited. Acronyms used in this report include: CVA- cerebral vascular accident hrs - hours mg - milligram prn - as needed SLP - speech and language pathologist SNF - Skilled Nursing Facility	B 000		
BB174	16.03.14.310.02 Records 02. Records. Nurses shall maintain records that document patient status, progress and care given using descriptive measurable data. This documentation shall include but not be limited to: (10-14-88) a. Admission note; and (10-14-88) b. Vital signs; and (10-14-88) c. Medication record; and (10-14-88) d. Rationale for and results of PRN drug administration; and (10-14-88) e. Patient teaching; and (10-14-88) f. Adverse drug or blood reaction; and (10-14-88)	BB174	Tag BB174 - Records Responsible Parties: Cynthia Gearhard, Interim CNO, Dawn Lombardo, Sr, Director Heart, Liz Jorgensen, Director of Nursing , Marylynn Hippe, Clinical Nurse Specialist. Process Improvements: Ensure nursing interventions are documented in the medical record. Discharge disposition will be standardized to include the primary nurse documenting discharge disposition in the medical record.	

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TITLE

(X6) DATE

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ID1LGZ	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/21/2013
NAME OF PROVIDER OR SUPPLIER ST LUKE'S REGIONAL MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 190 EAST BANNOCK STREET BOISE, ID 83712		
(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
BB174	<p>Continued From page 2</p> <p>On 2/25/13 at 6:14 AM, Morphine 1 mg. On 2/25/13 at 8:10 PM, Morphine 1 mg. On 2/26/13 at 10:46 PM, Acetaminophen 500 mg. On 2/28/13 at 5:53 PM, Acetaminophen 500 mg. On 3/01/13 at 8:10 PM, Ativan 1 mg. On 3/02/13 at 6:32 AM, Ativan 1 mg. On 3/02/13 at 3:16 PM, Ativan 1 mg. On 3/02/13 at 7:39 PM, Morphine 2 mg. On 3/02/13 at 11:06 PM, Morphine 4 mg. On 3/03/13 at 4:40 AM, Ativan 1 mg. On 3/03/13 at 4:08 PM, Morphine 2 mg. On 3/04/13 at 3:44 PM, Ativan 0.5 mg. On 3/04/13 at 4:53 PM, Morphine 10 mg. On 3/04/13 at 11:00 PM, Morphine 10 mg. On 3/05/13 at 6:31 PM, Morphine 10 mg. On 3/05/13 at 1:01 PM, Ativan 0.5 mg. On 3/05/13 at 1:01 PM, Morphine 10 mg. On 3/05/13 at 3:09 PM, Ativan 0.5 mg.</p> <p>During an interview on 10/21/13 beginning at 2:10 PM, Nurse B reviewed Patient #5's medical record and Medication Administration Record. She confirmed nursing staff had not documented the effectiveness of prn medications.</p> <p>Patient #5's medical record did not contain documentation of effectiveness of prn drug administration.</p> <p>2. Patient #5's record indicated she was transferred to a Skilled Nursing Facility on 3/05/13. Her actual time of discharge was not documented.</p> <p>A worksheet was provided by the Department Manager on 10/21/13 at 2:00 pm. It was a page from a desk calendar that contained a list that recorded the admissions, discharges and transfers of patients on that unit. The</p>	BB174		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ID1LGZ	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/21/2013
NAME OF PROVIDER OR SUPPLIER ST LUKE'S REGIONAL MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 190 EAST BANNOCK STREET BOISE, ID 83712		
(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
BB174	<p>Continued From page 3</p> <p>Department Manager stated the unit secretary would update the list as each patient admission, discharge or transfer occurred. The worksheet noted Patient #5 was transferred to a SNF on 3/05/13 at 3:28 PM.</p> <p>The RN who was assigned to Patient #5 on 3/05/13 last entered a note on 3/05/13 at 10:43 AM. There were no further entries in the medical record from that nurse.</p> <p>Patient #5's medical record contained a "Support Services Progress Notes," dated 3/05/13 at 12:07 PM. The note contained a summary of a meeting held with Patient #5's family members, physician, and the MSW. The note documented Patient #5 would be placed on a full liquid diet and pain medications would be assessed by the physician. The note did not include documentation of the disposition of Patient #5.</p> <p>A form titled "Discharge Planning Documentation," dated 3/05/13 at 3:00 PM, noted "...Transport arranged via non-emergent stretcher. (Hospice) will plan to meet w (with) patient & family shortly after arrival. No further need identified."</p> <p>A policy, titled "Discharge Planning Process and Discharge of Patient," revised 4/25/13, noted "Documentation will reflect patients and/or caregiver's understanding and completion of education goals, patient's instructions for post-discharge care and patient's destination."</p> <p>The Department Manager reviewed the record and confirmed the nurse had not documented provision of care for Patient #5 in excess of 4 hours directly before and including the discharge assessment and disposition.</p>	BB174		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ID1LGZ	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/21/2013
NAME OF PROVIDER OR SUPPLIER ST LUKE'S REGIONAL MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 180 EAST BANNOCK STREET BOISE, ID 83712		
(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
BB174	Continued From page 4	BB174	Tag BB175 - Patient Care Plans	
	Patient #5's medical record did not include complete and timely documentation.		Responsible Parties: Cynthia Gearhard, Interim CNO, Dawn Lombardo, Sr. Director Heart, Liz Jorgensen, Director of Nursing, Marylynn Hippe, Clinical Nurse Specialist.	
BB175	16.03.14.310.03 Patient Care Plans	BB175	Process Improvements: Ensure nursing interventions for patient repositioning, pain management, and assistance with meals is clearly communicated on the care plan and documentation of interventions throughout the patient stay.	
	03. Patient Care Plans. Individual patient care plans shall be developed, implemented and kept current for each inpatient. Each patient care plan shall include but is not limited to: (10-14-88)		Action Plan Implementation / Training & Education	
	a. Nursing care treatments required by the patient; and (10-14-88)		1. Mandatory education for nurses and nursing assistants:	1/6/2014
	b. Medical treatment ordered for the patient; and (10-14-88)		a. Development and documentation of Individualized patient plan of care	
	c. A plan devised to include both short-term and long-term goals; and (10-14-88)		b. Expectations of treatments and documentation of specific patient populations and their needs	
	d. Patient and family teaching plan both for hospital stay and discharge; and (10-14-88)		QAPI Integration:	1/6/2014
	e. A description of socio-psychological needs of the patient and a plan to meet those needs. (10-14-88)		Weekly Audits of 10 randomly selected patientsx 4 months per inpatient unit to verify a Individualized Care Plan was developed and updated to reflect patient needs.	
	This Rule is not met as evidenced by: Refer to Federal Deficiency A-396 as it relates to the failure of the facility to ensure the patients' care plans were individualized and/or kept current in order to meet their needs.		Audit Results reported to Quality and Patient Safety Committee.	



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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October 29, 2013

Chris Roth, Administrator
St Lukes Regional Medical Center
PO Box 2577
Boise, ID 83701-2577

RE: St Luke's Regional Medical Center, Provider #130006

Dear Mr. Roth:

On **October 21, 2013**, a complaint survey was conducted at St Luke's Regional Medical Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00006245

Allegation #1: Patients were given medications they were allergic to.

Findings #1: An unannounced visit was made to the hospital on 10/18/13 -10/21/13. Staff were interviewed. Eight medical records were reviewed. Hospital policies were reviewed.

The hospital had a process outlined in a policy titled "Allergy, Intolerance, and Side Effect Assessment," revised 10/01/13, to determine whether reported allergies were true allergies or side effects. Pharmacists reviewed all inpatient and outpatient records prior to the administration of medications for this information. If the pharmacists determined the reported allergies constituted true allergies, then they took steps to prevent staff from administering that medication. Otherwise, those medications could be ordered and administered.

One medical record documented a 53 year old female who was hospitalized from 4/03/13 to 4/05/13 for abdominal surgery. Her "HISTORY AND PHYSICAL," dated 3/21/13, stated "ALLERGIES: VICODIN CAUSING NAUSEA AND PRURITUS." (Pruritis means itching.)

Vicodin contains hydrocodone and acetaminophen. The pharmacist reviewed the allergy list and determined the patient did not have a true allergy to Vicodin.

Untimed orders, dated 4/04/13, called for the above patient to receive "Lortab elixir (Hydrocodone 7.5 mg/acetaminophen 500 mg per 15 ml) give 10-15 ml q 4 hrs prn pain." This patient received the Lortab on 4/04/13 at 3:49 PM and 11:20 PM. She also received Lortab at 6:37 AM on 4/05/13. An order, dated 4/05/13 at 7:20 AM, called for the patient to receive Benadryl 50 mg "now." The accompanying progress note by the PA that wrote the order stated "Benadryl for likely allergic (###) to Hydrocodone."

A second medical record documented an 80 year old female was hospitalized from 5/13/13 to 5/23/13 for leg ulcers. Her "HISTORY AND PHYSICAL," dated 5/13/13, stated she was allergic to "CODEINE, MORPHINE, FENTANYL, ALL CAUSE GI DISTURBANCES."

An order dated 5/18/13 at 6:00 PM called for the second patient to receive oral Morphine every 12 hours. No documentation was present that the medication was administered to this patient. The Morphine order was discontinued on 5/19/13 at 11:45 AM. A physician progress note, written at the same time, stated "Treating (###) pain adequately with opioids will (###) her risk of falls, constipation, and anorexia."

An addendum to the "DISCHARGE SUMMARY," dated 5/24/13, stated the second patient was discharged to a rehabilitation facility on 5/23/13. A "DISCHARGE PRESCRIPTION" form, dated 5/21/13 at 2:45 PM, stated the patient was to receive oral Morphine 2 times a day for pain after she was discharged from the hospital.

The second patient was readmitted to the hospital from 5/28/13 to 6/05/13 after a fall. Her history and physical, dated 5/28/13, again listed she was allergic to Morphine which it stated caused nausea and vomiting. Morphine was ordered 2 times a day on admission on 5/28/13 at 10:15 AM. The medical record stated she received the Morphine on 5/28/13, 5/29/13, and 5/30/13.

A third medical record documented a 68 year old male who was hospitalized from 5/05/13 to 5/20/13 for sepsis. His "HISTORY AND PHYSICAL," dated 5/05/13, stated he was allergic to Morphine.

The form "St. Lukes Admission and Discharge Medication Reconciliation Orders," dated 5/05/13 at 3:20 PM, stated the third patient was allergic to Morphine which caused "Mental Changes." An order, dated 5/06/13 at 9:50 AM, stated the patient was to receive Morphine IV every 4 hours as needed for pain. The patient's medical record documented he received the Morphine on 5/06/13 at 10:45 AM. An order dated 5/06/13 at 11:40 AM discontinued the Morphine.

All 3 medical records documented a pharmacist had reviewed the allergies and determined they were not true allergies prior to administration. Since the medications had been evaluated prior to administration of the suspected medications, it was determined the complaint was not substantiated.

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: Patients were not informed medications were ordered that they had reported allergies to.

Findings #2: An unannounced visit was made to the hospital on 10/18/13 -10/21/13. Staff were interviewed. Eight medical records were reviewed. Hospital policies were reviewed.

The hospital had a process outlined in a policy titled "Allergy, Intolerance, and Side Effect Assessment," revised 10/01/13, to determine whether reported allergies were true allergies or side effects. If a pharmacist determined the patient was not truly allergic to a medication, that medication could be ordered and administered to the patient. The policy did not address how patients would be informed if a medication was ordered that had been listed as an allergy so they could make decisions regarding their care.

One medical record documented a 53 year old female who was hospitalized from 4/03/13 to 4/05/13 for abdominal surgery. Her "HISTORY AND PHYSICAL," dated 3/21/13, stated "ALLERGIES: VICODIN CAUSING NAUSEA AND PRURITUS." After the pharmacist determined the patient was not truly allergic to the medication, the patient received Lortab elixir on 4/04/13 and 4/05/13. The Lortab contained identical ingredients to Vicodin. No documentation was present that the patient was informed the Lortab contained the same medication she had reported an allergy to.

A second medical record documented an 80 year old female was hospitalized from 5/13/13 to 5/23/13 for leg ulcers. Her "HISTORY AND PHYSICAL," dated 5/13/13, stated she was allergic to "CODEINE, MORPHINE, FENTANYL, ALL CAUSE GI DISTURBANCES." Her "PALLIATIVE CARE CONSULTATION," dated 5/21/13, stated she was also allergic to "CODEINE, MORPHINE AND NARCOTICS." The term narcotics was not defined. Norco, which contained Hydrocodone, a narcotic, was administered to the patient from admission on 5/13/13 to 5/23/13.

Chris Roth, Administrator
October 29, 2013
Page 4 of 5

An order dated 5/18/13 at 6:00 PM called for the second patient to receive oral Morphine every 12 hours. No documentation was present that the medication was administered to this patient. The Morphine order was discontinued on 5/19/13 at 11:45 AM. A physician progress note, written at the same time, stated "Treating (###) pain adequately with opioids will (###) her risk of falls, constipation, and anorexia."

An addendum to the "DISCHARGE SUMMARY," dated 5/24/13, stated the second patient was discharged to a rehabilitation facility on 5/23/13. A "DISCHARGE PRESCRIPTION" form, dated 5/21/13 at 2:45 PM, stated the patient was to receive oral Morphine 2 times a day for pain after she was discharged from the hospital. While the hospital did not give the patient this medication, there was no documentation the patient was informed the Morphine had been ordered for the rehabilitation facility to administer and she was given the opportunity to refuse the medication and discuss alternatives.

The second patient was readmitted to the hospital from 5/28/13 to 6/05/13 after a fall. Her history and physical, dated 5/28/13, again listed she was allergic to Morphine which it stated caused nausea and vomiting. Morphine was ordered 2 times a day on admission on 5/28/13 at 10:15 AM. The medical record stated she received the Morphine on 5/28/13, 5/29/13, and 5/30/13. Again, there was no documentation the patient was informed about the order and administration of Morphine.

A third medical record documented a 68 year old male who was hospitalized from 5/05/13 to 5/20/13 for sepsis. His "HISTORY AND PHYSICAL," dated 5/05/13, stated he was allergic to Morphine. The record stated a pharmacist had reviewed the allergies and determined he was not truly allergic to Morphine.

An order, dated 5/06/13 at 9:50 AM, stated the patient was to receive Morphine IV every 4 hours as needed for pain. The patient's medical record documented he received the Morphine on 5/06/13 at 10:45 AM. No documentation was present that the patient was informed the Morphine had been ordered or that he had participated in the decision.

The hospital administered medication to patients who had a reported allergy to the medication. A deficiency was cited at 42 CFR Part 482.13(b,2) for the hospital's failure to inform patients of the orders and to allow them to request or refuse the medication.

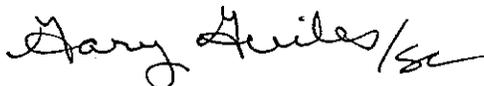
Conclusion #2: Substantiated. Federal and State deficiencies related to the allegation are cited.

Chris Roth, Administrator
October 29, 2013
Page 5 of 5

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 was addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,



GARY GUILLES
Health Facility Surveyor
Non-Long Term Care



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

GG/pt



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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November 01, 2013

Chris Roth, Administrator
St Lukes Regional Medical Center
PO Box 2577
Boise, ID 83701-2577

COPY

RE: St Lukes Regional Medical Center, Provider #130006

Dear Mr. Roth:

On October 21, 2013, a complaint survey was conducted at St Luke's Regional Medical Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00006029

Allegation #1: The facility did not ensure patients was repositioned every 2 hours.

Findings #1: An unannounced, on-site complaint survey was conducted from 10/15/13 to 10/17/13. Clinical records and facility policies were reviewed, patient and staff interviews were conducted. Grievance logs from March 2013 to September 2013, were reviewed. Medical records of 10 patients who required assistance with mobility and repositioning were reviewed for documentation of position changes.

One patient record was that of a patient with dementia who was admitted for care on 2/24/13 after falling at her residence. It was determined by the facility she had a stroke and her wrist had been broken when she fell. The medical record indicated the patient was right handed and she was unable to reposition herself in her bed independently. The medical record contained documentation of patient position changes during each shift, but the frequency of that nursing intervention was inconsistent as follows:

2/24/13 (night shift) - turned 1 time in 12 hours
2/25/13 (night shift) - turned 1 time in 12 hours
2/26/13 (night shift) - turned 4 times in 12 hours
2/28/13 (night shift) - turned 2 times in 12 hours
3/01/13 (night shift) - turned 4 times in 12 hours

Chris Roth, Administrator

November 01, 2013

Page 2 of 6

3/02/13 (day shift) - turned 4 times in 12 hours
3/02/13 (night shift) - turned 1 time in 12 hours
3/04/13 (day shift) - turned 4 times in 12 hours
3/04/13 (night shift) - turned 3 times in 12 hours

The record documented the patient's orders were changed on day 5 of her hospitalization to comfort care measures. The new physician's orders contained the statement "DISCONTINUE ALL PREVIOUS ORDERS." The new set of orders included bedrest as the activity ordered. For skin care, the physician had marked "Per unit guidelines to prevent pressure ulcers." Requests were made to the facility and Department Manager for specific unit guidelines for repositioning bedfast patients. They were unable to provide written policies or guidelines.

A form in each medical record, titled "Interdisciplinary Care Management Plan," included daily orders and interventions for the patient. In the section "Hygiene/Activity" and "Treatments," interventions such as repositioning, oral care, ambulation and mobility level were left unmarked until 3/01/13, which was the day the patient was placed on comfort care. After that date, the sections contained a handwritten note of "Turn PT (patient) per family Request".

Multiple nursing staff that had provided care to the patient during her hospitalization were interviewed. Each nurse stated the standard of practice for patients with limited mobility was repositioning every 2 hours. After reviewing the record, the nurses confirmed the documentation did not indicate the patient had been turned every 2 hours.

Discrepancies were not noted in the other 9 medical records reviewed.

The facility did not ensure repositioning of a patient consistent with her condition. A federal deficiency was cited at 42 CFR 482.23(b)(4) related to development and update of plans of care. A state licensing deficiency was also cited at IDAPA 16.03.14.310.02 as it relates to patient records and nursing documentation.

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

Allegation #2: The nursing staff did not assess and treat patients' anxiety.

Findings #2: One patient record was that of a patient with dementia who was admitted for care after falling at her residence. It was determined by the facility she had a stroke and her wrist had been broken when she fell.

The patient's medical record contained orders on 3/01/13 for an anti-anxiety medication when she was transitioned to Comfort Care. There was documentation the patient received medication for anxiety on 7 occasions, however, the record did not indicate she was reassessed after the medications were administered to determine if the medication was effective or if further

interventions were needed. Assessment of effectiveness was not completed subsequent to the following medication administrations.

- 3/01/13 at 8:10 PM, Ativan 1 mg.
- 3/02/13 at 6:32 AM, Ativan 1 mg.
- 3/02/13 at 3:16 PM, Ativan 1 mg.
- 3/03/13 at 4:40 AM, Ativan 1 mg.
- 3/04/13 at 3:44 PM, Ativan 0.5 mg.
- 3/05/13 at 1:01 PM, Ativan 0.5 mg.
- 3/05/13 at 3:09 PM, Ativan 0.5 mg.

Similar discrepancies were not noted in the other 9 patient records.

While the patient received medication for anxiety, it could not be determined the medication was effective in relieving the patient's anxiety. A state hospital licensing deficiency was cited at IDAPA 16.03.14.310.02 as it relates to patient records and nursing documentation.

Conclusion #2: Substantiated. State deficiencies related to the allegation are cited.

Allegation #3: The nursing staff failed to implement pain management measures for a patient that had dementia and was at times non-verbal.

Findings #3: One patient with dementia was admitted after a fall at the assisted living facility she resided in. She was noted to have right sided weakness, facial droop and slurred speech, in addition to bruising and pain in her right arm. She was admitted with diagnoses of cardiovascular vascular accident (CVA) and fracture of the right arm. The patient was placed on "Comfort Care" status on the fifth day after admission and discharged to a Skilled Nursing Facility with Hospice on the ninth day after admission. The patient was on multiple prn medications for pain. Documentation that staff assessed the effectiveness of the pain medications was not found in her medical record for 14 administrations of Morphine and 3 administrations of Acetaminophen 500 mg, as follows:

- 2/24/13 at 4:56 PM, Morphine 0.5 mg.
- 2/24/13 at 8:27 PM, Acetaminophen 500 mg.
- 2/24/13 at 8:27 PM, Morphine 1 mg.
- 2/24/13 at 11:14 PM, Morphine 1 mg.
- 2/25/13 at 12:45 AM, Morphine 2 mg.
- 2/25/13 at 2:30 AM, Morphine 1 mg.
- 2/25/13 at 6:14 AM, Morphine 1 mg.
- 2/25/13 at 8:10 PM, Morphine 1 mg.
- 2/26/13 at 10:46 PM, Acetaminophen 500 mg.

- 2/28/13 at 5:53 PM, Acetaminophen 500 mg.
- 3/02/13 at 7:39 PM, Morphine 2 mg.
- 3/02/13 at 11:06 PM, Morphine 4 mg.
- 3/03/13 at 4:08 PM, Morphine 2 mg.
- 3/04/13 at 4:53 PM, Morphine 10 mg.
- 3/04/13 at 11:00 PM, Morphine 10 mg.
- 3/05/13 at 1:01 PM, Morphine 10 mg.
- 3/05/13 at 6:31 PM, Morphine 10 mg.

During an interview with a nurse that had been assigned to care for the patient, she confirmed nursing staff had not documented the effectiveness of prn pain medications.

Additionally, the patient's care plan dated 2/24/13 to 3/01/13, included interventions of ice and elevation for her right arm fracture. There was no documentation ice had been utilized as an intervention. The patient's care plan dated 3/02/13 to 3/06/13, did not include ice or elevation for the fractured arm.

During an interview on 10/21/13 beginning at 2:10 PM, a nurse reviewed the patient's medical record and confirmed nursing staff had not updated and maintained the care plan to include non-medication interventions such as ice for pain management.

The hospital did not ensure effective pain relief was achieved and documented. A federal deficiency was cited at 42 CFR 482.23(b)(4) related to the failure of the facility to maintain and update patients' care plans consistent with their needs. A deficiency was cited at IDAPA 16.03.14.310.02, as it relates to the failure of the facility to ensure nursing staff documented patients' responses to pain medications.

Conclusion #3: Substantiated. Federal and State deficiencies related to the allegation are cited.

Allegation #4: The facility failed to ensure a patient was assisted with meals, as well as to ensure appropriate foods were ordered according to the patient's ability.

Findings #4: One patient record was that of a patient with dementia who was admitted for care after falling at her residence. It was determined by the facility she had a stroke and her wrist had been broken when she fell. The medical record contained documentation of a Speech Language Pathologist (SLP) evaluation on the day of her admission, with additional assessments and dietary modifications as noted:

- On the day of admission, a "Dysphagia Evaluation" was completed by an SLP. Diet orders were written and included a general diet texture with any liquid and 1:1 assistance during meals because of her fractured right arm.

- The day after the patient was admitted, a SLP follow up visit progress note documented a decline in her swallow function. Orders per "Swallow Protocol" were written for a Dysphagia 2 mechanically altered diet with liquids thickened to nectar consistency.
- The second day after admission, an SLP follow up visit progress note documented the patient did not tolerate thin liquids, and her diet orders were changed. Orders per "Swallow Protocol" were written for a Dysphagia 2 mechanically altered diet with liquids thickened to honey consistency. The 1:1 assistance was continued to ensure oral clearing between bites.
- The third day after admission, an SLP progress note documented the patient had no difficulty with any viscosity of liquids. Orders were written for ADA (American Diabetic Association) dysphagia 2 mech-soft (mechanical soft), with any liquids.
- The fourth day after admission, a SLP progress note recommended the patient continue with the dysphagia 2 diet. The dietary modifications were not continued when she was placed on Comfort Care on the fifth day after admission, at which time all her previous orders were discontinued and a "General Diet" was ordered.

After the patient was placed on Comfort Care her care plan called for her to have a general diet. It did not include dysphagia precautions and mechanical soft texture as previously ordered.

During an interview on 10/21/13 beginning at 2:10 PM, a nurse assigned to care for the patient on 3/04/13, stated the care plan indicated a "General Diet." The nurse stated a general diet included foods without restrictions, such as low sodium, no concentrated sweets, etc. She was not aware of the texture requirements the patient had prior to being placed on "Comfort Care". She stated she was unaware the patient had been on a dysphagia 2 diet and 1:1 assistance with meals was required. She stated multiple family members were with the patient throughout that day and she had assumed they assisted their mother with lunch and dinner. The nurse stated when a family member told her the food was not appropriate, she thought they had meant Patient #5 did not want to eat and had refused the meal.

A federal deficiency was cited at 42 CFR 482.23(b)(4) as it relates to the failure of the facility to ensure a nursing care plan was developed and updated to ensure the patient's nutritional and dining needs were met.

Conclusion #4: Substantiated. Federal deficiencies related to the allegation are cited.

Allegation #5: The facility failed to maintain patients' privacy by leaving the curtain open.

Chris Roth, Administrator
November 01, 2013
Page 6 of 6

Findings #5: A tour of the hospital was conducted. During that time, three patient care units were observed for the provision of patient privacy. Although, at times, the privacy curtains were open and allowed visibility of patients, no patient care activities were noted to occur with the curtains open.

One patient record was that of a patient with dementia who was admitted for care after falling at her residence. It was determined by the facility she had a stroke and her wrist had been broken when she fell. The medical record documented that during her hospitalization she was transitioned to Comfort Care, had a bed alarm, and was a fall risk.

Multiple nursing staff that provided care to the patient during her hospitalization were interviewed. The nurses stated patients who are at risk for falls will have the curtain pulled for easy visibility of the patient. The nurses who were interviewed stated during patient care activities the curtain would be pulled to protect the patients' privacy.

It could not be determined through the investigative process that the hospital violated patients' privacy when privacy curtains remained open.

Conclusion #5: 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 was 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,



SUSAN COSTA
Health Facility Surveyor
Non-Long Term Care



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/pt