



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

January 2, 2015

Rodney Reider, Administrator
St Alphonsus Regional Medical Center
1055 North Curtis Road
Boise, ID 83706

RE: St Alphonsus Regional Medical Center, Provider #130007

Dear Mr. Reider:

This is to advise you of the findings of the complaint investigation, which was concluded at your facility on December 19, 2014.

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

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

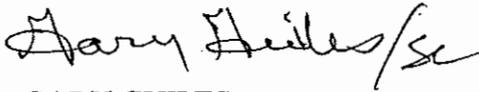
- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date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

Rodney Reider, Administrator
January 2, 2015
Page 2 of 2

Whether you choose to provide a plan of correction or not, please sign and date the form and return it to our office by **January 15, 2015**. 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, option 4.

Sincerely,



GARY GUILLES
Health Facility Surveyor
Non-Long Term Care



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

GG/pmt
Enclosures



**Saint Alphonsus
Regional Medical Center**

January 15, 2015

Sylvia Creswell
Idaho Department of Health and Welfare
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036

RECEIVED

JAN 20 2015

FACILITY STANDARDS

Dear Ms. Creswell:

Enclosed please find Saint Alphonsus Regional Medical Center's plan of correction (POC), which is intended to address a deficiency cited during a complaint investigation concluded on December 19, 2014.

The hospital does not admit or concede to a deficiency, but to the extent that an actual deficiency does exist, Saint Alphonsus Regional Medical Center is taking appropriate action to correct the deficiency, including the steps outlined in the attached POC. This plan of correction addresses Medicare tag A144.

We want to emphasize our absolute commitment to quality patient care and continued efforts to fulfill all regulatory requirements. Please contact me at 367-2902, if you have any questions or concerns regarding these documents.

Respectfully submitted,

Aline Lee, RN
Director of Patient Safety, Regulatory Compliance, and Infection Prevention
Saint Alphonsus Health System

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

PRINTED: 01/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/19/2014
NAME OF PROVIDER OR SUPPLIER ST ALPHONSUS REGIONAL MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1055 NORTH CURTIS ROAD BOISE, ID 83706	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS The following deficiency was cited during the complaint investigation of your hospital conducted from 12/16/14 to 12/19/14. The surveyors conducting the investigation were: Gary Guiles, RN, HFS, Team Leader Nancy Bax RN, HFS The survey was conducted to evaluate compliance with the Conditions of Participation of Patient Rights, Nursing Services, Infection Control, and Surgical Services. Acronyms used in this report include: OR - Operating Room	A 000		
A 144	482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: Based on staff interview and review of medical records and incident reports, it was determined the hospital failed to ensure surgical patients received care in a safe setting. This directly impacted 1 of 14 surgical patients (#19) whose records were reviewed and had the potential to impact all surgical patients. This resulted in the inability of the hospital to ensure further adverse events would not occur. Findings include: Patient #19's medical record documented a 59 year old female who was admitted for acute appendicitis on 11/25/14. She had an	A 144		1/15/15

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

TITLE

(X6) DATE

01/15/2015

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 144	<p>Continued From page 1 appendectomy on 11/25/14 and was discharged on 11/27/14.</p> <p>Patient #19's "Discharge Summary," dated 11/27/14 at 10:03 AM, stated "During the procedure, the patient slid off the Operating Room table." A physician progress note, dated 11/26/14 at 6:07 AM, stated Patient #19's operation was complicated by a fall from the Operating Room table. It stated she slid off when the table was placed in a head down position. It stated she did not appear to suffer any injuries from the fall. A physician progress note, dated 11/27/14 at 9:59 AM, stated Patient #19 was discharged home and would complete a 7 day course of antibiotics due to intraoperative contamination during the fall.</p> <p>The Manager of General, Vascular, and Trauma Surgery was interviewed on 12/18/14 beginning at 3:45 PM. The Manager stated Patient #19 had a safety strap across her thighs and one arm was strapped to an arm board when she fell from the OR table. She stated hospital staff had not determined a cause for the incident.</p> <p>An untitled incident report, not dated, stated Patient #19 had fallen from the OR table. The report stated she was secured to the table with a safety belt and arm straps. The report did not assign a cause for the event. The report stated the "Team" was looking into ways to "further secure" patients. No specific actions were documented to prevent further incidents of this type.</p> <p>The Director of Perioperative Services was interviewed on 12/19/14 beginning at 11:35 AM. He confirmed the incident. He stated the OR</p>	A 144		

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A 144	Continued From page 2 table was tilted to the side and with the head down. He stated he did not know the cause of the incident. He stated he had not completed an investigation of the incident. He stated no formal actions had been taken in response to the event. He stated he did not know of the time frame for completion of the investigation or for further action. The hospital failed to ensure a thorough investigation had been conducted following the incident. The hospital failed to take immediate steps to prevent similar incidents from occurring.	A 144			



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January 13, 2015

Rodney Reider, Administrator
St Alphonsus Regional Medical Center
1055 North Curtis Road
Boise, ID 83706

Provider #130007

Dear Mr. Reider:

On **December 19, 2014**, a complaint survey was conducted at St Alphonsus Regional Medical Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00006532

Allegation #1: The hospital failed to report infectious diseases to the appropriate state agency.

Findings #1: An unannounced visit was made to the hospital on 12/16/14-12/19/14. Patients and staff were interviewed. Clinical records of 20 patients, hospital policies, infection control and quality improvement records, and personnel records were reviewed.

The Idaho Administrative Procedures Act, 16.02.10-rules for "Idaho Reportable Diseases," accessed 12/19/14, stated hospitals are required to report "Streptococcus Pyogenes (Group A Strep), Invasive" to the Idaho Department of Health and Welfare within 3 working days.

The hospital had a list of infections that were required to be reported to the state. If a patient was diagnosed with one of the infectious organisms on the list, the state was notified of this. The hospital documented 546 infections were reported to the appropriate state agency in 2013. In 2014, 598 cases had been reported through 12/16/14. Invasive Streptococcus Pyogenes was included on the list of reportable infections. Two cases of Streptococcus Pyogenes were reported in 2013 and 2 were reported in 2014.

One patient's clinical record documented a 39 year old female who delivered a baby via Caesarean Section on 5/28/13. She was discharged on 6/01/13. A culture of the surgical wound on 6/24/13 grew Streptococcus Pyogenes.

The Hospital's Infection Prevention Specialist was interviewed on 12/17/14 beginning at 9:15 AM. She confirmed the overall numbers of infections reported to the state. She stated the hospital had software that linked directly to the state for reporting certain infections. She stated the above patient's Streptococcal infection was not reported because it did not meet the reporting criteria.

The Centers for Disease Control website, accessed on 12/19/14, defined invasive disease as "Laboratory Criteria for Diagnosis Isolation of group A Streptococcus (Streptococcus Pyogenes) by culture from a normally sterile site (e.g., blood or cerebrospinal fluid, or, less commonly, joint, pleural, or pericardial fluid)."

The Streptococcus Pyogenes the patient had did not meet the requirements for a reportable disease because it was cultured from an open wound instead of from a normally sterile site. This interpretation was confirmed via telephone with the Idaho Bureau of Communicable Disease Prevention on 12/17/14 at 10:15 AM.

No evidence was found to indicate the hospital failed to report infections as required.

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: Staff providing services in the operating room were not properly trained.

Findings #2: An unannounced visit was made to the hospital on 12/16/14-12/19/14. Patients and staff were interviewed. Clinical records of 20 patients, hospital policies, infection control and quality improvement records, and personnel records were reviewed.

Personnel files of 6 RNs, and 1 Certified Surgical Technologist (CST), who provided surgical services in the Maternity Center, were reviewed. Each of the files documented the clinician held a current state license, and certifications as required by hospital policy. Additionally, each file documented annual training and annual evaluations of the clinician's performance.

An RN who provided surgical services in the maternity center was interviewed on 12/18/14 at 1:35 PM. She stated Maternity Center RNs go through a 12 week orientation process upon hire, and work with an experienced RN in the OR until they are proficient.

A Certified Surgical First Assistant was interviewed on 12/18/14 at 2:50 PM. She stated her responsibilities included orientation and training of new CSTs. She stated the length of orientation for a new CST was individualized based on previous experience, but was approximately 6 months. The orientation included education on hospital policies and practices, as well as, individualized training in the OR.

A CST who worked in the Maternity Center was interviewed on 12/18/14 at 2:35 PM. She stated a CST is required to complete at least 60 continuing education units every 4 years to maintain certification. Additionally, she stated the hospital provided quarterly in-services for the CSTs, and annual training in hand hygiene and fire safety in the OR.

Review of personnel files and staff interviews indicated staff providing surgical services in the Maternity Center were licensed, and received training upon hire and annually. Their performance was evaluated on an annual basis. The allegation that staff were not properly trained could not be substantiated.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: The hospital failed to prevent surgical site infections.

Findings #3: An unannounced visit was made to the hospital on 12/16/14-12/19/14. Patients and staff were interviewed. Clinical records of 20 patients, hospital policies, infection control and quality improvement records, and personnel records were reviewed.

The hospital had an extensive hospital wide infection prevention program. Three full time certified Infection Prevention Practitioners were employed by the hospital. All positive cultures and reports of infections were reported to the Practitioners who maintained data and analyzed it.

The program was overseen by a group of Infectious Disease Physicians. One of these physicians was interviewed on 12/18/14 beginning at 9:35 AM. He stated he met weekly with a working group consisting of the Infection Prevention Practitioners, physicians, pharmacy personnel, and laboratory personnel to discuss infection prevention issues. He stated a larger Infection Prevention Committee consisting of physicians, nurses, laboratory personnel, administrative personnel, the Epidemiologist for the state of Idaho, and others met every other month to direct the hospital's infection prevention efforts. He stated the hospital monitored surgical site infection rates related to surgeries of the colon, hips, knees, laminectomies, hysterectomies, and others.

Infection Prevention Committee minutes, dated 10/28/14, 8/26/14, and 6/24/14, were reviewed. Broad ranging data and statistics accompanied the minutes. Standardized Infection Ratios for surgical site infections for 2013 and 2014 were lower than expected, indicating lower than average infection rates. The hospital performed hand washing surveillance, to determine staff compliance with hand hygiene. Current hand hygiene rates, with staff not aware they were being observed, were above 99%.

Three physicians who performed surgery at the hospital were interviewed during the survey. All of the surgeons were asked if they had concerns regarding infection prevention in the operating rooms. None of the physicians expressed concerns about infection prevention in the operating rooms. They were asked if they could identify any cases about which they had infection prevention concerns. None of the physicians were able to identify such cases.

The records of 5 patients with surgical site infections following Caesarean Section surgery from 1/01/13 through 12/15/14 were reviewed. In addition, 3 records of patients with surgical site infections following hysterectomies were reviewed. No infection prevention issues were identified.

Conclusion #3: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: The hospital failed to protect surgical patients from accidents.

Findings #4: An unannounced visit was made to the hospital on 12/16/14-12/19/14. Patients and staff were interviewed. Clinical records of 20 patients, hospital policies, infection control and quality improvement records, and personnel records were reviewed.

One patient's medical record documented a 59 year old female who was admitted for acute appendicitis on 11/25/14. She had an appendectomy on 11/25/14 and was discharged on 11/27/14.

The patient's "Discharge Summary," dated 11/27/14 at 10:03 AM, stated "During the procedure, the patient slid off the Operating Room table." A physician progress note, dated 11/26/14 at 6:07 AM, stated the patient's operation was complicated by a fall from the Operating Room table. It stated she slid off when the table was placed in a head down position. It stated she did not appear to suffer any injuries from the fall. A physician progress note, dated 11/27/14 at 9:59 AM, stated the patient was discharged home and would complete a 7 day course of antibiotics due to intraoperative contamination during the fall.

The Manager of General, Vascular, and Trauma Surgery was interviewed on 12/18/14 beginning at 3:45 PM. The Manager stated at the time of the fall the patient had a safety strap across her thighs and one arm was strapped to an arm board to help maintain an intravenous line. She stated hospital staff had not determined a cause for the incident.

An untitled incident report, not dated, stated the patient had fallen from the Operating Room table. The report stated she was secured to the table with a safety belt and arm straps. The report did not assign a cause for the event. The report stated the "Team" was looking into ways to "further secure" patients. No causes were identified and no specific actions were documented to prevent further incidents of this type.

The Director of Perioperative Services was interviewed on 12/19/14 beginning at 11:35 AM. He confirmed the incident. He stated the Operating Room table was tilted to the side and with the head down when the incident occurred. He stated he did not know the cause of the incident. He stated he had not completed an investigation of the incident. He stated no formal actions had been taken in response to the event. He stated he did not know of the time frame for completion of the investigation or for further action.

The hospital did not conduct a thorough investigation following the incident. As of 12/19/14, 22 days after the incident, the hospital had not taken steps to prevent similar incidents from occurring. A deficiency was cited at 42 CFR Part 482.13(c)(2) for the failure of the hospital to ensure surgical services were provided in a safe setting.

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

Allegation #5: Newborn babies were not examined by a physician in a timely manner.

Findings #5: An unannounced visit was made to the hospital on 12/16/14-12/19/14. Patients and staff were interviewed. Clinical records of 20 patients, hospital policies, infection control and quality improvement records, and personnel records were reviewed.

The hospital's Medical Staff Bylaws, Section 4, Article 7, approved 2/11/14, stated all patients required a complete history and physical examination within 24 hours of admission.

The medical records of 6 newborn babies were reviewed.

- One baby, born on 2/05/13, was examined by a physician 2 hours after birth.
- Another baby, born on 5/28/13, was examined by a physician 23.5 hours after birth.
- Another baby, born on 2/27/14, was examined by a physician 4 hours after birth.
- Another baby, born on 11/26/14, was examined by a physician 21 hours after birth.
- Another baby, born on 12/04/14, was examined by a physician 9 hours after birth.
- Another baby, born on 11/27/14, was examined by a physician 9 hours after birth.
- Another baby, born on 5/28/13, was examined by a physician 23.5 hours after birth.

Six of 6 newborn babies, whose records were reviewed, were examined by a physician within 24 hours of birth, as required by hospital bylaws. None of the newborn's records documented a problem/illness that was not addressed by a physician in a timely manner. Newborn babies were examined consistent with Medical Staff Bylaws.

Conclusion #5: Unsubstantiated. Lack of sufficient evidence.

Allegation #6: Laboratory reports were accidentally given to unauthorized persons.

Findings #6: An unannounced visit was made to the hospital on 12/16/14-12/19/14. Patients and staff were interviewed. Clinical records of 20 patients, hospital policies, infection control and quality improvement records, and personnel records were reviewed.

The 2 most recent "HIPAA (Health Insurance Portability and Accountability Act) Privacy and Security Council" meeting minutes dated 10/31/14 and 8/11/14 were reviewed. The minutes encompassed a 4 month period. Four incidents of persons receiving information meant for another were noted. These included 2 patients who received the wrong discharge instructions, a pharmacy that received a wrong fax, and a patient who received a wrong billing statement. These included incidents for the hospital and approximately 30 clinics.

The Health Systems Integrity and Compliance Officer was interviewed on 12/17/14 beginning at 3:30 PM. She described systems in place to investigate and track incidents involving persons who received unauthorized personal health information.

The hospital had systems in place to identify and track breaches in the protection of personal health information. It could not be proven through the investigative process that the hospital failed to maintain protected health information.

Conclusion #6: Unsubstantiated. Lack of sufficient evidence.

Allegation #7: Physician notes could be altered and deleted after they were dictated.

Findings #7: An unannounced visit was made to the hospital on 12/16/14-12/19/14. Patients and staff were interviewed. Clinical records of 20 patients, hospital policies, infection control and quality improvement records, and personnel records were reviewed.

Three physicians were interviewed during the survey. All 3 stated dictated reports were presented to physicians for review after they were transcribed. Physicians then checked the transcript for accuracy and changes could be made. All of the physicians stated they did not think progress notes could be altered or deleted after they were finalized.

The Health Systems Integrity and Compliance Officer was interviewed on 12/17/14 beginning at 3:30 PM. She stated progress notes could not be altered or deleted after they were finalized.

No evidence was found that progress notes could be altered or deleted after they were finalized.

Conclusion #7: Unsubstantiated. Lack of sufficient evidence.

Allegation #8: Impaired nurses were allowed to provide surgical services in the Maternity Center.

Findings #8: An unannounced visit was made to the hospital on 12/16/14-12/19/14. Patients and staff were interviewed. Clinical records, hospital policies, infection control and quality improvement records, and personnel records were reviewed.

A hospital policy, titled Injury, Illness and Exposure Reporting-Colleague, dated 7/08/14, stated an employee must have a return to work authorization from the treating provider, or clearance from Employee Health Services for:

- an absence from work of 3 or more days
- an illness or injury which results in work restrictions that may affect the ability of the employee to safely and effectively perform
- a medical condition or use of medication that may affect the ability of the employee to safely and effectively perform

Personnel files of 6 RNs who provided surgical services in the Maternity Center were reviewed. Each of the files documented annual evaluations of the clinician's performance. Any concerns with performance were addressed in a timely and appropriate manner to ensure the RNs were competent to provide surgical services.

An RN who provided surgical services in the maternity center was interviewed on 12/18/14 at 1:35 PM. She stated Maternity Center RNs went through a 12 week orientation process upon hire, and work with an experienced RN in the OR until they are proficient.

During the interview, the RN was noted to wear glasses which resembled sunglasses. Upon questioning, the RN stated the glasses were prescription glasses that were treated to filter the light due to her light sensitivity. She stated she had been wearing the glasses for approximately 2 years and stated they did not darken her vision. She allowed the surveyor to examine the glasses and look through them. It was confirmed the glasses did not darken the visual field.

Five current patients of the Maternity Center were interviewed. All 5 patients stated the nurses were attentive to their needs and competent in their duties.

RNs in the Maternity Center were trained and received annual performance evaluations. The hospital's policy required medical authorization to determine employees were competent to perform their duties. Current patients expressed satisfaction with the care provided. The allegation that impaired nurses were allowed to provide services in the Maternity Center could not be substantiated through the investigative process.

Conclusion #8: Unsubstantiated. Lack of sufficient evidence.

Rodney Reider, Administrator
January 13, 2015
Page 8 of 8

Allegation #9: Newborn babies were not handled in a safe manner by Maternity Center nurses.

Findings #9: An unannounced visit was made to the hospital on 12/16/14-12/19/14. Patients and staff were interviewed. Clinical records, hospital policies, infection control and quality improvement records, and personnel records were reviewed.

The Maternity Center Supervisor was interviewed on 12/17/14 at 10:20 AM. She stated the nurses in the Maternity Center were trained and experienced in handling babies. She stated a nurse may bathe a baby in the bassinet or at the sink, and may obtain a baby's footprints while they are in the bassinet or while they are holding the baby. She stated the hospital did not have a policy specifying how to hold a baby during bathing or to obtain footprints, however, the nurses were experienced in the care of newborns and in securing them safely.

Four women who had recently given birth at the Maternity Center were interviewed. All 4 patients stated they observed the nurses in the Maternity Center with their newborn babies and they felt confident the babies were handled in a safe manner.

RNs in the Maternity Center were trained and experienced in the care of newborns. Current patients expressed confidence that their babies were handled safely by the RNs. The allegation that newborn babies were not handled in a safe manner by Maternity Center nurses could not be substantiated through the investigative process.

Conclusion #9: 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, option 4. 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

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