Saint Alphonsus

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AUG 25 2010

FACILITY STANDARDS

August 23, 2010

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

Dear Ms. Creswell:

Attached please find Saint Alphonsus Regional Medical Center's plan of correction, which is intended to address and rectify deficiencies cited during a complaint investigation conducted on August 3-4, 2010. This plan of correction addresses the Medicare deficiencies found for tag A123.

We want to emphasize our absolute commitment to quality patient care and continued efforts to fulfill all regulatory requirements. We thank you for identifying this improvement opportunity.

Respectfully submitted,

Aline Lee

Aline Lee
Director of Patient Safety and Regulatory Compliance

1055 North Curtis Road
Boise, ID 83706-1370
Phone: (208) 367-2121
www.saintalphonsus.org

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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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August 16, 2010

Sally Jeffcoat, Administrator
St Alphonsus Regional Medical Center
1055 North Curtis Road
Boise, ID 83706

RE: St Alphonsus Regional Medical Center, Provider #130007

Dear Ms. Jeffcoat:

This is to advise you of the findings of the complaint investigation, which was concluded at your facility on August 4, 2010.

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.

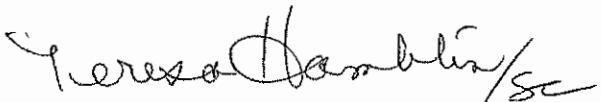
An acceptable plan of correction (PoC) contains the following elements:

- 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.

Whether you choose to provide a plan of correction or not, please sign and date the form and return it to our office by **August 30, 2010**. 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,



TERESA HAMBLIN
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

TH/srp
Enclosures

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

PRINTED: 08/13/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	130007		C 08/04/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ALPHONSUS REGIONAL MEDICAL CENTER	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 deficiencies were cited during the complaint investigation survey completed at your hospital. The surveyors conducting the survey were: Teresa Hamblin, RN, MS, HFS, Team Leader Gary Banister, RN, HFS Susan Costa, RN, HFS Acronyms used in this report include: IV = Intravenous MRSA = Methicillin-Resistant Staphylococcus Aureus NICU = Neonatal Intensive Care Unit PCL = Patient Concern Line RN = Registered Nurse	A 000	RECEIVED AUG 25 2010 FACILITY STANDARDS	
A 123	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 grievances and facility policy, and staff interview it was determined the facility failed to provide a written response which included all the results of the grievance process for 3 of 4 patients (#2, #5 and #6) and/or family members who filed grievances related to patient injury and who had been referred to Risk Management. This failure resulted in a lack of	A 123	Please see attached plan of correction.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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 123	Continued From page 1 clarity and closure regarding the resolution of the grievance and had the potential to interfere with patient/family understanding and satisfaction. Findings include: The hospital's grievance policy, "CONCERN AND GRIEVANCE MANAGEMENT PROGRAM," dated 9/85, and reviewed 9/04, stated "The complainant and/or family, as appropriate, will receive an indication of how the investigation will be conducted and who the contact person will be during the investigation. The issues will then be forwarded to the appropriate division/department(s) director/manager(s) who will ensure that an investigation is completed and appropriate action is taken, with the goal of completing the (grievance) process within one week." The grievance policy described multiple options for a patient or family member to enter a concern, complaint, or grievance. One such method was by phone, called "Patient Concern Line" (PCL), which was triaged by the Patient Relations Coordinator. In an interview on 8/03/10 at 1:55 PM, the Patient Relations Coordinator stated her department documented patient and family contact from the point of complaint or grievance through to closure using a software program called "i-Sight." The i-Sight document would indicate the status of the case, which would include documentation of the dates created, assigned, confirmed, and closed. She further explained that when her department referred a case to Risk Management, an incident report would then be generated in another software system called QSTATIM Incident Manager, and the i-Sight record was then closed	A 123		

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A 123	Continued From page 2 by Patient Relations. In an interview on 8/03/10 at 2:35 PM the Risk Management Specialist stated upon receipt of a referral, her department would follow the grievance through to resolution as per the written policy. The Risk Management Specialist stated her department utilized a different software program from the Patient Relations department. She said the two different programs did not interface with one another, and her department relied upon a software program "QSTATIM Incident Manager" to identify if the referral was due to patient injury or a grievance. In the following examples, patients/family members did not receive written responses from the hospital related to their grievances. 1. A call to the PCL on 6/10/10 by a family member of Patient #2 was documented in i-Sight. The family member had stated Patient #2 had fallen out of bed after the use of a sitter had been discontinued. The document indicated the case had been determined to be a grievance, and triaged to Risk Management. Closure for the i-Sight document was 6/11/10 at 11:05 AM. A QSTATIM Incident Manager incident report, opened on 6/11/10 at 11:04 AM, identified the incident as a fall. In the "Incident Description" section of the report, there was an e-mail describing the PCL grievance from the family member of Patient #2. There was no evidence the family member of Patient #2 had been informed in writing of the grievance investigation or outcome. In an interview on 8/03/10 at 2:45 PM, the Risk Management Specialist stated the QSTATIM	A 123		

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A 123	Continued From page 3 Incident Manager report had identified the incident as a fall, rather than a grievance. She stated the investigation for the fall had been completed 7/20/10. The Risk Management Specialist stated she had not contacted the family of Patient #2 or followed up with a written response. 2. A call to the PCL on 5/18/10 by a family member of Patient #6 was documented in i-Sight. A family member had called with a complaint that Patient #6 had been scheduled to be discharged home, but the discharge would be postponed. Patient #6's IV had disconnected and he experienced a large blood loss as a result, requiring multiple transfusions. The document indicated the grievance filed by Patient #6's family member had been determined to be a grievance, and had been triaged to Risk Management. Closure for the i-Sight document was 5/18/10 at 4:39 PM. A QSTATIM Incident Manager report, opened on 5/18/10 at 4:38 PM, identified the incident as "Patient Care." In the "Incident Description" of the report was a note describing the PCL grievance initiated by the family member of Patient #6. There was no evidence the son of Patient #6 had been informed in writing of the grievance investigation or outcome. In an interview on 8/03/10 at 3:00 PM, the Risk Management Specialist stated the incident report had identified the incident as patient care related, rather than a grievance. The Risk Management Specialist stated she had not contacted the family of Patient #6 or followed up with a written response. 3. A call to the PCL on 5/26/10 by the mother of Patient #8 was documented in i-Sight. The	A 123		

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A 123	Continued From page 4 mother called with a complaint that Patient #8 had contracted a MRSA infection during his hospitalization. Patient #8 had previously tested negative for this infection. The document indicated the case had been determined to be a grievance, and triaged to Risk Management. Closure for the i-Sight document was on 5/26/10 at 11:50 AM. A QSTATIM Incident Manager report, opened on 5/26/10 at 11:42 AM, identified the incident as "Patient Care." In the "Incident Description" of the report was a note describing the PCL grievance phone call with the family member of Patient #8. There was no evidence the family member of Patient #8 had been informed in writing of the grievance investigation or outcome. In an interview on 8/03/10 at 3:10 PM, the Risk Management Specialist stated the incident report had identified the incident as patient care related, rather than a grievance. The Risk Management Specialist stated the NICU Manager, Physician, and Infection Control Nurse had met with a family member of Patient #8, and she felt the issue had been resolved. The Risk Management Specialist reviewed the incident report and confirmed the grievance had not been followed up with a written response. The hospital failed to investigate, resolve, and respond to complainants in writing.	A 123		

Saint Alphonsus Regional Medical Center's Plan of Correction
Survey August 3-4, 2010
Tag A 123

The lack of grievance response letters was related to having two separate systems to manage grievances and incidents. To improve the referral of grievances from the Patient Relations Department to the Risk Management department, a short-term and a long-term plan has been developed. The long-term solution is that Trinity Health System is in the process of purchasing and implementing a combined incident reporting and grievance management system which will be implemented at Saint Alphonsus within the next year. In the meantime and effective immediately, grievances that are referred to Risk Management from Patient Relations will be labeled as "Grievances" in the incident reporting system (QStatim) so that they will be immediately identified by Risk Management for a follow-up letter.

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August 16, 2010

Sally Jeffcoat, Administrator
St Alphonsus Regional Medical Center
1055 North Curtis Road
Boise, ID 83706

Provider #130007

Dear Ms. Jeffcoat:

On **August 4, 2010**, a complaint survey was conducted at St Alphonsus Regional Medical Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004662

Allegation #1: Hospital staff failed to maintain appropriate measures to prevent a patient from falling out of bed. Specifically, the hospital inappropriately discontinued the use of a patient sitter and failed to keep side rails up, resulting in a patient's fall. There was a delay in reporting the fall to the patient's family.

Findings #1: An unannounced visit was made to the hospital on August 3 through August 4, 2010. During the complaint investigation, surveyors interviewed staff and reviewed patient records, hospital policies, incident reports, grievances, and the hospital's plan to reduce the risk of patient falls.

Overall, it was found the hospital focused on efforts to prevent patient falls. The hospital had Fall Prevention teams dedicated to prevent patient falls from occurring. Representatives included: Nurse Managers, Risk Management, Patient Safety, Performance Improvement, Clinical Education, and nursing representation. As of July of 2009 the hospital established "Unit Champions," nursing clinical leaders selected to represent their inpatient units with the overall goal to implement interventions to improve patient safety and quality. In addition to measures to reduce

the risk of patients falling, the hospital established a debriefing process after falls. Anyone involved with the care of the patient who fell was expected to be involved with the debriefing process to discuss what contributed to the fall and how future falls could be prevented.

The hospital's policy, "Fall Risk Assessment and Prevention," stated patients would be evaluated for the risk of falling within 12 hours of admission and at least twice daily. Interventions to prevent falls would be based on patients' risk level (as determined by use of a Fall Risk Assessment Scale) and on clinical judgment. The policy recommended interventions to reduce the risk of patients falling. For example, the policy recommended putting the upper two side rails in the up position for patients considered low risk of falling, and putting four side rails up for patients at moderate risk of falling. There were multiple interventions listed in the policy as potential measures to help reduce the risk of patients falling. The policy stated that if a patient fell, the doctor and the family would be notified immediately if an injury was suspected and within 8 hours if no injury was suspected or observed.

The hospital also had a policy, titled "Patient Safety Attendants (PSA)" (also called patient sitters). The policy listed eligibility criteria for patients to receive sitters. For example, a patient was supposed to meet 3 out of 4 of the following listed conditions to qualify for a sitter: 1) be impulsive; 2) demonstrate self-injurious behavior; 3) be cognitively impaired or confused; and/or 4) be unsteady on his/her feet. When an RN identified a need for a patient sitter, the RN was required to complete and submit a request form for approval of a patient sitter. The form had to be filled out every 8 hours to get continued sitter support (based on meeting eligibility criteria). The policy did not require a doctor's order to initiate or discontinue use of a patient sitter, except under special circumstances. For example, an RN could not discontinue a sitter without a physician's order if a patient was suicidal or under a legal hold. Otherwise, the RN could discontinue sitter services based on assessment of the patient's need for a sitter, according to established criteria.

In spite of the hospital's efforts to prevent falls, documentation of incident reports indicated patient falls still occurred. One example follows:

One 80 year old patient was admitted to the hospital on 5/09/10 after a serious accident resulting in multiple pelvic fractures. The patient had been receiving sitter services up until several hours prior to sustaining a fall in his hospital room on 6/07/10 around 7:45 PM.

An RN note written prior to the fall, dated 6/07/10 at 10:30 AM, documented the RN

had evaluated the patient and discontinued the patient's sitter. The RN's note described the patient as alert and able to follow commands and stated the patient had not attempted to get out of bed or pull at any lines. Based on the nursing documentation, the patient did not meet eligibility criteria for continued sitter services. The nursing plan of care was to continue to monitor the patient closely. The following fall prevention measures were documented in the patient's record prior to the fall: 1) the patient was in a room close to the nursing station; 2) the call bell was within reach; 3) the patient was checked on every one to two hours; 4) the patient was verbally reminded to use the call light; 5) a yellow arm band was on the patient's wrist and a yellow flag on the patient's door to alert staff to the patient's risk of falling; 6) personal items were within reach; and 7) a light was on in the patient's room.

A nursing note, dated 6/07/10 at 7:45 PM indicated the patient was found on the floor in his room with blood on his gown from a urinary catheter being pulled out. The nursing note documented nursing staff evaluated the patient for injuries after discovering the patient on the floor. No lacerations or bruises were present. Although the patient reported hitting his head during the fall, no redness or open areas were visible on his head. Vital signs were found to be within normal limits. The patient's pupils were equal and reactive. No new skin issues were identified. The patient was alert and did not appear to be in distress. With the assistance of several people and a bath blanket, the patient was assisted back to bed and cleaned up. The physician was notified right away and orders were received for an x-ray. There was no documentation in the record as to when the family was notified. It would have been the intention of staff, based on policy, to contact the family immediately if staff suspected an injury or within 8 hours if no injuries were suspected. There may have been a delay in staff contacting family. Federal and State regulations do not include a specific timeframe for family notification.

As per hospital policy, the incident was documented to allow for investigation into the causes of the fall and to implement measures to reduce the risk of additional injury. The hospital took immediate measures to keep the patient safe. Sitter services were re-started.

During the investigation, grievances were reviewed related to patient incidents/injuries. A grievance, related to the patient incident referenced above was included in the grievance files that were reviewed. In reviewing the hospital's responses to grievances, it was determined the hospital failed to send complainants written responses to their grievances informing them of the steps taken to investigate the grievances and the results of the investigation. The hospital was cited at CFR

482.13(a)(2)(iii) for failure to provide patients/complainants with a written response to grievances.

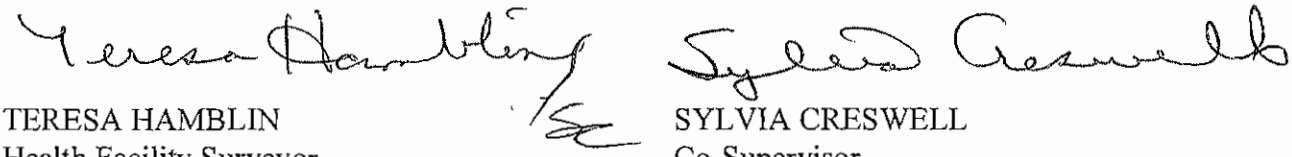
Although it is possible the patient's fall may have been prevented if a sitter had been present in the patient's room, there was a lack of evidence to suggest the hospital staff failed to make efforts to prevent falls or inappropriately discontinued sitter services.

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.

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

Sincerely,



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