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 83720-0036
PHONE 208-334-6626
FAX 208-364-1888



September 8, 2008

Sheryl Rickard
Bonner General Hospital
520 North Third Avenue
Sandpoint, ID 83864

Provider #130024

Dear Ms. Rickard:

On **August 28, 2008**, a omplaint Survey was conducted at Bonner General Hospital. The complaint allegations, findings, and conclusions are as follows:

**Complaint #ID00003570**

**Allegation #1**: Patients were treated without compassion or respect at a hospital clinic.

Findings: An unannounced visit was made to the hospital and a hospital based clinic in Priest River, Idaho, on August 28, 2008. Client files, hospital Policies and Procedures, and grievances were reviewed at this time. Clinic and hospital staff were interviewed. An independent physician and a clinic patient were interviewed to validate findings of the investigation.

Another clinic was referenced in the complaint. This clinic was located on hospital property, however, it was owned and operated independently. The physician who operated the clinic just rented the space from the hospital. He was not a hospital employee. Services at the clinic were not billed under the hospital's provider number. Since the clinic was not a hospital-based entity, the Conditions of Participation did not apply. No problems with care or patient rights at the hospital based clinic were identified.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

**Allegation #2**: Clinic patients' pain issues were not adequately addressed, nor were their pain issues taken seriously.

Findings: The allegations referenced in the complaint took place at a private clinic that was not owned or operated by the hospital or billed through the hospital. Since it was not a hospital-based entity, the Conditions of Participation did not apply. During the course of the investigation, problems with the hospital's grievance procedure were identified. Deficiencies unrelated to the complaint were cited at 42 CFR 482.13.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

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

Sincerely,

Teresa Hamblin for Gary

GARY GUILES
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

GG/mlw

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September 8, 2008

Sheryl Rickard
Bonner General Hospital
520 North Third Avenue
Sandpoint, ID 83864

RE: Bonner General Hospital, provider #130024

Dear Ms. Rickard:

This is to advise you of the findings of the complaint survey at Bonner General Hospital which was concluded on August 28, 2008.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicare deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. It is important that your Plan of Correction address each deficiency in the following manner:

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for <u>all</u> individuals potentially impacted by the deficient practice.

2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.

3. Identify the date each deficiency has been, or will be, corrected.

4. Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **September 21, 2008**, and keep a copy for your records.

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

Sincerely,

Teresa Hamblin for

GARY GUILES
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

GG/mlw

Enclosures

BGH BONNER GENERAL HOSPITAL, INC.

September 16, 2008

Teresa Hamblin
Bureau of Facility Standards
PO Box 83720
Boise, ID 83720-0036

Dear Teresa,

I would like to thank you for the visit we received August 28, 2008. It was a difficult process but I have learned a lot from the visit and feel our grievance process is much more streamlined and very close to being compliant.

I reviewed the Statement of Deficiencies/Plan of Correction and addressed each problem with a plan of action. Sheryl Rickard, BGH CEO, reviewed plan of action afterwards and signed and dated as requested.

If I haven't addressed any/ or all deficiencies to your satisfaction please contact me so I may do so. I take my responsibility seriously and again thank you for bringing non-compliant issues and heading me in the right direction.

Respectfully,

Linda Rammler

Linda Rammler
Quality/Risk Management Director
Bonner General Hospital
PO Box 1448
Sandpoint, ID 83864-0877
linda.rammler@bonnergen.org
208-265-1234

PRINTED: 09/03/2008
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: | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 130024 | | C<br>08/28/2008 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BONNER GENERAL HOSPITAL | 520 NORTH THIRD AVENUE<br>SANDPOINT, ID 83864 |

| (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 |
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| A 000 | INITIAL COMMENTS<br><br>The following deficiencies were cited during a complaint survey of your hospital.<br><br>The following surveyors conducted the survey:<br><br>Gary Guiles, RN, HFS, Team Leader<br>Teresa Hamblin, RN, MS, HFS<br>Sharon Mauzy, RN, HFS | A 000 | RECEIVED<br>SEP 22 2008<br>FACILITY STANDARDS | |
| A 119 | 482.13(a)(2) PATIENT RIGHTS: REVIEW OF GRIEVANCES<br><br>[The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance.] The hospital's governing body must approve and be responsible for the effective operation of the grievance process, and must review and resolve grievances, unless it delegates the responsibility in writing to a grievance committee.<br><br>This STANDARD is not met as evidenced by: Based on interview with the Director of Quality/Risk Management, review of hospital policies, procedures, and grievance files, it was determined the hospital failed to ensure effective operation of the grievance process. This resulted in: 1) inconsistency between hospital policies and actual practice; 2) failure to designate and track grievances as grievances; 3) failure to consistently document measures taken to resolve grievances; 4) failure to consistently provide written responses to patients and or families as to the steps taken to investigate and resolve grievances; 5) failure to integrate the grievance process into the hospital's quality improvement activities. These failures had the potential to interfere with effective investigation and resolution of grievances. Findings include: | A 119 | process for prompt resolution developed & implementation will be complete by 10/1/08 | 10/01/08 |

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 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.

Linda Ramer RN Quality/Risk Management Director



Sheryl L Rickard, CEO Sheryl L Rickard 9/18/08 Linda Ramer

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| A 119 | Continued From page 1 | A 119 | | |
| | 1) Inconsistency between Hospital Policies and Actual Practice | | 1) | |
| | The hospital policy titled "Patient Grievance," dated March 28, 2006, included the following excerpts: 1) "...Information obtained in resolving such issues will be used to the extent possible, in the ... Performance Improvement Process to prevent similar concerns from recurring." 2) "The Board will receive reports from the Quality Management Committee, which will include the nature of the grievance, the results of the investigation and subsequent follow-up with the grievance, and any changes in ... processes resulting from the investigation." 3) Documentation of the grievance, investigation, analysis, and subsequent resolution will be completed on a ... Risk Management form and submitted to the Risk Management Department." | | 1. policy updated - SEE ATTACHED.<br>2. Qrtly reports to the Quality committee + the Board of directors.<br>3. Risk management form will be re-instated. Form updated - SEE attached | 9/19/08<br>Qrtly mtg OCTOBER.<br>9/19/08 |
| | During an interview on 8/28/08 at 3:18 PM, the Director for Quality/Risk Management 1) denied that there was any current practice in place for integrating grievances into the hospital's performance improvement process; 2) denied that the Board received reports from the Quality Management Committee regarding the grievance investigation, resolution, and changes in ... processes that occurred as a result of the grievance investigation and analysis; 3) stated that the hospital had not used the "Risk Management" form (referred to in the hospital policy) since at least January of 2008. | | | |
| | 2) Failure to Designate and Track Grievances as Grievances | | 2) Excell grievance log immediately created. All completed grievances filed in pt. complaint notebook. No longer part of Incident Reports | complete 8/29/08 |
| | During an interview on 8/28/08 at 9:54 AM, the | | | |

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| A 119 | Continued From page 2<br>Director for Quality and Risk Management explained that the hospital did not keep a grievance log or have dedicated files or forms for grievances. Instead, grievances relating to patient care were documented by hospital staff on incident report forms along side hospital incidents, such as needle sticks and patient falls. In order to review grievances, it was necessary to sort through all incident reports and extract grievances. This process did not allow for effective retrieval, analysis, and processing of grievances. | A 119 | | |
| | 3) Failure to Consistently Document Measures Taken to Resolve Grievances<br><br>During an interview on 8/28/08 at 9:54 AM, the Director for Quality and Risk Management explained that although hospital staff do their best to respond to grievances of patients and family members, they have not been consistent in documenting all the steps taken to investigate and resolve the grievances. For example, they may not have documented conversations between staff or specifics of phone calls with complainants. Failure of the hospital to document steps that were taken had the potential to make it difficult to evaluate whether grievances were investigated and responded to in an appropriate manner. | | 3. Risk management form re-instituted to be completed for any pt/family complaint or grievance | 9/19/08 |
| | 4) Failure to Consistently Provide Written Responses to Grievances<br><br>Refer to Federal tag 123 as it relates to the hospital's failure to provide written responses to grievances. | | 4. written notice to patient developed which includes summary of grievance, date grievance received, hospital decision, steps taken to investigate + results | 9/5/08 initiated |
| | 5) Failure to Integrate the Grievance Process into | | | |

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| A 119 | Continued From page 3<br>the Hospital's Quality Improvement Activities<br><br>Surveyors reviewed minutes of seven meetings held between July 2007 and April 2008 for the Quality Management Committee. No documentation was found in the meeting minutes to indicate that Committee members discussed the grievance process, addressed any specific grievances, or attempted to incorporate information related to grievances into the discussions for quality assurance or performance improvement. During an interview on 8/28/08 at 3:18 PM, the Director of Quality and Risk Management confirmed that information related to grievances had not been incorporated into the Quality Management Committee meetings for quality improvement activities.<br><br>The hospital failed to operate an effective grievance process. | A 119 | 5. Qrtly reports to quality committee c̄ agenda to discuss grievances for quality assurance / PI | 1ST Qtrly meeting OCTOBER |
| A 123 | 482.13(a)(2)(iii) PATIENT RIGHTS: NOTICE OF GRIEVANCE DECISION<br><br>At a minimum:<br>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.<br><br>This STANDARD is not met as evidenced by:<br>Based on interviews with the Director of Quality and Risk Management and review of grievance files, it was determined the hospital failed to provide written responses to 4 of 5 patients (#'s 1, 2, 3, 4 and 5) and/or family members who had initiated grievances against the hospital. This | A 123 | WRITTEN NOTICE implemented. See attached<br><br>EACH written notice, risk management form sent to CEO for review + initialed for documentation. Implemented immediately | 9/5/08<br><br>9/5/08 |

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| A 123 | Continued From page 4 resulted in a lack of clarity and closure about the resolution of the grievances and had the potential to interfere with patient understanding and satisfaction. Findings include:<br><br>Surveyors initially requested to view the grievance log for May, June, and July of 2008. Instead of being given the grievance log, staff provided surveyors with the incident reports for the same time period. During an interview on 8/28/08 at 9:54 AM, the Director of Quality and Risk Management explained that the hospital did not keep a grievance log or have dedicated files or forms for grievances. Instead, grievances relating to patient care were documented by hospital staff on Incident Report forms along side hospital incidents, such as needle sticks and patient falls. Surveyors read the incident reports, found and extracted 5 complaints or grievances that had required follow-up on the part of the hospital.<br><br>No documentation was found in 4 out of 5 grievances (#'s 1, 2, 3, 4, and 5) to indicate the hospital responded in writing to the parties that filed complaints/grievances. During an interview on 8/28/08 at 3:18 PM, the Director of Quality and Risk Management confirmed that the hospital did not respond in writing to patients and/or families at the conclusion of the grievance investigation in 4 out of the 5 grievances. She explained that instead of writing letters, the grievances were often handled with phone calls and that the steps taken to resolve the grievances were not consistently documented.<br><br>In its resolution of grievances, the hospital failed to provide written notification to patients and families. | A 123 | | |

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