IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

CERTIFIED MAIL: 7007 0710 0002 7979 0536

November 10, 2010

Gary Fletcher, Administrator
St Lukes Regional Medical Center
190 East Bannock Street
Boise, ID 83712

RE: St Lukes Regional Medical Center, Provider #130006

Dear Mr. Fletcher:

Based on the survey completed at St Lukes Regional Medical Center, on October 28, 2010, by our staff, we have determined St Lukes Regional Medical Center, is out of compliance with the **Condition of Participation of Governing Body (42 CFR 482.12)**. To participate as a provider of services in the Medicare Program, a hospital must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

The deficiencies, which caused these conditions to be unmet, substantially limit the capacity of St Lukes Regional Medical Center, to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). Enclosed also, is a similar form describing State licensure deficiencies.

You have an opportunity to make corrections of those deficiencies, which led to the finding of non-compliance with the Conditions of Participation referenced above by submitting a written Credible Allegation of Compliance/Plan of Correction.

An acceptable Plan of Correction contains the following elements:

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction

for each deficiency cited;

- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the PoC is effective in bringing the hospital into compliance, and that the hospital remains in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
- The administrator's signature and the date signed on page 1 of each form.

Such corrections must be achieved and compliance verified by this office, before December 12, 2010. To allow time for a revisit to verify corrections prior to that date, it is important that the completion dates on your Credible Allegation/Plan of Correction show compliance no later than December 2, 2010.

Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **November 23, 2010**.

Failure to correct the deficiencies and achieve compliance will result in our recommending that CMS terminate your approval to participate in the Medicare Program. If you fail to notify us, we will assume you have not corrected.

We urge you to begin correction immediately.

If you have any questions regarding this letter or the enclosed reports, please contact me at (208) 334-6626.

Sincerely,

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/srm
ec: Debra Ransom, R.N., R.H.I.T., Bureau Chief
Kate Mitchell, CMS Region X Office

Nationally Recognized for Nursing Excellence

November 19, 2010

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: 13-0006

Dear Ms. Creswell:

This letter is in follow-up to your correspondence and Statement of Deficiencies dated November 10, 2010, advising us of your findings relative to the full Life Health and Life Safety Survey completed during October at St. Luke's.

Enclosed you will find our Plan of Correction describing procedures we have implemented and/or begun to implement in response to the processes cited as deficiencies.

The deficiencies cited were of great concern to St. Luke's. As you will see on the enclosed Plan of Correction we are promptly and diligently addressing the cited deficiencies.

Thank you for allowing us the opportunity to respond to your findings. If you have any questions or concerns, please feel free to contact me at (208) 381-3595.

Sincerely,

Mary Cronin, MHS, CPHQ
Director, Accreditation and Nursing Operations

Enclosures

cc: Kate Mitchell, CMS – Survey and Certification

St. Luke's Boise Medical Center
St. Luke's Meridian Medical Center
Gary L. Fletcher, CEO
190 East Bannock Street

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

PRINTED: 11/09/2010
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
	130006		10/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES REGIONAL MEDICAL CENTER	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 The following deficiencies were cited during the recertification survey of your hospital. Surveyors conducting the recertification were: Patrick Hendrickson, RN, HFS, Team Leader Gary Guiles, RN, HFS Teresa Hamblin, RN, HFS Gary Banister, RN, HFS Sylvia Creswell, NLTC Supervisor Acronyms used in this report include: CCU = Critical Care Unit CT = Computed Tomography ED = Emergency Department F = Fahrenheit FDA = Food and Drug Administration O2 = oxygen OR = Operating Room PICU = Pediatric Intensive Care Unit pt = patient RN = Registered Nurse x = times	A 000	Action Plan Responsible Party: Joanne Clavelle, MS, RN, FACHE, NE-BC, Vice President Patient Care Services/ Chief Nursing Officer and Pam Bernard, MSN, RN, Meridian Chief Operating Officer Process Improvements and Action Plan Implementation: ✓ The defective NeoStat was immediately sequestered and replaced with a functioning NeoStat by DaVita Dialysis Biomed at the St. Luke's Boise hospital campus on Monday, October 18, 2010. Verification of this action was performed by Pam Bernard, St. Luke's Managing Director for dialysis contracted services. ✓ The staff member who failed to report the equipment malfunction and complete electroconductivity quality control prior to patient care will be subject to DaVita Dialysis's corrective action process and will not provide patient care at St. Luke's until performance measures, mutually agreed upon by DaVita Dialysis and St. Luke's, have been met. Any DaVita staff members who fail to follow procedures specific to quality control will also be subject to the corrective action process.	
A 043	482.12 GOVERNING BODY The hospital must have an effective governing body legally responsible for the conduct of the hospital as an institution. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body. This CONDITION is not met as evidenced by: Based on staff interview, observation, review of patients' clinical records and policies and procedures, it was determined the governing	A 043		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — (X6) DATE: 11/19/10

A 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.

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A 043	Continued From page 1 body failed to provide the operational oversight and direction necessary to ensure contracted dialysis services provided to hospital patients were safe. This resulted in immediate jeopardy to the health and safety of dialysis patients. The findings include: 1. Refer to A084 as it relates to the failure of the governing body to ensure one of two contract dialysis service providers provided care in a safe manner. The effect of this negative facility practice seriously impeded the ability of the hospital to provide care of adequate quality and placed dialysis patients at risk of serious harm or death. Note: The facility was notified of the findings related to the immediate jeopardy on 10/18/10 starting at 4:05 PM. A Plan of Correction was reviewed and accepted on 10/19/10 at 9:00 AM. The Plan of Correction included: Obtaining and retaining 2 functioning Neo-Stats on the hospital premises in Boise, implementing a concurrent auditing process for all dialysis patients, formalizing and implementing a reporting system for dialysis equipment malfunctions, and education was provided to all dialysis and hospital staff for the concurrent audit process, equipment malfunction reporting process and quality control measures. A survey of current dialysis patients was conducted on 10/19/10. The hospital's contractor was in compliance with cares and treatment of hospital patients and the immediate jeopardy was abated.	A 043	✓ DaVita Dialysis was provided written notice regarding their breach of contract expectations on October 19, 2010. Any subsequent issues will result in immediate termination of the contract, as specified in the written communication. ✓ Back-up meters were secured and dedicated for each campus by DaVita Dialysis on Monday, October, 18, 2010. One back-up meter was obtained for Both campuses and was to be couriered if necessary by Liberty Dialysis prior to patient care on Tuesday, October 19, 2010. Liberty Dialysis dedicated that meter to the Boise campus. Liberty (Boise) Dialysis at St Luke's Meadowlake (on the Meridian campus) will provide the backup to Meridian inpatient when needed. Verification of this action was performed by Pam Bernard, St. Luke's Managing Director for dialysis contracted services. ✓ A concurrent audit process was initiated on Tuesday, October 19, 2010, to ensure appropriate quality control documentation by DaVita Dialysis contract staff. The concurrent audit tool was modified to reflect the appropriate ranges for quality control measures. The revised flowsheet now reflects the appropriate ranges and the tool was modified once again to remove the	
A 084	482.12(e)(1) CONTRACTED SERVICES The governing body must ensure that the services performed under a contract are provided in a safe and effective manner.	A 084		

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A 084	Continued From page 2 This STANDARD is not met as evidenced by: Based on review of clinical records and policies, observations, and contract staff interviews, it was determined, the Governing Body failed to ensure 1 of 2 contract dialysis providers performed independent conductivity and pH checks prior to dialyzing one of two inpatients (#65), whose records were reviewed and were observed receiving dialysis treatments. The lack of testing had the potential to cause serious injury or death to dialysis patients. This placed the health and safety of all hospital patients who received dialysis services in immediate jeopardy. The findings include: The hospital's Governing Body contracted all its inpatient hemo-dialysis services. This was documented in a contract with Provider A, dated 05/01/07. On 10/18/10 during a tour of the hospital's CCU at 1:35 PM, Patient #65 was noted to be receiving hemo-dialysis by a Registered Dialysis Nurse that worked for Provider A. During the observations, it was noted that a Neo-Stat was not in the possession of the Registered Dialysis Nurse. A Neo-Stat is a hand-held, syringe-style meter used to verify the conductivity, pH and temperature of the final dialysate water and verified the accuracy of dialysis machine readings. Not verifying the machine's conductivity and temperature readings with an independent comparison could lead to the rapid development of acid/base imbalance in the patient's body, resulting in potential serious injury or death. The FDA Quality Assurance Guidelines recommend that the conductivity, pH and	A 084	✓ A process was formalized on Monday, October 18, 2010 outlining the reporting requirements, for St. Luke's staff and dialysis contract staff, in the event of dialysis equipment malfunction. This process is in place. ✓ Education was initiated for St. Luke's staff on the new reporting process on Monday, October 18, 2010. Education occurred over the next week to ensure appropriate staff received the information. Rosters were maintained to ensure maximum participation. ✓ Education was initiated for DaVita Dialysis and Liberty Dialysis staff on the new reporting process on Monday, October 18, 2010. Education occurred over the next week to ensure appropriate staff received the information. Contracted staff were educated prior to providing patient care at St. Luke's. ✓ A flowsheet was developed by St Luke's, DaVita, and Liberty Dialysis which will be used as a report/handoff sheet. This flowsheet includes the QC testing and is titled "Hemodialysis Treatment Record". The flowsheet was implemented on November 8th. ✓ A Contract Services Task Force has been established and will continue until full action plan implementation	

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A 084	Continued From page 3 temperature of the final dialysate be checked with an independent reference meter before every treatment. Provider A's "PRESCRIPTION VERIFICATION AND SAFETY CHECKS" policy, dated 9/09, stated a manual conductivity and pH of the dialysate prior to each dialysis treatment must be completed. This policy was not followed. On 10/18/10 starting at 1:35 PM, the Registered Dialysis Nurse who dialyzed Patient #65 was interviewed. She stated that on Friday, 10/15/10, she noticed the Neo-Stat meter was not working properly. She stated she did not report the broken equipment to Provider A's bioengineering department, and they only had one Neo-stat available at the hospital's Boise location. She stated she did not work during the weekend, but on 10/18/10 at 1:35 PM, she stated the Neo-Stat meter was not used before Patient #65 was dialyzed because the Neo-Stat meter remained broken. On 10/18/10 starting at 2:45 PM, dialysis Provider A's Out-Patient Manager was interviewed. She stated the Registered Dialysis Nurse who dialyzed Patient #65 should have performed a manual conductivity and pH test of the dialysate water prior to dialyzing the patient. She said that by not doing a manual conductivity and pH test of the dialysate water, patients were at risk for electrolyte imbalances that could lead to injury or death. The hospital failed to ensure contracted dialysis services were provided to hospital patients in a safe manner.	A 084	✓ Cy Gearhard and Pam Bernard met DaVita regional vice presidents Ray Follett and Mark Steffari in addition to Dianne Allen (national acute specialist) to discuss what had occurred regarding the dialysis nurse failure to follow policy and the resulting condition identified in the CMS exit conference. An action plan and response letter were presented. ✓ Multiple meetings have occurred with DaVita Dialysis for action plan follow up. ✓ A dedicated St Luke's position has been posted to assume project management oversight for clinical contractual agreements. This position will be responsible for ensuring quality metrics are defined, tracked, and reported for each clinical contract. QAPI Integration: ✓ The Quality Committee of the Board reviewed and approved the original action plan, submitted to surveyors on November 19, 2010. ✓ DaVita Dialysis implemented an action plan to address non-compliance. Liberty Dialysis will initiate an action plan as appropriate for non-compliance. ✓ Audit data and action plans will be reviewed during quarterly meetings between St. Luke's Administration and DaVita Dialysis and Liberty Dialysis leadership. ✓ Audit findings were reviewed by the St. Luke's Quality and Patient Safety Committee. ✓ Annual reports on clinical contracts will continue to be provided to the	
A 143	482.13(c)(1) PATIENT RIGHTS: PERSONAL	A 143		

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A 143	Continued From page 4 PRIVACY The patient has the right to personal privacy. This STANDARD is not met as evidenced by: Based on observations and interview it was determined the hospital failed to ensure patient privacy of protected health information for 1 of 2 current patients (#70), whose physicians were observed discussing cares and treatments. This resulted in a violation of a patient's right to privacy. Findings include: During a tour of the hospital's outpatient Orthopedic Surgery Center on 10/22/10 at 8:30 AM, a physician was observed discussing Patient #70's arthroscopic procedure, in the main lobby, with Patient #70's family members. The surveyor could overhear the conversation. Another patient's family member and two employees were also present within hearing distance. An empty consultation room was observed to be present off of the lobby. The family members of Patient #70 were interviewed on 10/22/10 starting at 8:51 AM. They stated the physician did not offer privacy before discussing Patient #70's arthroscopic procedure. Hospital management was asked if they had a policy in place to protect patient's health information in these instances. As of 10/29/10, a policy was not provided. The hospital failed to ensure physicians did not discuss patients' health information in common areas where other people could overhear the	A 143	Action Plan Responsible Parties: Christine Neuhoff, VP/ General Counsel and Steven Pitts, Compliance Officer Process Improvements: ✓ Provide a policy and education to ensure that patient privacy is protected when Protected Health Information (PHI) is being shared verbally by implementing reasonable safeguards. Specific issues will include using consult rooms, keeping discussions in public areas to a minimum, and involving the patient in decisions regarding sharing of their PHI. Action Plan Implementation: ✓ Draft and obtain approval for a policy that addresses patient privacy when verbal sharing of Protected Health Information (PHI) occurs by December 31, 2010. ✓ Presentation to the Medical Executive Committee regarding provider's responsibilities to partner with staff in ensuring patient privacy is protected during the month of January 2011. ✓ Rollout of new policy during January 2011, with accompanying education. ✓ Add new policy to the listing of Privacy and Security Policies that is already available. QAPI Integration: ✓ The Quality Committee of the Board will review and approve the action plan. ✓ Ongoing privacy concerns will be monitored by the Compliance department/ Privacy Officer. ✓ Observational audits will be initiated by February 2011 and continue	

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A 143	Continued From page 5 information.	A 143		
A 168	482.13(e)(5) PATIENT RIGHTS: RESTRAINT OR SECLUSION The use of restraint or seclusion must be in accordance with the order of a physician or other licensed independent practitioner who is responsible for the care of the patient as specified under §482.12(c) and authorized to order restraint or seclusion by hospital policy in accordance with State law. This STANDARD is not met as evidenced by: Based on review of policies, clinical records, and staff interviews, it was determined the hospital failed to ensure that 5 of 7 patients reviewed for whom restraints were used (#22, #23, #24, #40, and #41), had a physician's order or a complete physician's order for physical restraints. This had the potential to cause a lack of appropriate physician oversight in the management of restraints. Findings include: 1. According to the hospital's policy titled, "Restraints," revised 9/21/10, "All restraints are applied and continued pursuant to an order by the physician who is responsible for the patient's ongoing care. If a physician is not available to issue an order, an RN may initiate the use of restraints based on an assessment of the patient indicating a significant change in the patient's condition. In that case, the physician managing the patient's care is notified within minutes of the initiation of restraint, and a telephone or written order is obtained from that physician and entered into the patient's medical record. A complete restraint order must include: [the] type of restraint; clinical justification for the restraints; order duration [and] signature, date, and time."	A 168	Action Plan Responsible Parties: Dawn Lombardo, Administrator Med Surg/ ED and Bev Holland, Administrator Children's Hospital Process Improvements: ✓ Implement a validation process to ensure that written restraint orders are complete and implemented appropriately. Action Plan Implementation: ✓ Revise Restraints policy to align with CMS standards by January 1, 2011. ✓ Update the Charge RN audit tool by January 1, 2011. ✓ Add Critical Care Non-Violent Restraint Algorithm as an appendix to the Restraints policy by January 1, 2011. ✓ Educate staff regarding policy changes during the month of January 2011. Education to include: o Reason for change of status (i.e. description of behavior), and / or o Lesser restrictive measures used QAPI Integration: ✓ The Quality Committee of the Board will review and approve the action plan. ✓ Audits will be initiated by March 2011 and continue for a minimum of four consecutive months to monitor compliance with the revised process.	

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A 168	Continued From page 6 In the two examples that follow, this policy was not followed. a. Patient #41 was an 11 month old female, who was admitted to the hospital on 9/06/10. A "PICU Observation Record" documented RN application of bilateral soft wrist restraints beginning on 9/12/10 at 10:00 AM. There was not a valid physician's order present at the time Patient #41 was restrained. A physician's order for restraints was obtained and written on 9/12/10 at 12:00 PM, 2 hours after the application of restraints. During an interview on 10/25/10 at 2:56 PM, the Clinical Nurse Specialist for the Medical/Surgical Units reviewed Patient #41's record and confirmed the previous order was not valid. She also confirmed the delay in obtaining a physician's order. The hospital failed to obtain a physician's order to restrain Patient #41 within minutes of the initiation of restraints. b. Patient #40 was a 13 year old female who was admitted to the hospital on 9/26/10. "Physical Restraint Orders," dated 9/26/10 at 3:50 PM, documented physician orders to initiate soft bilateral wrist restraints. The order failed to document the reason (clinical justification) for the use of restraints. In an interview conducted on 10/25/10 at 3:27 PM, a Pediatric Clinical Nurse Specialist reviewed Patient #40's record and confirmed the physician's order for restraints was incomplete.	A 168		

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A 168	Continued From page 7 The hospital failed to ensure patients had complete restraint orders. 2. Patient #24's medical record documented a 34 year old female who was admitted to the ED on 9/12/10 at 2:55 PM. Patient #24 was placed on an "involuntary mental health hold" at 2:57 PM on 9/12/10. The Triage note by the RN, dated 9/12/10 at 3:28 PM, stated, "Pt. arrives from home fighting and yelling that she needs to kill herself. Per significant other, off psych meds x 3 days, drank alcohol today...The patient is combative and awake with an affect that is loud and agitated." An anti-psychotic medication [Haldol 5 mg] and an anti-anxiety medication [Ativan 2 mg] were administered intramuscularly at 3:21 PM on 9/12/10. A physician order to apply 4-point restraints [wrists and ankles] to Patient #24 was written at 3:12 PM on 9/12/10. A "Progress Note" by the RN at 3:15 PM on 9/12/10, stated Patient #24 was, "...alert and oriented to person and place and agrees to be more cooperative. We discussed why we gave her Haldol and Ativan and that we would remove the restraints one by one as she was more cooperative. She agreed to this." At 3:38 PM on 9/12/10, nursing notes documented Patient #24 was "...kicking. Patient poses a risk of injury to self or ED staff." At 3:40 PM on 9/12/10, nursing notes documented Patient #24 was sleeping. At 3:44 PM on 9/12/10, nursing notes documented, "Vital signs/weight rechecked: O2 saturation. Tolerated procedure well." At 4:05 PM on 9/12/10, nursing notes documented Patient #24 was resting. At 4:09 PM on 9/12/10, nursing notes documented Patient	A 168		

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A 168	Continued From page 8 #24 was catheterized. Her response to this procedure was not documented. At 4:54 PM on 9/12/10, nursing notes documented Patient #24's, "Condition improved: Pt. wakes when addressed, calm, cooperative. One arm and one leg still in restraints...significant other visited and they kissed." Nursing notes did not document when the 2 limb restraints had been removed. The next nursing note was dated 9/12/10 at 5:44 PM. It stated, "At 17:40 (5:40 PM) removed left ankle restraint pt tolerated well remains compliant to safety measures." The next nursing note was dated 9/12/10 at 6:05 PM. It stated, "Pt. sleeping. Last restraints removed." Patient #24 was then admitted to a medical floor as an inpatient. The Director of the ED was interviewed on 10/20/10 at 9:30 AM. She reviewed the medical record and confirmed the documentation. Patient #24 had physician orders for 4-point restraints. At some point between 4:09 PM on 9/12/10 and 4:54 PM on 9/12/10, 2 of those restraints were removed and 2 were left in place. A third restraint was removed 50 minutes later. Patient #24 remained in one point restraint for another 25 minutes until that last restraint was removed. New orders were not obtained for the 2 point and 1 point restraints. 3. Patient #22's medical record documented a 14 year old female who was admitted to the ED, on 9/25/10 at 9:30 AM, for a mental health examination. A note by the RN at 5:31 PM on 9/25/10, stated, "Pt's behaviors escalated and pt began screaming at parents and staff. Pt left her room and was screaming at parents and staff in the hallway. Pt's father was able to get pt into room. Pt continues to scream, hit, and kick. Pt	A 168		

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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 10/28/2010
NAME OF PROVIDER OR SUPPLIER ST LUKES REGIONAL MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 190 EAST BANNOCK STREET BOISE, ID 83712	

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A 168	Continued From page 9 does not redirect well with verbal commands and after several attempts pt is placed in four point restraints and given Zyprexa [an anti-psychotic medication]." A physician order was obtained for "Soft restraints Four-point." A note by the RN at 5:47 PM on 9/25/10, 16 minutes later, stated, "pt cooperative with blood draw, tolerated well. R (right) wrist restraint removed." A note by the RN at 6:01 PM on 9/25/10, 14 minutes later, stated, "pt remains cooperative, bilateral leg restraints removed. pt thankful." A note by the RN at 6:32 PM on 9/25/10, stated, "patient was discharged via wheelchair accompanied by parent/guardian." The time the left wrist restraint was removed was not documented. The Director of the ED was interviewed on 10/20/10 at 9:30 AM. She reviewed the medical record and confirmed the documentation. Patient #22 had a physician order for 4-point restraints. At 5:47 PM on 9/25/10, 1 of those restraints was removed and 3 were left in place. At 6:01 PM on 9/25/10, 14 minutes later, 2 more restraints were removed and 1 was left in place. This violated the original order. New orders for restraints were not obtained. 4. Patient #23's medical record documented a 72 year old male who was admitted to the ED on 9/21/10 at 5:44 PM. At 6:06 PM on 9/21/10, the physician documented, "[Patient #23] is very confused, severely demented, and typically not verbally interactive at all. He is also trying repeatedly to get out of bed, pulling at his IV, and will not help us to maintain cervical spine immobilization." At 6:15 PM on 9/21/10, the nurse documented, "Pt is not violent, he is trying to sit up and get out of bed...Security is in to place	A 168		

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

PRINTED: 11/09/2010
FORM APPROVED
OMB NO. 0938-0391

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A 168	Continued From page 10 pt in four points [restraints] until neck is cleared." An order for "Soft restraints four point" was written on 9/21/10 at 6:03 PM. A nursing note at 6:40 PM on 9/21/10, stated "Condition improved: pt is now laying on stretcher without fighting the restraints..." A nursing note at 7:01 PM on 9/21/10 stated, "Condition improved: pt returns from CT relaxed, eyes open and responding to wife verbally, leg restraints are off and pt is not fighting, [bilateral] hands are pink and warm, able to place two fingers under restraints." The nursing note at 8:34 PM, 93 minutes later, stated Patient #23 was medically cleared and the hand restraints were removed. The Director of the ED was interviewed on 10/20/10 at 9:30 AM. She reviewed the medical record and confirmed the documentation. Patient #23 had physician orders for 4-point restraints. At 7:01 PM on 9/21/10, 2 of those restraints were removed and 2 were left in place. This violated the original order. New orders for restraints were not obtained. The policy "Restraints," revised 9/21/10, did not address the practice of removing restraints one limb at a time and how the practice affected the original restraint order. The Clinical Nurse Specialist for the Medical/Surgical Units was interviewed about the policy on 11/01/10 at 9:30 AM. She stated nurses were trained to remove restraints one limb at a time. However, she said the policy did not address this practice. The hospital did not ensure patients were restrained consistent with physician orders.	A 168		

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

PRINTED: 11/09/2010
FORM APPROVED
OMB NO. 0938-0391

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A 169	482.13(e)(6) PATIENT RIGHTS: RESTRAINT OR SECLUSION Orders for the use of restraint or seclusion must never be written as a standing order or on an as needed basis (PRN). This STANDARD is not met as evidenced by: Based on staff interview and review of records and hospital policy, it was determined the hospital failed to ensure restraint orders did not constitute PRN orders for 1 of 2 pediatric patients (#41) whose records were reviewed for restraint orders. This had the potential to result in a lack of physician oversight. The hospital also failed to ensure clarity of the restraint policy. This had the potential to lead to inadvertent PRN use of restraints. Findings include: 1. A hospital policy, "Restraints," revised 9/21/10, stated, "Restraint orders must be implemented within 1 hour" (after receipt of the order). Allowing an hour for implementation of restraints raises the question as to whether restraints were clinically justified (needed to ensure immediate physical safety of the patient). Allowing an hour for implementation also had the potential to allow staff to delay application of restraints to see if they were really needed, which would result in PRN use of restraints. A meeting on 10/27/10 beginning at 10:25 AM included restraint focus team members (the Director of Quality and Patient Safety, the Director of Accreditation and Nursing Operations, the Chief Nursing Officer, the Administrator for Women's Services, the Vice President of Medical Affairs, and the Clinical Nurse Specialist for Medical Surgical). Team members stated it was	A 169	Action Plan Responsible Parties: Dawn Lombardo, Administrator Med Surg/ ED and Bev Holland, Administrator Children's Hospital Process Improvements: ✓ Implement a validation process to ensure that written restraint orders are complete and implemented appropriately. Action Plan Implementation: ✓ Revise Restraints policy to align with CMS standards by January 1, 2011. ✓ Educate staff regarding policy changes during the month of January 2011. QAPI Integration: ✓ The Quality Committee of the Board will review and approve the action plan. ✓ Audits will be initiated by March 2011 and continue for a minimum of four consecutive months to monitor compliance with the revised process.	

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

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A 169	Continued From page 12 not the intent of the policy to allow PRN use of restraints, rather it was the intent of the policy to give concrete guidelines to nursing staff. The Chief Nursing Officer expressed appreciation for surveyors' perspective and stated she could see how the policy might be misinterpreted. 2. Patient #41 was an 11 month old female admitted to PICU on 9/06/10 for respiratory distress. According to a "HISTORY AND PHYSICAL," dated 9/06/10, Patient #41 was intubated after arrival and placed on a ventilator. A "CONSULTATION REPORT," dated 9/07/10, stated Patient #41 had been intubated, paralyzed and ventilated since admission. An initial physician's restraint order, dated 9/06/10 at 05:00 AM, for soft bilateral wrist restraints, had two boxes checked to indicate the clinical justification for restraints. The language next to the checked boxes stated the patient was unable to consistently follow directions and had a potential for unplanned removal of tubes. The restraint orders were renewed every day for 9 days (9/07/10 at 9:50 AM, 9/08/10 at 8:30 AM, 9/09/10 at 9:00 AM, 9/10/10 at 4:20 PM, 9/11/10 at 12:35 PM, 9/12/10 at 12:00 PM, 9/13/10 at 9:35 AM, 9/14/10 at 7:00 AM, 9/15/10 at 8:10 AM). The clinical justification listed on the physician's order form remained the same for each of the 10 days. According to nursing documentation on "Restraint Observation Records," Patient #41 was not restrained between 9/07/10 at 10:00 PM and 9/12/10 at 10:00 AM. RN documentation (9/08/10 at 7:30 AM, 9/10/10 at 3:00 PM, and 9/11/10 at 8:00 PM) described Patient #41 as "paralyzed."	A 169		

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

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OMB NO. 0938-0391

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A 169	Continued From page 13 This provided justification for not restraining Patient #41 even though physician orders for restraints were present. Physician progress notes (9/08/10 at 8:53 AM, 9/09/10 at 8:31 AM, 9/10/10 at 4:29 PM, and 9/11/10 at 12:58 PM) similarly described Patient #41 as sedated, paralyzed and on a ventilator. The notes did not state Patient #41 had breakthrough movement from the paralysis which could have provided clinical justification for the need for restraints. A specific and individual assessment of Patient #41's need for restraints was not documented. On 10/26/10 at 3:00 PM, the physician was interviewed who wrote restraint orders for Patient #41. When asked why he ordered restraints for a patient who was chemically paralyzed, he explained that he had seen patients in the past have breakthrough movement, even though they were chemically paralyzed. He explained this put them at risk for self-extubation. He stated he trusted the RNs who provided care for his patients and deferred to their judgment as to whether restraints were or were not needed. This explanation left the decision to restrain Patient #41 up to the RNs based on their own assessments (a PRN restraint). Restraints were ordered based on the potential for self-extubation based on past experience with other patients rather than based on an individual assessment of Patient #41 at specific points in time to determine specific need for restraints. This constituted a PRN order.	A 169		
A 174	482.13(e)(9) PATIENT RIGHTS: RESTRAINT OR SECLUSION	A 174		

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

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A 174	Continued From page 14 Restraint or seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order. This STANDARD is not met as evidenced by: Based on review of medical records and hospital policies and staff interview, it was determined the hospital failed to ensure restraints were discontinued at the earliest possible time for 2 of 5 restrained ED patients whose medical records were reviewed. This resulted in the potential for patients to be unnecessarily restrained longer than they needed to be. Findings include: 1. Patient #24's medical record documented a 34 year old female who was admitted to the ED on 9/12/10 at 2:55 PM. The triage note by the RN, dated 9/12/10 at 3:28 PM, stated Patient #24 was combative. An anti-psychotic medication (Haldol 5 mg) and an anti-anxiety medication (Ativan 2 mg) were administered intramuscularly at 3:01 PM. A physician order to apply 4-point restraints (wrists and ankles) to Patient #24 was written at 3:12 PM on 9/12/10. A "Progress Note" by the RN at 3:15 PM on 9/12/10, stated Patient #24 was, "...alert and oriented to person and place and agrees to be more cooperative. We discussed why we gave her Haldol and Ativan and that we would remove the restraints one by one as she was more cooperative. She agreed to this." At 3:38 PM on 9/12/10, nursing notes documented Patient #24 was, "...kicking. Patient poses a risk of injury to self or ED staff." At 3:40 PM on 9/12/10, nursing notes documented Patient #24 was sleeping. At 3:44 PM on 9/12/10, nursing notes documented, "Vital signs/weight rechecked: O2 saturation. Tolerated procedure	A 174	Action Plan Responsible Parties: Dawn Lombardo, Administrator Med Surg/ ED and Bev Holland, Administrator Children's Hospital Process Improvements: ✓ Reinforce the expectation that staff responsible for assessment of restraint use will document changes in restraint status (i.e. behavior changes, etc.). Action Plan Implementation: ✓ Re-educate staff during the month of January 2011 regarding the required documentation indicating any changes in restraint status: o Timeframe for removal of restrained extremities before a new order is required o Reason for change of status (i.e. description of behavior), and / or o Behavioral/ medical status warranting continued restraint use QAPI Integration: ✓ The Quality Committee of the Board will review and approve the action plan. ✓ Audits will be initiated by March 2011 and continue for a minimum of four consecutive months to monitor compliance with the revised process.	

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A 174	Continued From page 15 well." At 4:05 PM on 9/12/10, nursing notes documented Patient #24 was resting. At 4:09 PM on 9/12/10, nursing notes documented Patient #24 was catheterized. Her response to this procedure was not documented. At 4:54 PM on 9/12/10, nursing notes documented Patient #24's, "Condition improved: Pt. wakes when addressed, calm, cooperative. One arm and one leg still in restraints...significant other visited and they kissed." The next nursing note was dated 9/12/10 at 5:44 PM. It stated, "At 17:40 (5:40 PM) removed left ankle restraint pt tolerated well remains compliant to safety measures." The next nursing note was dated 9/12/10 at 6:05 PM. It stated, "Pt. sleeping. Last restraints removed." An assessment of the need for continued restraint, including specific behaviors and rationale, was not documented after they were applied. No combative behaviors were documented after 3:38 PM on 9/12/10. An assessment of the need for continued restraint was not documented before completely removing the restraints at 6:05 PM. The Director of the ED was interviewed on 10/20/10 at 9:30 AM. She reviewed the medical record and confirmed the documentation. Hospital staff failed to assess Patient #24 in order to determine the earliest time when restraints could be safely discontinued. 2. Patient #22's medical record documented a 14 year old female who was admitted to the ED on 9/25/10 at 9:30 AM for a mental health examination. A note by the RN at 5:31 PM on 9/25/10, stated "Pt's behaviors escalated and pt	A 174		

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

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A 174	Continued From page 16 began screaming at parents and staff. Pt left her room and was screaming at parents and staff in the hallway. Pt's father was able to get pt into room. Pt continues to scream, hit, and kick. Pt does not redirect well with verbal commands and after several attempts pt is placed in four point restraints and given Zyprexa [an anti-psychotic medication]." A physician order was obtained for "Soft restraints Four-point." A "Patient right flowsheet" documented Patient #22 was "Cooperative" at 5:22 PM, 5:46 PM, and 6:00 PM on 9/25/10. A note by the RN at 5:47 PM on 9/25/10, stated "pt cooperative with blood draw, tolerated well. R wrist restraint removed. A note by the RN at 6:01 PM on 9/25/10, stated "pt remains cooperative, bilateral leg restraints removed. pt thankful." A note by the RN at 6:32 PM on 9/25/10, stated "patient was discharged via wheelchair accompanied by parent/guardian. The time the left wrist restraint was removed was not documented. No combative behaviors were documented after 5:31 PM on 9/25/10. An assessment of the need for continued restraint was not documented before completely removing the restraints. The Director of the ED was interviewed on 10/20/10 at 9:30 AM. She reviewed the medical record and confirmed the documentation. Hospital staff failed to assess Patient #24 in order to determine the earliest time when restraints could be safely discontinued.	A 174		
A 395	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient.	A 395		

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

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A 395	Continued From page 17 This STANDARD is not met as evidenced by: Based on observations, record review, and staff interview, it was determined the hospital failed to ensure an RN provided sufficient supervision to ensure seizure precautions were implemented per physician orders for 1 of 1 current patient (#60), who was observed and who had orders for seizure precautions. The lack of nursing supervision and failure to follow physician orders had the potential to put a patient at risk for injury. Findings include: Patient #60 was a 54 year old female who was admitted to the hospital on 10/18/10. A "History and Physical," dated 10/18/10 that was untimed, stated Patient #60 was found at home by her daughter, noted to have a gash on her forehead and the TV lying on the floor. Patient #60 was transported to the hospital's ED where she was observed by staff to have a 45-second generalized tonic-clonic seizure and bite her tongue. A physician's order, dated 10/18/10 at 2:00 PM, stated Patient #60 was to be admitted to the hospital's CCU unit for further observations and placed on seizure precautions. The hospital's CCU was toured in the afternoon of 10/19/10. At 2:40 PM, the CCU's Charge Nurse was interviewed. He stated that seizure precautions included padding the rails of the patient's bed. Patient #60 was observed at this time and her bed rails were noted to be without pads. The RN caring for Patient #60 was interviewed on 10/19/10 starting at 2:45 PM. She stated she had received a physician's order to discontinue the seizure precautions but did not write down the	A 395	Action Plan Responsible Parties: Rick Bassett, director nursing practice, Kim Krutz, adult health clinical nurse specialist, and Allie Gooding, adult health clinical nurse specialist Process Improvements: ✓ Implement a seizure precautions policy and algorithm Action Plan Implementation: ✓ The Adult Health PI/ Practice Council will develop a seizure precautions policy and algorithm by January 11, 2011. ✓ The Nursing Practice Council will review and finalize the seizure precautions policy and algorithm before February 1, 2011. ✓ Staff will be educated on the new policy/ algorithm during the month of February 2011. QAPI Integration: ✓ The Quality Committee of the Board will review and approve the action plan. ✓ Monthly spot check audits will be initiated by March 2011 and continue for a minimum of four consecutive months to monitor compliance with the revised seizure precautions process.	

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A 395	Continued From page 18 order. On 10/19/10 at 3:30 PM, Patient #60's physician was interviewed. She stated that she did not discontinue Patient #60's seizure precautions. Sufficient RN supervision was not provided to ensure seizure precautions were followed for Patient #60.	A 395	Action Plan Responsible Parties: Chris Roth, Boise COO, and Roger Dean, director support services Process Improvements and Action Plan Implementation: ✓ Food will be stored in smaller quantities, and in smaller pans. Metal is preferred because of temperature conduction, however, plastic can be used in case of vegetables freezing, etc. This change is to be done in all areas, including the ice table in the exhibition cooking area. ✓ Refrigerator doors are to be kept closed when not in use. ✓ Temperatures are to be recorded every two hours as is currently practiced. QAPI Integration: ✓ The Quality Committee of the Board will review and approve the action plan.	
A 726	482.41(c)(4) VENTILATION, LIGHT, TEMPERATURE CONTROLS There must be proper ventilation, light, and temperature controls in pharmaceutical, food preparation, and other appropriate areas. This STANDARD is not met as evidenced by: Based on observations, staff interview, and review of federal guidelines, it was determined the hospital failed to maintain food at recommended temperatures in 1 of 2 kitchens observed during a tour of the facility. Failure to maintain appropriate temperatures in food storage areas had the potential to promote bacterial growth and increase the risk of food-borne illness. Findings include: According to the government website "FoodSafety.Gov," bacteria grow most rapidly in temperatures that range between 40 and 140 °F. Some harmful bacteria can double in number in as little as 20 minutes. During a tour of the hospital's kitchen on 10/27/10 at 8:45 AM, the following temperatures of food were measured in a cold holding unit: ham 48 degrees F (7 degrees too high), sausage 50 degrees F (9 degrees too high), and turkey 52 degrees F (11 degrees too high). A large	A 726		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 726	Continued From page 19 container of liquid eggs on ice registered a temperature of 49 degrees F (8 degrees too high). The observations were confirmed, at the time of the tour, by a chef that worked in the kitchen. The hospital failed to maintain temperatures of food to reduce the risk of food-borne illnesses.	A 726		

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Bureau of Facility Standards

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 10/28/2010
NAME OF PROVIDER OR SUPPLIER ST LUKES 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 The following deficienciew were cited during the state licensure survey of your hospital. Surveyors conducting the licensure review were: Patrick Hendrickson, RN, HFS, Team Leader Gary Guiles, RN, HFS Teresa Hamblin, RN, HFS Gary Banister, RN, HFS Sylvia Creswell, NLTC Supervisor	B 000	Action Plan Responsible Parties: Bart Hill, VPMA, and Deb Gaspar, interim director quality and patient safety **Endoscopy** Process Improvements: ✓ Implement appropriate processes for dilution procedures Action Plan Implementation: ✓ Policies will be updated to reflect accurate and consistent dilution procedures, as specified by the manufacturer, by January 1, 2011 ✓ Sinks will be permanently marked to ensure accurate diluents used for the disinfectant solution by January 15, 2011 ✓ Education on proper dilution methods will be provided to Endoscopy staff by February 1, 2011. QAPI Integration: ✓ The Quality Committee of the Board will review and approve the action plan. ✓ The following metrics will be ~~monitored through March 2011:~~ o Percent of endoscopy staff receiving education on proper dilution methods o Proper dilution methods used (observational audits)	
BB540	16.03.14.540.03 Infection Control & Prevention Procedures 03. Infection Control and Prevention Procedures. There shall be a written infection control procedure which shall include aseptic techniques, cleaning, sanitizing, and disinfection of all instruments, equipment and surfaces, for all departments and services of the hospital where patient care is rendered. (10-14-88) This Rule is not met as evidenced by: Based on observations, staff interview, and review of hospital policies, it was determined the hospital failed to ensure specific infection control procedures had been developed for the disinfection of all instruments and equipment. This resulted in the potential for exposure to infectious organisms for all patients, who had surgical or endoscopic procedures performed. The findings include: 1. During a tour of the hospital's Meridian campus Endoscopy Unit on 10/26/10 at 10:30 AM, the endoscopy sanitation area was observed. Noted was a sink filled with water and sanitizer. During the observation, the Endoscopy Technician was interviewed. When asked regarding the dilution of sanitizer to water, she stated the sanitizer was	BB540		

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BB540	Continued From page 1 to be diluted 1 ounce of sanitizer to one gallon of water. When asked about how much water was in the sink, she stated that she thought it was filled with about six gallons of water and she put in six ounces of sanitizer. However, she could not ensure the sink did truly did contain six gallons of water. 2. During the tour of the hospital's Meridian campus Surgical Unit on 10/26/10 at 10:00 AM, the surveyor observed detergent stored under a sink used to clean soiled equipment. The detergent's label stated to dilute 2 ounces of detergent to every gallon of water. During the observation, the Director and the Manager on the unit were asked how staff pre-mixed detergents to ensure proper dilution of detergent. The managers stated they did not have a system in place to ensure detergents were properly diluted. The hospital failed to develop systems to ensure sanitizing agents were diluted to the proper strength.	BB540	**Housekeeping** Process Improvements: ✓ Implement appropriate processes for dilution procedures. Action Plan Implementation: ✓ Housekeeping policy will be updated to reflect accurate and consistent dilution procedures, as specified by the manufacturer, by January 1, 2011 ✓ Education on proper dilution methods will be provided to housekeepers and USAs by January 15, 2011. QAPI Integration: ✓ The Quality Committee of the Board will review and approve the action plan. ✓ The following metrics will be monitored through February 2011: o Percent of housekeeper/ USA staff receiving education on proper dilution methods o Proper dilution methods used (observational audits)	
BB559	16.03.14.550.09 Housekeeping 09. Housekeeping. Each hospital shall establish an organized housekeeping service with sufficient personnel to maintain and provide a pleasant, safe, and sanitary environment. (10-14-88) a. The service shall be under the supervision of a person competent in environmental sanitation and management; and (10-14-88) b. There shall be specific written procedures for appropriate cleaning of all service areas in the hospital, giving special emphasis to procedures applying to infection control; and (10-14-88)	BB559		

Bureau of Facility Standards

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BB559	Continued From page 2 c. All mop heads shall be removable and changed daily; and (10-14-88) d. Suitable equipment and supplies shall be provided for cleaning of all surfaces. Such equipment shall be maintained in a safe, sanitary condition; and (10-14-88) e. Selection of germicides shall be under the supervision of the infection committee; and (10-14-88) f. Solutions, cleaning compounds, and hazardous substances shall be labeled properly and stored in safe places; and (10-14-88) g. Dry dusting and sweeping are prohibited; and (10-14-88) h. Surgeries, nurseries, delivery rooms, dietary, and laundry shall have separate housekeeping equipment; and (10-14-88) i. There shall be evidence of orientation training for all new employees and continuing education for all employees. (10-14-88) This Rule is not met as evidenced by: Based on observations and staff interview, it was determined the hospital failed to ensure specific procedures had been developed for the appropriate cleaning of all service areas in the hospital. This resulted in the potential to expose patients to infections organisms. The findings include: 1. During a tour of the hospital's Boise campus Surgical Unit on 10/21/10 from 2:07 PM to 3:00 PM, housekeeping staff was observed cleaning a surgical suite. The staff wiped down and mopped	BB559	Action Plan Responsible Parties: Bart Hill, VPMA, and Deb Gaspar, interim director quality and patient safety Process Improvements: ✓ Implement appropriate processes for the use of mops within the surgical areas. Action Plan Implementation: ✓ Policies will be updated to reflect procedures for mop usage/ transport, proper PPE use, and handling of dirty materials in the OR by January 1, 2011 ✓ Education on proper cleaning methods will be provided to housekeepers and other staff responsible for cleaning by January 15, 2011. QAPI Integration: ✓ The Quality Committee of the Board will review and approve the action plan. ✓ The following metrics will be monitored through February 2011: o Percent of housekeeper/ USA staff receiving education on proper cleaning methods o Proper cleaning methods used (observational audits)	

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BB559	Continued From page 3 the suite. Upon finishing, one of the housekeeping staff was observed carrying the dirty mop and the dirty cleaning rags out of the OR suite without bagging them. She then walked down two halls and opened a utility room door with the dirty gloves. There she bagged the dirty items. The Director of the Surgical Unit was interviewed during the observations. He agreed the dirty equipment, rags and mop head, should have been bagged before leaving the room to prevent cross-contamination. Additionally, he agreed the staff member should not have opened the door with her dirty gloves. 2. During a tour of the hospital's Outpatient Orthopedic Surgical Center on 10/22/10 at 9:38 AM, an employee that cleaned the OR suites was interviewed. She stated when she cleaned the OR suites, after each case she carried the dirty supplies down a (clean) hall into a utility room where she bagged the dirty supplies. This process raised the potential for cross-contamination. During the tour, the surveyor requested a policy from the OR Manager as to how cleaning staff was to handle dirty cleaning supplies in the OR. He stated such the policy had not been developed. 3. During a tour of the hospital's Meridian campus Surgical Unit on 10/26/10 at 9:30 AM, housekeeping staff were observed cleaning a surgical suite. Upon finishing, one of the housekeeping staff placed the dirty mop back in the mop bucket. She then removed dirty supplies with her dirty gloves, pushed the supplies out of the OR suite, down two halls and left them in a	BB559		

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BB559	Continued From page 4 dirty utility room. She then carried other dirty supplies down two halls and pushed a button that opens a door to another hallway with her dirty gloves. The Manager of the Surgical Unit was interviewed during the observation. She stated the mop water was clean and staff were to mop the floor with a single dip. She stated the staff member should not have introduced the dirty mop back into the clean water in the mop bucket. She also agreed the staff member should have changed her gloves before touching any clean surface areas. The hospital failed to ensure housekeeping staff practiced infection control measures to prevent cross contamination.	BB559		

Pamela Bernard 10/19/10

St. Luke's Regional Medical Center LTD
Corrective Action Plan
Bureau of Facility Standards CMS Survey, October 18, 2010

Approved by - Joanne G. Clavelle 10/19/10

10/19/10 President + CEO St. Luke's Health System

A-0083: The governing body must be responsible for services furnished in the hospital whether or not they are furnished under contracts. The governing body must ensure that a contractor of services (including one for shared services and joint ventures) furnishes services that permit the hospital to comply with all applicable conditions of participation and standards for the contracted services.

Action Plan Responsible Party: Joanne Clavelle, MS, RN, FACHE, NE-BC, Vice President Patient Care Services/ Chief Nursing Officer and Pam Bernard, MSN, RN, Meridian Chief Operating Officer

The following immediate process improvements were implemented:

- ✓ The defective NeoStat was immediately sequestered and replaced with a functioning NeoStat by DaVita Dialysis Biomed at the St. Luke's Boise hospital campus on Monday, October 18, 2010. Verification of this action was performed by Pam Bernard, St. Luke's Managing Director for dialysis contracted services.
- ✓ The staff member who failed to report the equipment malfunction and complete electroconductivity quality control prior to patient care will be subject to DaVita Dialysis's corrective action process and will not provide patient care at St. Luke's until performance measures, mutually agreed upon by DaVita Dialysis and St. Luke's, have been met. Any DaVita staff members who fail to follow procedures specific to quality control will also be subject to the corrective action process.
- ✓ DaVita Dialysis will be provided written notice regarding their breach of contract expectations on Tuesday, October 18, 2010. Any subsequent issues will result in immediate termination of the contract, as specified in the written communication.
- ✓ Back-up meters were secured and dedicated for each campus by DaVita Dialysis on Monday, October, 18, 2010. One back-up meter has been obtained for both campuses and will be couriered if necessary by Liberty Dialysis prior to patient care on Tuesday, October 19, 2010. Liberty Dialysis will arrange for a dedicated back-up meter for each campus. Verification of this action will be performed by Pam Bernard, St. Luke's Managing Director for dialysis contracted services.
- ✓ A concurrent audit process was initiated on Tuesday, October 19, 2010, to ensure appropriate quality control documentation by DaVita Dialysis contract staff.
- ✓ A process was formalized on Monday, October 18, 2010 outlining the reporting requirements, for St. Luke's staff and dialysis contract staff, in the event of dialysis equipment malfunction.
- ✓ Education was initiated for St. Luke's staff on the new reporting process on Monday, October 18, 2010. Education will occur over the next week to ensure appropriate staff receive the information. Rosters will be maintained to ensure maximum participation.
- ✓ Education was initiated for DaVita Dialysis and Liberty Dialysis staff on the new reporting process on Monday, October 18, 2010. Education will occur over the next week to ensure appropriate staff receive the information. Contracted staff will be educated prior to providing patient care at St. Luke's.

The action plan will be integrated within St. Luke's QAPI program in the following ways:

- ✓ DaVita Dialysis and Liberty Dialysis will initiate an audit process to ensure appropriate documentation of electroconductivity quality control.

St Luke's™

Cascade Learning Activity

Dialysis/TPE Equipment Malfunctions

GOAL: To orient St. Luke's staff and dialysis/TPE (therapeutic plasma exchange) contracted staff on their responsibilities to follow the proper procedures when there is a malfunction of dialysis/TPE equipment.

GROUP SIZE: St. Luke's RN staff and Dialysis/TPE contract staff

TIME REQUIRED: 15-30 minutes

MATERIALS: Dialysis/TPE Equipment Malfunctions Overview Algorithm

PHYSICAL SETTING: At change of shift, morning and evening report, a staff meeting or other department gathering.

ACTIVITY: Review the following information:

Background: Dialysis/TPE services at St. Luke's are provided through contracted resources. Currently our contractors are Davita Dialysis and Liberty Dialysis. Dialysis RN's providing these services have responsibility to ensure all appropriate procedures are followed, including ensuring equipment is functioning properly prior as evidenced by quality controls before providing treatment for our patients.

In the event of an equipment malfunction, immediately discontinue the use of the equipment and secure back-up equipment prior to dialyzing the patient.

The Dialysis RN (Contractor) will adhere to the following processes in the event of an equipment malfunction resulting in significant delays:

1. ***Immediately*** stop treatment and notify the following:
    a. The ordering physician
    b. Contracted Service Biomed (24 hour/7 coverage)
    c. The St. Luke's Department Charge RN and primary RN caring for patient
    d. Contracted Service Leadership

2. After the notifications, the Dialysis RN will a complete a contractor incident report by the end of shift.

Upon notification, Contracted Service Leadership will report the incident to the St. Luke's Managing Director immediately.

Upon notification, the St. Luke's Charge RN will notify the St. Luke's Administrative Supervisor (PIE will be initiated by Charge RN and/or Administrative Supervisor)

Please carefully review the algorithm on the next page.

PRINT NAME BELOW	SIGN NAME BELOW

St. Luke's Regional Medical Center LTD
Corrective Action Plan
Bureau of Facility Standards CMS Survey, October 18, 2010

A-0083: The governing body must be responsible for services furnished in the hospital whether or not they are furnished under contracts. The governing body must ensure that a contractor of services (including one for shared services and joint ventures) furnishes services that permit the hospital to comply with all applicable conditions of participation and standards for the contracted services.

Action Plan Responsible Party: Joanne Clavelle, MS, RN, FACHE, NE-BC, Vice President Patient Care Services/ Chief Nursing Officer and Pam Bernard, MSN, RN, Meridian Chief Operating Officer

The following addendum to our corrective action plan was implemented on the afternoon of October 19, 2010:

✓ The concurrent audit tool was modified to reflect the appropriate ranges for quality control measures.

10/19/10
President + CEO, SLHS

COPY

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

December 10, 2010

Gary Fletcher, Administrator
St Lukes Regional Medical Center
190 East Bannock Street
Boise, ID 83712

Provider #130006

Dear Mr. Fletcher:

On **October 28, 2010**, a complaint survey was conducted at St Lukes Regional Medical Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004679

ALLEGATIONS:

A patient was transferred to a long term care facility without the consent of the parent and without advance notice of the transfer.

FINDINGS:

An unannounced visit was made to the hospital on 10/18/10 through 10/28/10. The investigation was conducted in conjunction with a Medicare recertification survey in which all conditions of participation and state licensure requirements were reviewed. Seventy-six medical records were reviewed including records from all inpatient units and patient care services. Observations were made on all inpatient units. Approximately 15 patients/families were interviewed regarding discharge planning. Staff were also interviewed. Policies were reviewed.

No problems with discharge planning were identified through medical record review or interview with current patients.

One medical record documented a 27 year old female who presented to the hospital on 5/26/10 at 10:09 AM. She was intubated and her respirations were supported by bagging. She was unresponsive to stimuli. She was placed on a ventilator and admitted to the Critical Care Unit. A tracheostomy was performed on 6/03/10. The patient did not regain consciousness and was discharged on 6/07/10 with a diagnosis of "anoxic central nervous system injury with considerable bilateral cerebral hemispheric infarcts including the majority of her frontal and parietal lobes, acute hypoxemic respiratory failure which is resolved..." She was discharged to an ECF (extended care facility) in a nearby town on 6/07/10.

The patient's mother was very involved in the patient's care and acted as her representative. Progress notes referred to the mother's devotion to the patient. The medical record documented communication between staff and the mother. A "PALLIATIVE CARE CONSULTATION," dated 5/28/10 stated the patient's "...prognosis for meaningful recovery is grim...(###) was informed of the CT results and the grim prognosis for recovery earlier today." A physician progress note, dated 5/31/10, stated "I talked with the patient's mother for about 15 minutes regarding the prognosis and our goals of care...We talked about ECF placement as well and she understands that that would be the next step." The Case Manager referred the patient to 3 separate Long Term Acute Hospitals. They all refused to accept the patient, stating she did not meet their admission criteria. Case Management notes documented the mother was informed of this and of the need for ECF placement on 6/03/10. At that time, the mother was also informed that the patient would be ready for transfer in 3-5 days. The mother met with the ECF's Clinical Liaison on 6/04/10. A Case Management note on 6/07/10 at 12:49 PM stated the patient was to be transferred to the ECF on that date. The note stated "Mother updated and aware of plan." The patient was transferred by ambulance at 1:30 PM on 6/07/10.

A visit was made to the ECF and the Administrator was interviewed. She stated the transfer had gone smoothly. She said the ECF had received timely and complete information and paperwork from the transferring hospital.

No deficiencies were identified during the recertification survey related to discharge planning. The hospital screened patients for discharge planning needs, developed discharge plans when needed, and worked with families and community resources to implement those plans. Patients were transferred to other facilities appropriately.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

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

Sincerely,

GARY GUILES
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

GG/srm