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HEALTH & WELFARE

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April 30, 2012

Nicholas Genna, Administrator
Treasure Valley Hospital
8800 West Emerald Street
Boise, ID 83704

Provider #130063

Dear Mr. Genna:

On **April 4, 2012**, a complaint survey was conducted at Treasure Valley Hospital. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00005302

Allegation #1: The facility did not provide information to patients regarding advanced directives.

Findings #1: An unannounced visit was made to the hospital on 4/02/12-4/04/12. Ten medical records were reviewed. Hospital policies, administrative documents, staffing schedules, and grievance/complaint logs were reviewed. Four patients were interviewed. Staff were interviewed. Nursing staff were observed while providing patient care.

Six closed records and four records of current patients were reviewed. All records contained a signed copy of a document titled, "ADVANCED DIRECTIVE ACKNOWLEDGMENT." The signature on the documents indicated the patient's understanding and receipt of advanced directives. Some patients chose to sign a copy of a document titled, "IDAHO LIVING WILL AND DURABLE POWER OF ATTORNEY FOR HEALTH CARE," while some patients brought a copy of their living will from home.

One medical record reviewed documented a 47 year old female who was admitted to the hospital with a pre-operative diagnosis of lateral recess stenosis and disc herniation at the L3-4 and L4-5 on the right with lumbar radiculopathy and disc degeneration. A hemi-laminectomy at L3-4 on

the right was performed. Also, a surgical decompression of the lateral recess at L4-5 and L4-5, as well as a partial discectomy at L4-5 on the right was performed. An "ADVANCED DIRECTIVE ACKNOWLEDGMENT" form was signed by the patient on 10/31/12. A copy of the "IDAHO LIVING WILL AND DURABLE POWER OF ATTORNEY FOR HEALTH CARE" was also signed by the patient on 10/31/12.

Four current patients were interviewed about living wills and advanced directives. All patients stated they had been presented with information about advanced directives and living wills during the admission process. The patients also stated they understood the information before signing.

The Quality Management Coordinator was interviewed during the survey about the hospital's process related to living wills and advanced directives. She stated the information and documents concerning living wills and advanced directives were presented and explained to patients during the admission process. She then stated the patients have the opportunity to ask questions before choosing to sign the documents.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: The nurses did not administer pain medication as ordered.

Findings #2: An unannounced visit was made to the hospital on 4/02/12-4/04/12. Ten medical records were reviewed. Hospital policies, administrative documents, staffing schedules, and grievance/complaint logs were reviewed. Four patients were interviewed. Staff were interviewed. Nursing staff were observed while providing patient care.

Six closed records and four current records were reviewed related to post-operative pain management. All records included individualized orders for pain management. The orders included various pain medications. Some medications were ordered intravenously (IV) and some were to be given by mouth (PO). In all records that were reviewed, post-operative pain medications were administered as ordered.

Four current patients on the in-patient floor were interviewed about pain management during the survey. All stated they were satisfied with the management and control of post-operative pain during their hospitalization. All stated they were given pain medication when they requested it.

One medical record reviewed documented a 47 year old female who was admitted to the hospital with a pre-operative diagnosis of lateral recess stenosis and disc herniation at the L3-4 and L4-5 on the right with lumbar radiculopathy and disc degeneration. A hemi-laminectomy at L3-4 on the right was performed. Also, a surgical decompression of the lateral recess at L4-5 and L4-5,

as well as a partial discectomy at L4-5 on the right was performed. The following medications were ordered to treat post-operative pain and discomfort: Fentanyl, Dilaudid, Percocet, Valium, Flexeril and Soma. Following surgery, while in the post anesthesia care unit, Fentanyl was administered IV for pain three times between 12:50 PM and 1:04 PM. Dilaudid was administered IV for pain two times between 1:14 PM and 1:35 PM. The notes stated the patient documented pain levels between 9 and 10, on a scale of 1 to 10 during this time. Between 1:44 PM and 2:30 PM, documentation showed Valium was administered IV on one occasion for muscle spasms and Percocet was administered for pain once by mouth. Pain was rated by the patient between 8-9 on a scale of 1 to 10 during this time.

Documentation indicated the patient was transferred to the in-patient floor at 2:30 PM. Between 2:30 PM and 11:05 AM on the following day, the "Medication Administration Record" (MAR) documented Dilaudid was administered IV for pain on 15 separate occasions. Percocet was administered PO for pain 5 different times during this period. The MAR also documented Valium was given IV for muscle spasms on 5 occasions. The medication, Soma, was administered for spasms 3 times as well. During this time frame, on a scale of 1 to 10, documentation showed the patient rated her pain at 8 around the time she was transferred to the in-patient floor, then gradually decreased to 6 and finally to 5. Other methods for pain control were ordered during this time, including ice to the operative area, re-positioning in bed and ambulation.

During the survey, two nurses were interviewed who cared for the patient. It was reported that the patient's pain was well controlled during the evening and night of surgery. The nurse who had worked the evening/night shift stated the patient was pleased with the management of her pain. The nurse who worked with the patient the following morning stated the patient became agitated and upset when IV medications where discontinued and the patient was transitioned to PO pain medications. She stated the patient was transitioned to oral pain medications because the patient was being discharged home.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: Nurses did not wash their hands prior to caring for patients.

Findings #3: An unannounced visit was made to the hospital on 4/02/12-4/04/12. Ten medical records were reviewed. Hospital policies, administrative documents, staffing schedules, and grievance/complaint logs were reviewed. Four patients were interviewed. Staff were interviewed. Nursing staff were observed while providing patient care.

Nurses on the in-patient floor were observed while caring for patients. They were observed washing their hands before, after and in between providing care for patients. On several

occasions, nursing staff was observed using antibacterial hand sanitizer that was located throughout the hospital.

Four patients on the in-patient floor were interviewed during the survey regarding hand washing behaviors of the nursing staff. All patients who were interviewed stated they had observed the nurses performing hand washing before and after providing care.

The Infection Control Officer was interviewed during the survey about the hospital's infection control plan and policies as they related to hand washing. She stated hand washing was monitored continuously and was included in random, monthly surveillance rounds. The Infection Control Officer also stated the hospital achieved a 94% compliance rate related to hand washing in 2011, and the compliance goal for 2012 is 96%. She provided documentation to support these claims.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: The facility did not ensure patients' privacy regarding personal information.

Findings #4: An unannounced visit was made to the hospital on 4/02/12-4/04/12. Ten medical records were reviewed. Hospital policies, administrative documents, staffing schedules, and grievance/complaint logs were reviewed. Four patients were interviewed. Staff were interviewed. Nursing staff were observed while providing patient care.

Nurses were observed during the survey while providing patient care. There were no incidents of staff discussing patients' personal information with other staff members.

Several patients on the in-patient floor were interviewed during the survey as well. Patients who were interviewed stated they had been treated with respect during their stay and had not witnessed any incidents of staff violating patients' privacy.

The Quality Manager was interviewed during the survey about patients' rights. She said it was the practice of the hospital to protect the rights of privacy for all patients in the facility. The Quality Manager also stated the nursing staff is educated annually regarding the hospital's policies and practices regarding patients' rights.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #5: The facility did not allow patients to participate in plans of care.

Findings #5: An unannounced visit was made to the hospital on 4/02/12-4/04/12. Ten medical

records were reviewed. Hospital policies, administrative documents, staffing schedules, and grievance/complaint logs were reviewed. Four patients were interviewed. Staff were interviewed. Nursing staff were observed while providing patient care.

The medical records that were reviewed all contained plans of care that addressed the needs of each patient.

Four patients on the in-patient floor were interviewed. All patients who were interviewed stated their care plans were discussed with them, and they had participated in the plan.

One medical record reviewed documented a 47 year old female who was admitted to the hospital with a pre-operative diagnosis of lateral recess stenosis and disc herniation at the L3-4 and L4-5 on the right with lumbar radiculopathy and disc degeneration. A hemilaminectomy at L3-4 on the right was performed. Also, a surgical decompression of the lateral recess at L4-5 and L4-5, as well as a partial discectomy at L4-5 on the right was performed.

The plan of care and nursing notes documented the patient was originally scheduled to undergo surgery on an out-patient basis. An over night stay was not planned. The notes also stated that after surgery the patient requested to stay over night. The facility made arrangements for her to do so. Documentation also indicated the patient stated Zofran, the medication administered for nausea, was not effective. The patient then requested a specific medication for nausea, Phenergan. According to the documentation, the physician was contacted and Zofran was discontinued, while Phenergan was ordered and administered on two occasions.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #6: The facility did not provide adequate nursing staff to appropriately care for patients, such as assisting them to the bathroom.

Findings #6: An unannounced visit was made to the hospital on 4/02/12-4/04/12. Ten medical records were reviewed. Hospital policies, administrative documents, staffing schedules, and grievance/complaint logs were reviewed. Four patients were interviewed. Staff were interviewed. Nursing staff were observed while providing patient care.

Nursing staffing schedules were reviewed for the week of 10/30/11-11/05/11 and 3/25/12-4/03/12. Staffing ratios did not exceed 1 RN to 3 patients plus 1 Certified Nursing Assistant during that time. On 4/02/12 and 4/03/12, 3 RNs and 1 Certified Nursing Assistant were on duty caring for 6 patients on both the day and night shifts.

Two RNs were interviewed regarding staffing levels on the morning of 4/03/12. Three RNs and 1 Certified Nursing Assistant were on duty caring for 6 patients at the time. Both RNs stated this staffing level was common and both RNs stated they never had more than 3 patients to care for at once. They also stated on call staff were available when needed.

Four post operative patients were interviewed on the morning of 4/03/12. All four patients stated nursing staff were available and attentive to their needs. They stated wait times were minimal for nurses to answer call lights.

Sufficient nursing staff were present to meet patients' needs.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #7: Nurses were not trained in the use of IV pumps and flushing IV lines.

Findings #7: An unannounced visit was made to the hospital on 4/02/12-4/04/12. Ten medical records were reviewed. Hospital policies, administrative documents, staffing schedules, and grievance/complaint logs were reivewed. Four patients were interviewed. Staff were interviewed. Nursing staff were observed while providing patient care.

Ten medical records were reviewed. All 10 records documented patients recieved IV fluids and medications as ordered.

The hospital used standard IV pumps for fluids and medications and PCA (Patient Controlled Analgesia) pumps to deliver pain medication. Two RNs were interviewed, 1 on the afternoon of 4/02/12 and 1 on the morning of 4/03/12. An IV pump was present for both interviews. Both nurses were knowedgeable regarding use of the pumps and care of IVs.

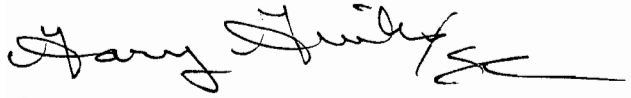
Four post operative patients were interviewed on the moring of 4/03/12. All four patients had IVs. All four patients stated staff appeared competent in the use of those pumps and in caring for their IVs.

Three RN personnel records were reviewed on 4/03/12. All 3 RNs had documented competencies in the care of IVs and pumps during orientation and annually there after.

RNs were trained in the care of IVs and the use of IV pumps.

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,



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