DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
Consortium For Quality Improvement and Survey & Certification Operations
Western Division of Survey & Certification

January 26, 2012

Kathleen Connerley, RN, MS
Vice President, Patient Care Services
St. Joseph Regional Medical Center
415 Sixth Street (PO Box 816)
Lewiston, ID 83501

CMS Certification Number: 13-0003

Re: Plan of correction received

Dear Ms. Connerley:

The Centers for Medicare and Medicaid Services (CMS) is in receipt of St. Joseph Regional Medical Center's voluntarily-submitted plan of correction in response to the complaint survey completed December 9, 2011, by the Idaho Bureau of Facility Standards (State survey agency). As per our December 27, 2011 letter, an unannounced full health and life safety code survey will be conducted by the Idaho Bureau of Facility Standards.

If you have any questions, please contact me at (206) 615-2432 or by e-mail catherine.mitchell@cms.hhs.gov .

Sincerely,

Kate Mitchell

Kate Mitchell, RN, Health Insurance Specialist
Survey, Certification and Enforcement Branch

cc: Idaho Bureau of Facility Standards

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IMPORTANT NOTICE – PLEASE READ CAREFULLY

December 27, 2011

Timothy Sayler, President and CEO
St. Joseph Regional Medical Center
415 Sixth Street (PO BOX 816)
Lewiston, ID 83501

CMS Certification Number: 13-0003

Re: Complaint survey 12/09/2011 and CoP not met
Deemed status removed and placed under State survey jurisdiction
Full health and life safety code survey to be conducted

Dear Mr. Sayler:

To participate as a provider of services in the Medicare and Medicaid Programs, a hospital must meet all of the Conditions of Participation (CoP) established by the Secretary of Health and Human Services.

The Idaho Bureau of Facility Standards (State agency) completed a complaint investigation authorized by the Centers for Medicare & Medicaid Services (CMS) on December 9, 2011. Based on a review of the deficiencies identified during this investigation, we have determined that St. Joseph Regional Medical Center **is not in substantial compliance** with the Medicare hospital Condition of Participation – Patient Rights (42 Code of Federal Regulations (CFR)) § 482.13.

Section 1865 of the Social Security Act (The Act) and pursuant regulations provide that a hospital accredited by The Joint Commission will be "deemed" to meet all Medicare health and safety requirements with the exception of those relating to utilization review. Section 1864 of The Act authorizes the Secretary of Health and Human Services to conduct a survey of an accredited hospital participating in Medicare if there is a substantial allegation of a serious deficiency which would, if found to be present, adversely affect the health and safety of patients. Therefore, as a result of the December 9, 2011, complaint survey findings, we are required following timely notification to the accrediting body, to place the hospital under Medicare State agency survey jurisdiction until the hospital is in compliance with all Conditions of Participation.

The deficiencies cited limit the capacity of St. Joseph Regional Medical Center to furnish services of an adequate level or quality. The deficiencies, which led to our decision, are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). It is not a requirement to submit a plan of correction; however, under federal disclosure rules, findings of the inspection, including the plan of correction submitted by the facility, become publicly disclosable if requested.

You may therefore wish to submit your plans for correcting the deficiencies cited within 10 calendar days of receipt of this letter. An acceptable plan of correction contains the following elements:

- The plan for correcting each specific deficiency cited;
- The plan should address improving 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;
- All plans of correction must demonstrate how the hospital has incorporated its improvement actions into its Quality Assessment and Performance Improvement (QAPI) program, addressing improvements in its systems in order to prevent the likelihood of the deficient practice reoccurring. The plan must include the monitoring and tracking procedures to ensure the plan of correction is effective and that specific deficiencies cited remain corrected and/or in compliance with the regulatory requirements; and
- The plan must include the title of the person responsible for implementing the acceptable plan of correction.

Each deficiency should be corrected as soon as possible. Additionally, please sign and date page one where indicated prior to returning the CMS-2567 to our office. Please send the completed plan of correction to the address below, with a copy to the State agency:

CMS – Survey and Certification
Attention: Kate Mitchell
2201 Sixth Avenue, RX-48
Seattle, WA 98121
Fax: (206) 615-2088

Additionally, in accordance with § 1865(b) of The Act, the Idaho Bureau of Facility Standards, will conduct a full unannounced health and life safety code survey of your hospital to assess compliance with all the Medicare Conditions of Participation, within the next 60 days.

The recommendation that St. Joseph Regional Medical Center submit a plan to correct its Medicare deficiencies does not affect its accreditation, its Medicare payments, or its current status as a participating provider of hospital services in the Medicare program. When St. Joseph Regional Medical Center has been found to meet <u>all</u> the Medicare Conditions of Participation for hospitals, the State agency will discontinue its survey jurisdiction.

Under CMS regulations 42 CFR § 498.3(d), this notice of findings is an administrative action, not an initial determination by the Secretary, and therefore formal reconsideration and hearing procedures do not apply.

Copies of this letter are being provided to the State agency and The Joint Commission. You can also pursue any concerns you may have with The Joint Commission at any time.

If you have any questions, please contact either Kate Mitchell or Linda Bedker of my staff at (206) 615-2313.

Sincerely,

for Kate Mitchell

Jerilyn McClain, RN, MPH
Survey, Certification and Enforcement Branch Manager

Enclosure

cc: Idaho Bureau of Facility Standards
The Joint Commission

People committed to life

St. Joseph
Regional Medical Center
Member of ASCENSION HEALTH

415 6th Street ~ P.O. Box 816 ~ Lewiston, Idaho 83501
(208)743-2511 ~ www.sjrmc.org

January 7, 2012

Sylvia Creswell
Supervisor, Non-Long Term Care
Bureau of Facility Standards
3232 Elder Street
Boise ID 83705

CMS Certification Number: 13-0003

RE: Complaint survey 12/09/2011 and CoP not met

Dear Ms. Creswell,

Enclosed please find a copy of the St. Joseph Regional Medical Center Plan of Correction (PoC) in response to the statement of deficiencies resulting from the on-site survey completed on December 9, 2011.

Should there be any questions regarding the enclosed POC, please do not hesitate to contact me (208-799-5485).

Sincerely,

Kathleen Connerley, RN, MS
Vice President, Patient Care Services

KC/tf

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	130003		C 12/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH REGIONAL MEDICAL CENTER	415 SIXTH STREET LEWISTON, ID 83501

(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	A 000		
	The following deficiencies were cited during the complaint investigation survey of your hospital. The surveyors conducting the investigation were: Aimee Hastriter RN, BS, HFS, Team Leader Suzi Costa RN, HFS The following acronyms were used in this report: CNA - Certified Nursing Assistant LIP - Licensed Independent Practitioner ml - milliliters OP - Out Patient PCU - Progressive Care Unit POA - Power of Attorney POC - Plan of Care RN - Registered Nurse VP - Vice President			
A 115	482.13 PATIENT RIGHTS A hospital must protect and promote each patient's rights. This CONDITION is not met as evidenced by: Based on observations, staff and patient interview, and review of hospital policies, grievance documentation, and patient records, it was determined the facility failed to ensure its policies identified Geri-chairs and four side rails raised on hospital beds as potential restraints and a comprehensive grievance process was in place which ensured grievances were identified, thoroughly investigated, and each grievant provided with a written response. The cumulative effect of these negative practices resulted in 1) a systemic failure which allowed patients throughout the hospital to be restrained at staffs'	A 115	The corrective actions for the individual findings of geri chair usage, side rails raised and management of grievances are addressed in the A tags referenced by the surveyors beginning on page 2 of this report. The completion dates are listed with each A tag. All will be completed by 1/13/12 to eliminate the "condition out" for patient rights.	1/13/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kathleen Connerly — TITLE: Vice President - PCS — (X6) DATE: JAN 7, 2012

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 115	Continued From page 1 discretion, without physician authorization, and without documentation of the need for, and use of, the restraints; and 2) the failure to identify grievances, document thorough timely resolution, and provide written responses to each grievant. Findings include: 1. Refer to A 118 as it relates to the facility's failure to ensure the process for grievance identification had been thoroughly developed and implemented. 2. Refer to A 123 as it relates to the facility's failure to provide written notice of the resolution of grievances. 3. Refer to A 159 as it relates to the facility's failure to identify uses of Geri-chairs and four side rails raised on a hospital bed as potential restraints. 4. Refer to A 164 as it relates to the facility's failure to ensure restraints were only utilized after a comprehensive assessment and when less restrictive interventions were determined to be ineffective. 5. Refer to A 166 as it relates to the facility's failure to ensure the use of physical restraints was incorporated into patients' plans of care. 6. Refer to A 168 as it relates to the facility's failure to ensure physical restraints were used only as ordered by a physician or other LIP.	A 115		
A 118	482.13(a)(2) PATIENT RIGHTS: GRIEVANCES The hospital must establish a process for prompt resolution of patient grievances and must inform	A 118		

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A 118	Continued From page 2 each patient whom to contact to file a grievance. This STANDARD is not met as evidenced by: Based on review of complaint information and hospital policies, and staff interview, it was determined the facility failed to ensure the process for grievance identification had been thoroughly developed and implemented. This impacted 6 of 6 sample patients (#11 - #16) whose registered concerns were reviewed. It had the potential to impact all patients/representatives who expressed concerns. Lack of clarity related to the grievance process resulted in the failure to identify issues as grievances and the failure to provide written responses to those grievances. Findings include: 1. The facility failed to establish an adequate definition of a grievance to guide staff in making a determination between complaints and grievances as follows: The hospital's "Patient/Visitor Complaints or Grievances" policy, last reviewed by the hospital 8/2008, defined a grievance as "a matter that was not resolved promptly by department staff with support staff contacted to assist in resolution of the matter... Grievances may either be submitted verbally or in writing to the Medical Center. (This may include concerns noted from Patient Satisfaction Surveys.)" The policy did not define the time frame intended by "resolved promptly." The policy also indicated, "Every effort is made to address these matters [concerns, complaints or other expressions of dissatisfaction] promptly by the most appropriate staff. However, there may be times when the matter remains unresolved. At	A 118	The Patient Complaint/Grievance Policy and Procedure was revised to provide explicit steps in management of complaints/grievance. Revisions were under the direction of the Director of Qaulity/Risk Management. In the policy statement a specific definition of a grievance was explicated as: Grievance: an expression by the patient, or representative, of concern or dissatisfaction with the patient care services provided that: 1) Cannot be resolved by the staff present at the department level within one subsequent calendar day, requiring further investigation or further actions; 2) Is presented in writing (including email or fax); 3) Is a Medicare beneficiary billing complaint related to rights and limitations provided by 42 CFR 489; 4) Is a verbal or written complaint regarding abuse, neglect, patient harm; 5) Includes information from patient satisfaction surveys where the patient identifies self and requests a response/resolution; In the header of the Patient Complaint/Grievance Policy and Procedure the review date was 5/2010. The revised date was 8/2008. The time frame associated with prompt resolution was defined in the policy statement as "Once a grievance is received, all attempts will be made to resolve the grievance within 7 days. If not resolved by day 7, the patient or representative will be contacted by the Patient Affairs Assistant informing the patient that staff are continuing to try to resolve the grievance and providing them with an estimated date of resolution."	12/21/11

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A 118	Continued From page 3 that time, the patient or his/her representative will be reminded of their option to file a grievance with the respective Department Director and/or Patient Affairs/Compliance Director, and have such grievance reviewed and responded to within a reasonable time frame." Reminding a complainant of the option to file a grievance if the matter was not resolved contradicted the policy's definition of a grievance. The policy defined a grievance as a matter that was not resolved promptly by staff, whether or not the patient/representative opted "to file a grievance." The policy defined the procedure utilized for complaint resolution. According to the policy, "Every effort will be made at the department level to resolve the patient/family/visitor complaint/concern related to services provided by the Medical Center in a timely manner by department staff. Staff may consult Department Directors and/or Patient Affairs Director for assistance with resolving complaints/concerns...If resolution is not achieved, the matter will be referred to the Patient Affairs/Compliance Director for further follow up. The Patient Affairs Director may involve Department Directors and/or members of the Administrative Team to seek resolution, and at this point a determination should be made if the matter will be considered a grievance." Determining if an unresolved matter was to be considered a grievance contradicted the hospital's definition of a grievance. In addition, according to the policy, the final response to a grievance included "name of the contact person and phone number; steps taken on behalf of the patient to investigate the grievance, the results of the process; and the	A 118	Revised the Patient Complaint/Grievance Policy and Procedure by removing statement "Patient representative is reminded of their option to file a grievance" and replacing with the following language: Prompt Resolution: Within one subsequent day from the time the complaint is received at the department level. This time frame is established to be able to mobilize appropriate resources and provide the opportunity for investigation and resolution. Grievance: an expression by the patient, or representative, of concern or dissatisfaction with the patient care services provided that: 1) Cannot be resolved by the staff present at the department level within one subsequent calendar day, requiring further investigation or further actions; Clarified grievance definition as: Grievance: an expression by the patient, or representative, of concern or dissatisfaction with the patient care services provided that: 1) Cannot be resolved by the staff present at the department level within one subsequent calendar day, requiring further investigation or further actions; This change removes the contradiction from the Patient Complaint/Grievance Policy and Procedure. Edited the grievance process by requiring the provision of a written response to the complainant which includes name of contact person and phone number, steps taken to investigate and resolve the issue, the resolution and date of completion.	12/21/11

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A 118	Continued From page 4 date of completion. In lieu of a written response, a meeting or phone conversation may be held to discuss the matter if agreed upon by both parties." However, the regulation requires a written response be provided even if other measures (such as meetings) were used to resolve issues. The definition of a grievance did not clearly guide staff in determining when an issue was to be treated as a complaint and when it would be considered a grievance and handled as such. The policy did not specify that if a patient care complaint was not resolved by the staff present, was postponed for later resolution, referred to other staff for later resolution, required investigation, and/or required further action for resolution, the complaint would be considered a grievance. The definition of a grievance did not include the information that written complaints were always considered grievances. The policy did not indicate that when a patient or their representative requested to make a "formal complaint," it was to be considered a grievance. The policy did not address complaints regarding allegations of abuse, neglect, or patient harm. A "Complaint Summary Report," from 1/01/11 to 11/30/11 was reviewed. The report contained basic information, including the date of the occurrence, type of complaint, and the resolution date for 107 patient concerns registered. Excluding the billing complaints, 50 of the concerns listed were documented as resolved between one and sixty days after the date of occurrence, which indicated the issue was not resolved promptly by department staff at the time	A 118	Clarified grievance definition as: Grievance: an expression by the patient, or representative, of concern or dissatisfaction with the patient care services provided that: 1) Cannot be resolved by the staff present at the department level within one subsequent calendar day, requiring further investigation or further actions; This change removes the contradiction from the Patient Complaint/Grievance Policy and Procedure. In the policy statement a specific definition of a grievance was explicated as: Grievance: an expression by the patient, or representative, of concern or dissatisfaction with the patient care services provided that: 1) Cannot be resolved by the staff present at the department level within one subsequent calendar day, requiring further investigation or further actions; 2) Is presented in writing (including email or fax); 3) Is a Medicare beneficiary billing complaint related to rights and limitations provided by 42 CFR 489; 4) Is a verbal or written complaint regarding abuse, neglect, patient harm; 5) Includes information from patient satisfaction surveys where the patient identifies self and requests a response/resolution; Analysis of grievance database report by the Director of Quality/Risk Management revealed that the report included issues that were not complaint/grievances. Two of nineteen issues were related to billing and one issue was related to risk management. Two issues were omissions of resolution dates which have subsequently been corrected. The analysis of the database report was utilized to define the QAPI process to improve the documentation of complaint and grievance management. The Director of Quality/Risk	12/21/11 1/3/11

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A 118 Continued From page 5

the complaint was raised. Between the first concern registered on 1/03/11, and the last concern received on 11/15/11, 19 concerns did not have a resolution date listed.

During an interview on 11/30/11 at 10:15 AM, the VP of Patient Care Services stated that she could only recall one patient concern that had risen to the level of a grievance in the several years she had been employed at the facility.

On 12/01/11 at 9:40 AM, the Patient Affairs Assistant was interviewed regarding the facility's grievance process. She stated she had been hired into the position as of 8/01/11. She confirmed that no patient concern had risen to the level of a grievance since she had assumed the role of Patient Affairs Assistant and no letters of resolution had been sent to patients or patients' representatives.

During the interview, she stated patients/representatives often spoke with her (or with the previous Patient Affairs Assistant) in person. She stated the typical procedure was for any patient concern to be referred to the Patient Affairs Assistant for investigation and resolution. She confirmed that occasionally issues could have been resolved by nursing personnel in the department involved, but were routinely referred to Patient Affairs.

On 12/01/11 at 9:40 AM, the Patient Affairs Assistant reviewed documentation of six concerns, related to Patients #11 - 16, listed on the "Complaint Summary Report," from 1/01/11 to 11/30/11. The Patient Affairs Assistant confirmed the documentation for concerns related to

A 118 Management will monitor the Patient Affairs Assistant's data entry accuracy, timeliness and completion on an ongoing basis and intervene when opportunities for improvement are identified.

This statement was made based on existing definition of grievances. Response now would be different based on new definition. On 1/4/11 the Department Directors were informed of the CMS findings and notified that a complete review of the revised policy and their accountability to address and resolve complaints at department level would occur on 1/11/12.

This statement was based on existing definition which has been revised. Education and training was provided 1/3/12 by Director of Quality/Risk who supervised the Patient Affairs Assistant regarding definition of complaints/grievances in policy; reviewed with emphasis on her role in expediting resolution and data entry improvements including patient communications as outlined in revised Patient Grievance/Complaint policy.

This statement made by the Patient Affairs Assistant was based on the organization's existing definition of a grievance. Her response now would be based on the new definition of a grievance included in the revised "Patient Grievance/Complaint" policy and procedure.

On 1/4/11 a request was filed to include in the dictionary choices of resolution type of a written response to prompt the Patient Affairs Assistant to complete and document the written process. Evidence of policy implementation of addressing complaints at the department level will be monitored via review of the department logs used by department directors to record complaints addressed within their department. The VP/Patient Care Services is accountable for monitoring compliance.

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A 118 Continued From page 6

Patients #11, #15, and #16 indicated the complaints were resolved one or more days after the date the concerns were registered and were therefore grievances by policy definition. She confirmed the documentation of investigation and resolution information related to Patients #12 - #14 was dated after the date the concern was registered and documented as resolved. She confirmed the additional documentation made it difficult to determine when the complaint was actually resolved. If the complaint was actually resolved days after it was registered it should have been considered a grievance. She confirmed that none of the concerns reviewed for Patients #11 - #16 were treated as grievances, and no one received a written response regarding the steps of the investigation and the results.

The facility failed to ensure the process for grievance identification and resolution had been thoroughly developed and implemented.

A 123 482.13(a)(2)(iii) PATIENT RIGHTS: NOTICE OF GRIEVANCE DECISION

At a minimum:
In its resolution of the grievance, the hospital must provide the patient with written notice of its decision that contains the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion.

This STANDARD is not met as evidenced by:
Based on staff interview and review of complaint information and hospital policy, it was determined the hospital failed to provide written notice of the resolution of grievances for 6 of 6 patients (#11 -

A 118 Implementation of Corrective Action Plans include:

- Education/training with Patient Affairs Assistant on January 3, 2012
- Overview and requirements of Grievance/ Complaint Policy communicated to all associates via Meditech communication January 11, 2012
- Education for all managers on January 11, 2012
- Introduced Grievance/Complaint education into Mandatory Updates January 11, 2012
- Managers will be conducting staff level education with expected completion by January 12, 2012

Integration into QA/PI Program

Adherence to revised process will be assessed through:

- Report grievance/complaint occurrence through Patient Safety/Quality Council
- Audit completion of database entries to insure timely resolution and documentation including validation of written responses, via grievance database report.

A 123 Responsible person: Director, Quality/Risk Management

The Patient Grievance/Complaint Policy and Procedure has been revised and includes a requirement for a written response of the resolution of a grievance. The response includes:

- date of grievance
- date of followup
- date of resolution
- details of the investigation
- name of contact and phone number

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A 123	Continued From page 7 #16) whose complaint/grievance information was reviewed. This had the potential to result in a lack of clarity for complainants as to the steps taken to resolve the grievances, the resolution of the grievances, and who the complainant could contact for further information or communication. Findings include: The hospital's "Patient/Visitor Complaints or Grievances" policy, last reviewed by the hospital 8/2008, defined a grievance as "a matter that was not resolved promptly by department staff with support staff contacted to assist in resolution of the matter... Grievances may either be submitted verbally or in writing to the Medical Center. (This may include concerns noted from Patient Satisfaction Surveys.)" According to the policy, the final response to a grievance included "name of the contact person and phone number; steps taken on behalf of the patient to investigate the grievance, the results of the process; and the date of completion. In lieu of a written response, a meeting or phone conversation may be held to discuss the matter if agreed upon by both parties." However, the regulation requires a written response be provided even if other measures (such as meetings) were used to resolve issues. A "Complaint Summary Report," from 1/01/11 to 11/30/11 was reviewed. The report contained basic information, including the date of the occurrence, type of complaint, and the resolution date for 107 patient concerns registered. Excluding the billing complaints, 50 of the concerns listed were documented as resolved between one and sixty days after the date of	A 123	In the header of the Patient Grievance/Complaint Policy and Procedure the review date was 5/2010. The revised date was 8/2008. The time frame associated with prompt resolution was defined in the policy statement as "Once a grievance is received, all attempts will be made to resolve the grievance within 7 days. If not resolved by day 7, the patient or representative will be contacted by the Patient Affairs Assistant informing the patient that staff are continuing to try to resolve the grievance and providing them with an estimated date of resolution." Policy revision requires a written response after resolution. The written communication will include date of grievance, date of followup, date of resolution and details of the investigation, name of contact and phone number.	12/21/11

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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 123	Continued From page 8	A 123		

occurrence. This would have indicated the issue was not resolved promptly by department staff at the time the complaint was registered and should have been considered a grievance based on the hospital policy definition. Between the first concern registered on 1/03/11, and the last concern received on 11/15/11, 19 concerns did not have a resolution date listed.

The Patient Affairs Assistant was interviewed on 12/01/11 at 9:40 AM. She stated she assumed her current position on 8/01/11. Samples of the concerns found on the "Complaint Summary Report," from 1/01/11 to 11/30/11, were reviewed with her. She confirmed that none of the complainants received a written notice of response to their concern, even though the complaint was not promptly resolved. She confirmed that in some cases the documentation did not clearly indicated whether or not the issue was resolved promptly, which made it difficult to determine if the concern should have been treated as a grievance. Examples follow:

1. On 12/01/11 at 9:40 AM, the Patient Affairs Assistant reviewed documentation from a concern she had been involved in regarding Patient #16. She stated Patient #16's husband spoke with her in person, on 8/29/11, regarding his concerns of his wife's recent falls on the medical/oncology floor. The Patient Affairs Assistant reviewed her documentation regarding the investigation. She stated she reviewed Patient #16's medical record and discussed Patient #16's course of care with nursing staff and physicians. She stated the resolution of the investigation included the Department Director reviewing all the documentation related to the

In the policy statement a specific definition of a grievance was explicated as: 12/21/11
Grievance: an expression by the patient, or representative, of concern or dissatisfaction with the patient care services provided that:
1) Cannot be resolved by the staff present at the department level within one subsequent calendar day, requiring further investigation or further actions;
2) Is presented in writing (including email or fax);
3) Is a Medicare beneficiary billing complaint related to rights and limitations provided by 42 CFR 489;
4) Is a verbal or written complaint regarding abuse, neglect, patient harm;
5) Includes information from patient satisfaction surveys where the patient identifies self and requests a response/resolution;

Review of the definition and accountability for resolution was discussed with management on 1/4/12 and scheduled for comprehensive review on 1/11/12. 1/11/12

On 1/4/11 a request was filed to include in the dictionary choices of resolution type of a written response to prompt the Patient Affairs Assistant to complete and document the written process.

This statement was based on existing definition which has been revised. Education and training was provided by Director of Quality/Risk Management on 1/3/12, who supervised the Patient Affairs Assistant regarding definition of complaints/grievances in policy; reviewed with emphasis on her role in expediting resolution and data entry improvements including patient communications as outlined in revised Patient Grievance/Complaint Policy. The revisions of the policy provides clarity in the definition of grievances and the defined procedure to manage a grievance, and emphasizes the requirement of a written response section.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	130003		C 12/09/2011

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A 123	Continued From page 9 falls with Patient #16's husband, and physician follow up evaluation. She stated she spoke with Patient #16's husband following the investigation and he was satisfied with the response he received. The Patient Affairs Assistant stated the issue was resolved on 8/31/11. She agreed that the issue was not promptly resolved by department staff at the time of the complaint. She confirmed no written response was provided to the complainant. The investigation of the complaint took three days to complete and therefore met the definition of a grievance based on the hospital policy. The complainant did not receive a final response with the steps taken to investigate the concern, results of the investigation, contact person's name and number, and the date of completion. 2. Documentation regarding a concern for Patient #15 was reviewed. The first page of the documentation was composed of several items to which the author wrote in a response. It was documented the date occurrence was 1/10/11 and the resolution date was 1/11/11. The location of the occurrence was the billing office/admitting and the resolution type was an "Apology." The author documented a summary of the concern "...STAFF RUDE TO SON REGARDING IDENTIFICATION OF SELF." The author documented the resolution, "DD [Department Director] AWARE AND APOLOGY TO FAMILY IN ADDITION TO ASSIST WITH ACCOUNT." The identity of the author could not be determined in the printed information. A second page contained a narrative written by the Patient Affairs Assistant on 1/31/11 at 12:10	A 123	Education for Department Directors provided 1/4/12 and scheduled for 1/11/12 emphasis requirement for resolution of complaints at department level. Department Directors are accountable for maintaining a log of complaint resolutions and providing a summary to the VP/ Patient Care Services who reviews the content. The revision of the policy clarified the definition of prompt resolution at the department level and the requirement of a written response to the complainant. Education and training was provided on 1/3/12 by director of Quality/Risk Management who supervised the Patient Affairs Assistant regarding definition of complaints/grievances in policy; reviewed with emphasis on her role in expediting resolution and data entry improvements including patient communications as outlined in revised Patient Grievance/Complaint policy.	1/11/12

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A 123 Continued From page 10

PM (20 days after the documented resolution date). She documented, "STAFF ARGUED WITH MOM ADN [sic] THAT SHE REALLY WASN'T MOTHER AND WOULD NOT PROVIDE SSN [Social Security Number] INFO [Information]."

A third page contained additional information documented by the Patient Affairs Assistant on 1/31/11 at 12:10 PM. "[Department Director] AWARE WILL F/U [Follow up] WITH STAFF AND PROVIDE EDUCATION.

MOM VERY NICE, [Department Director] F/U WITH HER AS WELL. SHE GOT NEEDED INFO FROM SS [Social Security] OFFICE - UNNECESSARY [sic] EXTRA STEP." It is unclear when the Department Director was notified of, and resolved, the concerns. It was not clear whether this "MOM" referred to was the same individual mentioned on the second page who argued that "SHE REALLY WASN'T MOTHER."

The current Patient Affairs Assistant was interviewed on 12/01/11 at 9:40 AM. She reviewed the above information and stated that it appeared the Department Director was involved with the complainant at the time the event occurred and the Department Director resolved the complaint and provided resolution to the parties involved. However, she confirmed the date of resolution was not the same date as the date of occurrence, and the additional documentation from the Patient Affairs Assistant was much later than the date of resolution. She confirmed the lack of clarity in the documented information related to the timeline and details of

A 123

In regards to Patient #15, during the survey a database screen print of the case summary and the complaint page were provided to the surveyors. At the top of page labeled complaint, the author was identified.

Subsequent to the date of the occurrence impacting Patient #15, there has been a change in person appointed as Patient Affairs Assistant (July, 2011). Deficiencies in documentation have been addressed through orientation and education of the new Patient Affairs Assistant. Education and training was provided on 1/3/12 by director of Quality/Risk Management who supervised the Patient Affairs Assistant regarding definition of complaints/grievances in policy; reviewed with emphasis on her role in expediting resolution and data entry improvements including patient communications as outlined in revised Patient Grievance/Complaint policy and Procedure.

The revision of the Patient Complaint/Grievance Policy and Procedure provides clarity in the definition of a grievance time line requirement. The defined procedure to manage a grievance, emphasizes the requirement of a written response and provisions of details of investigation.

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A 123	Continued From page 11 the investigation and resolution of the concern. She confirmed this complaint was not treated as a grievance and Patient #15 did not receive a written response. The facility failed to ensure the complainant received a written response which included the steps of investigation and the result of the grievance process. 3. Documentation regarding a concern for Patient #11 was reviewed. The first page of the documentation was composed of several items to which the author wrote in a response. It was documented the date occurrence was 4/07/11 and the resolution date was 6/15/11. The location of the occurrence was the medical/oncology floor and the resolution type was an "Apology." The author documented a summary of the concern "...ATMOSPHERE OF NOT CARING - NO BATH, DIRTY GOWN/LINES, [sic]." The author documented the resolution, "MET W/ [with] BOTH DAUGHTER&SON [sic], MATTER RESOLVED, APOLOGIZED..." A second page contained a narrative, "...the overall feeling was that staff were too concerned with the routine that they did not exhibit compassionate care. She states that he laid in a filthy gown/bed, offered no bath. He was transferred to ICU [Intensive Care Unit] and that is where I met them. Upon further interview face to face - no c/ [complaint] in ICU and son had none voiced period...	A 123	Subsequent to the date of the occurrence impacting Patient #11, there has been a change in person appointed as Patient Affairs Assistant (July, 2011). Deficiencies in documentation have been addressed through orientation and education of the new Patient Affairs Assistant. Education and training was provided on 1/3/12 by director of Quality/Risk Management who supervised the Patient Affairs Assistant regarding definition of complaints/grievances in policy; reviewed with emphasis on her role in expediting resolution and data entry improvements including patient communications as outlined in revised Patient Grievance/Complaint policy. The revision of the Patient Complaint/Grievance Policy and Procedure provides clarity in the definition of a grievance time line requirement. The defined procedure to manage a grievance, emphasizes the requirement of a written response and provisions of details of investigation.	

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A 123	Continued From page 12 Apologized and offered for her to meet with again [sic] - wanted to hear the story, etc. she has yet to contact us... She did bring up a concern about d/c [discharge] instructions from OP [out patient] (admitted after a bronch [bronchoscopy]) as she thought it was confusing. Upon review [name] and I noted opportunity to improve and [name] took the matter up for review with her staff..." The date the narrative was entered and the author of the information could not be determined. It was unclear when the author met with the family or if the family was interviewed more than one time. There was no evidence the concern about care had been investigated or that a resolution had been presented to the family. The concern with the OP discharge instructions was evaluated and processes changed as a result, however it did not appear the complainant received a response regarding the resolution. The current Patient Affairs Assistant reviewed the above information on 12/01/11 at 9:40 AM. She reviewed the information on her computer and located some additional information to further explain the investigation. She stated the daughter and son spoke with the Patient Affairs Assistant in person. She stated, following that conversation the information was reviewed with the ICU Department Director who in turn spoke with her staff. However, the documentation indicated the concerns were related to the medical/oncology floor, not ICU. The current Patient Affairs Assistant stated that Patient #11's medical record was reviewed by the Department	A 123	The database contained the author; the printed form provided to the surveyor did not. However, the summary sheet did contain the author, but was not provided to the surveyor. Subsequent to the date of the occurrence impacting Patient #11, there has been a change in person appointed as Patient Affairs Assistant (July, 2011). Deficiencies in documentation have been addressed through orientation and education of the new Patient Affairs Assistant. Education and training was provided on 1/3/12 by director of Quality/Risk Management who supervised the Patient Affairs Assistant regarding definition of complaints/grievances in policy; reviewed with emphasis on her role in expediting resolution and data entry improvements including patient communications as outlined in revised Patient Grievance/Complaint policy.	

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A 123	Continued From page 13 Director (unclear which Department Director) to look for opportunities to improve care. She confirmed that the timeline of conversations with the family and the process of the investigation and resolution were not clearly delineated. She explained that the previous Patient Affairs Assistant was waiting to hear back from the family after Patient #11's full stay at the hospital. She stated the family did not follow up, and therefore, the account was closed. She confirmed the family did not receive a written notice regarding the steps taken to investigate the concerns or the results of the investigation. The facility failed to ensure the complainant received a written response which included the steps of investigation and the result of the grievance process. 4. Documentation regarding a concern filed by Patient #13 was reviewed. The first page of the documentation was composed of several items to which the author wrote in a response. It was documented the date occurrence was 2/25/11 and the resolution date was 2/24/11 (one day prior to the date of the occurrence.) The location of the occurrence was the radiology department and the resolution type was an "Apology." The author documented a summary of the concern "...STAFF WERE RUDE, ROUGH AND WE'E [sic] HURTING ME,WANTS TO LODGE FORMALCOM [sic]." It appeared as if Patient #13 wished to file a formal complaint, which would be considered a grievance. The author documented the resolution, "TALK TO [name of Department Director], HE REFERRED TO ME, APOLOGIZED, SHE WAS SATISFIED." It was unclear what the author meant by "HE	A 123	Edited the grievance process by requiring the provision of a written response which includes name of contact person and phone number, steps taken to investigate and resolve the issue, the resolution and date of completion.	

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A 123	Continued From page 14 REFERRED TO ME." The identity of the author could not be determined based on the printed information. A second page of information contained a narrative of the report. It could not be determined who wrote the information, or when the information was gathered or entered into the computer. The author documented, "RUDE AND ROUGH. SHE C/ [complained] SHE WAS HURTING AND IT WAS WORSE WHEN THEY WERE GRABBING HER ARMS AND LEGS AND THE OLD GUY GRABBED HER NECK. JUST THREW ME BACK ON THE BED, GAVE ME A PILLOW AND SENT ME BACK. I ASKED THE ER [Emergency Room] NURSE FOR [Radiology Department Director]'S NUMBER. I DID NOT REFUSE I TOLD THEM JUST TO TAKE THE PICTURE. THAT HURTS THAT HURTS. NEVER IN MY LIFE HAVE I HAD TO SCREAM FOR HELP LIKE THAT IN A HOSPITAL. IF THEY DON'T LIKE THEIR JOB THEY SHOULDN'T WORK THERE. I KNOW YOU TRY. I HATE [name of another facility] WON'T GO THERE. I NEEDED PAIN MED. THEY SAID THEY'D GIVE ME SOMETHING IN ER. I HAVE MORE SWELLING IN MY BRAIN NOW, NOT DOING WELL, STILL HURT - LEGS AND RIBS AND STUFF FROM FALLING. I ASSURED HER THAT [Radiology Department Director] IS AWARE AND THAT HE WILL F/U [follow up] WITH HIS STAFF. I THANKED HER FOR SHARING HER CONCERNS AND SHE THANKED ME FOR CALLING 'SORRY I DIDN'T CALL YOU.' WHEN ASKED IF THERE WAS ANYTHING ELSE I COULD DO FOR HER SHE SAID NO. I TOLD HER THAT WE WANT TO	A 123	In regards to Patient #13, during the survey a database screen print of the case summary and the complaint page were provided to the surveyors. At the top of page labeled complaint, the author is identified.	

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A 123	Continued From page 15 DO WELL AND SERVE OUR PT [patient] WITH RESPECT AND COURTESY AND WE WILL USE HER FEED BACK TO IMPROVE OUR SERVICES." The date, time, and manner in which the concern was registered was not documented clearly (i.e. did Patient #13 phone the hospital after leaving or was she referred to the Patient Affairs Assistant while still in the facility). It was unclear exactly when Patient #13 was interviewed regarding the details of her treatment by radiology staff. The narrative did not describe the events in an understandable manner, and it was unclear if Patient #13 was suffering pain from a fall that occurred during the rough treatment or if the injuries were sustained prior to receiving care at the hospital. The report did not contain sufficient information to determine a thorough investigation of the grievance had been conducted, i.e., were staff involved interviewed. The report did not contain information regarding the resolution of the investigation or a written notice sent to Patient #13. Because no dates were documented on the second page of the information provided, and the resolution date was unclear, it was difficult to determine when Patient #13's concerns were resolved. The current Patient Affairs Assistant reviewed the information regarding Patient #13's concern, on 12/01/11 at 9:40 AM. She stated that it appeared the Radiology Department Director deferred to the Patient Affairs Assistant to complete the investigation and provide the resolution to Patient #13. She confirmed it was difficult to accurately determine when the concern was received by the facility and the timeline and details of the	A 123	Subsequent to the date of the occurrence impacting Patient #13, there has been a change in person appointed as Patient Affairs Assistant (July, 2011). Deficiencies in documentation have been addressed through orientation and education of the new Patient Affairs Assistant. Education and training was provided on 1/3/12 by director of Quality/Risk Management who supervised the Patient Affairs Assistant regarding definition of complaints/grievances in policy; reviewed with emphasis on her role in expediting resolution and data entry improvements including patient communications as outlined in revised Patient Grievance/Complaint policy. The revision of the Patient Complaint/Grievance Policy and Procedure provides clarity in the definition of a grievance time line requirement. The defined procedure to manage a grievance, emphasizes the requirement of a written response and provisions of details of investigation.	

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A 123	Continued From page 16 investigation and resolution. She confirmed the written narrative was difficult to follow and no written notice was provided to Patient #13. The facility failed to ensure the complainant received a written response which included the steps of investigation and the result of the grievance process. 5. Documentation regarding a concern for Patient #12 was reviewed. The first page of the documentation was composed of several items to which the author wrote in a response. It was documented the date occurrence was 3/10/11 and the resolution date was 3/10/11. However, additional information was documented on 3/14/11 at 12:37 PM by the Patient Affairs Assistant, making it difficult to determine the actual timeline of the investigation. The location of the occurrence was the surgical/orthopedic floor and the resolution type was an "Apology." The author documented a summary of the concern "...NRS [nurses] WERE MEAN TO WIFE AND UNPROFESSIONAL, HOLDING PAIN MEDS." The author documented the resolution, "APOLOGIZED, ASSURED REVIEW & ACTION WHERE APPROPR [appropriate] DD [Department Director] - SOC [Standard of Care] MET." The identity of the author could not be determined in the printed information. A second page of information contained a narrative of the report. The Patient Affairs Assistant entered a narrative dated 3/14/11 at 12:37 PM. "SO [significant other] - [name], PLEASANT BUT UPSET. OVERWHELMED WITH SICK SO [significant other] AND YOUNG CHILDREN.	A 123	In regards to Patient #12, during the survey database screen print of the case summary and the complaint page were provided to the surveyors. At the top of page labeled complaint, the author is identified. The confusion in date documentation is the result of late entry of work notes by the previously employed Patient Affairs Assistant, without reference to the occurrence date. As a component of education of the Patient Affairs Assistant, which occurred on January 3, 2012, it was emphasized by the Director of Quality/Risk Management that every entry must reference the date of occurrence.	

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A 123	Continued From page 17	A 123		

SEEMS THAT NURSES ARE SWEET AS ROSES WHEN HE WAS THERE BUT SO [significant other] WOULD CALL HIM AND TELL THEY WERE MEAN WHEN HE WAS GONE.

PAIN MED ISSUES, [Department Director] WAS AWARE AND REVIEWED AT THE TIME AND MEDICATED ACCORDING TO ORDERS - NOT WITHOLDING. PT [patient] WOULD COME TO DESK OR ANOTHER PT'S ROOM TO ASK FOR MEDS. STAFF AWARE AND WERE TRYING TO ADDRESS HER CONCERNS IN COMPASSIONATE AND CARING MANNER." It was not clear when the complainant was spoken with, if Patient #12 was interviewed, when the Department Director reviewed the record, or if the complainant received a response to the concerns noted. The date of the narrative, 3/14/11, conflicted with the date of resolution of 3/10/11.

The current Patient Affairs Assistant reviewed the information regarding the above concern on 12/01/11 at 9:40 AM. She stated it did not appear that Patient #12 was interviewed and it could not be determined that the complainant actually received a response. She confirmed this was not treated as a grievance and no written response was provided to Patient #12.

The facility failed to ensure the complainant received a written response which included the steps of investigation and the result of the grievance process.

6. Documentation regarding a concern for Patient #14 was reviewed. The first page of the documentation was composed of several items to

The confusion in date documentation is the result of late entry of work notes by the previously employed Patient Affairs Assistant, without reference to the occurrence date. As a component of education of the Patient Affairs Assistant, which occurred on January 3, 2012, it was emphasized by the Director of Quality/Risk Management that every entry must reference the date of occurrence.

Subsequent to the date of the occurrence impacting Patient #12, there has been a change in person appointed as Patient Affairs Assistant (July, 2011). Deficiencies in documentation have been addressed through orientation and education of the new Patient Affairs Assistant. Education and training was provided by director of Quality/Risk Management on 1/3/12 who supervised the Patient Affairs Assistant regarding definition of complaints/grievances in policy; reviewed with emphasis on her role in expediting resolution and data entry improvements including patient communications as outlined in revised Patient Grievance/Complaint policy.

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A 123 Continued From page 18

which the author wrote in a response. It was documented the date of occurrence was 2/14/11 and the resolution date was 2/14/11. However, additional information was documented on 2/18/11 at 10:43 AM by the Patient Affairs Assistant, making it difficult to determine the actual timeline of the investigation. The location of the occurrence was the medical/oncology floor and the resolution type was an "Apology." The author documented a summary of the concern "...UPSET RE: [regarding] COMMUNICATION W/ [with] NURSES - MOM'S CONDITION WORSE THAN IS." It was not clear what the miscommunication between the family and nursing staff was. The author documented the resolution, "F/U WITH STAFF, MD [Medical Doctor] SPOKE WITH FAMILY, CALL BACK, NO FURTHER CONCERN." It was not clear what was meant by "CALL BACK." It could have meant the facility contacted the family involved, but the individual who made the call was not noted. The documentation did not indicate what "F/U WITH STAFF" involved. The identity of the author could not be determined in the printed information.

A second page contained a narrative written by the Patient Affairs Assistant on 2/18/11 at 10:43 AM. "NURSE GOT CONFUSED RE PT SHE WAS TALING [sic] ABOUT - COMFORT CARE - FREAKED DAUGHTER OUT [sic]

THEN PT CONFUSED AND NR [nurse] SAID WOULD MOST LIKELY DO CT [Computerized Topography] IF NOT CLEARED AND DAUGHTER ASSUMED THAT MEANT CA [cancer] IN BRAIN...[sic]

A 123 emphasizes the requirement of a written response and provisions of details of investigation.

The confusion in date documentation is the result of late entry of work notes, without reference to the occurrence date. As a component of education which occurred on January 3, 2011, it was emphasized that every entry must reference the date of occurrence.

In regards to Patient #14, during the survey a data base screen print of the case summary and the complaint page were provided to the surveyors. At the top of page labeled complaint, the author is identified.

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A 123	Continued From page 19 WORKED IT OUT...[sic]" The events surrounding the concern were not clearly documented. It was not clear when nursing staff were spoken to or exactly how the concern was investigated or resolved. The Patient Affairs Assistant documented information on 2/18/11, so it was not clear when the concern was resolved. The results of the investigation were not noted. The current Patient Affairs Assistant reviewed the above information on 12/01/11 at 9:40 AM. She stated the previous Patient Affairs Assistant contacted Patient #14's physician and asked the physician to clarify the medical issues concerning Patient #14. She stated the Patient Affairs Assistant also spoke with nursing staff to clarify the issues related to the miscommunication. She stated it was unclear what the timeline of the investigation and resolution of the complaint was based on the documentation. She confirmed this was not treated as a grievance and no written response was provided to Patient #14. The facility failed to provide written notice regarding the resolution of the grievance.	A 123	Subsequent to the date of the occurrence impacting Patient #14, there has been a change in person appointed as Patient Affairs Assistant (July, 2011). Deficiencies in documentation have been addressed through orientation and education of the new Patient Affairs Assistant. Education and training was provided by director of Quality/Risk Management on 1/3/12 who supervised the Patient Affairs Assistant regarding definition of complaints/grievances in policy; reviewed with emphasis on her role in expediting resolution and data entry improvements including patient communications as outlined in revised Patient Grievance/Complaint policy. The revision of the Patient Complaint/Grievance Policy and Procedure provides clarity in the definition of a grievance time line requirement. The defined procedure to manage a grievance, emphasizes the requirement of a written response and provisions of details of investigation.	
A 159	482.13(e)(1)(i)(A) PATIENT RIGHTS: RESTRAINT OR SECLUSION Definitions. (i) A restraint is- (A) Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely; or This STANDARD is not met as evidenced by:	A 159		

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Based on staff and patient interviews, observation, and review of medical records and hospital policies, it was determined the hospital failed to identify uses of Geri-chairs and four side rails raised on a hospital bed as potential restraints. This directly impacted 2 of 5 current patients (#2 and #8) who were observed in Geri-chairs, and 2 of 5 current patients (#1 and #2) who were known to have four side rails raised on their beds. This resulted in a systemic failure which allowed patients throughout the hospital to be restrained at staffs' discretion, without physician authorization, and without documentation of the need for, and use of, the restraints. Findings include:

The hospital had 145 beds and 4 floors. Patient care areas were on floors 3 and 4. The use of Geri-chairs and four side rails up on beds as restraints, was identified on 2 of the 4 adult units (the Medical/Oncology Department and Surgical/Orthopedic Department) and confirmed to be used hospital-wide at staffs' discretion. The policies related to Geri-chairs, and the use of four side rails on hospital beds, were as follows:

1. The "RESTRAINTS" policy, revised 3/01/11, was reviewed. The policy defined a physical restraint as "Any manual method or physical or mechanical device that immobilized or reduces the ability to move his/her body, head, or limbs." The policy contained a section, "EXEMPTIONS FROM THE REQUIREMENTS IN THIS POLICY." Geri-chairs and top bed rails were among the devices listed as being exempt from the classification of restraints. The use of the Geri-chair and other devices were identified in the policy as "Protective devices used to

A 159 Accountable person: VP/Patient Care Services

Geri chairs were in use as a therapeutic devise described in a policy titled: Geri-Chairs - Therapeutic Use. The intent of use was to respond to unique patient needs.

Immediate action was taken to improve documentation to distinguish use of the chair from a restraint and document therapeutic objectives. An electronic communication was issued to nursing personnel by the Director of Nursing Operations on 12/11/11 stating the need to immediately improve documentation of the patient's individual needs for therapeutic use of a geri chair. Documentation enhancement was promoted through the building of specific data screens in the electronic medical record.

The surveyor findings were reviewed with all directors on 12/12/11 with notification that the documentation enhancement was under development and required their implementation as soon as finalized.

On 12/17/11, the Medical/Surgical Director was requested by the VP/ Patient Care Services to seek a modification of the chair configuration so trays could be removed by patients, or to seek an alternate product. On January 5, 2012 all geri-chairs were taken from service and replaced with a therapeutic chair.

The policy entitled "Geri-chairs, Therapeutic Use" was revised on 1/5/12 as follows:

- Retitled "Therapeutic Chair Use"
- Defined a therapeutic chair as "a chair with NO front tray barrier and side trays for patient belongings"
- Clarified therapeutic indications for patient socialization, change in patient's environment, etc.

On 1/6/12, the Restraint Policy was revised regarding exemptions to restraints. Geri chairs were removed as protective device exemptions.

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support/sustain the delivery of care and/or ADL.." It additionally stated "Need for these devices will be based on an assessment of the patient."

The facility had a policy, "RESTRAINTS: Geri-chairs, Therapeutic Use," last reviewed by the hospital on 2/09/11. According to this policy, "Use of geriatric chairs provides a safe method of meeting care needs for patients which may eliminate the need for restraint." The policy indicated Geri-chairs could be used for the following purposes:

- "For motor activities. Should be used in conjunction with supplies or activities for hand use.
- "For calming effect. Allows patient to be closer to other people. Provides a different environment which may help calm the patient. Provides a different interaction level, can talk while sitting rather than lying in bed."
- "For re-orientation. To place patient in a social situation with familiar surroundings."
- "For socialization. To allow more opportunities to talk with other patients, visitors, nurses, secretaries, etc."
- "For mental stimulation. To allow for more contact with other people. To encourage reading, puzzles, contact with the environment. To make patients more aware of day/night, time, etc."
- "For a change of environment from their room. To allow the patient to change environment from a single room to a group room, nearer to activity areas, etc."

In addition, the policy indicated documentation accompanying use of the Geri-chair was to identify the patient's need for the chair in

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conjunction with at least one of the following seven a nursing diagnosis: Fear, Diversional Activity Deficit, Anxiety, Impaired Thought Processes, Ineffective Individual Coping, Social Isolation, and Altered Thought Processes. A plan of care was to address the identified diagnosis(es). The policy did not state that Geri-chairs needed to be easy for the patient to get out of to ensure they were not restraints. The policy did not state that a physician's or LIP's order for restraints would be required if a patient was not able to easily remove the tray and exit the chair on his/her own.

The policy did not guide staff in assessing patients to determine if the Geri-chair could be appropriately used to meet the therapeutic needs of patients. The policy did not indicate what monitoring protocols, such as for toileting, repositioning, attending to personal needs, were to be put into place once a patient was seated in the Geri-chair and could not get out. In addition, the policy did not outline the documentation required in the medical record to support the use of the Geri-chair as restraint.

Geri-chairs were used by staff as follows:

a. Patient #2 was a 71 year old male, admitted to the Medical/Oncology department on 11/28/11, with a diagnosis of esophageal cancer and dehydration. He was receiving daily radiation treatment. His admission nursing assessment on 11/28/11, documented Patient #2 was alert and oriented. It also indicated he ambulated independently. An 11/29/11 Psychosocial Assessment documented Patient #2 was confused and did not want to stay in bed. A

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The policy entitled "Geri-chairs, Therapeutic Use" was revised on 1/5/12 as follows:

- Retitled "Therapeutic Chair Use"
- Defined a therapeutic chair as "a chair with NO front tray barrier and side trays for patient belongings"
- Clarified therapeutic indications for patient socialization, change in patient's environment, etc.

The replacement of the Geri-chairs with the therapeutic chairs eliminated the potential of the devise functioning as a restraint. This was completed on 1/5/12 under the direction of the VP/ Patient Care Services.

The replacement of the Geri-chairs with the therapeutic chairs eliminated the potential of the devise functioning as a restraint, thus eliminating the need for restraint orders, monitoring and other restraint use requirements.

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A 159	Continued From page 23 physician progress note, dated 11/30/11 at 8:00 AM, indicated Patient #2 was still very weak and unsteady on his feet. On 12/01/11 at 10:45 AM, Patient #2 was observed sitting in a Geri-chair in the doorway to his room. Upon initiation of a conversation with Patient #2, he requested a hacksaw. When he was questioned why he needed a hacksaw, he stated "I need a hacksaw to get out of this chair; two nurses were not able to take off this table." (He indicated the tray connected to the Geri-chair). A review of Patient #2's record with the Department Director of the Medical/Surgical Units was completed on 12/01/11 at 8:45 AM. She confirmed the record did not document an assessment for the need of a Geri-chair, there were no physician's orders, and no modifications to his plan of care to include Geri-chair use. In a subsequent interview on 12/01/11 at 10:45 AM, she stated the Geri-chair was used for patient safety, and not considered to be a restraint. b. Patient #8 was a 97 year old female, admitted to the Medical/Oncology department on 11/29/11, with a diagnosis of back spasms. Patient #8 had been admitted from an assisted living facility. Her Adult Admission Assessment completed the date of admission indicated Patient #8 had mild dementia and was very forgetful and impulsive. It also stated she had poor balance and weakness and listed a front wheeled walker and gait belt as assistive devices. The assessment further stated she could be up with the assistance of one person. Her 11/29/11 physician admission orders indicated under "Activity" that she was to be up	A 159	The replacement of the Geri-chairs with the therapeutic chairs eliminated the potential of the devise functioning as a restraint, thus eliminating the need for restraint orders, monitoring and other restraint use requirements.	

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with assistance only.

On 11/30/11 beginning at 3:10 PM, Patient #8 was observed sitting in a Geri-chair with the tray secured. Patient #8's Geri-chair was situated close to the nursing station. Patient #8 was observed for approximately 30 minutes while this surveyor reviewed her medical record with the Department Director of the Medical/Surgical Units. During that time Patient #8 called out to staff members, "Please help me, please help me get out," and reached out with her hands to try and grab staff when they walked close to her. During the observation time, there were three hospital staff members at the desk area, and two in the hallway area. No one was observed to address Patient #8 or her concerns.

A review of Patient #8's record with the Department Director of the Medical/Surgical Units was completed on 12/01/11 at 8:30 AM. She confirmed the record did not document an assessment for the need of a Geri-chair, there were no physician's orders, and no modifications to her plan of care to include Geri-chair restraint use.

c. A CNA in the Medical/Oncology department was interviewed on 12/01/11 at 2:40 PM. She stated Geri-chairs were used frequently for patients who were at risk for a fall or who were confused.

A Medical/Oncology department RN was interviewed on 12/01/11 at 2:45 PM. She stated more than 50% of patients in the department were at risk for falls. She stated Geri-chairs were used to prevent falls. The RN was asked if she

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The replacement of the Geri-chairs with the therapeutic chairs eliminated the potential of the devise functioning as a restraint, thus eliminating the need for restraint orders, monitoring and other restraint use requirements.

This patient had dementia and was at risk for falls. The staff use of a Geri-chair to maintain safety and enhance socialization was viewed as a restraint by the CMS surveyors. The replacement of the Geri-chair with a therapeutic chair on 1/5/12 eliminates the potential of unintended restraint. A therapeutic chair will now be utilized as warranted by patient assessment.

To monitor compliance to the elimination of geri chairs and the proper use of therapeutic chairs, the nursing supervisors began collecting data on 1/6/12. Data collection indicators include the following:

- Patient name
- Room number
- Reason for use of therapeutic chair documented in EMR
- Concurrence of appropriateness based on patient condition

Data collection forms will be submitted to the VP/Patient Care Services to evaluate compliance to expected usage of therapeutic chairs. Interventions for improvement will be implemented as identified.

On 1/5/12, written communication was provided to nursing personnel from the Director of Medical/Surgical Services, reminding nursing staff of the geri chairs being removed from service and replaced with therapeutic chairs. Additional therapeutic chairs were ordered to meet the needs of this organization's senior population.

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would consider the Geri-chair a restraint and she stated, "I probably would, but not really, it is for patient safety."

A Surgical/Orthopedic RN was interviewed on 12/02/11 at 8:30 AM. She stated staff used Geri-chairs with the tray "a lot" for confused patients so that they do not get up on their own and get hurt. She stated some patients fall out of regular wheelchairs and therefore are placed in a Geri-chair. She also stated that after spinal surgeries patients may be placed in them to help maintain appropriate positioning.

On 12/02/11 at 9:45 AM, the Department Director of the Medical/Surgical Units confirmed that confused patients were often placed in Geri-chairs. However, she explained the patients were always placed in the direct line of sight of nursing staff. She stated that patients could not easily get out of a Geri-chair themselves but required the assistance of staff. She stated this was the reason patients in Geri-chairs were always visible to staff. The VP of Patient Care Services, present during the interview on 12/02/11 at 9:45 AM, stated for confused patients the tray was set up with tissues, water, and perhaps something to occupy the patient's attention. She stated utilizing the Geri-chairs encouraged socialization and stimulation for patients. Both individuals stated that the facility did not consider the use of Geri-chairs to be a restraint based on the manner in which they are used.

On 12/07/11 at 2:35 PM, the VP of Patient Care Services was interviewed. She explained that since the change to the electronic medical record

A 159 The organization has a policy entitled "Fall Guidelines: High Risk". Geri-chairs are not considered an intervention for fall prevention. A refresher educational process will be provided on 1/11/12 regarding restraints, via online education testing process. The education will also reinforce that therapeutic chairs are not intended for fall prevention.

The replacement of the Geri-chairs with the therapeutic chairs eliminated the potential of the devise functioning as a restraint, thus eliminating the need for restraint orders, monitoring and other restraint use requirements.

The nurse statement that chairs can be used to maintain appropriate position is addressed in the Restraint policy. Interpretive guideline 482.13(e)(1)(:)(c) Mechanical support used to achieve proper body position is not considered a restraint.

Geri-chairs were replaced on 1/5/12 with the therapeutic chair.

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staff were not prompted to document, and stated that she did not believe staff had been instructed to document an assessment and reason for the therapeutic use of the Geri-chair. She confirmed that staff often did not differentiate in their documentation when a patient was in a Geri-chair or other type of chair. She stated it was routine for staff to complete rounding on each patient on an hourly basis to assess for pain, positioning, personal, and toileting needs. She stated this was routinely documented in the medical record.

Geri-chairs were used for patients as restraints.

2. The "RESTRAINTS" policy, revised 3/01/11, was reviewed. The policy defined a physical restraint as "Any manual method or physical or mechanical device that immobilized or reduces the ability to move his/her body, head, or limbs." The policy did not address the use of four side rails as either a restraint, or being exempt from the requirements of the policy. When side rails prevent a patient from voluntarily getting out of bed, they are, by definition, a restraint.
Four side rails were used for patients as follows:

a. Patient #2 was a 71 year old male, admitted to the third floor on 11/28/11 with a diagnosis of esophageal cancer and dehydration. Patient #2 was a 71 year old male, admitted to the Medical/Oncology department on 11/28/11, with a diagnosis of esophageal cancer and dehydration. He was receiving daily radiation treatment. His admission nursing assessment on 11/28/11, documented Patient #2 was alert and oriented. It also indicated he ambulated independently. An 11/29/11 Psychosocial Assessment documented Patient #2 was confused and did not want to stay

A 159 Immediate action taken was to improve documentation to distinguish use of the chair and document therapeutic objectives. This document enhancement was made through building specific data content in EMR. The surveyor findings were reviewed with all directors with notification that documentation enhancement was under development and required their implementation as soon as finalized.

The replacement of the Geri-chairs with the therapeutic chairs eliminated the potential of the devise functioning as a restraint. This was completed on 1/5/12 under the direction of the VP/ Patient Care Services.

The organization's policy entitled, "Restraints/Seclusion", was revised on 1-6-12 to include as an exemption, "the use of bed rails that provide a mechanism for patient safety, do not enclose the bed and allow the patient to exit without climbing over the rail or the bottom of the bed." In addition, the use of four bed rails when used on beds equipped with pressure reduction air mattresses, protect the patient from potentially falling out of bed. This approach is consistent with the CMS Interpretive Guidelines for A-0161 that states, "When a patient is on a bed that constantly moves to improve circulation or prevent skin breakdown, raised side rails are a safety intervention to prevent the patient from falling out of bed and are not viewed as a restraint." Within the same section of Interpretive Guidelines, the following is stated, "For example, if the side rails are segmented and all but one segment are raised to allow the patient to freely exit the bed, the side rail is not acting as a restraint and the requirements of this rule would not apply." The beds in use at the organization are specially designed to the patient to exit from either side of the bed even when 4 side rails are raised as the rails do not enclose the bed. The second rail and the foot board include a hand grip to assist the patient in exiting out of the bed via either side. In

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in bed. A physician progress note, dated 11/30/11 at 8:00 AM, indicated Patient #2 was still very weak and unsteady on his feet.

The Charge Nurse in the Medical/Oncology department was interviewed on 11/30/11 at 3:00 PM. She explained that Patient #2 became increasingly confused during his first night in the hospital and fall prevention measures were implemented around midnight on 11/28/11. The Charge Nurse stated measures for fall prevention included posting a sign outside of Patient #2's room, keeping the room free of clutter, activation of the bed alarm, wearing rubber-soled socks, and placing all four side rails up when Patient #2 was in bed.

Patient #2's medical record contained "Safety Precautions" documentation which indicated Patient #2 was on "Fall Precautions" with four side rails raised on his bed at the following times:

- 11/29/11 at 12:00 AM, 8:00 AM, and 5:00 PM. An RN documented that Patient #2 had a fall at 4:30 PM and the "FALL PROTICAL [sic]" was instituted. In addition, nursing notes documented Patient #2 had an unwitnessed fall on 11/29/11 at 4:30 PM. The record entry stated Patient #2 had slipped when he was getting out of bed, and was found on the floor towards the foot of the bed.
-11/30/11 at 1:00 AM, 8:00 AM, and 4:00 PM.
-12/01/11 at 12:30 AM, 8:00 AM, 4:00 PM, and 11:44 PM. At 4:00 PM, the RN documented that Patient #2 was "SOMETIMES CONFUSED AND IMPULSIVE."

In an interview on 11/30/11 at 3:30 PM, the RN in the Medical/Oncology department who cared for

A 159 actuality, when the side rails are raised, a space of 22.5 inches remains open for exit. Also, the rail controls are designed to be released by the patient, therefore in concurrence with the Interpretive Guideline A-0161, "If a patient can easily remove a device, the device would not be considered a restraint." Also, "A restraint does not include methods that protect the patient from falling out of bed. Examples include raising the side rails when a patient is: .....or on certain types of therapeutic beds to prevent the patient from falling out of the bed." An additional patient safety feature of this bed is the raised side rails provide an "edge reminder" without limiting the patient's ability to exit the bed. The use of this type of bed, with the 4 side rails raised, increases the patient's safety, is therapeutic in preventing skin breakdown while still allowing the patient freedom to exit the bed. The innovative technology associated with this bed may not be known by all persons accustomed to four rails enclosing the length of the bed.

CMS Interpretive Guideline A-0161 states, "A restraint does not include methods that protect the patient from falling out of bed. Examples include raising the side rails when a patient is: on a stretcher, recovering from anesthesia, sedated, experiencing involuntary movement or on certain types of therapeutic beds to prevent the patient from falling out of bed. The use of side rails in these situations protects the patient from falling out of bed and therefore, would not be subject to the requirements of standard (e)." The organization's policy entitled, "Fall Guidelines-High Risk" includes as an intervention, use of four bed side rails where four rails do not create a full length bed enclosure and still allows the patient to freely exit the bed. This clarification was added to the policy on 1-6-12 by the VP of Patient Care Services to aide nursing staff in assessment and introduction of appropriate intervention.

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A 159	Continued From page 28 Patient #2 at the time of his fall, stated she had been called to the room after the fall. The RN stated all four side rails had been up on Patient #2's bed, and she did not know how he scooted to the foot of the bed. In an interview with Patient #2 on 12/01/11 at 3:50 PM, he stated he had to go to the bathroom, and had been trying to get out of bed when he fell. Patient #2 stated he was not sure if he had requested assistance before attempting to get out of bed. A CNA in the Medical/Oncology department was interviewed on 12/01/11 at 2:40 PM. She stated patients determined to be at risk for falls would have four side rails up. A Medical/Oncology department RN was interviewed on 12/01/11 at 2:45 PM. She stated more than 50% of patients in the Medical/Oncology department were at risk for falls. She stated four side rails were used to prevent falls. The RN was asked if she would consider bed rails a restraint and she stated, "I probably would, but not really, it is for patient safety." b. Patient #1 was a 60 year old female admitted to the fourth floor of the hospital on 11/27/11 for repair of an incarcerated ventral hernia. According to the website freemd.com, last updated 8/19/10, a ventral hernia is a piece of intestine that protrudes through an abnormal opening in the abdominal wall. In a person with an incarcerated hernia, the intestine has become stuck in the abnormal opening. When this	A 159	The organization's policy entitled, "Fall Guidelines-High Risk" includes as an intervention, use of four bed side rails where four rails do not create a full length bed enclosure and still allows the patient to freely exit the bed. This clarification was added to the policy on 1-6-12 by the VP of Patient Care Services to aide nursing staff in assessment and introduction of appropriate intervention.	

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happens, the blood supply to the intestine is reduced, and the intestinal tissue starts to die. Patient #1's medical record contained documentation related to "Safety Precautions." On 11/27/11 at 4:03 PM, and on 11/28/11 at 12:00 AM, 12:46 PM, and 5:11 PM, nursing staff documented Patient #1 was on fall precautions and hourly rounding, and had four side rails raised on her bed for safety. Subsequent documentation indicated Patient #1 remained on fall precautions but had only two bed rails raised. On 11/30/11 at 1:33 PM, nursing documentation indicated that Patient #1 had a steady gait and had ambulated independently multiple times. The RN documented that Patient #1 was no longer a fall risk.

An RN documented, on 12/01/11 at 5:49 AM, that Patient #1 fell out of bed and hit the right side of her head, which was tender to the touch. The RN indicated Patient #1 complained of left knee pain and sustained a scratch on the knee. The RN then documented, "ROOM LIGHTS ON, ALL FOUR BED RAILS UP POST FALL PROTOCOL SET."

The "POST FALL PROTOCOL," dated 7/2006, was reviewed. The protocol did not include direction to staff to raise four side rails for safety after a patient fall.

The "FALL GUIDELINES, High Risk" policy, last revised by the hospital 3/16/11, was reviewed. The policy contained a section related to "Post fall protocol..." According to the policy, numerous assessments would be completed immediately after the fall and in the following 48 hours. The patient's fall risk was to be re-evaluated as well

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The variation in the use of four bed rails versus two bed rails was directly related to the nursing assessment and the current needs of the patient regarding their falls risk.

The organization's policy entitled, "Post Fall Protocol" was designed to direct patient assessment and to identify potential causes of the fall and not necessarily to direct the nurse in selecting interventions. The policy "Fall Guideline-High Risk" is the policy that provides staff with direction regarding potential interventions. On 1-6-12, The "Post Fall Protocol" was revised to include a statement of "Consider use of four bed rails where four rails do not create a full length bed enclosure and still allows the patient to freely exit the bed." On 1-6-12, a written communication including the updates of policy changes associated with fall prevention and restraints was authored by the VP of Patient Care Services and distributed to nursing personnel.
The organization's policy entitled, "Fall Guidelines-

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as the appropriateness of interventions. The care plan was to be updated as needed. The policy did not include direction for the staff to raise all four side rails on the bed.

In an interview with the Department Director of the Medical/Surgical Units, on 11/30/11 at 4:10 PM, she stated a component of fall prevention is to have the bed's four side rails up. She stated orders to raise four side rails were not obtained, and the use of four raised rails was for "patient safety."

An RN working in the Surgical/Orthopedic department was interviewed on 12/02/11 at 8:30 AM. She stated all four side rails would be raised on a patient who was confused or after a patient had a fall. She stated she had patients attempt to climb over or through the rails. She stated it could be considered a restraint but that it was either raise all four rails or risk the patient falling out of bed.

On 12/02/11 at 9:45 AM, the VP of Patient Care Services and the Department Director of the Medical/Surgical Units were interviewed jointly. The VP of Patient Care Services stated that the specific bed chosen by the hospital was designed to allow all four rails to be up without being considered a restraint. She stated the hospital thoroughly researched this aspect of the bed before deciding to purchase.

On 12/07/11 at 2:35 PM, the VP of Patient Care Services explained when all four rails of the bed are raised, there is an exit space between the top and bottom rails. She stated because the facility did not view the use of four side rails as a

A 159 High Risk" includes as an intervention, use of four bed side rails where four rails do not create a full length bed enclosure and still allows the patient to freely exit the bed. This clarification was added to the policy on 1-6-12 by the VP of Patient Care Services to aide nursing staff in assessment and introduction of appropriate intervention.

CMS Interpretive Guideline A-0161 states, "A restraint does not include methods that protect the patient from falling out of bed. Examples include raising the side rails when a patient is: on a stretcher, recovering from anesthesia, sedated, experiencing involuntary movement or on certain types of therapeutic beds to prevent the patient from falling out of bed. The use of side rails in these situations protects the patient from falling out of bed and therefore, would not be subject to the requirements of standard (e)."

Utilizing the Mosby online education and testing system, a review of restraint policy and practices and falls prevention will be initiated on 1-11-12 and completed in 30 days. Written documentation will serve as evidence of completion which will be monitored by the directors. Restraint usage is concurrently monitored by the nursing supervisors to ensure compliance with expected practices. Variations are addressed in real time.

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restraint they were used at the staff's discretion for a variety of patient needs.

However, on 12/08/11 at 5:18 PM, the VP of Patient Care Services provided photographs of staff exiting the bed. The exit space was noted to be toward the foot of the bed, not between the top and bottom rails as previously discussed.

The facility failed to identify Geri-chairs and four side rails on a hospital bed as potential restraints.

A 164 482.13(e)(2) PATIENT RIGHTS: RESTRAINT OR SECLUSION

Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm.

This STANDARD is not met as evidenced by:
Based on staff and patient interviews, observation, and review of medical records and hospital policies, it was determined the facility failed to ensure restraints were only utilized after a comprehensive assessment and when less restrictive interventions were determined to be ineffective. This directly impacted 2 of 5 current patients (#2 and #8) who were observed in Geri-chairs and 2 of 5 current patients (#1 and #2) who were known to have four side rails raised on their beds. This resulted in patients being restrained without an assessment to determine if the use of the restraint outweighed the risk of not using the restraint. Findings include:

1. Patient #2 was a 71 year old male, admitted to the Medical/Oncology department on 11/28/11, with a diagnosis of esophageal cancer and

A 159 The replacement of the Geri-chairs with the therapeutic chairs eliminated the potential of the devise functioning as a restraint. This was completed on 1/5/12 under the direction of the VP/ Patient Care Services.

The bed used throughout the facility is equipped with rails that do not create a full length bed enclosure and still allows the patient to freely exit the bed even with four rails up. Based on CMS Interpretive Guidelines cited above, the use of rails would not be considered a restraint.

A 164 CMS Interpretive Guideline A-0161 states, "A restraint does not include methods that protect the patient from falling out of bed. Examples include raising the side rails when a patient is: on a stretcher, recovering from anesthesia, sedated, experiencing involuntary movement or on certain types of therapeutic beds to prevent the patient from falling out of bed. The use of side rails in these situations protects the patient from falling out of bed and therefore, would not be subject to the requirements of standard (e)."

Accountable person: VP/Patient Care Services

Geri chairs were in use as a therapeutic devise described in a policy titled: Geri-Chairs - Therapeutic Use. The intent of use was to respond to unique patient needs.

Immediate action was taken to improve documentation to distinguish use of the chair from a restraint and document therapeutic objectives. Documentation enhancement was promoted through the building of specific data screens in the electronic medical record.

On 12/17/11, the Medical/Surgical Director was requested by the VP/ Patient Care Services to seek a modification of the chair configuration so trays could be removed by patients, or to seek an alternate product. On January 5, 2012 all geri-chairs were taken from service and replaced with a therapeutic chair.

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dehydration. He was receiving daily radiation treatment. His admission nursing assessment on 11/28/11, documented Patient #2 was alert and oriented. It also indicated he ambulated independently. An 11/29/11 Psychosocial Assessment documented Patient #2 was confused and did not want to stay in bed. A physician progress note, dated 11/30/11 at 8:00 AM, indicated Patient #2 was still very weak and unsteady on his feet. Patient #2 was physically restrained without a comprehensive assessment to determine if less restrictive interventions would suffice. Examples include:

a. During an observation on 12/01/11 at 10:45 AM, Patient #2 was noted to be sitting in a Geri-chair in the doorway to his room. Upon initiation of a conversation with Patient #2, he requested a hacksaw. When he was questioned why he needed a hacksaw, he stated "I need a hacksaw to get out of this chair; two nurses were not able to take off this table." (He indicated the tray connected to the Geri-chair).

Patient #2's medical record was reviewed. It did not contain documentation of an assessment of Patient #2 prior to use of the Geri-chair to determine the rationale for use of the Geri-chair as opposed to the less restrictive interventions.

On 12/02/11 at 9:45 AM, the Department Director of the Medical/Surgical Units confirmed that confused patients were often placed in Geri-chairs. However, she explained the patients were always placed in the direct line of sight of nursing staff. She stated that patients could not easily get out of a Geri-chair themselves but required the assistance of staff. She stated this

A 164 The policy entitled "Geri-chairs, Therapeutic Use" was revised on 1/5/12 as follows:

- Retitled "Therapeutic Chair Use"
- Defined a therapeutic chair as "a chair with NO front tray barrier and side trays for patient belongings"
- Clarified therapeutic indications for patient socialization, change in patient's environment, etc.

On 1/6/12, the Restraint Policy was revised regarding exemptions to restraints. Geri chairs were removed as protective device exemptions.

The replacement of the Geri chairs with the therapeutic chairs eliminated the potential of the devise functioning as a restraint, thus eliminating the need for restraint orders, monitoring and other restraint use requirements.

Immediate action was taken to improve documentation to distinguish use of the chair from a restraint and document therapeutic objectives. An electronic communication was issued to nursing personnel by the Director of Nursing Operations on 12/11/11 stating the need to immediately improve documentation of the patient's individual needs for therapeutic use of a geri chair. Documentation enhancement was promoted through the building of specific data screens in the electronic medical record.

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was the reason patients in Geri-chairs were always visible to staff.

On 12/07/11 at 2:35 PM, the VP of Patient Care Services was interviewed. She explained that since the change to the electronic medical record staff were not prompted, and she did not believe staff had been instructed, to document an assessment and reason for the use of the Geri-chair. She confirmed that staff often did not differentiate in their documentation when a patient was in a Geri-chair or other type of chair.

Patient #2's medical record did not contain documentation of a comprehensive assessment to support the use of the Geri-chair restraint.

b. Patient #2's medical record contained "Safety Precautions" documentation which indicated Patient #2 was on "Fall Precautions" with four side rails raised on his bed at the following times:

-11/29/11 at 12:00 AM, 8:00 AM, and 5:00 PM. An RN documented that Patient #2 had a fall at 4:30 PM and the "FALL PROTICAL [sic]" was instituted. The nursing notes documented the fall was unwitnessed. The record entry stated Patient #2 had slipped when he was getting out of bed and was found on the floor towards the foot of the bed.
-11/30/11 at 1:00 AM, 8:00 AM, and 4:00 PM.
-12/01/11 at 12:30 AM, 8:00 AM, 4:00 PM, and 11:44 PM. At 4:00 PM, the RN documented that Patient #2 was "SOMETIMES CONFUSED AND IMPULSIVE."

The Charge Nurse in the Medical/Oncology department was interviewed on 11/30/11 at 3:00

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The policy entitled "Geri-chairs, Therapeutic Use" was revised on 1/5/12 as follows:

- Retitled "Therapeutic Chair Use"
- Defined a therapeutic chair as "a chair with NO front tray barrier and side trays for patient belongings"
- Clarified therapeutic indications for patient socialization, change in patient's environment, etc.

On 1/6/12, the Restraint Policy was revised regarding exemptions to restraints. Geri chairs were removed as protective device exemptions.

The replacement of the Geri chairs with the therapeutic chairs eliminated the potential of the devise functioning as a restraint, thus eliminating the need for restraint orders, monitoring and other restraint use requirements.

Immediate action was taken to improve documentation to distinguish use of the chair from a restraint and document therapeutic objectives. An electronic communication was issued to nursing personnel by the Director of Nursing Operations on 12/11/11 stating the need to immediately improve documentation of the patient's individual needs for therapeutic use of a geri chair. Documentation enhancement was promoted through the building of specific data screens in the electronic medical record.

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A 164	Continued From page 34 PM. She explained that Patient #2 became increasingly confused during his first night in the hospital and fall prevention measures were implemented around midnight on 11/28/11. The Charge Nurse stated measures for fall prevention included posting a sign outside of Patient #2's room, keeping the room free of clutter, activation of the bed alarm, wearing rubber-soled socks, and placing all four side rails up when Patient #2 was in bed. Patient #2 was interviewed on 12/01/11 at 3:50 PM. He stated he had to go to the bathroom and had been trying to get out of bed when he fell. Patient #2 stated he was not sure if he had requested assistance before attempting to get out of bed. The RN in the Medical/Oncology department who cared for Patient #2 at the time of the fall was interview on 11/30/11 at 3:30 PM. She stated she had been called to the room after the fall. The RN stated all four side rails had been up on Patient #2's bed and she did not know how he scooted to the foot of the bed. Patient #2's record was reviewed. It did not contain a comprehensive assessment to determine if the use of four side rails up on his bed outweighed the risk of not having all four side rails up. The VP of Patient Care Services was interviewed on 12/07/11 at 2:35 PM. She explained that the bed used by the hospital was specifically designed to not be considered a restraint when all four rails were in use. She stated, as a result of this, four bed rails were used for a variety of	A 164	CMS Interpretive Guideline A-0161 states, "A restraint does not include methods that protect the patient from falling out of bed. Examples include raising the side rails when a patient is: on a stretcher, recovering from anesthesia, sedated, experiencing involuntary movement or on certain types of therapeutic beds to prevent the patient from falling out of bed. The use of side rails in these situations protects the patient from falling out of bed and therefore, would not be subject to the requirements of standard (e)."	

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reasons, not just for patient safety. She confirmed that there was no particular assessment completed prior to implementing the use of four side rails and they were used at the staff's discretion.

A Geri-chair with a tray attached and a bed with all four side rails raised were used for Patient #2 without comprehensive assessments to determine the appropriateness of their use.

2. Patient #8 was a 97 year old female, admitted to the Medical/Oncology department on 11/29/11, with a diagnosis of back spasms. Patient #8 had been admitted from an assisted living facility. Her Adult Admission Assessment completed the date of admission indicated Patient #8 had mild dementia and was very forgetful and impulsive. It also stated she had poor balance and weakness and listed a front wheeled walker and gait belt as assistive devices. The assessment further stated she could be up with the assistance of one person. Her 11/29/11 physician admission orders indicated under "Activity" that she was to be up with assistance only.

During an observation on 11/30/11 beginning at 3:10 PM, Patient #8 was observed sitting in a Geri-chair with the tray secured. Patient #8's Geri-chair was situated close to the nursing station. Patient #8 was observed for approximately 30 minutes while this surveyor reviewed medical records with the Department Director of the Medical/Surgical Units. During that time Patient #8 called out to staff members "Please help me, please help me get out," and reached out with her hands to try to grab staff when they walked close to her. During the

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Accountable person: VP/Patient Care Services

Geri chairs were in use as a therapeutic devise described in a policy titled: Geri-Chairs - Therapeutic Use. The intent of use was to respond to unique patient needs.

Immediate action was taken to improve documentation to distinguish use of the chair from a restraint and document therapeutic objectives. An electronic communication was issued to nursing personnel by the Director of Nursing Operations on 12/11/11 stating the need to immediately improve documentation of the patient's individual needs for therapeutic use of a geri chair. Documentation enhancement was promoted through the building of specific data screens in the electronic medical record.

The surveyor findings were reviewed with all directors on 12/12/11 with notification that the documentation enhancement was under development and required their implementation as soon as finalized.

On 12/17/11, the Medical/Surgical Director was requested by the VP/ Patient Care Services to seek a modification of the chair configuration so trays could be removed by patients, or to seek an alternate product. On January 5, 2012 all geri-chairs were taken from service and replaced with a therapeutic chair.

The policy entitled "Geri-chairs, Therapeutic Use" was revised on 1/5/12 as follows:

- Retitled "Therapeutic Chair Use"
- Defined a therapeutic chair as "a chair with NO front tray barrier and side trays for patient belongings"
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On 1/6/12, the Restraint Policy was revised regarding exemptions to restraints. Geri chairs were removed as protective device exemptions.

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A 164	Continued From page 36 observation time, there were three hospital staff members at the desk area, and two in the hallway area. No one was observed to address Patient #8 or her concerns. Patient #8's medical record was reviewed. It did not contain documentation of an assessment of Patient #8 prior to use of the Geri-chair to determine the rationale for use of the Geri-chair as opposed to the less restrictive alternatives. A review of Patient #8's record with the Department Director of the Medical/Surgical Units was completed on 12/01/11 at 8:30 AM. She confirmed the record did not document an assessment for the need of a Geri-chair. On 12/02/11 at 9:45 AM, the Department Director of the Medical/Surgical Units confirmed that confused patients were often placed in Geri-chairs. However, she explained the patients were always placed in the direct line of sight of nursing staff. She stated that patients could not easily get out of a Geri-chair themselves but required the assistance of staff. She stated this was the reason patients in Geri-chairs were always visible to staff. On 12/07/11 at 2:35 PM, the VP of Patient Care Services was interviewed. She explained that since the change to the electronic medical record staff were not prompted, and she did not believe staff had been instructed, to document an assessment and reason for the use of the Geri-chair. She confirmed that staff often did not differentiate in their documentation when a patient was in a Geri-chair or other type of chair.	A 164	Immediate action was taken to improve documentation to distinguish use of the chair from a restraint and document therapeutic objectives. An electronic communication was issued to nursing personnel by the Director of Nursing Operations on 12/11/11 stating the need to immediately improve documentation of the patient's individual needs for therapeutic use of a geri chair. Documentation enhancement was promoted through the building of specific data screens in the electronic medical record.	

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A 164	Continued From page 37 Patient #8's medical record did not contain documentation of a comprehensive assessment to support the use of the Geri-chair restraint.	A 164		
	3. Patient #1 was a 60 year old female admitted to the fourth floor of the hospital on 11/27/11, for repair of an incarcerated ventral hernia. According to the website freemd.com, last updated 8/19/10, a ventral hernia is a piece of intestine that protrudes through an abnormal opening in the abdominal wall. In a person with an incarcerated hernia, the intestine has become stuck in the abnormal opening. When this happens, the blood supply to the intestine is reduced, and the intestinal tissue starts to die. Patient #1's medical record contained documentation related to "Safety Precautions." On 11/27/11 at 4:03 PM, and on 11/28/11 at 12:00 AM, 12:46 PM, and 5:11 PM, nursing staff documented Patient #1 was on fall precautions and hourly rounding, and had four side rails raised on her bed for safety. Subsequent documentation indicated Patient #1 remained on fall precautions but had only two bed rails raised. On 11/30/11 at 1:33 PM, nursing documentation indicated that Patient #1 had a steady gait and had ambulated independently multiple times. The RN documented that Patient #1 was no longer a fall risk.			
	An RN documented, on 12/01/11 at 5:49 AM, that Patient #1 fell out of bed and hit the right side of her head, which was tender to the touch. The RN indicated Patient #1 complained of left knee pain and sustained a scratch on the knee. The RN then documented, "ROOM LIGHTS ON, ALL FOUR BED RAILS UP POST FALL PROTOCOL SET."		The variation is the use of four bed rails versus two bed rails was directly related to the nursing assessment and the current needs of the patient regarding their falls risk.	

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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

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The "POST FALL PROTOCOL," dated 7/2006, was reviewed. The protocol did not include direction to staff to raise four side rails for safety after a patient fall.

The "FALL GUIDELINES, High Risk" policy, revised 3/16/11, was reviewed. The policy contained a section related to "Post fall protocol..." According to the policy, numerous assessments would be completed immediately after the fall and in the following 48 hours. The patient's fall risk was to be re-evaluated as well as the appropriateness of interventions. The care plan was to be updated as needed. The policy did not include direction for the staff to raise all four side rails on the bed.

Patient #1's record was reviewed. It did not include an assessment of Patient #1 to determine the reason for the fall and the risks and benefits of having all four side rails raised versus less restrictive alternatives.

The VP of Patient Care Services was interviewed on 12/07/11 at 2:35 PM. She explained that the bed used by the hospital was specifically designed to not be considered a restraint when all four rails were in use. She stated, as a result of this, four bed rails were used for a variety of reasons, not just for patient safety. She confirmed that there was no particular assessment completed prior to implementing the use of four side rails and they were used at the staff's discretion.

Assessments of Patient #1 were not completed prior to having four side rails raised on her bed for

A 164 The organization's policy entitled, "Post Fall Protocol" was designed to direct patient assessment and to identify potential causes of the fall and not necessarily to direct the nurse in selecting interventions. The policy "Fall Guideline-High Risk" is the policy that provides staff with direction regarding potential interventions. On 1-6-12, The "Post Fall Protocol" was revised to include a statement of "Consider use of four bed rails where four rails do not create a full length bed enclosure and still allows the patient to freely exit the bed." On 1-6-12, a written communication including the updates of policy changes associated with fall prevention and restraints was authored by the VP of Patient Care Services and distributed to nursing personnel.

The organization's policy entitled, "Fall Guidelines-High Risk" includes as an intervention, use of four bed side rails where four rails do not create a full length bed enclosure and still allows the patient to freely exit the bed. This clarification was added to the policy on 1-6-12 by the VP of Patient Care Services to aide nursing staff in assessment and introduction of appropriate intervention.

CMS Interpretive Guideline A-0161 states, "A restraint does not include methods that protect the patient from falling out of bed. Examples include raising the side rails when a patient is: on a stretcher, recovering from anesthesia, sedated, experiencing involuntary movement or on certain types of therapeutic beds to prevent the patient from falling out of bed. The use of side rails in these situations protects the patient from falling out of bed and therefore, would not be subject to the requirements of standard (e)."

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A 164	Continued From page 39 fall prevention.	A 164		
A 166	482.13(e)(4)(i) PATIENT RIGHTS: RESTRAINT OR SECLUSION The use of restraint or seclusion must be-- (i) in accordance with a written modification to the patient's plan of care. This STANDARD is not met as evidenced by: Based on staff and patient interviews, observation, and review of medical records and hospital policies, it was determined the facility failed to ensure the use of physical restraints was incorporated into patients' plans of care. This directly impacted 2 of 5 current patients (#2 and #8) who were observed in Geri-chairs and 2 of 5 current patients (#1 and #2) who were known to have four side rails raised on their beds. This resulted in patients being restrained without clear and consistent guidance to staff regarding the use of the restraints. Findings include: 1. Patient #2 was a 71 year old male, admitted to the Medical/Oncology department on 11/28/11, with a diagnosis of esophageal cancer and dehydration. He was receiving daily radiation treatment. His admission nursing assessment on 11/28/11, documented Patient #2 was alert and oriented. It also indicated he ambulated independently. An 11/29/11 Psychosocial Assessment documented Patient #2 was confused and did not want to stay in bed. A physician progress note, dated 11/30/11 at 8:00 AM, indicated Patient #2 was still very weak and unsteady on his feet. Patient #2 was physically restrained without the use of the restraints incorporated into his plan of care. Examples include:	A 166	The organization's policy, "Restraints", requires a plan of care to be updated when restraints are used, however, because the use of a geri chair was not considered a restraint and the use of four raised bed rails that do not enclose the bed and provide an exit does not constitute a restraint, the care plan would not be expected to be updated in the scenarios described. The electronic medical record includes a nursing diagnosis related to restraint use and applicable intervention is utilized when restraints are used.	

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a. During an observation on 12/01/11 at 10:45 AM, Patient #2 was noted to be sitting in a Geri-chair in the doorway to his room. Upon initiation of a conversation with Patient #2, he requested a hacksaw. When he was questioned why he needed a hacksaw, he stated "I need a hacksaw to get out of this chair; two nurses were not able to take off this table." (He indicated the tray connected to the Geri-chair).

Patient #2's plan of care was reviewed. The use of the Geri-chair was not included in his plan of care. The Department Director of the Medical and Surgical units reviewed Patient #2's medical record on 12/01/11 at 9:30 AM, and confirmed there was no modification to the POC for the use of a Geri-chair.

The facility did not modify Patient #2's POC to include the use of the Geri-chair restraint.

b. Patient #2's medical record contained "Safety Precautions" documentation which indicated Patient #2 was on "Fall Precautions" with four side rails raised on his bed at the following times:

-11/29/11 at 12:00 AM, 8:00 AM, and 5:00 PM. An RN documented that Patient #2 had a fall at 4:30 PM and the "FALL PROTICAL [sic]" was instituted. The nursing notes documented the fall was unwitnessed. The record entry stated Patient #2 had slipped when he was getting out of bed and was found on the floor towards the foot of the bed.
-11/30/11 at 1:00 AM, 8:00 AM, and 4:00 PM.
-12/01/11 at 12:30 AM, 8:00 AM, 4:00 PM, and 11:44 PM. At 4:00 PM, the RN documented that

A 166

The policy entitled "Geri-chairs, Therapeutic Use" was revised on 1/5/12 as follows:

- Retitled "Therapeutic Chair Use"
- Defined a therapeutic chair as "a chair with NO front tray barrier and side trays for patient belongings"
- Clarified therapeutic indications for patient socialization, change in patient's environment, etc.

On 1/6/12, the Restraint Policy was revised regarding exemptions to restraints. Geri chairs were removed as protective device exemptions.

The replacement of the Geri chairs with the therapeutic chairs eliminated the potential of the devise functioning as a restraint, thus eliminating the need for restraint orders, monitoring and other restraint use requirements.

Immediate action was taken to improve documentation to distinguish use of the chair from a restraint and document therapeutic objectives. An electronic communication was issued to nursing personnel by the Director of Nursing Operations on 12/11/11 stating the need to immediately improve documentation of the patient's individual needs for therapeutic use of a geri chair. Documentation enhancement was promoted through the building of specific data screens in the electronic medical record.

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A 166	Continued From page 41 Patient #2 was "SOMETIMES CONFUSED AND IMPULSIVE." The Charge Nurse in the Medical/Oncology department was interviewed on 11/30/11 at 3:00 PM. She explained that Patient #2 became increasingly confused during his first night in the hospital and fall prevention measures were implemented around midnight on 11/28/11. The Charge Nurse stated measures for fall prevention included posting a sign outside of Patient #2's room, keeping the room free of clutter, activation of the bed alarm, wearing rubber-soled socks, and placing all four side rails up when Patient #2 was in bed. Patient #2 was interviewed on 12/01/11 at 3:50 PM. He stated he had to go to the bathroom and had been trying to get out of bed when he fell. Patient #2 stated he was not sure if he had requested assistance before attempting to get out of bed. The RN in the Medical/Oncology department who cared for Patient #2 at the time of the fall was interview on 11/30/11 at 3:30 PM. She stated she had been called to the room after the fall. The RN stated all four side rails had been up on Patient #2's bed and she did not know how he scooted to the foot of the bed. Patient #2's record was reviewed. The use of the four side rails on Patient #2's bed was not included on his plan of care. In an interview on 11/29/11 at 3:30 PM, a Clinical Care Coordinator in the Medical/Oncology department reviewed Patient #2's record and	A 166	CMS Interpretive Guideline A-0161 states, "A restraint does not include methods that protect the patient from falling out of bed. Examples include raising the side rails when a patient is: on a stretcher, recovering from anesthesia, sedated, experiencing involuntary movement or on certain types of therapeutic beds to prevent the patient from falling out of bed. The use of side rails in these situations protects the patient from falling out of bed and therefore, would not be subject to the requirements of standard (e)."	

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confirmed the POC did not address the use of all four side rails.

The facility did not modify Patient #2's POC to include the use of the four side rails restraint.

2. Patient #8 was a 97 year old female, admitted to the Medical/Oncology department on 11/29/11, with a diagnosis of back spasms. Patient #8 had been admitted from an assisted living facility. Her Adult Admission Assessment completed the date of admission indicated Patient #8 had mild dementia and was very forgetful and impulsive. It also stated she had poor balance and weakness and listed a front wheeled walker and gait belt as assistive devices. The assessment further stated she could be up with the assistance of one person. Her 11/29/11 physician admission orders indicated under "Activity" that she was to be up with assistance only.

During an observation on 11/30/11 beginning at 3:10 PM, Patient #8 was observed sitting in a Geri-chair with the tray secured. Patient #8's Geri-chair was situated close to the nursing station. Patient #8 was observed for approximately 30 minutes while this surveyor reviewed medical records with the Department Director of the Medical/Surgical Units. During that time Patient #8 called out to staff members "Please help me, please help me get out," and reached out with her hands to try to grab staff when they walked close to her. During the observation time, there were three hospital staff members at the desk area, and two in the hallway area. No one was observed to address Patient #8 or her concerns.

A 166

The policy entitled "Geri-chairs, Therapeutic Use" was revised on 1/5/12 as follows:

- Retitled "Therapeutic Chair Use"
- Defined a therapeutic chair as "a chair with NO front tray barrier and side trays for patient belongings"
- Clarified therapeutic indications for patient socialization, change in patient's environment, etc.

On 1/6/12, the Restraint Policy was revised regarding exemptions to restraints. Geri chairs were removed as protective device exemptions.

The replacement of the Geri chairs with the therapeutic chairs eliminated the potential of the devise functioning as a restraint, thus eliminating the need for restraint orders, monitoring and other restraint use requirements.

Immediate action was taken to improve documentation to distinguish use of the chair from a restraint and document therapeutic objectives. An electronic communication was issued to nursing personnel by the Director of Nursing Operations on 12/11/11 stating the need to immediately improve documentation of the patient's individual needs for therapeutic use of a geri chair. Documentation enhancement was promoted through the building of specific data screens in the electronic medical record.

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A 166

A review of Patient #8's record with the Department Director of the Medical/Surgical Units was completed on 12/01/11 at 8:30 AM. She confirmed the record did not show modifications to Patient #8's plan of care to include Geri-chair use.

The facility did not modify Patient #8's POC to include the use of the Geri-chair restraint.

3. Patient #1 was a 60 year old female admitted to the fourth floor of the hospital on 11/27/11, for repair of an incarcerated ventral hernia. According to the website freemd.com, last updated 8/19/10; a ventral hernia is a piece of intestine that protrudes through an abnormal opening in the abdominal wall. In a person with an incarcerated hernia, the intestine has become stuck in the abnormal opening. When this happens, the blood supply to the intestine is reduced, and the intestinal tissue starts to die.

Patient #1's medical record contained documentation related to "Safety Precautions." On 11/27/11 at 4:03 PM, and on 11/28/11 at 12:00 AM, 12:46 PM, and 5:11 PM, nursing staff documented Patient #1 was on fall precautions and hourly rounding, and had four side rails raised on her bed for safety. Subsequent documentation indicated Patient #1 remained on fall precautions but had only two bed rails raised. On 11/30/11 at 1:33 PM, nursing documentation indicated that Patient #1 had a steady gait and had ambulated independently multiple times. The RN documented that Patient #1 was no longer a fall risk.

An RN documented, on 12/01/11 at 5:49 AM, that

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A 166	Continued From page 44 Patient #1 fell out of bed and hit the right side of her head, which was tender to the touch. The RN indicated Patient #1 complained of left knee pain and sustained a scratch on the knee. The RN then documented, "ROOM LIGHTS ON, ALL FOUR BED RAILS UP POST FALL PROTOCOL SET." The "FALL GUIDELINES, High Risk" policy, revised 3/16/11, was reviewed. The policy contained a section related to "Post fall protocol..." According to the policy, numerous assessments would be completed immediately after the fall and in the following 48 hours. The patient's fall risk was to be re-evaluated as well as the appropriateness of interventions. The care plan was to be updated as needed. The policy did not include the use of four side rails. An RN in the Surgical/Orthopedic department reviewed Patient #1's record. She confirmed that the use of four side rails was not documented in the medical record following the fall, and was not on the POC. The facility failed to ensure hospital staff had incorporated the use of the four side rails restraint into Patient #1's plan of care after her surgery and after her fall.	A 166	The variation in the use of four bed rails versus two bed rails was directly related to the nursing assessment and the current needs of the patient regarding their falls risk. The organization's policy entitled, "Fall Guidelines-High Risk" includes as an intervention, use of four bed side rails where four rails do not create a full length bed enclosure and still allows the patient to freely exit the bed. This clarification was added to the policy on 1-6-12 by the VP of Patient Care Services to aide nursing staff in assessment and introduction of appropriate intervention. CMS Interpretive Guideline A-0161 states, "A restraint does not include methods that protect the patient from falling out of bed. Examples include raising the side rails when a patient is: on a stretcher, recovering from anesthesia, sedated, experiencing involuntary movement or on certain types of therapeutic beds to prevent the patient from falling out of bed. The use of side rails in these situations protects the patient from falling out of bed and therefore, would not be subject to the requirements of standard (e)."	
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	A 168		

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State law.

This STANDARD is not met as evidenced by:
Based on staff and patient interviews, observation, and review of medical records and hospital policies, it was determined the facility failed to ensure physical restraints were used only as ordered by a physician or other LIP. This directly impacted 2 of 5 current patients (#2 and #8) who were observed in Geri-chairs and 2 of 5 current patients (#1 and #2) who were known to have four side rails raised on their beds. This resulted in patients being restrained at staffs' discretion. Findings include:

1. Patient #2 was a 71 year old male, admitted to the Medical/Oncology department on 11/28/11, with a diagnosis of esophageal cancer and dehydration. He was receiving daily radiation treatment. His admission nursing assessment on 11/28/11, documented Patient #2 was alert and oriented. It also indicated he ambulated independently. An 11/29/11 Psychosocial Assessment documented Patient #2 was confused and did not want to stay in bed. A physician progress note, dated 11/30/11 at 8:00 AM, indicated Patient #2 was still very weak and unsteady on his feet. Patient #2 was physically restrained without physician authorization. Examples include:

a. During an observation on 12/01/11 at 10:45 AM, Patient #2 was noted to be sitting in a Geri-chair in the doorway to his room. Upon initiation of a conversation with Patient #2, he requested a hacksaw. When he was questioned why he needed a hacksaw, he stated "I need a hacksaw to get out of this chair; two nurses were

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Physician orders were not obtained in the case scenarios described because the organization did not include the use of geri chairs as a restraint. The removal of geri chairs from service corrects the deficiency of no physician order. The same applies to the use of four rails. Because the rails do not include enclose the length of the bed and always have a patient exit, this is not considered a restraint as defined in the CMS Interpretive Guideline A-0161: "A restraint does not include methods that protect the patient from falling out of bed. Examples include raising the side rails when a patient is: on a stretcher, recovering from anesthesia, sedated, experiencing involuntary movement or on certain types of therapeutic beds to prevent the patient from falling out of bed. The use of side rails in these situations protects the patient from falling out of bed and therefore, would not be subject to the requirements of standard (e)."

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A 168	Continued From page 46 not able to take off this table." (He indicated the tray connected to the Geri-chair). Patient #2's medical record was reviewed. A physician order for the use of the Geri-chair was not found in the record. In an interview on 12/01/11 at 10:45 AM, the Department Director of the Medical/Surgical Units stated Patient #2 did not have orders for a restraint or for placement in a Geri-chair, as the chairs were for patient safety and not considered a restraint. Patient #2 was restrained in a Geri-chair without a physician order to do so. b. Patient #2's medical record contained "Safety Precautions" documentation which indicated Patient #2 was on "Fall Precautions" with four side rails raised on his bed at the following times: -11/29/11 at 12:00 AM, 8:00 AM, and 5:00 PM. An RN documented that Patient #2 had a fall at 4:30 PM and the "FALL PROTICAL [sic]" was instituted. The nursing notes documented the fall was unwitnessed. The record entry stated Patient #2 had slipped when he was getting out of bed and was found on the floor towards the foot of the bed. The documentation further stated Patient #2 continued to be impulsive and attempting to get out of bed and that he was confused and forgetful. -11/30/11 at 1:00 AM, 8:00 AM, and 4:00 PM. -12/01/11 at 12:30 AM, 8:00 AM, 4:00 PM, and 11:44 PM. At 4:00 PM, the RN documented that Patient #2 was "SOMETIMES CONFUSED AND IMPULSIVE." The Charge Nurse in the Medical/Oncology	A 168	The replacement of the Geri-chairs with the therapeutic chairs eliminated the potential of the devise functioning as a restraint. This was completed on 1/5/12 under the direction of the VP/ Patient Care Services. CMS Interpretive Guideline A-0161 states, "A restraint does not include methods that protect the patient from falling out of bed. Examples include raising the side rails when a patient is: on a stretcher, recovering from anesthesia, sedated, experiencing involuntary movement or on certain types of therapeutic beds to prevent the patient from falling out of bed. The use of side rails in these situations protects the patient from falling out of bed and therefore, would not be subject to the requirements of standard (e)."	

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A 168	Continued From page 47 department was interviewed on 11/30/11 at 3:00 PM. She explained that Patient #2 became increasingly confused during his first night in the hospital and fall prevention measures were implemented around midnight on 11/28/11. The Charge Nurse stated measures for fall prevention included posting a sign outside of Patient #2's room, keeping the room free of clutter, activation of the bed alarm, wearing rubber-soled socks, and placing all four side rails up when Patient #2 was in bed. Patient #2 was interviewed on 12/01/11 at 3:50 PM. He stated he had to go to the bathroom and had been trying to get out of bed when he fell. Patient #2 stated he was not sure if he had requested assistance before attempting to get out of bed. The RN in the Medical/Oncology department who cared for Patient #2 at the time of the fall was interview on 11/30/11 at 3:30 PM. She stated she had been called to the room after the fall. The RN stated all four side rails had been up on Patient #2's bed and she did not know how he scooted to the foot of the bed. Patient #2's record was reviewed. Physician orders for the use of the four side rails were not found. During an interview on 11/30/11 at 4:10 PM, the Department Director of the Medical/Surgical Units stated a component of fall prevention was to have the bed's four side rails up. She stated orders to raise four side rails were not obtained, and the use of four raised rails was for "patient safety."	A 168	CMS Interpretive Guideline A-0161 states, "A restraint does not include methods that protect the patient from falling out of bed. Examples include raising the side rails when a patient is: on a stretcher, recovering from anesthesia, sedated, experiencing involuntary movement or on certain types of therapeutic beds to prevent the patient from falling out of bed. The use of side rails in these situations protects the patient from falling out of bed and therefore, would not be subject to the requirements of standard (e)."	

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The facility failed to ensure restraints were implemented with a physician's order.

2. Patient #8 was a 97 year old female, admitted to the Medical/Oncology department on 11/29/11, with a diagnosis of back spasms. Patient #8 had been admitted from an assisted living facility. Her Adult Admission Assessment completed the date of admission indicated Patient #8 had mild dementia and was very forgetful and impulsive. It also stated she had poor balance and weakness and listed a front wheeled walker and gait belt as assistive devices. The assessment further stated she could be up with the assistance of one person. Her 11/29/11 physician admission orders indicated under "Activity" that she was to up with assistance only.

During an observation on 11/30/11 beginning at 3:10 PM, Patient #8 was observed sitting in a Geri-chair with the tray secured. Patient #8's Geri-chair was situated close to the nursing station. Patient #8 was observed for approximately 30 minutes while this surveyor reviewed medical records with the Department Director of the Medical/Surgical Units. During that time Patient #8 called out to staff members "Please help me, please help me get out," and reached out with her hands to try to grab staff when they walked close to her. During the observation time, there were three hospital staff members at the desk area, and two in the hallway area. No one was observed to address Patient #8 or her concerns.

The Department Director of the Medical/Surgical Units reviewed Patient #8's medical record on 12/01/11 at 9:30 AM, and confirmed there were

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Accountable person: VP/Patient Care Services

Geri chairs were in use as a therapeutic devise described in a policy titled: Geri-Chairs - Therapeutic Use. The intent of use was to respond to unique patient needs.

Immediate action was taken to improve documentation to distinguish use of the chair from a restraint and document therapeutic objectives. An electronic communication was issued to nursing personnel by the Director of Nursing Operations on 12/11/11 stating the need to immediately improve documentation of the patient's individual needs for therapeutic use of a geri chair. Documentation enhancement was promoted through the building of specific data screens in the electronic medical record.

The surveyor findings were reviewed with all directors on 12/12/11 with notification that the documentation enhancement was under development and required their implementation as soon as finalized.

On 12/17/11, the Medical/Surgical Director was requested by the VP/ Patient Care Services to seek a modification of the chair configuration so trays could be removed by patients, or to seek an alternate product. On January 5, 2012 all geri-chairs were taken from service and replaced with a therapeutic chair.

The policy entitled "Geri-chairs, Therapeutic Use" was revised on 1/5/12 as follows:

- Retitled "Therapeutic Chair Use"
- Defined a therapeutic chair as "a chair with NO front tray barrier and side trays for patient belongings"
- Clarified therapeutic indications for patient socialization, change in patient's environment, etc.

On 1/6/12, the Restraint Policy was revised regarding exemptions to restraints. Geri chairs were removed as protective device exemptions.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	130003		C 12/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH REGIONAL MEDICAL CENTER	415 SIXTH STREET LEWISTON, ID 83501

(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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no orders for a restraint or for placement in a Geri-chair, as the chairs were for patient safety and not considered a restraint.

The facility failed to ensure restraints were implemented with a physician's order.

3. Patient #1 was a 60 year old female admitted to the fourth floor of the hospital on 11/27/11, for repair of an incarcerated ventral hernia. According to the website freemd.com, last updated 8/19/10; a ventral hernia is a piece of intestine that protrudes through an abnormal opening in the abdominal wall. In a person with an incarcerated hernia, the intestine has become stuck in the abnormal opening. When this happens, the blood supply to the intestine is reduced, and the intestinal tissue starts to die.

Patient #1's medical record contained documentation related to "Safety Precautions." On 11/27/11 at 4:03 PM, and on 11/28/11 at 12:00 AM, 12:46 PM, and 5:11 PM, nursing staff documented Patient #1 was on fall precautions and hourly rounding, and had four side rails raised on her bed for safety. Subsequent documentation indicated Patient #1 remained on fall precautions but had only two bed rails raised. On 11/30/11 at 1:33 PM, nursing documentation indicated that Patient #1 had a steady gait and had ambulated independently multiple times. The RN documented that Patient #1 was no longer a fall risk.

An RN documented, on 12/01/11 at 5:49 AM, that Patient #1 fell out of bed and hit the right side of her head, which was tender to the touch. The RN indicated Patient #1 complained of left knee pain

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CMS Interpretive Guideline A-0161 states, "A restraint does not include methods that protect the patient from falling out of bed. Examples include raising the side rails when a patient is: on a stretcher, recovering from anesthesia, sedated, experiencing involuntary movement or on certain types of therapeutic beds to prevent the patient from falling out of bed. The use of side rails in these situations protects the patient from falling out of bed and therefore, would not be subject to the requirements of standard (e)."

The variation in the use of four bed rails versus two bed rails was directly related to the nursing assessment and the current needs of the patient regarding their falls risk.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
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and sustained a scratch on the knee. The RN then documented, "ROOM LIGHTS ON, ALL FOUR BED RAILS UP POST FALL PROTOCOL SET." The "POST FALL PROTOCOL," last reviewed by the hospital 7/2006, was reviewed. There was no direction to staff to raise four side rails for safety after a patient fall.

An RN in the Surgical/Orthopedic department was interviewed on 12/02/11 at 8:30 AM. She stated all four side rails would be raised on a patient who was confused or after a patient had a fall. She stated she had patients attempt to climb over or through the rails. She stated it could be considered a restraint but that it was either raise all four rails or risk the patient falling out of bed.

On 12/02/11 at 9:45 AM, the VP of Patient Care Services and the Department Director of the Medical/Surgical Units were interviewed jointly. The VP of Patient Care Services stated that the specific bed chosen by the hospital was designed to allow all four rails to be up without being considered a restraint. She stated the hospital thoroughly researched this aspect of the bed before deciding to purchase.

After her surgery and after her fall, Patient #1 was physically restrained by the use of the four side rails without a physician order.

The facility failed to ensure restraints were implemented with a physician's order.

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CMS Interpretive Guideline A-0161 states, "A restraint does not include methods that protect the patient from falling out of bed. Examples include raising the side rails when a patient is: on a stretcher, recovering from anesthesia, sedated, experiencing involuntary movement or on certain types of therapeutic beds to prevent the patient from falling out of bed. The use of side rails in these situations protects the patient from falling out of bed and therefore, would not be subject to the requirements of standard (e)."

The organization's policy entitled, "Fall Guidelines-High Risk" includes as an intervention, use of four bed side rails where four rails do not create a full length bed enclosure and still allows the patient to freely exit the bed. This clarification was added to the policy on 1-6-12 by the VP of Patient Care Services to aide nursing staff in assessment and introduction of appropriate intervention.

The bed used throughout the facility is equipped with rails that do not create a full length bed enclosure and still allows the patient to freely exit the bed even with four rails up. Based on CMS Interpretive Guidelines cited above, the use of rails would not be considered a restraint, therefore a physician's order would not be required.

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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February 2, 2012

Timothy Sayler, Administrator
St Joseph Regional Medical Center
PO Box 816
Lewiston, ID 83501

Provider #130003

Dear Mr. Sayler:

On **December 9, 2011**, a complaint survey was conducted at St Joseph Regional Medical Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004977

Allegation #1: Nursing staff were inattentive and did not meet a patient's needs.

Finding #1: An unannounced survey of the facility was conducted from 11/30/11 to 12/02/11. Ten medical records were reviewed. Staff and patients and their families were interviewed.

Two medical records were for patients cared for on units other than the Surgical/Orthopedic Unit. Eight medical records were reviewed for patients cared for at some point in their hospital stay on the Surgical/Orthopedic Unit. Four of these were records of discharged patients, and four were for patients currently being treated by the facility. All of the medical records were reviewed for nursing staff attentiveness to patient needs. Documentation of food intake, hygiene care, the medication administration record, and patient activity were reviewed. Each record contained documentation of attention provided to assist patients with personal cares such as ambulation, toileting, hygiene, and assistance with meal set up. Each medical record contained documentation of routine medication administration as ordered and use of as needed medications based on patient assessments.

One record documented a young male admitted to the facility following a traumatic gunshot

injury to the head. The injury left the patient blind. According to the documentation the patient was admitted to the Intensive Care Unit and eventually was able to move to the Surgical/Orthopedic Unit. The patient suffered additional complications and subsequently ended up back in the Intensive Care Unit. He was eventually moved back to the Surgical/Orthopedic Unit from which he was discharged after approximately two months.

During the patient's stay on the Surgical/Orthopedic Unit, nursing staff documented pain assessment with medication administration, as well as alternative pain relief methods, offered several times a day. Staff routinely documented hygiene and toileting cares and the level of assistance the patient requested or required. There were many occasions throughout the patient's stay on the Surgical/Orthopedic Unit when staff documented the patient was dependent or needed assistance with oral care, bathing, toileting, ambulating, and meal set up. The patient appeared to progress to being independent with most cares by the end of the hospitalization. The medical record contained documentation of nursing interventions based on patient assessment, such as notifying the physician when the patient had decreased urine output.

The Director of the Medical and Surgical Units was interviewed on 11/30/11. She explained that individuals with disabilities were assessed for their specific needs. For example, if a patient could not speak they were given a writing board (if that was appropriate). If a patient was blind, staff worked one to one with them as needed for ambulatory guidance and orientation to the room. She stated meal trays were set up and the patient oriented to the location of the food items on the tray to assist with eating. She explained that verbal communication was used to notify the patient of the specific steps during the provision of patient care. She stated the computer system did not specifically allow for the various interventions to be added to the care plan, but staff practiced these standards as a matter of routine.

A Registered Nurse (RN) who cared for the patient on the Surgical/Orthopedic unit was interviewed on 12/02/11. She stated communication was a little difficult with the patient because of his depression. She stated there seemed to be a barrier between the patient and nursing staff, however he interacted quite freely with his mother. The RN stated she had been aware the patient's mother was anxious to obtain information related to resources for the blind and stated a fellow staff member with a child who was blind shared information with the patient's mother. The RN stated it was normal for blind patients to receive assistance setting up the meal tray and if possible would be offered finger foods to allow the patient to be as independent as possible. She stated nursing staff worked with blind patients in educating them regarding things such as spatial relationships. She stated she remembered the patient to be very independent, not wanting a lot of assistance, and he would often tell nursing staff he could do things himself.

The family members and three patients who received care on the Surgical/Orthopedic Unit were interviewed between 11/30/11 and 12/02/11. The patients selected for interview were those who

were more likely dependent on nursing staff to meet their needs. Each patient and/or family member stated they felt like staff were attentive and provided care to meet the needs of the patients.

As a result of the investigation, it could not be determined that nursing staff were inattentive and did not meet patient needs. Therefore, the allegation could not be substantiated and no deficiencies were cited.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: Patients did not receive therapy or external resources for the new onset of a disablity.

Finding #2: An unannounced survey of the facility was conducted from 11/30/11 to 12/02/11. Ten medical records were reviewed. Five of these were records of discharged patients, and five were for patients currently being treated by the facility. Each of the records was reviewed for evidence of appropriate therapy interventions and any additional needs related to disabilities. All of the records contained documentation of the provision of therapy services as needed. There was documentation of social services involvement with discharge planning and continued provision of therapy services and provision of information needed for post-hospital care.

Only one record contained documentation of a patient with a new onset disability. The patient was admitted to the hospital following a traumatic gunshot wound to the head. As a result of the injuries, the patient was rendered blind. The medical record contained an order for occupational therapy to assist with training and education related to performing basic daily functions as a blind individual.

The medical record contained documentation from physicians and social workers regarding therapy required for the patient and the plans for discharge, which included inpatient rehabilitation. The social worker documented that the patient's family met with a local agency that provided advocacy to the blind to obtain information about available resources. Following this meeting, the social worker documented the family was interested in inpatient rehabilitation. About a month prior to the patient's discharge from the hospital the family declined inpatient rehabilitation despite the physician's recommendations. At the time of discharge the social worker documented the patient would return home with his family with therapy services to follow on an out-patient basis. In addition, the family had an appointment scheduled a few days after discharge with the Idaho Commission for the Blind to evaluate the patient for relevant resources.

The Director of Social Services, who worked with the patient described above, was interviewed

on 12/02/11. He stated the hospital had copious amounts of resource information for all types of disabilities and it was part of the discharge planning process to incorporate those resources as necessary. He explained that it had been the hospital's plan to transfer the patient to inpatient rehabilitation therapy and at that point incorporate more specific resources for the blind. He stated he felt the family was being very proactive regarding the blindness, but was still hesitant about the need for additional inpatient rehabilitation.

An RN who cared for the patient on the Surgical/Orthopedic unit was interviewed on 12/02/11. The RN stated she was aware the patient's mother was anxious to obtain information related to resources available to the blind and stated a fellow staff member with a child who was blind shared information with the patient's mother.

It could not be determined that therapy services and resources were not provided to patients with disabilities. Therefore, the allegation could not be substantiated and no deficiencies were cited.

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,

AIMEE HASTRITER
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

AH/srm