IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

July 6, 2015

Kathy Moore, Administrator
St Luke's Regional Medical Center
190 East Bannock Street
Boise, ID 83712-2577

RE: St. Luke's Regional Medical Center, Provider #130006

Dear Ms. Moore:

This is to advise you of the findings of the complaint investigation, which was concluded at your facility on June 19, 2015.

Enclosed is a Statement of Deficiencies/Plan of Correction form, CMS-2567, listing Medicare deficiencies. The hospital is under no obligation to provide a plan of correction for Medicare deficiencies. If you do choose to submit a plan of correction, provide it in the spaces provided on the right side of each sheet.

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

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the PoC is effective in bringing the facility into compliance, and that the hospital remains in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
- The administrator's signature and the date signed on page 1 of the Form CMS-2567.

Whether you choose to provide a plan of correction or not, please sign and date the form and return it to our office by **July 19, 2015**. Keep a copy for your records. For your information, the Statement of Deficiencies is disclosable to the public under the disclosure of survey information provisions.

Thank you for the courtesies extended to us during our visit. If you have any questions, please write or call this office at (208) 334-6626, option 4.

Sincerely,

LAURA THOMPSON
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/pt
Enclosures

St Luke's

July 16, 2015

Sent via facsimile to (208) 364-1888

Sylvia Creswell
Idaho Department of Health and Welfare
Bureau of Facility Standards
3232 Elder Street
PO Box 83720
Boise, ID 83720

Re: St. Luke's Regional Medical Center, Provider # 130006

Dear Ms. Creswell:

This letter is in follow-up to your correspondence and the Statement of Deficiencies dated July 6, 2015 advising us of your findings relative to the Complaint Survey completed in June, 2015 at St. Luke's Regional Medical Center, Boise.

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

Thank you for allowing us the opportunity to respond to your findings. If you have any questions or concerns, please feel free to contact me at (208) 381-9391.

Sincerely,

Jodi Brewster, RN

Jodi Brewster, BSN, RN, HACP
Director, Accreditation and Patient Relations

Enclosures

St. Luke's Health System
815 E. Park Blvd., 3rd Floor
Boise, Idaho 83712
P (208) 381-1838

stlukesonline.org

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130006	A. BUILDING _____ B. WING _____	C 06/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKE'S REGIONAL MEDICAL CENTER	190 EAST BANNOCK STREET BOISE, ID 83712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS The following deficiencies were cited during the complaint investigation survey of your hospital conducted on 6/16/15 to 6/19/15. The surveyors conducting the investigation were: Laura Thompson RN, BSN, HFS - Team Leader Teresa Hamblin RN, MS, HFS The following acronyms were used in this report: CCU - Critical Care Unit DNR - Do Not Resuscitate ED - Emergency Department EMS - Emergency Medical Services H&P - History & Physical ICU - Intensive Care Unit NICU - Neonatal Intensive Care Unit PICU - Pediatric Intensive Care Unit RN - Registered Nurse SNF - Skilled Nursing Facility	A 000	The following constitutes the facility's response to the findings of the Department of Health and Welfare and does not constitute an admission of guilt or agreement of the facts alleged or conclusions set forth on the summary statements of deficiencies. RECEIVED JUL 16 2015 FACILITY STANDARDS In response to A-123	
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 hospital policy and grievance documentation, it was determined the hospital failed to ensure written responses to grievances included steps taken on	A 123	The Director of Accreditation and Patient Relations is ultimately responsible for the monitoring of the grievance management process. Plan of Correction: -Grievance response letter language reviewed by Patient Relations and Risk Management. -Additional information regarding specific steps taken to investigate the patient concerns to be added to the	8/1/15

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

Jodi L Vaughn — Administrator QPS — 7-16-15

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130006	A. BUILDING _____ B. WING _____	C 06/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKE'S REGIONAL MEDICAL CENTER	190 EAST BANNOCK STREET BOISE, ID 83712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 123	Continued From page 1 behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion for 4 of 8 patients whose grievances were reviewed (#13, #14, #15, and #18). This resulted in a lack of information provided to patients and/or their representatives in response to their grievances. Findings include: 1. Patient #13 was a 53 year old male whose grievance documentation was reviewed. The following summary of complaints, dated 4/02/15, related to Patient #13's inpatient admission 3/27/15 to 3/30/15: "1. Patient not given warning about discharge time and was told he needed to find a ride 2. Patient said he had it set up with his insurance to pay for rehab, but was then told he did not qualify 3. Patient reports they did not tell him why did not qualify for rehab 4. Patient concerned that home health did not see him until 4/1 5. Patient concerned that there was no physical therapy ordered with home health 6. Patient reports his dressing did not get changed while he was in the hospital and it did not get changed until 4/1 7. Patient stated he was not bathed in the hospital until day 4 8. Patient reports his catheterization was done wrong (not sterile), and that they wanted to put	A 123	Response to A 123 Continued letter template based on the individual concerns of the patient. -Re-educated patient relations staff regarding need to provide more specific details as to the results of the investigation of elements of concerns expressed. -Re-educated patient relations staff to include date grievance file closed in letter to patient. <u>QAPI Integration:</u> A random sample of grievance response letters to be audited to ensure inclusion of required elements, monthly x 4 months then annually thereafter. Results of the audit to be shared during bi-annual report to the Quality and Patient Safety Council and annual report to the West Region Quality, Safety and Service Excellence Committee of the Board.	6/29/15 6/29/15 Audits to begin 8/1/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130006	A. BUILDING _____ B. WING _____	C 06/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKE'S REGIONAL MEDICAL CENTER	190 EAST BANNOCK STREET BOISE, ID 83712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 123	Continued From page 2 one in that would stay because of their error 9. Delays in getting call light answered 10. Pain medications were late" The hospital's letter of response to Patient #13 regarding his complaints, dated 5/01/15, was reviewed. The letter stated the concerns had been referred to the RN Director of the nursing unit Patient #13 resided on while hospitalized, the RN Director of Case Management, and the RN Director of Home Care. The letter stated these individuals "completed a thorough review" of concerns and "conducted the appropriate follow up with staff." Upon review, the hospital's internal grievance documentation included a more detailed review of Patient #13's complaints. However, the hospital's letter of response to Patient #13 did not state the steps taken to review the concerns, the results of the investigation, and the date of completion. During an interview on 6/16/15 between 1:20 PM - 2:35 PM, the Manager of Patient Relations confirmed details were not included in the letter of response. The hospital's response to Patient #13's complaints was incomplete. 2. Patient #15 was a 44 year old female whose grievance documentation was reviewed. The following complaint, dated 11/17/14, was documented related to an inpatient hospitalization for surgery, dated 11/10/14 through 11/14/14: "During the D/C [discharge] phone call on 11/17,	A 123		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130006	A. BUILDING _____ B. WING _____	C 06/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKE'S REGIONAL MEDICAL CENTER	190 EAST BANNOCK STREET BOISE, ID 83712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 123	Continued From page 3 pt was very unhappy on how she was treated, mostly on 11/12, the day after the surgery. Felt everyone was rushing for her to go home and not listening to her. She was in pain, could not urinate, could not pass gas. She said she had authorization from her insurance company, if that was the issue. It wasn't until she was in tears that she feel [sic] anyone listened to her." The hospital's letter of response to Patient #15's complaints, dated 11/21/14, was reviewed. The letter stated the concerns were referred to the RN Manager of the nursing unit Patient #15 resided on during her hospitalization. It further stated the RN Manager had "completed a thorough review" of concerns and "conducted the appropriate follow up and education with her staff." Upon review, the hospital's internal grievance documentation included a more detailed review of Patient #15's complaints. However, the hospital's letter of response to Patient #15 did not state the steps taken to review the concerns, the results of the investigation, and the date of completion. During an interview on 6/16/15 between 1:20 PM - 2:35 PM, the Manager of Patient Relations confirmed details were not included in the letter of response. The hospital's response to Patient #15's complaints was incomplete. 3. Patient #14 was a 98 year old female whose grievance documentation was reviewed. The documentation indicated a representative of the patient filed the complaint. The following complaint summary, dated 2/12/15, was related to an inpatient hospitalization from 1/17/15 to	A 123		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130006	A. BUILDING _____ B. WING _____	C 06/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKE'S REGIONAL MEDICAL CENTER	190 EAST BANNOCK STREET BOISE, ID 83712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 123	Continued From page 4 1/29/15. - Patient's DNR and medication list did not follow the patient from the ED to Nine East. The paperwork was lost. - Medications that were faxed over, were not instituted until the following day. - The patient did not receive her Mirtazapine on the first night of her stay. - A physician stopped six of the patient's medications. - Discharging nurse did not review the medication list with the representative at discharge. The hospital's letter of response to Patient #14, dated 2/27/15, was reviewed. The letter stated the complaints were referred to the Director of the Boise ED and the RN Supervisor of the unit Patient #14 resided on during her hospitalization. It further indicated staff "completed a thorough review" of concerns and "conducted the appropriate follow up and education with her staff." The letter stated the concerns regarding medications being discontinued at discharge were referred to medical staff leadership for review and follow-up and the review was confidential. Upon review, the hospital's internal grievance documentation included a more detailed review of the complaints regarding Patient #14's care. However, hospital's letter of response to Patient #14 did not address four of the five allegations. Additonally, it did not include the steps taken to review the concerns, the results of the	A 123		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130006	A. BUILDING _____ B. WING _____	C 06/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKE'S REGIONAL MEDICAL CENTER	190 EAST BANNOCK STREET BOISE, ID 83712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 123	Continued From page 5 investigation, and the date of completion. During an interview on 6/16/15 between 1:20 PM - 2:35 PM, the Manager of Patient Relations confirmed the details were not included in the letter of response. The hospital's response to the concerns identified by Patient #14's representative was incomplete. 4. Patient #18 was a 54 year old female whose grievance documentation was reviewed. A complaint, dated 7/31/14, documented many concerns about a male RN during a hospitalization from 7/18/14 to 7/21/14 and a desire not to have the RN provide care for her in the future. The hospital's letter of response to Patient #18's concern, dated 8/28/14, was reviewed. The letter stated the concern was referred to the Director of the unit Patient #18 resided on during her hospitalization, who "completed a thorough review" of concerns and "conducted the appropriate follow up and education with the staff involved." Upon review, the hospital's internal grievance documentation included a more detailed review of Patient #18's concern. However, the hospital's letter of response to Patient #18, did not state the steps taken to review the concerns, the results of the investigation, or the date of completion. During an interview on 6/16/15 between 1:20 PM - 2:35 PM, the Manager of Patient Relations confirmed the details were not included in the letter of response. She stated the male RN had been terminated and this information was	A 123		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130006	A. BUILDING _____ B. WING _____	C 06/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKE'S REGIONAL MEDICAL CENTER	190 EAST BANNOCK STREET BOISE, ID 83712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 123	Continued From page 6 confidential. The hospital's response to Patient #18's complaints was incomplete. 5. The hospital policy, "Patient Complaint and Grievance Process," dated 7/31/13, was reviewed. The policy stated, "After review of the complaint or grievance, the written notice of the hospital's determination regarding the grievance will be communicated to the patient or the patient's representative by Patient & Family Relations or under the direction of Patient & Family Relations in a language they understand. The written notice to the patient, family member or customer will not reveal confidential or privileged peer review or attorney-client privileged information. The hospital's grievance policy did not address the regulatory requirement to include the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion.	A 123		
A 165	482.13(e)(3) PATIENT RIGHTS: RESTRAINT OR SECLUSION The type or technique of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the patient or others from harm. This STANDARD is not met as evidenced by: Based on staff interview and review of hospital policy and medical records, it was determined the hospital failed to ensure the least restrictive type of restraints were used to protect patients or others from harm for 2 of 8 patients (#19 and	A 165	Response to A-165 The Associate Chief Nursing Officers and Chief of Staff have ultimate responsibility for the use of least restrictive interventions being utilized to restrain a patient. Plan of Correction: -Medical Records of patient #19 and #20 were reviewed by Emergency Department nursing and medical staff	7/31/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130006	A. BUILDING _____ B. WING _____	C 06/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKE'S REGIONAL MEDICAL CENTER	190 EAST BANNOCK STREET BOISE, ID 83712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 165	Continued From page 7 #20) who were physically restrained and whose records were reviewed. This resulted in patients being restrained in a manner that was more restrictive than warranted by their behavior. Findings include: 1. The hospital's policy, "Restraints," dated 5/05/14, was reviewed. The policy included, but was not limited to the following information: - Restraints may only be imposed to ensure the immediate physical safety of the patient, staff member, or public and through the use of the least restrictive device for the shortest possible time when restraints are clinically appropriate and adequately justified - Prior to the use of any restraint, the patient care provider must attempt and/or consider less restrictive measures to protect the patient, staff members, or others from harm. - Document the implementation of less restrictive measures or the reason less restrictive measures were not an option prior to restraint application/use. This policy was not followed. Examples include: a. Patient #19 was a 36 year old male seen in the ED on 3/16/15. The medical record included a physician's order, dated 3/16/15 at 1:36 PM, for 4 point hard restraints for 4 hours for violent/self-destructive behavior. There was no documentation that described violent or self-destructive behavior exhibited by Patient #19. Nursing restraint documentation indicated the hard restraints were applied by nursing staff on	A 165	Continuation of Response to A- 165 leadership for individual follow up with staff and providers involved with the care of the particular patients. -Educational tools to be created for Emergency Department Medical Staff and Nurisng care providers on *use of least restrictive measures possible *documentation of specific behaviors to justify the use of restraint. -Educational tools will be distributed to Nursing and Medical Staff in variety of ways including but not limited to department meetings, daily huddles, newsletters, and email communication -Modifications to Electronic Medical Record to prompt documentation of specific behaviors necessitating restraint use and least restrictive measures used. <u>QAPI Integration</u> Emergency Department Nursing Leadership to audit medical records of 100% of patient restraint in the Emergency Department monthly for the next 12 months. Accreditation	8/1/15 8/31/15 9/30/15 Audits to begin 9/1/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130006	A. BUILDING _____ B. WING _____	C 06/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKE'S REGIONAL MEDICAL CENTER	190 EAST BANNOCK STREET BOISE, ID 83712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 165	Continued From page 8 3/16/15 at 1:44 PM. The following less restrictive measures were documented as "tried" prior to the application of four point hard restraints on 3/16/15: - Diversional activities - Use of Patient Safety Attendant/family member to sit with the patient - Addressed physical/medical needs - Employed verbal de-escalation techniques There were no less restrictive physical restraints (such as 2 point soft restraints) considered or tried prior to the application of 4 point hard restraints. The nurse and physician who cared for Patient #19 were unavailable for interview. An ED RN was interviewed on 6/19/15 at 11:30 AM. She reviewed restraint documentation for Patient #19. She stated she did not see documentation to explain the use of hard four point restraints. An ED physician was interviewed on 6/19/15, at 12:00 PM. He reviewed restraint documentation for Patient #19 and confirmed documentation was lacking. Hospital staff did not use the least restrictive type of restraint that would be effective to protect Patient #19 or others from harm. b. Patient #20 was a 45 year old male seen in	A 165	Continuation of Response to A-165 staff will conduct random monthly audits of the medical records of restrained Emergency Department patients to ensure least restrictive measures utilized. Results of the audits will be shared at the Continual Regulatory Readiness Committee meetings and included in the Accreditation annual report to the Quality and Patient Safety Council and West Region Quality, Safety, and Service Excellence Committee of the Board.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130006	A. BUILDING _____ B. WING _____	C 06/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKE'S REGIONAL MEDICAL CENTER	190 EAST BANNOCK STREET BOISE, ID 83712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 165	Continued From page 9 the ED on 3/27/15. A nursing "Triage" note, dated 3/27/15 at 12:33 PM, documented Patient #20 had been transported via air ambulance after Patient #20's roommate found him punching walls in the bathroom and then becoming less responsive and frothing at the mouth. Patient #20 was described, after arrival at the ED, as confused, restless, and anxious. Physician history, dated 3/27/15 at 1:06 PM, described Patient #20 as combative and agitated. It further stated Patient #20 had been transported along with a large container of medications and a suicide note. The medical record included a physician's order, dated 3/27/15 at 1:35 PM, for 4 point hard restraints for 4 hours for aggressive/violent behavior and an inability to consistently follow or understand directions. There was no documentation included that explained what behaviors Patient #20 was exhibiting that were considered aggressive, violent, or combative. Nursing restraint documentation indicated the hard restraints were applied by nursing staff on 3/27/15 at 1:35 PM. The following less restrictive measures were documented in nursing notes, dated 3/27/15 at 1:35 PM, as "tried" prior to the application of 4 point hard restraints on 3/27/15: - Diversional activities -Verbal de-escalation techniques There were no less restrictive measures or physical restraints considered or tried prior to the	A 165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130006	A. BUILDING _____ B. WING _____	C 06/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKE'S REGIONAL MEDICAL CENTER	190 EAST BANNOCK STREET BOISE, ID 83712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHDULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 165	Continued From page 10 application of four point hard restraints. The nurse and physician who cared for Patient #20 were unavailable for interview. An ED RN was interviewed on 6/19/15 at 11:30 AM. She reviewed restraint documentation for Patient #20. She stated she did not see documentation to explain or justify use of hard four point restraints. An ED physician was interviewed on 6/19/15 at 12:00 PM. He reviewed the restraint documentation for Patient #20 and confirmed documentation was lacking. Hospital staff did not use the least restrictive type of restraint that would be effective to protect Patient #20 or others from harm.	A 165		
A 173	482.13(e)(8) PATIENT RIGHTS: RESTRAINT OR SECLUSION [Unless superseded by State law that is more restrictive,] (iii) Each order for restraint used to ensure the physical safety of the non-violent or non-self-destructive patient may be renewed as authorized by hospital policy. This STANDARD is not met as evidenced by: Based on staff interview and review of hospital policy and medical records, it was determined the hospital failed to ensure orders for non-violent restraints were renewed in accordance with hospital policy for 1 of 2 patients (#3) who were restrained for medical reasons and whose records were reviewed. This resulted in unauthorized restraint use. Findings include:	A 173	Response to Tag A-173 The Associate Chief Nursing Officers and Chief of Staff have ultimate responsibility for the renewal of orders for non-violent/ non-self-destructive restraints. <u>Plan of Correction A-173</u> - Review of medical record of Patient #3 with Nursing and Medical Staff providers involved and individualized follow up regarding renewal process.	7/31/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130006	A. BUILDING _____ B. WING _____	C 06/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKE'S REGIONAL MEDICAL CENTER	190 EAST BANNOCK STREET BOISE, ID 83712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 173	Continued From page 11 The hospital's policy, "Restraints," dated 5/05/14, was reviewed. The policy included, but was not limited to the following information: - The initial restraint order is good for 1 calendar day. - Continued use of nonviolent/non-self destructive restraint beyond the first calendar day requires a restraint renewal order by a physician each calendar day. Patient #3 was a 43 year old male who was admitted on 4/23/15 for care related to severe sepsis and chest pain. He died on 4/30/15. Patient #3's medical record documented Patient #3 was restrained with bilateral soft wrist restraints from 4/27/15 until 4/30/15 at 7:00 AM. An order for initiating bilateral soft wrist restraints was dated 4/27/15 at 11:00 PM. The medical record did not include an order for restraints on 4/28/15, although nursing documentation indicated continuous restraints. This was confirmed by the Accreditation Director on 6/17/15 at 1:30 PM. A restraint used to ensure the physical safety of the non-violent or non-self-destructive of Patient #3 was not renewed per calendar day in accordance with the hospital's policy.	A 173	Response to A-173 continued Plan of Correction Continued -St. Luke's Policy PC048 TV Restraints, reviewed and updated to reflect a change in non-violent/ non-self-destructive restraint order duration and renewal process. -St. Luke's Physical Restraint Order form (ms01-01-138) updated to reflect change in order duration and renewal process. -Review of Restraint Policy requirements with Nursing and medical staff- review to occur in a variety of ways, including but not limited to department meetings, huddles, summits, newsletters, and email communications. QAPI Integration Accreditation Staff to complete random audits of non-violent/ non-self-destructive audits monthly. Data to be shared at Continual Regulatory Readiness Committee and included in the Accreditation annual report to the Quality and Patient Safety Council and West Region Quality, Safety and Service Excellence Committee of the Board.	8/15/15 8/15/15 8/31/15 Audits to begin 9/1/15
A 174	482.13(e)(9) PATIENT RIGHTS: RESTRAINT OR SECLUSION Restraint or seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order.	A 174		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130006	A. BUILDING _____ B. WING _____	C 06/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKE'S REGIONAL MEDICAL CENTER	190 EAST BANNOCK STREET BOISE, ID 83712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 174	Continued From page 12 This STANDARD is not met as evidenced by: Based on staff interview and review of hospital policy and medical records, it was determined the hospital failed to ensure restraints were discontinued at the earliest possible time for 2 of 8 patients who were restrained (#19 and #20) and whose records were reviewed. This resulted in patients being restrained longer than was necessary to ensure safety. Findings include: 1. The hospital's policy, "Restraints," dated 5/05/14, was reviewed. The policy included, but was not limited to, the following information: - Restraints may only be imposed to ensure the immediate physical safety of the patient, staff member, or public and through the use of the least restrictive device for the shortest possible time when restraints are clinically appropriate and adequately justified - Restraints must be discontinued at the earliest possible time, regardless of the length of time identified in the order. Restraints were not discontinued at the earliest possible time as required by this policy. Examples include: a. Patient #19 was a 36 year old male seen in the ED on 3/16/15. There was a physician's order, dated 3/16/15 at 1:36 PM, for 4 point hard restraints for 4 hours for violent/self-destructive behavior. Nursing restraint documentation indicated 4 point restraints were applied at 1:44 PM. Nursing documentation on 3/16/15 at 2:14 PM, documented Patient #19 continued in hard restraints while "sedated and resting." There was	A 174	Response to A-174 The Associate Chief Nursing Officers have ultimate responsiblity for ensuring compliance with discontinuation of restraints at the earliest possible time. Plan of Correction -Review of Medical Records for patient #19 and #20 with individual nursing staff involved and specific education provided. -Modifications made to Electronic Medical Record restraint documentation areas requiring descriptions of specific patient behaviors necessitating the continuation of restraints. -Re-enforce education for Nursing Staff on the need to discontinue restraints at the earliest possible time. Review of education to occur in a variety of ways including staff meetings, huddles, summits, newsletters and email communications.	7/31/15 9/30/15 9/1/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130006	A. BUILDING _____ B. WING _____	C 06/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKE'S REGIONAL MEDICAL CENTER	190 EAST BANNOCK STREET BOISE, ID 83712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 174	Continued From page 13 no documentation to indicate 4 point hard restraints were required for safety at that time. An ED RN was interviewed on 6/19/15 at 11:30 AM. She reviewed restraint documentation for Patient #19. She confirmed the medical record documented Patient #20 continued to be restrained with four-point hard restraints while "sedated and resting." An ED physician was interviewed on 6/19/15 at 12:00 PM. He reviewed restraint documentation for Patient #19 and confirmed documentation was lacking. Patient #19 was not released from four point restraints at the earliest possible time. b. Patient #20 was a 45 year old male transported to the ED on 3/27/15 by air ambulance. Patient #20's medical record included a physician's order, dated 3/27/15 at 1:35 PM, for 4 point hard restraints for 4 hours for aggressive/violent behavior. Nursing restraint documentation indicated 4 point restraints were applied by nursing staff on 3/27/15 at 1:35 PM. Restraint documentation at 2:00 PM and 2:30 PM described Patient #20 as "sedated and resting" while continuing to be restrained in four point hard restraints. The nurse and physician who cared for Patient #20 were unavailable for interview. An ED RN was interviewed on 6/19/15 at 11:30 AM. She reviewed restraint documentation for Patient #20. She confirmed the documentation that Patient #20 continued to be restrained with 4 point hard restraints while "sedated and resting."	A 174	Response to A-174 continued QAPI Integration Accreditation staff to conduct random audits of restrained patients to verify restraints were discontinued at the earliest possible time. Identified areas of opportunity to be shared with unit leadership for individualized follow-up. Audit data to be reviewed at Continual Regulatory Readiness Committee, and included in the Accreditation Annual report to the Quality and Patient Safety Committee and West Region Quality, Safety, and Service Excellence Committee of the Board.	Audit to begin 9/1/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130006	A. BUILDING _____ B. WING _____	C 06/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKE'S REGIONAL MEDICAL CENTER	190 EAST BANNOCK STREET BOISE, ID 83712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 174	Continued From page 14 An ED physician was interviewed on 6/19/15 at 12:00 PM. He reviewed restraint documentation for Patient #19 and confirmed documentation was lacking. Patient #20 was not released from restraints at the earliest possible time.	A 174		
A 178	482.13(e)(12) PATIENT RIGHTS: RESTRAINT OR SECLUSION When restraint or seclusion is used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others, the patient must be seen face-to-face within 1-hour after the initiation of the intervention -- o By a-- - Physician or other licensed independent practitioner; or - Registered nurse or physician assistant who has been trained in accordance with the requirements specified in paragraph (f) of this section. This STANDARD is not met as evidenced by: Based on staff interview and review of medical records and the hospital's restraint policy, the hospital failed to ensure a face-to-face examination was completed within 1 hour of the application of behavioral restraints in the ED setting. This directly impacted 6 of 6 patients (#19, #20, #21, #22, #23, #24) who were restrained in the ED and whose records were reviewed. This resulted in the potential for adverse patient events to go undetected and untreated by hospital staff. Findings include:	A 178	Response to A-178 Plan of Correction A-178 -Creation of education materials for Emergency Department Medical Staff re-enforcing need for and clarifying expectations for documentation of face to face evaluation -Distribution of education materials to Emergency Department Medical Staff -Modification to Emergency Department electronic medical record to improve compliance with documentation of required elements that demonstrate evaluation took place within 1 hour of initiation of physical restraints and/or administration of chemical restraints. -Re-enforcement of education on requirements of face to face evaluation for departments of medical staff via physician newsletter.	7/31/15 8/31/15 9/30/15 9/1/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130006	A. BUILDING _____ B. WING _____	C 06/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKE'S REGIONAL MEDICAL CENTER	190 EAST BANNOCK STREET BOISE, ID 83712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 178	Continued From page 15 1. The hospital's policy, "Restraints," dated 5/05/14, was reviewed. The policy stated "Restraints used to manage violent/self-destructive behavior require a physician in person examination of the restrained/patient within one hour of initiation." The policy did not address documenting the 1-hour face-to-face medical and behavioral evaluation in the patient's medical record. The face-to-face evaluation was not conducted by a physician within 1 hour after application of restraints used to manage violent or self destructive behavior, as follows: a. Patient #19 was a 36 year old male seen in the ED on 3/16/15. The medical record included a physician's order, dated 3/16/15 at 1:36 PM, for 4 point hard restraints for 4 hours for violent/self-destructive behavior. Nursing restraint documentation indicated the restraints were applied at 1:44 PM. There was no documentation that a physician conducted a face-to-face examination within 1 hour of application of restraints. b. Patient #20 was a 45 year old male seen in the ED on 3/27/15 by air ambulance. The medical record included a physician's order, dated 3/27/15 at 1:35 PM, for 4 point hard restraints for 4 hours for aggressive/violent behavior and an inability to consistently follow or understand directions. Nursing restraint documentation indicated the restraints were applied by nursing staff on 3/27/15 at 1:35 PM. There was no documentation that a physician conducted a face-to-face examination within 1 hour of application of restraints. c. Patient #21 was a 41 year old male seen in the	A 178	Response to A-178 continued QAPI integration Accreditation staff to conduct random audits of restrained patients to verify documentation of the face to face evaluation was completed within 1 hour of violent physical restraint application and/or chemical restraint administration. Identified areas of opportunity to be shared with the Medical Staff office for individualized follow-up. Audit data to be reviewed at Continual Regulatory Readiness Committee, and included in the Accreditation Annual report to the Quality and Patient Safety Committee and West Region Quality, Safety, and Service Excellence Committee of the Board. Compliance with documentation of the Face to Face evaluation added to Emergency Medicine of Idaho (contracted provider of Emergency Department medical staff) contract as a quality and performance metric.	Audits to begin 9/1/15 Begining 10/1/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130006	A. BUILDING _____ B. WING _____	C 06/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKE'S REGIONAL MEDICAL CENTER	190 EAST BANNOCK STREET BOISE, ID 83712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 178	Continued From page 16 ED on 6/07/15, for smoking an unknown substance. He was brought in by EMS and accompanied by local police. Patient #21's medical record included a physician order, dated 6/07/15 at 10:11 PM, for 2 point hard restraints for 4 hours related to aggressive/violent behavior, destructive behavior, and inability to consistently follow or understand directions. Nursing restraint documentation indicated the restraints were applied by nursing staff on 6/07/15 at 10:12 PM. Patient #21's record did not include documentation a physician conducted a face-to-face examination within 1 hour of the application of restraints. d. Patient #22 was a 74 year old male seen in the ED on 5/18/15, for garbled speech. He was brought in by private auto from a physician's office. Patient #22's medical record included a physician order, dated 5/18/15 at 12:19 PM, for 4 point hard restraints for 4 hours related to violent/self-destructive behavior, aggressive/violent behavior, and inability to consistently follow or understand directions. Nursing restraint documentation indicated 4 point hard restraints were applied by nursing staff on 5/18/15 at 12:30 PM. Patient #22's record did not include documentation a physician conducted a face-to-face examination within 1 hour of the application of restraints. e. Patient #23 was a 24 year old male seen in the ED on 5/20/15, for a mental health hold. He was brought in by local police. Patient #23's medical record included a physician order, dated 5/20/15 at 6:15 PM, for 4 point hard restraints for 4 hours related to violent/self-destructive behavior and aggressive/violent behavior. Nursing restraint documentation indicated the restraints were	A 178		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130006	A. BUILDING _____ B. WING _____	C 06/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKE'S REGIONAL MEDICAL CENTER	190 EAST BANNOCK STREET BOISE, ID 83712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 178	Continued From page 17 applied by nursing staff on 5/20/15 at 6:02 PM. Patient #23's record did not include documentation a physician conducted a face-to-face examination within 1 hour of the application of restraints. f. Patient #24 was a 40 year old female seen in the ED on 5/28/15, for a mental health hold. She was brought in by local police. Patient #24's medical record included a physician order, dated 5/28/15 at 12:15 AM, for 4 point hard restraints for 4 hours related to violent/self-destructive behavior, aggressive/violent behavior, and inability to consistently follow or understand directions. Nursing restraint documentation indicated the restraints were applied by nursing staff on 5/28/15 at 1:50 AM. Patient #24's record did not include documentation a physician conducted a face-to-face examination within 1 hour of the application of restraints. During an interview on 6/18/15 at 4:10 PM, the Accreditation Director reviewed the records of Patients #19, #20, #21, #22, #23, and #24. She confirmed the records did not include documentation of the 1 hour face-to-face by a physician. She stated nursing staff were not qualified to perform the face-to-face according to hospital policy. An ED physician, who was identified as the Chair of the ED, was interviewed on 6/19/15 at 12:00 PM. He stated it was his understanding that seeing the patient face-to-face prior to the initiation of restraints met the face-to-face requirement. The hospital did not ensure a face-to-face evaluation was conducted by qualified staff within	A 178		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130006	A. BUILDING _____ B. WING _____	C 06/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKE'S REGIONAL MEDICAL CENTER	190 EAST BANNOCK STREET BOISE, ID 83712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 178	Continued From page 18 one hour after application of restraints used to manage violent or self-destructive behavior.	A 178		
A 185	482.13(e)(16)(ii) PATIENT RIGHTS: RESTRAINT OR SECLUSION [there must be documentation in the patient's medical record of the following:] A description of the patient's behavior and the intervention used. This STANDARD is not met as evidenced by: Based on staff interview and review of medical records and the hospital's restraint policy, it was determined the hospital failed to ensure medical records contained documentation of a description of the patient's behavior that justified the use of restraints for 1 of 8 patients (#19) who were restrained and whose records were reviewed. This resulted in a lack of clarity as to whether the patient's behavior warranted the use of restraints. Findings include: The hospital's policy, "Restraints," dated 5/05/14, was reviewed. The policy stated "Staff will document patient behavior necessitating restraint use." Patient #19 was a 36 year old male seen in the ED on 3/16/15. There was a physician's order, dated 3/16/15 at 1:36 PM, for 4 point hard restraints for 4 hours for violent/self-destructive behavior. Patient # 19's ED visit, dated 3/16/15 beginning at 1:15 PM, included the following descriptions of Patient #19's behavior:	A 185	Response A-185 The Associate Chief Nursing Officers and Chief of Staff have ultimate responsibility for ensuring proper documentation of behaviors justifying the use of restraints. Plan of Correction -Review of Medical Record for patient #19 with individual nursing staff involved and specific education provided. -Modifications made to Electronic Medical Record restraint documentation areas requiring descriptions of specific patient behaviors necessitating the use of restraints. -Re-enforce education for Nursing Staff and Medical Staff on the need to clearly document specific behaviors justifying the use of restraints. Review of education to occur in a variety of ways including staff meetings, huddles, summits, newsletters and email communications.	7/31/15 10/1/15 9/1/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130006	A. BUILDING _____ B. WING _____	C 06/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKE'S REGIONAL MEDICAL CENTER	190 EAST BANNOCK STREET BOISE, ID 83712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 185	Continued From page 19 -The patient on arrival to the emergency department had a tonic-clonic seizure witnessed by the nurse. -The patient is agitated and pacing the room. - He appears to be paranoid checking behind the curtains and having tangential thoughts. There was no documented description of Patient #19's behavior that demonstrated how he was at risk of hurting himself or others. The nurse and physician who cared for Patient #19 were unavailable for interview. An ED RN was interviewed on 6/19/15 at 11:30 AM. She reviewed restraint documentation for Patient #19 and confirmed there was no documentation present that explained the use restraints. An ED physician was interviewed on 6/19/15 at 12:00 PM. He reviewed restraint documentation for Patient #19 and confirmed documentation was lacking. Patient #19's medical record did not include documentation of the behavior that justified the use of hard four point restraints, or any other type of physical restraint.	A 185	QAPI Integration Accreditation staff to conduct random audits of restrained patients to verify documentation of specific behaviors necessitating the use of restraints. Identified areas of opportunity to be shared with unit leadership for individualized follow-up. Audit data to be reviewed at Continual Regulatory Readiness Committee, and included in the Accreditation Annual report to the Quality and Patient Safety Committee and West Region Quality, Safety, and Service Excellence Committee of the Board. Response to A-837	Audits to begin 9/1/15
A 837	482.43(d) TRANSFER OR REFERRAL The hospital must transfer or refer patients, along with necessary medical information, to appropriate facilities, agencies, or outpatient services, as needed, for follow-up or ancillary care.	A 837	The System Director of Health Information Management has ultimate responsibility for ensuring transfer of necessary medical information to appropriate facilities, agencies, or outpatient services, as needed for follow-up or ancillary care.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130006	A. BUILDING _____ B. WING _____	C 06/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKE'S REGIONAL MEDICAL CENTER	190 EAST BANNOCK STREET BOISE, ID 83712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 837	Continued From page 20 This STANDARD is not met as evidenced by: Based on staff interview and review of medical records and hospital policy, it was determined the hospital failed to ensure a process was established to consistently transfer necessary medical information at discharge for follow-up or ancillary care. This affected 1 of 1 patient (#7) whose closed medical record was reviewed for evidence of transfer information. This had the potential to interfere with continuity of patient care after discharge. Findings include: 1. The hospital's policy, "Discharge Planning Process and Discharge of Patient," dated 2/28/14, was reviewed. The policy stated that on or prior to the day of discharge, forms and/or activities would be completed for the patient to be ready for discharge. This included, but was not limited to, providing the receiving agency/facility with copies of the pertinent financial and medical information and the expectation the staff nurse complete the patient transfer report related to the patient's clinical status and the interdisciplinary plan of care for purposes of hand-off communication. The policy did not define what was considered "pertinent medical information." It did not address how or if information was sent to patients' physicians when patients were discharged home and the time frame for providing the information. The policy did not describe any expectation to list what information was transferred. It did not describe how information would be transferred to facilities or patients' physicians who did not have access to the electronic health record. The Director of Case Management and the	A 837	Response to A-837 continued The hospital will ensure a process to consistently transfer necessary medical information at discharge for follow-up or ancillary care. Plan of Correction -Review of discharge planning process for patients receiving Home Care with Case Management staff. Re-enforced need to document information provided to facilities and agencies provided care post discharge. -Implement process for dictation (i.e. History and Physicials, Consultations, Discharge summaries) to be automatically cc'd to patient primary care provider. -Modify discharge instructions to include additional elements of necessary medical information and instructions for patients to bring a copy of instructions to follow up appointments. -Educate nursing staff on process to document instructions to patient to bring copy of discharge instructions to follow up appointments	8/15/15 10/1/15 10/1/15 10/1/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130006	A. BUILDING _____ B. WING _____	C 06/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKE'S REGIONAL MEDICAL CENTER	190 EAST BANNOCK STREET BOISE, ID 83712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 837	Continued From page 21 Manager of Case Management were interviewed together on 6/17/15 at 9:30 AM. When asked about the process of transferring patients' medical information at discharge, they stated they thought the discharge summary was sent to the physician but it was not their role as discharge planners. The Accreditation Director was interviewed on 6/17/15, at 11:30 PM and again at 3:05 PM. She confirmed the hospital sent a discharge summary, when completed, within 30 days. She stated primary care doctors were sent a duplicate on any dictated notes, such as H&Ps and or consultations. She stated she was not sure how the information was sent to physicians who were not part of the St Luke's health system and who did not have electronic access. Later in the survey, she provided "Patient Facility/Agency Discharge Checklist" which listed information that was to be transferred at the time of discharge. On the bottom of the form it stated "Worksheet is not a part of the permanent medical record." The discharge planning process as it related to transfer of medical information was incomplete and lacked specificity. 2. Patient #7 was a 68 year old female who was admitted to the hospital on 4/25/15 related to respiratory problems. She was discharged on 4/27/15 to home with home health services. The medical record documented a referral via fax to the home health agency on 4/27/15. There was no documentation in Patient #7's medical record that identified what medical information was provided to the home health agency or to Patient #7's primary physician who would manage Patient #7's care after discharge. This was confirmed on	A 837	Response to A-837 continued Plan of Correction continued -Review Medical Records content policy to ensure required elements of medically necessary information are included in required content for dictations. -Review with Medical Staff required elements and completion timeframes for dicatations. -Update "Discharge Planning Process and Discharge of Patient" policy to define medically necessary information and responsibility for distributing this information. -Implement process for dictated discharge summaries to be identified as draft and forwarded to primary care physicians either electronically or via mail (based on physician preference) prior to signature of attending physician.	7/1/15 10/1/15 9/1/15 9/30/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130006	A. BUILDING _____ B. WING _____	C 06/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKE'S REGIONAL MEDICAL CENTER	190 EAST BANNOCK STREET BOISE, ID 83712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 837	Continued From page 22 6/17/15 by the Director and Manager of Case Management. There was no documentation the hospital transferred Patient #7's necessary medical information to the home health agency and to Patient #7's primary physician, upon discharge.	A 837	Response to A-837 continued QAPI Integration Implementation of the process to ensure required medically necessary information is sent to follow up providers will be evaluated by the Health Information Management department. This evaluation will include tracking of timeliness of dictation completion and compliance with inclusion of required elements within the dicatition. Audit data will be shared with the Medical Records Committee, Quality and Patient Safety Council, Medical Executive Committee, and West Region Quality, Safety and Service Excellence Committee of the Board.	Ongoing

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

July 20, 2015

Kathy Moore, Administrator
St Lukes Regional Medical Center
190 East Bannock Street
Boise, ID 83712-2577

Provider #130006

Dear Ms. Moore:

An unannounced on-site complaint investigation was conducted from June 16, 2015 to June 19, 2015 at St Luke's Regional Medical Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00006930

Allegation #1: Patients are not fully informed of the risks and benefits prior to surgical procedures.

Findings #1: Patient records and hospital policies were reviewed.

A request was made for a list of patients who were admitted to the hospital for a surgical procedure during July and August of 2014 and current patients admitted for surgical procedures. Hospital policies related to informed consent for surgery were also requested.

A policy, R1007 "Consent Process" revised 7/14/14, stated "Certain non-routine procedures or treatment involving more than a slight risk of harm, including surgical and invasive procedures requiring anesthesia, require specific consent beyond the admission consent or outpatient consent. The role of the Medical Center staff is to 'verify' that the patient has had this discussion with their physician or practitioner, understands the information provided them and consents to the procedure."

The records of 6 patients who had surgical procedures during July or August of 2014 and 1 record of a current surgical patient were reviewed for compliance with the surgical consent policy.

One record documented a 62 year old female who was admitted on 7/21/14, for spinal fusion. The record included an History and Physical (H&P) dated 7/21/14, in which the surgeon documented "After thoroughly discussing the nonoperative alternatives as well as the advantages and disadvantages of each option, the patient elected to proceed forward with the recommended surgical intervention ...I discussed with her the risks and benefits of surgery including but not limited to risk of infection, CSF (cerebral spinal fluid) leak, transient or permanent neurologic deficits and hemorrhage requiring transfusion."

The 7 records reviewed included a H&P completed by the surgeon. Each H&P documented a discussion with the patient of the risks and benefits of the surgery to be performed. Each H&P documented the patient's agreement to the surgical procedure after a discussion of risks and benefits.

The 7 records reviewed included a Verification of Informed Consent for Surgical or Medical Procedures. The form documented the patient was informed by the surgeon of the type of procedure to be performed, the reasons why it was to be performed, and the effects related to the surgery, which included potential problems. The Verification of Informed Consent was signed by 7 of 7 surgical patients whose records were reviewed.

Each Verification of Informed Consent included the signature of a hospital employee, verifying the patient had spoken with the surgeon and indicated they understood the information given, had no further questions, and consented to the procedure.

Each Verification of Informed Consent also included the signature of the surgeon, verifying the potential benefits and risks of the surgery were explained and the patient consented to the procedure.

The 7 surgical records reviewed documented the patient was informed of the risks and benefits of surgery and consent was properly obtained prior to surgical intervention. It could not be proven the patient was not informed of the risks related to her surgical procedure. Therefore, the allegation was unsubstantiated.

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: The patients were sent home from the hospital before they were ready.

Findings #2: Patient records and hospital policies were reviewed, and patients were interviewed.

A request was made for a list of patients who were admitted to the hospital for a surgical procedure during July and August 2014. Hospital policies related to the discharge process and planning were also requested.

A policy, CC003 "Discharge Planning Process and Discharge of the Patient" revised 2/21/14, stated on admission patients are assessed by nursing for discharge needs. Case Managers review the patient's medical record to identify patients at risk for discharge planning needs using a High Risk Screening Tool to identify patients which may require assistance. Patients may be referred to Case Managers by physicians, nursing staff, or the interdisciplinary team for additional assistance.

On 6/18/15 beginning at 9:30 AM, 3 adult surgical units were visited for patient interviews regarding discharge planning and patient rights. Four patients, who were scheduled to be discharged that day, were interviewed.

Four out of 4 patients interviewed stated they were aware of their pending discharge and were involved in their discharge planning. One patient stated she required medical equipment prior to her discharge, and it was already delivered to her home. Of the patients interviewed, 4 out of 4 stated they were satisfied with their discharge plans and instructions.

The record of a 62 year old female was reviewed. The female had a spinal fusion surgery on 7/21/14, and was discharged on 7/24/14. The patient began receiving occupational and physical therapy the day after her surgical procedure. She had a Case Manager assigned to her case and a Physician Assistant monitoring her progress from her surgeon's group.

Included in the record was documentation by the occupational and physical therapists regarding the patient's discharge, documenting the following:

- A physical therapy note dated 7/24/14 at 2:39 PM, documented the patient stated "I am going home today at 6pm." The physical therapist documented recommending the patient's spouse be at her side for safety and using a walker. The physical therapist documented the patient met her physical therapy goals.

- An occupational therapy note dated 7/24/14 at 4:50 PM, documented "Pt (patient) states she has a good support system at home and is ready to go home." The occupational therapist documented the patient had no barriers for discharging home.

Hospital policies and 4 surgical records were reviewed, and cnrrent patients were interviewed regarding discharge. There were no findings indicating patients were discharged before they were ready. Therefore, the allegation was unsubstantiated. However, a deficiency were cited at 42 CFR 482.43 (d), as it relates to the failure of the hospital to ensure necessary medical information is provided to other healthcare provider when a patient is discharged, to promote appropriate post-discharge care.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: Grievance concerns were not adequately addressed by the hospital.

Findings #3: Grievance reports and hospital policies were reviewed, and staff was interviewed.

The hospital policy, "Patient Complaint and Grievance Process," dated 7/31/13, was reviewed. The policy stated, "After review of the complaint or grievance, the written notice of the hospital's determination regarding the grievance will be communicated to the patient or the patient's representative by Patient & Family Relations or under the direction of Patient & Family Relations in a language they understand. The written notice to the patient, family member or customer will not reveal confidential or privileged peer review or attorney-client privileged information."

The hospital's grievance policy did not specifically address the regulatory requirement to include the following steps in the letters of response: the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion.

Grievance documentation, including letters of response, were reviewed with the Manager of Patient Relations on 6/16/15 beginning at 1:20 PM. She stated it was the hospital's policy to review and resolve grievances within 30 days. The Manager of Patient Relations confirmed sometimes the investigation process takes longer, but the patient or representative was contacted and notified of the delay.

Eight grievance records were chosen for review. The letters of response did not include detailed information regarding investigative findings, actions taken, or outcome related to the grievances for 4 out of 8 grievance records reviewed. Additionally, the hospital's letter of response to the patients did not address all of the allegations for 1 out of the 8 patient grievances reviewed.

The allegation was substantiated. A deficiency was cited at 42 CFR 482.13 (a)(2)(iii) as it related to the failure of the hospital to ensure a timely written response describing the investigative findings, actions taken, and outcome of the investigation.

Conclusion #3: Substantiated. Federal deficiencies related to the allegation are cited.

Allegation #4: The patient developed an infection post-operatively related to her surgery.

Findings #4: Patient records and hospital policies were reviewed, Quality Assessment and Performance Improvement (QAPI), and infection control documents were reviewed. Staff was also interviewed.

The hospital's policy, IP053 "Infection Prevention Process/Plan," revised 6/02/15, stated "Each site has an Infection Prevention Committee (IPC); and meets at least quarterly. The committee is responsible for the initiation and supervision of an active, infection control program for individual St. Luke's facilities and services." Included in the policy, as part of their responsibilities, the IPC reviewed data related to Hospital Associated Infections (HAI), approved surveillance and reporting systems, and recommended actions and follow-up related to HAIs.

Upon request, a report was presented for identified Klebsiella and Staphylococcus surgical infections which occurred from July 2014 to May 2015. The report included the patient name, medical record number, location of infection, surgical procedure, date of infection, American Society of Anesthesiologists score (ASA), wound class, risk index, and organism. Four patient records were chosen from the report for record review.

The 4 surgical patient records reviewed included documentation the patients were medicated pre-operatively with prophylactic intravenous antibiotics. Two of the 4 patient operative reports documented irrigating the surgical area with antibiotics prior to surgically closing the incision. Additionally, 4 of the 4 surgical patients received intravenous antibiotics post-operatively beginning either in the recovery room or the inpatient unit where they were admitted.

One record documented a 62 year old female who had a spinal fusion surgery. The record included documentation the patient received intravenous antibiotics in the pre-operative area. The patient received another dose of intravenous antibiotics a half an hour after her arrival to the post-anesthesia care unit. Additionally, the surgeon documented in the operative note the patient received pre-operative antibiotics prior to entering the operating room.

However, this patient was included in the report of identified Klebsiella and Staphylococcus surgical infections identified during the requested time period.

When asked on 6/16/15 at 11:15 AM, the Accreditation Director confirmed the infection date on the report related to the date of the surgical procedure. She stated reports were reviewed by the Infection Prevention Department on a daily basis and surgeons were notified if their patient developed an infection, if the surgeons were not the one who identified them. The Accreditation Director stated once an infection was identified patients were treated by their surgeon or by an Infectious Disease physician.

The hospital had an extensive hospital wide infection prevention program. An Infection Prevention Committee met bimonthly and the members of the committee included Infectious Disease Physicians, administration, a representative from the Quality and Patient Safety department, and representatives from several inpatient units. One of the identified performance improvement projects for 2015 was to reduce the number of surgical site infections as part of the QAPI.

The hospital followed definitions and guidelines from the Centers for Disease Control's National Healthcare Safety Network criteria. As part of the Infection Control program's goals 5 procedures were specifically identified for tracking of surgical site infections; spinal fusion, hysterectomy, colon surgery, arthroplasty of hip and knee, and breast surgery. Potential infections were reported to the Infection Prevention Department in a variety of ways, including review of culture reports, laboratory data, notification from a unit, electronic surveillance software, or notification by another hospital or facility.

Additionally, the hospital had a task force Surg2Zero, which focused on surgical site infection reduction and implementation of best practices through all surgical services.

The Quality and Patient Safety Administrator and Quality Director were interviewed on 6/16/15 at 1:30 PM. They stated the Quality and Patient Safety Committee would meet monthly to review and discuss reports tracking surgical site infections and HAI's, as well as other areas of concern, related to infection as part of their agenda. During the meeting they would review unit specific committee reports, if problems were identified in that area, and review processes or interventions implemented on the unit for improvement by the unit Performance Improvement coordinator.

The Quality and Patient Safety Administrator and Quality Director presented a quarterly dashboard report with the 2015 Quality and Patient Safety Committee goals. The Quality and Patient Safety Administrator stated the dashboard report was reviewed by the Quality and Patient Safety Committee, as well as the Medical Executive Committee on a regular basis. The report identified surgical site infections and HAI information being tracked. Additionally, the report provided data on a quarterly and monthly basis, with the goal for the fiscal year, and identified whether the hospital was on track or needed improvement for the identified goals related to SSIs and HAIs.

The records of 4 patients with surgical site infections between July 2014 and May 2015 were reviewed. Additionally, documents related to infection prevention and the QAPI programs were reviewed. No infection prevention issues were identified.

The allegation was substantiated, as patients did contract HAI. However, no deficiencies were cited, as the hospital had several infection prevention processes in place and was aggressively working to reduce the number of HAIs.

Conclusion #4: Substantiated. No deficiencies related to the allegation are cited.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it will be addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626, option 4. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

Teresa Hamblin for Laura Thompson

LAURA THOMPSON
Health Facility Surveyor
Non-Long Term Care

Sylvia Creswell

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

LT/pmt