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 23, 2015

Betsy Hunsicker
West Valley Medical Center
1717 Arlington Street
Caldwell, ID 83605

RE: West Valley Medical Center, provider #130014

Dear Ms. Hunsicker:

This is to advise you of the findings of the complaint investigation, which was concluded at your facility on July 9, 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 Hospital into compliance, and that the Hospital remains in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and

- The administrator's signature and the date signed on page 1 of the Form CMS-2567.

Please sign and date both of the forms and return them to our office by **August 5, 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,

Sylvia Creswell for

REBECCA LARA
Health Facility Surveyor
Non-Long Term Care

Sylvia Creswell

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

RL/pmt
Enclosures

WEST VALLEY MEDICAL CENTER
1717 Arlington Avenue • Caldwell, ID 83605
(208) 459-4641 • www.westvalleyisbetter.com

August 5, 2015

Rebecca Lara
Sylvia Creswell
Bureau of Facility Standards
3232 Elder Street
Boise, ID 83720-0036



RE: West Valley Medical Center, Provider #130014

Dear Ms. Lara; Ms. Creswell

Per your letter dated July 23, 2015 pursuant to the complaint investigation conducted July 9, 2015, please find enclosed the completed Statement of Deficiencies/Plan of Correction, CMS Form 2567.

If you have any questions, please contact me at (208) 455-3718.

Sincerely,

Betsy Hunsicker
Chief Executive Officer

Enc.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 130014 | A. BUILDING _____ B. WING _____ | C 07/09/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| WEST VALLEY MEDICAL CENTER | 1717 ARLINGTON STREET CALDWELL, ID 83605 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| A 000 | INITIAL COMMENTS<br><br>The following deficiencies were cited during the complaint investigation survey of your hospital. The surveyors conducting the investigation were:<br><br>Rebecca Lara, RN, BA, Health Facility Surveyor, Team Leader<br>Teresa Hamblin, RN, MS, Health Facility Surveyor<br><br>The following acronyms were used in this report:<br><br>HCA - Hospital Corporation of America<br>ED - Emergency Department<br>LIP - Licensed Independent Practitioner<br>PA - Physician Assistant<br>RN - Registered Nurse | A 000 | RECEIVED<br>AUG - 5 2015<br>FACILITY STANDARDS | |
| A 118 | 482.13(a)(2) PATIENT RIGHTS: GRIEVANCES<br><br>The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance.<br><br>This STANDARD is not met as evidenced by:<br>Based on review of grievance information, hospital policies, and staff interview, it was determined the facility failed to notify patients/representatives of whom to contact, within the hospital, to file a grievance. This had the potential to impact all patients/representatives who wished to file a grievance. It also had the potential to interfere with, or prevent, patients/representatives from filing a grievance. Findings include:<br><br>1. The hospital's policy "Patient/Family Complaint and Grievance," dated 10/12/10, was reviewed. It included, but was not limited to, the following | A 118 | The policy referenced in finding 1 of tags 118 and 121, Patient/Family Complaint and Grievance currently states: Notification of Rights Regarding Complaint/Grievance Resolution Each patient and/or patient representative is informed of the rights and responsibilities afforded patients upon entry into the facility, and the process by which they may lodge a complaint. This information includes the name of the designee of the organization, such as the Risk Manager, and the method of access to the designee to provide immediate assistance as needed.<br>The policy will be clarified by the CNO to say: Each patient and/or patient representative is informed of the rights and responsibilities afforded patients upon entry into the facility, and the process by which they may lodge a complaint. This information includes the name of the designee of the organization,such as the Risk Manager, or Patient Advocate at 208-455-3719, or by mail at 1717 Arlington Ave, Caldwell ID 83605, or email at patient.advocate@hcahealthcare.com.<br>This clarification will assist internal users of the policy to correctly advise patients and families regarding the process, should it become necessary.<br>The changes will be evidence by the track changes and revision date in the PolicyTech system and approved by the CEO.<br>Information regarding the policy update and new mailbox will be sent in a staff communication of employee need to know to all staff.<br>Responsible Party: CNO | 09/01/2015 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — (X6) DATE: 8/5/15

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.

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| A 118 | Continued From page 1<br>information:<br><br>"Each patient and/or the patient's representative will be informed of the grievance process, including whom to contact to file a grievance or complaint. The patient will be informed that a grievance maybe directly lodged with the Idaho Bureau of Facility Standards or the Joint Commission, regardless of whether he/she has first used the organization's grievance process." The policy did not inform each patient whom to contact, within the facility, to file a grievance. This was confirmed by the Interim Patient Advocate during interview on 7/07/15 at 11:12 AM.<br><br>2. A framed document containing patients' rights information was observed in the lobby area of the facility on 7/07/15 at approximately 11:12 AM. The poster included information on how to file a written or verbal complaint with the Joint Commission, Bureau of Facility Standards and the facility's parent company, HCA. The poster did not provide the name or contact information for the individual(s), in the facility, patients or representatives could contact to file a grievance. This was confirmed by the Interim Patient Advocate during interview on 7/07/15 at 11:12 AM.<br><br>3. An undated patient handout, "Your Patient Rights and Responsibilities," was reviewed. Although the handout included information about how to file a written or verbal complaint with the Joint Commission and Bureau of Facility standards, it did not provide the name or phone number of an individual(s), within the facility, patients' could contact to file a grievance. This was confirmed by the Interim Patient Advocate | A 118 | Deficiency 2, A118 and A121<br>The framed patients' rights posters have been reviewed and the Director of Health Information Management who will submit a print change request adding "or West Valley Risk Manager, or Patient Advocate at 208-455-3719, or by mail at 1717 Arlington Ave, Caldwell ID 83605, or email at patient.advocate@hcahealthcare.com"<br>All posters will be replaced in current frames by the Plant Operations department. This change will allow clear options for patients/families in regard to local contacts for complaints or concerns.<br>Future versions of these printed materials will be audited before distribution to maintain content (attachment #5, completed print shop requisition).<br>Deficiency 3, A118 and A121<br>The handout "Your Patient Rights and Responsibilities"<br>currently states a hospital administrator may be contacted in the case of any concerns.<br>Verbiage will be clarified to say "Concerns or complaints<br>may be directed to the West Valley Medical Center Risk Manager or Patient Advocate at 208-455-3719, or by mail at 1717 Arlington Ave, Caldwell ID 83605, or email at patient.advocate@hcahealthcare.com"<br>The change will be drafted and submitted to the print shop by the Director of Health Information Management and will clearly explain options for patients/families in regard to local contacts for complaints or concerns. Evidence of completion will include an updated revision date and request to print shop. Future versions of these printed materials will be audited before distribution to maintain content. | 10/01/2015<br><br>10/01/2015 |

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| A 118 | Continued From page 2<br>during interview on 7/07/15 at 11:12 AM.<br><br>Patients and representatives were not informed of who to contact, within the facility, to file a grievance. | A 118 | | |
| A 121 | 482.13(a)(2)(i) PATIENT RIGHTS: GRIEVANCE PROCEDURES<br><br>[At a minimum:]<br>The hospital must establish a clearly explained procedure for the submission of a patient's written or verbal grievance to the hospital.<br><br>This STANDARD is not met as evidenced by:<br>Based on staff interview, observation of patient rights posters, and review of hospital policy and patient rights information provided to patients upon admission, it was determined the hospital failed to establish a clearly explained procedure for the submission of a patients' written or verbal grievance to the hospital. This had the potential to interfere with the ability of patients to exercise their right to submit a grievance and have it promptly addressed. Findings include:<br><br>1. The hospital's policy "Patient/Family Complaint and Grievance," dated 10/12/10, was reviewed. It included, but was not limited to, the following information:<br><br>- "Each patient and/or the patient's representative will be informed of the grievance process, including whom to contact to file a grievance or complaint. The patient will be informed that a grievance maybe directly lodged with the Idaho Bureau of Facility Standards or the Joint Commission, regardless of whether he/she has first used the organization's grievance process." | A 121 | The policy referenced in finding 1 of tags 118 and 121, Patient/Family Complaint and Grievance currently states:Notification of Rights Regarding Complaint/Grievance Resolution Each patient and/or patient representative is informed of the rights and responsibilities afforded patients upon entry into the facility, and the process by which they may lodge a complaint. This information includes the name of the designee of the organization, such as the Risk Manager, and the method of access to the designee to provide immediate assistance as needed. The policy will be clarified by the CNO to say: Each patient and/or patient representative is informed of the rights and responsibilities afforded patients upon entry into the facility, and the process by which they may lodge a complaint. This information includes the name of the designee of the organization, such as the Risk Manager, or Patient Advocate at 208-455-3719, or by mail at 1717 Arlington Ave, Caldwell ID 83605, or email at patient.advocate@hcahealthcare.com.<br>This clarification will assist internal users of the policy to correctly advise patients and families regarding the process, should it become necessary.<br>The changes will be evidence by the track changes and revision date in the PolicyTech system and approved by the CEO. Information regarding the policy update and new mailbox will be sent in a staff communication of employee need to know to all staff.<br>Responsible Party: CNO | 09/01/2015 |

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| A 121 | Continued From page 3<br><br>- "Each patient and/or patient representative is informed of the rights and responsibilities afforded patients upon entry into the facility, and the process by which they may lodge a complaint. This information includes the name of the designee of the organization, such as the Risk Manager, and the method of access to the designee to provide immediate assistance as needed."<br><br>The policy did not state how patients would be informed of the hospital's grievance process including how to file a written and verbal grievance with the hospital. This was confirmed by the Interim Patient Advocate during interview on 7/07/15 at 11:12 AM.<br><br>2. An undated patient handout, "Your Patient Rights and Responsibilities, was reviewed. Although the handout included information on how to file a written or verbal grievance with the Joint Commission and Bureau of Facility standards, it did not inform the patient how to file a verbal or written grievance with the hospital or a phone number to call. This was confirmed by the Interim Patient Advocate during interview on 7/07/15 at 11:12 AM.<br><br>3. A patient rights poster, was observed in the hospital's lobby area on 7/07/15 at 11:12 AM. The poster did not include information on how to file a written and verbal grievance with the hospital. Although the handout included information on how to file a written or verbal complaint with the Joint Commission, Bureau of Facility Standards, and HCA, it did not inform the patient how to file a verbal or written grievance with the hospital or a phone number to call. This | A 121 | Deficiency 2, A118 and A121<br>The framed patients' rights posters have been reviewed and the Director of Health Information Management who will submit a print change request adding "or West Valley Risk Manager, or Patient Advocate at 208-455-3719, or by mail at 1717 Arlington Ave, Caldwell ID 83605, or email at patient.advocate@hcahealthcare.com"<br>All posters will be replaced in current frames by the Plant Operations department. This change will allow clear options for patients/families in regard to local contacts for complaints or concerns.<br>Future versions of these printed materials will be audited before distribution to maintain content (attachment #5, completed print shop requisition).<br><br>Deficiency 3, A118 and A121<br>The handout "Your Patient Rights and Responsibilities" currently states a hospital administrator may be contacted in the case of any concerns. Verbiage will be clarified to say "Concerns or complaints may be directed to the West Valley Medical Center Risk Manager or Patient Advocate at 208-455-3719, or by mail at 1717 Arlington Ave, Caldwell ID 83605, or email at patient.advocate@hcahealthcare.com"<br>The change will be drafted and submitted to the print shop by the Director of Health Information Management and will clearly explain options for patients/families in regard to local contacts for complaints or concerns. Evidence of completion will include an updated revision date and request to print shop. Future versions of these printed materials will be audited before distribution to maintain content.<br>Responsible Party: Director, Health Information | 10/01/2015<br><br>10/01/2015 |

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| A 121 | Continued From page 4<br>was confirmed by the Interim Patient Advocate during interview on 7/07/15 at 11:12 AM.<br><br>The hospital did not establish a clearly explained procedure for the submission of a patient's written or verbal grievance to the hospital. | A 121 | | |
| A 122 | 482.13(a)(2)(ii) PATIENT RIGHTS: GRIEVANCE REVIEW TIME FRAMES<br><br>At a minimum:<br>The grievance process must specify time frames for review of the grievance and the provision of a response.<br><br>This STANDARD is not met as evidenced by:<br>Based on review of grievance information and hospital policy and staff interview, it was determined the hospital failed to ensure grievances were responded to within the time frame specified in policy, or notified when a delay was anticipated to occur in accordance with policy, for 2 of 6 patients (#8 and #9) whose grievances were reviewed. This resulted in unexplained delays in communicating results of the grievance investigation. Findings include:<br><br>1. The hospital's policy "Patient/Family Complaint and Grievance," dated 10/12/10, was reviewed. The policy included, but was not limited to the following information:<br><br>- "Upon receipt of a grievance, the Risk Manager, House Supervisor, or other designee of the organization, will confer with the patient and/or patient representative within seven days of receipt of the grievance with the exception of complaints that endanger the patient (i.e., abuse or neglect). These grievances should be | A 122 | A122<br>The tracking mechanism for follow up on grievances includes a spreadsheet tracking the date of receipt of the complaint. The interim patient advocate will draft letter content to be sent to any patients/family member whose grievance cannot be adequately invested and closed within 7 days. The log used to track grievances will be updates to reflect when this letter is needed and a copy of the letter retained. The letter will state "We appreciate your time in bringing your concerns to our attention. We are currently in the process of investigating your concerns and hope to have follow up or resolution in the very near future. Please expect a response within 21 days. Thank you for your continued patience as we work to evaluate and respond to your concern". (attachment # 8)This update to our process will ensure we have clear documentation of all follow up provided and that our customers know what to expect during the process, should it become necessary to extend the review process.<br>The interim patient advocate will audit his/her spreadsheet and provide results in a quarterly review of the spreadsheet with hospital administration. Audit results will be reported to Quality Results Committee (MEC) and the CEO for determination of ongoing audit need.<br>Responsible Party: Interim Patient Advocate | 09/01/2015 |

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| A 122 | Continued From page 5<br>reviewed immediately given the seriousness of the allegations and the potential for harm to the patient. A representative of the administrative staff will oversee and assist with the resolution process as needed. medical staff leadership may be involved as needed to resolve physician delivery of care issues.<br><br>- Occasionally, a grievance is complicated and may require an extensive investigation. If the grievance will not be resolved, or if the investigation is not or will not be completed within seven days, the complainant should be informed that the facility is still working to resolve the grievance and that the facility will follow-up with a written response within 21 days.<br><br>The hospital's letter of response to patients/complainants was not within the time frame specified in policy. Examples include:<br><br>a. A complaint was received 4/12/15, on behalf of Patient #8 regarding physician care and behavior for an ED visit in December, 2014. Two letters of response were provided, dated 4/24/15 and 4/28/15. There was no documentation to indicate the complainant was informed of the delay beyond the seven days specified in hospital policy. This was confirmed by the Interim Patient Advocate during interview on 7/07/15 at 11:15 AM.<br><br>b. A complaint was received on 4/18/15, on behalf of Patient #9 related to physician care in the ED the prior week. Letters of response were dated 5/21/15 and 6/02/15. There was no documentation to indicate the complainant was informed of the delay beyond the seven days specified in hospital policy. This was confirmed by | A 122 | | |

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| A 122 | Continued From page 6<br>the Interim Patient Advocate during an interview on 7/07/15 at 11:24 PM.<br><br>Patient #8 and Patient #9 were not sent responses to their grievances within the time frame specified in policy, nor were they notified the response would be delayed. | A 122 | | |
| A 123 | 482.13(a)(2)(iii) PATIENT RIGHTS: NOTICE OF GRIEVANCE DECISION<br><br>At a minimum:<br>In its resolution of the grievance, the hospital must provide the patient with written notice of its decision that contains the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion.<br><br>This STANDARD is not met as evidenced by:<br>Based on review of letters of response to grievances, hospital policy, and staff interview, it was determined the hospital failed to ensure written notice of response included the date of completion of the investigation of complaints for 4 of 6 patients (#5, #7, #8 and #9) whose grievances were reviewed. This resulted in a lack of clarity as to whether the investigation was complete. Findings include:<br><br>1. The hospital's policy "Patient/Family Complaint and Grievance," dated 10/12/10, was reviewed. The policy stated "In resolution of the grievance, a written notice of the decision must be provided to the complainant that contains the name of the facility contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance investigation, and the | A 123 | A123<br>It will be the consistent practice, at the time a grievance investigation is complete and a response provided, to clearly communicate to the patient that the investigation is considered closed. Effective immediately, all final correspondence will clarify the closure of the investigation through standard language, "At this time, we will consider this matter closed. If there are any issues you consider unresolved, please do not hesitate to contact me at 208-455-3770."<br>Verbal education was provided to the interim patient advocate by the CNO.<br>The interim patient advocate is responsible to ensure this standard language is incorporated.<br>The most recent 2 responses were audited by the CNO and included this language. The interim patient advocate will audit his/her spreadsheet and provide results in a quarterly review of the spreadsheet with hospital administration.<br>Audit results will be reported to Quality Results Committee (MEC) and the CEO for determination of ongoing audit need.<br>Responsible Party: Interim Patient Advocate | 09/01/2015 |

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| A 123 | Continued From page 7<br>date of completion."<br><br>The following are examples of letters of response to grievances that did not include the date the investigation was considered complete:<br><br>a. A complaint was received on 4/02/15, on behalf of Patient #5 regarding physician care during an ED visit on 4/01/15. The letter of response, dated 4/10/15 did not include the date the investigation was considered complete. This was confirmed by the Interim Patient Advocate during interview on 7/07/15 at 11:12 AM.<br><br>b. A complaint was received 4/12/15, on behalf of Patient #8 regarding physician care and behavior for an ED visit in December, 2014. Two letters of response were provided, dated 4/24/15 and 4/28/15. Neither letter indicated the date the investigation was considered complete. This was confirmed by the Interim Patient Advocate during interview on 7/07/15 at 11:15 AM.<br><br>c. A complaint was received on 4/10/15, by Patient #7 related to nursing care in the ED during a visit on 4/10/15. Letters of response, dated 4/15/15 and 6/10/15, did not include the date the investigation was considered complete. This was confirmed by the Interim Patient Advocate during interview on 7/07/15 at 11:15 AM.<br><br>d.. A complaint was received on 4/18/15, by Patient #9 related to physician care in the ED the prior week. Letters of response, dated 5/21/15 and 6/02/15, did not include the date the investigation was considered complete. This was confirmed by the Interim Patient Advocate during an interview on 7/07/15 at 11:24 PM. | A 123 | | |

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| A 123 | Continued From page 8<br><br>Letters of response to grievances for Patients #5, #7, #8 and #9 were incomplete. | A 123 | | |
| A 133 | 482.13(b)(4) PATIENT RIGHTS: ADMISSION STATUS NOTIFICATION<br><br>The patient has the right to have a family member or representative of his or her choice and his or her own physician notified promptly of his or her admission to the hospital.<br><br>This STANDARD is not met as evidenced by:<br>Based on staff interview, policy review, and medical record review, it was determined the hospital failed to ensure a process was established to ask patients if they wanted a family member/representative and/or personal physician notified of their admission to the hospital. This directly impacted 3 of 11 patients (#1, #3 and #4) whose admission documents were reviewed for this purpose. This had the potential to interfere with the ability of patients to coordinate their personal and healthcare needs. Findings include:<br><br>1. An undated patient handout, "Your Patient Rights and Responsibilities," was reviewed. The policy stated the patient could expect "prompt notification to your physician and a family member, per your request, if you are admitted to the hospital."<br><br>Documentation was not found in the following records indicating the facility had asked patients whether they wanted the hospital to notify a family member/representative and/or a personal physician of admission to the facility as follows: | A 133 | A133<br>Personal physician notification: Primary care notification for general inpatients is provided with an automated process at admission registration. When a patient is asked if they have a primary care provider (PCP) by registration and a provider is chosen, there is an autofax function that notifies the provider. Behavioral Health, because of the confidential nature of admission, requires asking patients if they would like their PCP notified of admission.<br>The Director of Advanced Clinical will elevate a change request to the administrators of our electronic health record, behavioral health documentation. (attachment 7)<br>The current admission assessment requires the nurse to ask the patient who their PCP is but does not provide a documentation solution for whether the patient would like the PCP notified nor an option to document that notification has been completed. A data element for each of these questions will be requested as an add to documentation.<br>The autofax option is in place and was not clearly articulated at the time of survey. Adding documentation rows to the electronic health record will allow nurses to adequately chart notification of the PCP, if desired by the patient.<br>Family member/representative notification: The Director of Advanced Clinical will elevate a change request to the administrators of our electronic health record, behavioral health and inpatient documentation regarding addition of a field for requests for staff to notify family member/friend of admission and field for documenting notification has been completed. | 09/01/2015 |

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| A 133 | Continued From page 9<br>- Patient #1 was a 54 year old female admitted to the Mental Health Unit of the facility on 4/01/15. Her diagnoses included bipolar 1 disorder with manic with psychotic features. There was no documentation in Patient #1's medical record indicating she had been asked if she wanted the facility to notify a personal physician of her admission.<br><br>- Patient #3 was a 32 year old female admitted to the facility on 4/17/15, for care related to a hernia repair. Documentation was not found in her medical record indicating she had been asked if she wanted the facility to notify a family member/representative or personal physician of her admission.<br><br>- Patient #4 was a 35 year old female admitted to the facility on 5/03/15, for delivery of a male infant. Documentation was not found in her medical record indicating she had been asked if she wanted the facility to notify a family member/representative or personal physician of her admission.<br><br>The Director of Advanced Clinical & Meaningful Use Coordinator was interviewed on 7/07/15, beginning at 1:05 PM. She reviewed the inpatient admission records of Patients #1, #3 and #4 and confirmed she did not see documentation of family members/patient representative notification of admission for Patients #3 and #4. She also said she did not see documentation of notification of personal physicians for Patients #1, #3 or #4.<br><br>The Director of the Mental Health Unit was interviewed on 7/07/15, beginning at 1:51 PM. She stated patients were asked if they wanted a family member or representative notified of their | A 133 | While awaiting approval and implementation of the change request, nursing will be advised by Advanced Clinicals Director to document notification of family member/representative or physician, as desired by the patient in the comment field. An audit of documentation will be conducted by the department director or charge nurse designee in Behavioral Health, Family Maternity and Med/Surg units beginning September 1. Review will be completed on, at minimum, 50% of admitted patients for 30 days or until 100% compliance is achieved, whichever is longer.<br>Audit results will be reported to Quality Results Committee (MEC) and the CEO for determination of ongoing audit need<br>Responsible Party:Directors of respective departments | |

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| A 133 | Continued From page 10<br>admission during the initial, psychiatric-social assessment. The Director of the Mental Health Unit also said she was not aware of a hospital process or document instructing staff to ask patients if they wanted their family/personal physicians notified of their admission.<br><br>The hospital did not have a uniform process in place to ensure patients were asked if they wanted family members or representatives and/or a personal physician notified of their admission. | A 133 | | |
| A 168 | 482.13(e)(5) PATIENT RIGHTS: RESTRAINT OR SECLUSION<br><br>The use of restraint or seclusion must be in accordance with the order of a physician or other licensed independent practitioner who is responsible for the care of the patient as specified under §482.12(c) and authorized to order restraint or seclusion by hospital policy in accordance with State law.<br><br>This STANDARD is not met as evidenced by:<br>Based on staff interview and review of hospital policy and medical records, it was determined the hospital failed to ensure restraint use was in accordance with the order of a physician or other LIP for 2 of 2 patients placed in behavioral restraints in the ED (#12 and #17) whose medical records were reviewed. This resulted in unauthorized restraint use. Findings include:<br><br>1. The "Restraint/Seclusion" policy, dated 6/03/14, was reviewed. The policy included, but was not limited to the following information:<br><br>- "An order for restraint or seclusion must be obtained from an LIP/physician who is | A 168 | A168<br>In investigating the issues around inability to locate provider orders for restraints from the emergency department, it was found that a hard copy paper order form is being used to ensure timeliness of the order being documented as the providers' practices are to be at bedside and communicate the order to the RN after assessment of the patient. The form being used to document the order and 1 hour face to face did not have a bar code and therefore did not scan to the orders section of the legal medical record. The form has been updated by the quality specialist and has replaced the new form as of July 10, 2015. (attachment #1)<br>Education regarding ensuring the form is fully complete and added to the paper chart was provided by the emergency department director to all RN staff at mandatory staff meetings completed the week of July 21, 2015 (items covered attachment #6).<br>100% of restrained patient charts will be audited (attachment #4) for physician order by the emergency department director or designee and reported to Quality Results Committee (MEC) and the CEO for determination of ongoing audit need.<br>Responsible Party:Director of Emergency Department | 09/01/2015 |

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| A 168 | Continued From page 11<br>responsible for the care of the patient prior to the application of restraint or seclusion."<br><br>This policy was not followed. Examples include:<br><br>a. Patient #12 was a 52 year old male seen in the ED on 4/01/14, after being brought into the ED by police and placed on an involuntary hold due to suicidal and homicidal ideation. Nursing documentation indicated physical restraints were initiated on 4/01/15 at 5:40 PM. The time of discontinuation of restraints was not indicated in Patient #12's record. There was no order documented in the record, by a physician or other LIP, for restraints for Patient #12. This was confirmed by the Director of Advanced Clinicals and Meaningful Use Coordinator during interview on 7/08/15 at 1:20 PM.<br><br>b. Patient #17 was a 45 year old female seen in the ED on 4/15/15 and 4/16/15, for care related to a drug overdose. Nursing documentation indicated Patient #17 was placed in locking synthetic leather restraints (number or limbs not documented) at 4/15/15 at 9:50 PM, related to violent behavior. The physician's order for restraints was dated 4/16/15 at 2:38 AM, more than 4 hours after initiation of restraints.<br><br>An ED RN and the Director of Advanced Clinicals and Meaningful Use Coordinator were interviewed together at 7/08/15 at 12:45 PM. The ED RN stated there should have been a hard copy of an order written at the time of restraint initiation and scanned into Patient #17's medical record by the Medical Records Department. She confirmed the hard copy of the order was not in the record and she did not know why. | A 168 | | |

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| A 168 | Continued From page 12<br>The use of restraint was not in accordance with the order of a physician or other licensed independent practitioner for Patient #12 and Patient #17 in accordance with hospital policy. | A 168 | | |
| A 173 | 482.13(e)(8) PATIENT RIGHTS: RESTRAINT OR SECLUSION<br><br>[Unless superseded by State law that is more restrictive,]<br>(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.<br><br>This STANDARD is not met as evidenced by:<br>Based on staff interview and review of hospital policy and medical records, it was determined the that the hospital failed to ensure restraints used to ensure the physical safety of the non-violent or non-self-destructive patients, were renewed in accordance with hospital policy. This directly impacted 2 of 2 patients (#13 and #14) who were restrained for medical reasons. This resulted in unauthorized restraint use. Findings include:<br><br>1. The "Restraint/Seclusion" policy, dated 6/03/14, was reviewed. The policy stated an order for restraint for non-violent or non-self destructive behavior "must not exceed twenty-four hours for the initial order" and "a new order must be written each calendar day." The hospital's policy was not followed in the following examples:<br><br>a. Patient #13 was a 72 year old male admitted to the critical care unit of the hospital on 6/26/15. Nursing notes documented continuous upper extremity soft wrist restraints from 6/26/15 at 9:15 | A 173 | A173<br>Hospital policy regarding non-violent restraints states that the initial order may be written for up to 24 hours and subsequent orders will be written each calendar day. Reeducation to the staff in the ICU will be conducted by the manager of ICU or designee regarding to all ICU RNs calendar day orders for providers. Provider education materials will be updated by the CNO to clarify the requirement to write a new order each calendar day (attachment #2).<br>100% of restrained patient charts will be audited (attachment #4) for physician order by the Behavioral Health, Med/Surg, ICU director or designee and reported to Quality Results Committee and the CEO for determination of ongoing audit need.<br>Audit results will be reported to Quality Results Committee (MEC) and the CEO for determination of ongoing audit need<br>Responsible Party:<br>Directors of respective departments | 09/01/2015 |

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| A 173 | Continued From page 13<br>PM until 7/05/15 at 11:00 AM.<br><br>Physician orders for upper extremity bilateral wrist restraints were documented at the following dates and times for 24 hours each time:<br><br>- 6/26/15 11:16 PM<br>- 6/28/15 6:27 PM<br>- 6/29/15 4:56 PM<br>- 7/01/15 4:00 PM<br>- 7/02/15 9:34 AM<br>- 7/02/15 4:00 PM<br>- 7/03/15 4:00 PM<br>- 7/04/15 9:11 AM<br><br>There were no orders present for the following times when Patient #13 was in bilateral wrist restraints:<br><br>- 6/27/15 at 11:16 PM until 6/28/15 at 6:27 PM<br>- 6/30/15 at 4:56 PM until 7/01/15 at 4:00 PM<br>- 7/05/15 at 9:11 AM until 7/15/15 at 11:00 AM<br><br>Orders "per calendar day," were missing on 6/27/15, 6/30/15, and 7/05/15.<br><br>The Director of Advanced Clinical & Meaningful Use Coordinator reviewed Patient #13's record on 7/07/15 at 1:35 PM with the surveyor and confirmed there were missing orders for restraints.<br><br>b. Patient #14 was a 78 year old female, admitted to the hospital on 6/08/15, for surgery related to lumbar stenosis. The hospital's restraint log indicated Patient #14 was restrained from 6/12/15 at 12:00 PM until 6/16/15 at 11:45 AM.<br><br>Physician orders for bilateral upper extremity | A 173 | | |

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| A 173 | Continued From page 14<br>restraints were documented at the following dates and times for 24 hours each time:<br><br>- 6/11/15 at 12:04 PM<br>- 6/12/15 at 5:30 PM<br>- 6/13/15 at 9:00 PM<br>- 6/15/15 at 6:44 PM<br><br>There were no orders present for the following times when Patient #14 was restrained:<br><br>- 6/13/15 at 5:30 PM until 6/13/15 at 9:00 PM<br>- 6/14/15 at 9:00 PM until 6/15/15 at 6:44 PM.<br><br>An order "per calendar day," was missing on 6/14/15.<br><br>The Director of Advanced Clinical & Meaningful Use Coordinator reviewed Patient #14's record on 7/07/15 at 1:35 PM, with the surveyor and confirmed there were missing orders for restraints.<br><br>Restraints used to ensure the physical safety of the non-violent or non-self-destructive patients, were not renewed every 24 hours as authorized by hospital policy. | A 173 | | |
| A 176 | 482.13(e)(11) PATIENT RIGHTS: RESTRAINT OR SECLUSION<br><br>Physician and other licensed independent practitioner training requirements must be specified in hospital policy. At a minimum, physicians and other licensed independent practitioners authorized to order restraint or seclusion by hospital policy in accordance with State law must have a working knowledge of hospital policy regarding the use of restraint or | A 176 | A-176<br>Hospital policy is that physicians and other LIPs authorized to order restraint will have a working knowledge of the policy on the use of restraint and seclusion. A provider fact sheet (attachment #2) with provider specific information and a resource for obtaining the full policy has been added to new hire physician orientation. | 09/01/2015 |

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| A 176 | Continued From page 15<br>seclusion.<br><br>This STANDARD is not met as evidenced by:<br>Based on staff interview and review of hospital policy and staff orientation documents, it was determined the hospital failed to ensure physicians and other LIPs had a working knowledge of hospital policy regarding the use of restraint or seclusion. This had the potential to interfere with patient safety and lead to inappropriate continued restraint use. Findings include:<br><br>1. The "Restraint/Seclusion" policy, dated 6/03/14, was reviewed. The policy stated "Physicians and other LIPs authorized to order restraint will have a working knowledge of this policy on the use of restraint and seclusion."<br><br>A page of physician orientation was provided for review that included information provided to physicians at orientation. There was a half a page of information related to "Restraint and seclusion" and a referral to the hospital's restraint and seclusion policy for more information.<br><br>The Medical Staff Coordinator was interviewed on 7/08/15, beginning at 9:14 AM. She said reminders of necessary education were emailed at various times throughout the year, including reminders concerning restraint training. She indicated physicians were prompted to review the restraint policy and the 1 page document previously discussed. She stated physicians were not required to provide proof of competency or attest that they have reviewed the restraint policy.<br><br>An ED physician was interviewed by telephone on | A 176 | At that time will sign an attestation (attachment #3) of their working knowledge regarding the use of restraints/seclusion.<br>The provider fact sheet will be provided to 100% hospitalists, psychiatric and emergency department physicians before September 1, 2015 by the medical staff coordinator. Reeducation will be completed periodically, no less than every 2 years.<br>Completion of current provider attestations will be reported to Quality Results Committee (MEC).<br>Responsible Party: Medical Staff Coordinator | |

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| A 176 | Continued From page 16<br>7/08/15 at 10:06 AM. When asked about his understanding of the face-to-face requirement for restraints used to manage violent or self-destructive behavior, he stated he was not sure of the specific requirements and he was not sure they applied to the ED setting since providers were in and out of the room and would likely see a patient within one hour of initiation of restraints. He stated nurses usually document "doctor in room" which would be evidence a face-to-face was conducted.<br><br>The hospital failed to ensure physicians had a working knowledge of restraint policy.<br><br>2. Refer to A184 as it relates to the failure of the hospital to ensure patients were assessed within one hour of the application of behavioral restraints. | A 176 | | |
| A 184 | 482.13(e)(16)(i) PATIENT RIGHTS: RESTRAINT OR SECLUSION<br><br>When restraint or seclusion is used, there must be documentation in the patient's medical record of the following:<br><br>The 1-hour face-to-face medical and behavioral evaluation if restraint or seclusion is used to manage violent or self-destructive behavior.<br><br>This STANDARD is not met as evidenced by:<br>Based on staff interview and review of hospital policies and medical records, it was determined the hospital failed to ensure a face-to-face evaluation was conducted within one hour of application of behavioral restraints to assess the patient's immediate situation, the patient's reaction to the intervention, the patient's medical | A 184 | A184<br>Providers will be reeducated on the 1 hour face to face and other policy components by the medical staff coordinator using the restraint fact sheet.<br>In order to assist in completing the 1 hour face to face, a paper format was added to the paper emergency department order form (attachment #1) highlighting the requirements. New, electronic emergency department templates will be provided to emergency department providers as part of a late fall update, this year. One component of the health record update is an electronic 1 hour face to face note. Education on use of the updated notes will be provided by the advanced clinical team after the update is available.<br>In inpatient psychiatric services, a template is available. The director of advanced clinical will meet with the inpatient providers and provide education regarding use of the template. | 09/01/2015 |

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| A 184 | Continued From page 17<br>and behavioral condition, and the need to continue or terminate the restraint or seclusion, for 2 of 2 ED patients (#12 and #17) whose medical records were reviewed. Findings include:<br><br>The hospital's "Restraint/Seclusion" policy, dated 6/03/14, was reviewed. The policy included, but was not limited to, the following information:<br><br>"a. A face-to-face assessment by a physician or LIP, RN or physician assistant with demonstrated competence, must be done within one hour of restraint or seclusion initiation or administration of medication to manager violent or self-destructive behavior that jeopardized the immediate physical safety of the patient, a staff member, or others. At the time of the face-to-face assessment, the LIP/physician/RN/PA will:<br><br>1) Work with staff and patient to identify ways to help the patient regain control<br><br>2) Evaluate the patient's immediate situation<br><br>3) Evaluate the patient's reaction to the intervention<br><br>4) Evaluate the patient's medical and behavioral condition<br><br>5) Evaluate the need to continue or terminate the restraint or seclusion<br><br>6) Revise the plan of care, treatment, and services as needed<br><br>Note: A telephone call or telemedicine methodology does not constitute face-to-face | A 184 | 100% of restrained patient charts will be audited (attachment #4) for 1 hour face to face by the ICU, ED and Mental Health director or designee and reported to Quality Results Committee (MEC) and the CEO for determination of ongoing audit need. Responsible Party: Directors of respective departments and medical staff coordinator. | |

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| A 184 | Continued From page 18<br>assessment.<br><br>b. When the 1 hour face-to-face is performed by a RN or physician assistant with demonstrated competence, the following must occur:<br><br>1) The RN or physician assistant with demonstrated competence must consult the attending physician or LIP who is responsible for the care of the patient as soon as possible after the completion of the 1-hour face-to-face evaluation. ('As soon as possible' is to be as soon as the attending physician is able to be reached by phone or in-person.) A consultation that is not conducted prior to renewal of the order would not be consistent with the requirement "as soon as possible."<br><br>2) The consultation should include, at a minimum, a discussion of the findings of the 1 hour face-to-face evaluation, the need for other treatments, and the need to continue of discontinue the use of restraint or seclusion.<br><br>3) If a patient who is restrained or secluded for aggressiveness or violence quickly recovers and is released before the physician arrives to perform the face-to-face assessment, the physician must still see the patient face-to-face to perform the assessment within 24 hours after the initiation of restraint or seclusion."<br><br>The records of 2 ED patients who were restrained in the ED for violent or self-destructive behavior were reviewed. There was no documentation to confirm a qualified individual conducted a face-to-face evaluation within one hour of initiation of restraints to manage violent or self-destructive behavior. Examples include: | A 184 | | |

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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 184 | Continued From page 19<br><br>a. Patient #12 was a 52 year old male who was seen in the ED on 4/01/14 after being brought to the ED by police, and placed on an involuntary hold, due to suicidal and homicidal ideation. Nursing documentation indicated physical restraints were initiated on 4/01/15 at 5:40 PM. The time of discontinuation of restraints was not indicated in Patient #12's record. There was no documentation that Patient #12 was evaluated face-to-face for Patient his reaction to the restraints, behavioral condition, and the need to continue or terminate restraints. This was confirmed by the Director of Advanced Clinicals and Meaningful Use Coordinator and an ED RN during an interview on 7/08/15 at 12:45 PM.<br><br>b. Patient #17 was a 45 year old female who was seen in the ED on 4/15/15 and 4/16/15 for care related to a drug overdose. Nursing documentation indicated Patient #17 was placed in locking synthetic leather restraints (number or limbs not documented) at 4/15/15 at 9:50 PM related to violent behavior. There was no documentation that Patient #17 was evaluated face-to-face for her reaction to the restraints, behavioral condition, and the need to continue or terminate restraints.<br><br>An ED physician was interviewed by telephone on 7/08/15 at 10:06 AM. When asked about his understanding of the face-to-face requirement for restraints used to manage violent or self-destructive behavior, he stated he was not sure of the specific requirements and he was not sure they applied to the ED setting since providers were in and out of the room and would likely see a patient within one hour of initiation of restraints. He stated nurses usually document | A 184 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 130014 | A. BUILDING _____ B. WING _____ | C 07/09/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WEST VALLEY MEDICAL CENTER | 1717 ARLINGTON STREET CALDWELL, ID 83605 |

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|---|---|---|---|---|
| A 184 | Continued From page 20<br>"doctor in room" which would be evidence a face-to-face was conducted.<br><br>The hospital failed to ensure patients restrained in the ED for behavioral reasons received a one hour face-to-face assessment related to the use of the restraints. | A 184 | | |

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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September 2, 2015

Betsy Hunsicker, Administrator
West Valley Medical Center
1717 Arlington Street
Caldwell, ID 83605

Provider #130014

Dear Ms. Hunsicker:

An unannounced on-site complaint investigation was conducted from July 6, 2015 to July 9, 2015 at West Valley Medical Center. The complaint allegations, findings, and conclusions are as follows:

**Complaint #ID00007020**

**Allegation #1:** The hospital did not allow visitors at the patient's request.

**Findings #1:** During the investigation, several patients and hospital staff were interviewed. Additionally, seventeen patient records and information concerning Patient Rights, including hospital visitation rights and visitation rules specific to the Mental Health Unit, were reviewed.

Patients were interviewed on the Mental Health Unit and Orthopedic Floor concerning visitation rights. The patients said family and friends were allowed to visit without staff interference. Patients who were interviewed on the Mental Health Unit stated there were specific times visitors were allowed on the unit, and that the times could be found in the unit's handbook.

One of the patients who was interviewed on the Mental Health Unit said she had been allowed special visitation with a family member outside the documented visitation hours. She also stated she spoke with her social worker to arrange the visit.

Visitation rights for the hospital were included on the "Conditions of Admission and Consent for Outpatient Care." The document included, "...Further I understand that the hospital may need to place clinically necessary or reasonable restrictions or limitations on my visitors to protect my health and safety in addition to the health and safety of other Patients. The hospital will clearly explain the reason for any restrictions or limitations if imposed. If I believe my rights have been violated, I or my representative has the right to utilize the hospital's complaint resolution system."

According to an RN on the Mental Health Unit, and the Director of the unit, it was the practice on the unit to give patients a "PATIENT AND FAMILY HANDBOOK" when admitted to the unit and review the information with the patient. The handbook contained a section concerning "Visitors." The section of the document included, "...Visiting hours are from 6:15 to 7:15 pm Monday through Saturday. Visiting on Sunday will be from 1:00 to 2:15 PM...Visitors under the age of 16 are not allowed due to the acute nature of the unit. Exceptions can be made through the social worker and/or charge nurse for a special visit...If visitors need to come at a time other than visiting hours please advise them to check with the charge nurse or social worker. Some exceptions may be made in regard to visiting hours for therapeutic reasons with clinical staff approval..."

One patient record included information about a 47 year old male who was admitted on 5/21/15 to the hospital's Mental Health Unit. The patient presented to the hospital's ED after having attempted suicide for the second time in two weeks. The patient's "Discharge Summary" indicated he had taken 300 units of another individual's short-acting insulin. The document also included the patient was stabilized using IV glucose, but was transferred to the ICU for further blood sugar monitoring, before he was later transferred to the Mental Health Unit.

Contained within the patient's record was a document titled "Acknowledgement of Unit Rules." The document was signed by the patient on 5/22/15. The document included, "...I have read and understand the unit rules. I agree to abide by them....I have read and understand the patient rights and responsibilities..."

It could not be verified that patients were not allowed to visit with family members at appropriate times.

**Conclusion #1:** Unsubstantiated. Lack of sufficient evidence.

**Allegation #2:** The hospital did not inform/educate the patient about medications he was given. The patient was not allowed the option to refuse treatment/medication.

**Findings #2:** During the investigation, several patients and hospital staff were interviewed, and seventeen patient records were reviewed.

Patients were interviewed on the Mental Health Unit and Orthopedic Floor concerning medication therapy and the right to refuse treatment and/or medications. The patients said they had no complaints about medication regimens. Patients also stated the nursing staff provided education about all medications that were prescribed.

A patient on the Orthopedic Floor stated the nursing staff provided routine education about her medications. She said written information had been provided about some of her medications. Though the patient stated she had not refused any of her medications, she said she would do so if she felt it necessary.

One of the patients who was interviewed on the Mental Health Unit said the nursing staff explained what each medication was for and the potential side effects each time medications were administered. She also stated nurses provided medication education classes that occurred routinely on the unit. The patient also said she had never refused a medication, but she felt comfortable doing so.

The Mental Health Unit Director and Clinical Nurse Supervisor for the Mental Health Unit were interviewed on 7/07/15. They discussed the process for beginning patients on new medications. Both stated medication education is an important focus on the unit. They stated all medications are thoroughly discussed during each medication pass. Additionally, they stated medication education groups are routinely conducted by nursing staff, and patients, if able, are required to attend.

One patient record included information about a 47 year old male who was admitted on 5/21/15 to the hospital's Mental Health Unit and discharged on 5/24/15. The patient presented to the hospital's ED after having attempted suicide for the second time in two weeks. The patient's "Discharge Summary" indicated he had taken 300 units of another individuals short-acting insulin. The document also included the patient was stabilized using IV glucose, but was transferred to the ICU for further blood sugar monitoring, before he was later transferred to the Mental Health Unit.

Contained within the patient's medical record, was a document titled, "PSYCHIATRIC EVALUATION." The document included "...INFORMED CONSENT: He was apprised of the risks and benefits of pharmacotherapy and did consent to the proposed treatment regimen."

Evidence could not be found indicating patients were not educated about their medications or that patients were not allowed to refuse treatment/medication.

**Conclusion #2:** Unsubstantiated. Lack of sufficient evidence.

**Allegation #3:** Hospital staff ignored the patient when he reached the unit, delaying treatment. Staff was rude and unprofessional, treating the patient with disrespect.

**Findings #3:** During the investigation, several patients were interviewed. Hospital staff were observed and interviewed. Seventeen patient records were reviewed.

Patients were interviewed on the Mental Health Unit and Orthopedic Floor concerning communication with hospital staff. The patients who were interviewed said they found staff to be polite and professional.

Staff was observed while speaking with patients and family members. Staff were found to have conducted themselves in a professional manner and treated others with respect and dignity.

Evidence could not be found indicating staff was rude or unprofessional when communicating with patients or that treatments were delayed.

While the complaint could not be substantiated due to a lack of sufficient evidence, it is possible staff did not behave in an entirely professional manner, causing a patient to feel he/she had not been treated with respect.

**Conclusion #3:** Unsubstantiated. Lack of sufficient evidence.

**Allegation #4:** The patient was not provided information or instructions about how to file a grievance.

**Findings #4:** The hospital failed to provide information or instructions about how to file a grievance.

During the complaint investigation, seventeen patient records were reviewed, six grievance records were reviewed, policies were reviewed, staff were interviewed, and patient rights information, including hospital grievance documentation, was reviewed.

There was evidence found that indicated the hospital failed to provide a process that clearly informed patients who to contact to file a grievance or the procedure for patients to submit a written and/or verbal grievance. Additionally, the hospital did not inform patients of time frames for review and response time to grievances.

The hospital's policies and patient rights documents lacked necessary information, and hospital policies were not followed. Examples include:

* "Patient/Family Complaint and Grievance," dated 10/12/10, stated the following.

"Each patient and/or the patient's representative will be informed of the grievance process, including whom to contact to file a grievance or complaint. The patient will be informed that a grievance maybe directly lodged with the Idaho Bureau of Facility Standards or the Joint Commission, regardless of whether he/she has first used the organization's grievance process."

However, the policy did not inform patients of whom to contact, within the facility, to file a grievance.

* A framed document containing patients' rights information was observed in the lobby area of the facility on 7/07/15 at approximately 11:12 AM. The poster included information on how to file a written or verbal complaint with the Joint Commission, Bureau of Facility Standards and the facility's parent company, HCA. The poster did not provide the name or contact information for the individual(s), in the facility, patients or representatives could contact to file a grievance.

* An undated patient handout, "Your Patient Rights and Responsibilities," was reviewed. Although the handout included information about how to file a written or verbal complaint with the Joint Commission and Bureau of Facility standards, it did not provide the name or phone number of an individual(s), within the facility, patients' could contact to file a grievance.

* The hospital's policy "Patient/Family Complaint and Grievance," dated 10/12/10, did not include how patients would be informed of the hospital's grievance process, including how to file a written and verbal grievance with the hospital.

* A patient handout titled, "Your Patient Rights and Responsibilities," was reviewed. Although the handout included information on how to file a written or verbal grievance with the Joint Commission and Bureau of Facility standards, it did not inform the patient how to file a verbal or written grievance directly with the hospital or a phone number to call. The Interim Patient Advocate was interviewed on 7/07/15 at 11:12 AM and confirmed this information.

* The hospital's policy "Patient/Family Complaint and Grievance," dated 10/12/10, also included "Upon receipt of a grievance, the Risk Manager, House Supervisor, or other designee of the organization, will confer with the patient and/or patient representative within seven days of receipt of the grievance..." The policy also stated, "...If the grievance will not be resolved, or if the investigation is not or will not be completed within seven days, the complainant should be informed that the facility is still working to resolve the grievance and that the facility will follow-up with a written response within 21 days." Two of the six grievance records reviewed showed the hospital did not respond within the time frame specified in hospital policy.

* The hospital's policy "Patient/Family Complaint and Grievance," dated 10/12/10, was reviewed. The policy stated "In resolution of the grievance, a written notice of the decision must be provided to the complainant that contains the name of the facility contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance investigation, and the date of completion." Four of the six grievances reviewed, did not include a date of completion. The Interim Patient Advocate was interviewed on 7/07/15 at 11:15 AM, and confirmed this information.

The hospital failed to ensure a clear, complete grievance process was established and policies were followed.

The following deficiencies were cited related to the hospital's grievance process:
- 42 CFR 482.13(a)(2) for failure to inform patients who to contact within the hospital to file a grievance.
- 42 CFR 482.13(a)(2)(i) for failure of the hospital to establish a clearly explained procedure for patients to submit written and verbal grievances to the hospital.
- 42 CFR 482.13(a)(2)(ii) for failure of the hospital to ensure patients' grievances were responded to within the time frames established in hospital policy, or patients notified of a delay.
- 42 CFR 482.13(a)(2)(iii) for failure of the hospital to ensure written responses to patients' grievances included the date of completion.

**Conclusion #4:** Substantiated. Federal 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 was 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,

Sylvia Creswell for

REBECCA LARA
Health Facility Surveyor
Non-Long Term Care

Sylvia Creswell

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

RL/pmt