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December 23, 2015

Doug Crabtree, Administrator
Eastern Idaho Regional Medical Center
PO Box 2077
Idaho Falls, ID 83403-2077

Provider #130018

Dear Mr. Crabtree:

An unannounced on-site complaint investigation was conducted from September 28, 2015 to September 29, 2015 at Eastern Idaho Regional Medical Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00006749

Allegation #1: Patients and family members are not included in care planning.

Findings #1: During the investigation, record reviews and interviews with patients, family members, and facility staff were completed.

Records of 18 patients were reviewed for documentation of patient and family involvement in the plan of care for each patient. Five of those were open records of patients who were currently in the facility at the time of the survey.

One record reviewed was that of an 80 year old female who was admitted to the facility on 10/14/14, following a stroke. The patient was in the facility for nine days, her record included physician dictated progress notes each day, which described discussion of the plan of medical care with the patient and her family members. The medical record also included documentation the nursing staff updated the patient and her family and solicited input related to her plan of care on a daily basis.

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Interviews were conducted with two patients' families that were in the hospital at the time of the investigation. Both families verbalized confirmation that the facility staff kept them informed and included in the plan of care. All patients' records indicated they and/or family members were involved in the care planning process.

The allegation that the facility failed to include patients and/or family members in the plan of care could not be verified through the investigative process.

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: The hospital staff are not aware of patients' physician orders and plans of care.

Findings #2: During the investigation, record reviews and interviews with facility staff were completed. Patients' records reflected implementation of physician orders and care plan interventions.

One record was that of an 80 year old female who was admitted to the facility on 10/14/14, for care related to a stroke. The record included documentation by the nursing staff of changes to the plan of care as the physician orders were written. The record included notations by each of the physician orders that indicated the RN had noted the orders, with the date and time.

Interviews with 2 RNs were completed on 9/28/15. The RNs were able to discuss the plan of care and current physician orders for their patients. One RN stated ancillary staff such as a therapist, may not know the most recent plan of care, especially if a patient was going for a procedure or surgery that was scheduled after their most recent therapy visit. The RN stated they attempted to keep staff involved in the care of a patient updated.

Concerns regarding plans of care and physicians' orders were not found in the other patients' records reviewed.

The allegation that the staff were not aware of physician orders and plans of care could not be substantiated.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: Nursing staff are unaware of how to administer medications through a feeding tube.

Findings #3: During the investigation, record reviews and interviews with patients, family members, and facility staff were completed.

One RN was interviewed on 9/29/15, she described how she administered medications through a feeding tube. She stated feeding tubes were common on her nursing unit, and she felt comfortable caring for patients who had them. Additionally, the RN stated when she had nursing students assigned to her patients, she was a resource for procedures and would expect the students to contact her for supervision before medications were administered.

Two family members of patients were interviewed on 9/29/15. One was the husband of a patient on the medical floor. He stated the staff appeared confident with caring for his wife's tube feedings and administering her medications through the feeding tube. Another family member of a patient in ICU stated she observed much of her daughter's care, and the staff appeared competent with her tube feedings and medication administration.

One record reviewed was that of an 80 year old female who was admitted to the facility on 10/14/14, for care related to a stroke. Her record included documentation that she had an inadequate swallow and a feeding tube was placed to provide nutrition until she would be able to safely swallow. The record also included documentation the patient was cared for by a nursing student on 10/20/14 and 10/21/14. The RN assigned to the patient provided oversight for the nursing student during the time the student provided care.

It could not be proven through the investigative process that nursing staff were unaware of how to administer medications through a feeding tube.

Conclusion #3: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: The nursing staff did not maintain patients' IVs. Patients suffer multiple IV attempts, and several IVs are inserted and maintain, whether they are needed or not.

Findings #4: During the investigation, record reviews and interviews with facility staff were completed.

Patients' records reviewed included identification of IV sites and the status of them.

One record was that of an 80 year old female that was admitted to the facility on 10/14/14, for care related to a stroke. The record included documentation by the nursing staff of assessments of the IV site(s). The documentation was easy to follow, as each IV site was sequentially numbered. The record included nursing documentation each shift which included the IV number, location, date of the IV insertion, and a description of the site.

- IV #1 was in the patient's right hand, it was started on 10/14/14, the day of her admission. The IV remained in place until 10/20/14. The nursing documentation noted the IV was patent, and no fluids were infusing through the site.

- IV #2 was started on 10/15/14, placed in her left arm, and remained in place until 10/20/15. The nursing documentation noted the IV site was infusing fluids until 10/18/14, at which time it was placed to heparin lock, to keep the IV site open and available for future use.

- IV #3 was started on 10/20/14, placed in her left neck, and remained in place until 10/21/15.

- IV #4 was started on 10/20/14, placed in her right hand, and remained in place until the day of her discharge, 10/23/14.

The patient had a surgical procedure performed on 10/20/14. Her record documented she received antibiotics and other medications via IV route. The attempts at IV insertion were not documented, but the initial assessment after she returned to her room from surgery noted she had three IV's in place.

The patient's record did not include documentation as to the reason IV #1 and #2 were discontinued. However, a Patient Safety Network article recommendation published 9/2012, by the Agency for Healthcare Research and Quality, states to "Replace peripheral IV catheters every 72-96 hours."

During an interview with an RN, she stated if a patient was scheduled for a surgical procedure, and had an IV, the IV would remain in place until after it was no longer needed. She stated the routine for the facility was to flush the IV site once a shift, and document the assessment of the site.

Patients' records reviewed indicated staff followed appropriate IV protocols. It could not be verified that IV sites were established or maintained inappropriately.

Conclusion #4: Unsubstantiated. Lack of sufficient evidence.

Allegation #5: The facility failed to inform, and consult with, patients' personal specialty physicians.

Findings #5: During the investigation, record reviews and interviews with facility staff were completed.

Patient records reviewed documented communication between hospital physicians and patients' personal physicians, where appropriate.

One record was that of an 80 year old female who was admitted to the facility on 10/14/14, for care related to a stroke. The record included physician progress notes that documented that the patient's cardiologist was contacted by the neurologist on 10/20/14, and her case was discussed.

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Additionally, the progress note included a "cc" to her cardiologist, which indicated a copy of the progress note was to be sent to her cardiologist.

The patient record included multiple entries by the physicians involved in her care that documented physician collaboration and communication.

A lack of physician to physician communication could not be confirmed.

Conclusion #5: Unsubstantiated. Lack of sufficient evidence.

Allegation #6: The facility does not facilitate the discharge of patients to facilities in other communities, so patients may be closer to family members.

Findings #6: During the investigation, record reviews and interviews with facility staff were completed.

One record was that of an 80 year old female who was admitted to the facility on 10/14/14, for care related to a stroke. The record included documentation by a social worker, in the form of case management notes regarding discharge planning.

The first case management report was dated 10/15/14, at 3:21 PM, the day following the patient's admission. At that time, the social worker documented she met with the patient, her son, and daughter in law. She noted that options were discussed for rehabilitation, in-patient rehab, versus SNF. She documented the patient's son indicated she could live with him and his wife, who could provide care. Additional documentation by the social worker was completed on 10/16/14, 10/17/14, 10/20/14, 10/22/14, and 10/23/14.

The social worker documented a discharge planning note dated 10/22/14, at 4:18 PM. The note stated that during a phone conversation with the patient's daughter, it was determined that she would be transferred to a SNF in another community. The daughter and the social worker discussed Medicare's payment for ambulance transfer. The social worker documented her experience was that Medicare would not pay for the transfer and the ambulance company would require payment prior to the transport. She stated that the patient's daughter told her she believed that Medicare would pay for the transfer.

A discharge planning note dated 10/22/14 at 5:41 PM, documented the patient's daughter made arrangements for transportation. The social worker noted she faxed orders to the receiving facility, and documented the transfer to the SNF would occur around 2:00 PM the following day.

The allegation that the facility failed to facilitate discharges to skilled nursing facilities in another community could not be verified.

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Conclusion #6: Unsubstantiated. Lack of sufficient evidence.

Allegation #7: The facility failed to recognize that the patient did not have a bowel movement for 10 days.

Findings #7: During the investigation, record reviews and interviews with facility staff were completed.

One record was that of an 80 year old female that was admitted to the facility on 10/14/14, for care related to a stroke. The patient's record documented that initially, she did not eat, and received IV fluids. On 10/16/15 at 4:15 PM, a feeding tube was placed, and NG tube feedings were slowly advanced to determine her tolerance. Her record included documentation she had a gastrostomy tube inserted on 10/20/14, due to her inability to safely take feedings orally.

The patient's record included entries by the nursing staff each shift that documented if she did or did not have a bowel movement. The twice daily nursing assessments were consistent with documenting no bowel movements. However, the assessments also documented an assessment of her bowel sounds, appearance of her abdomen, and efforts to assist her to try and have a bowel movement.

The record included a physician progress note, dated 10/21/14, dictated by her physician that placed the gastrostomy tube that included constipation as a current problem. The progress note indicated a laxative would be administered daily.

A laxative was ordered on 10/21/14, at 2:44 PM, and a bowel stimulant was ordered on 10/21/14 at 9:54 PM. On 10/23/14, at 9:46 AM, the physician ordered enemas, the first one to be performed STAT, and repeated every 30 minutes until results were noted.

In a nursing note on 10/23/14 at 12:00 PM, the RN noted the patient had good results from the enema.

Although the allegation that the patient did not have a bowel movement for 10 days was substantiated, the nursing and medical team were aware of her status, and documentation related to assessments were appropriate.

Conclusion #7: Substantiated. No deficiencies related to the allegation are cited.

Allegation #8: The physician performed a surgical procedure without the patient/family permission.

Findings #8: During the investigation, record reviews and interviews with facility staff were completed.

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One record was that of an 80 year old female that was admitted to the facility on 10/14/14, for care related to a stroke. The record included documentation that on 10/20/14 a procedure was performed to insert a gastrostomy feeding tube.

The patient record included two consents for procedures performed on 10/20/14. One consent included the letterhead of a gastroenterology group. The consent was signed by the patient's POA (Power of Attorney) dated 10/19/14, and authorized any of the 5 partners listed to perform a gastroscopy with possible biopsy. The other consent included the letterhead of the facility. It included authorization for the physician named, or associates as may be selected by the physician to perform a esophagogastroduodenoscopy with percutaneous endoscopic gastrostomy tube placement. The consent also included authorization for any additional procedures that was in the physicians' professional judgement determined to be necessary. The consent was signed by the patient's POA, and dated 10/19/14.

The operative report included documentation that chronic gastritis was noted, and a biopsy of the area was performed. The surgeon documented multiple ulcers that were treated with thermal therapy.

The allegation that a surgical procedure was performed without permission was unsubstantiated.

Conclusion #8: Unsubstantiated. Lack of sufficient evidence.

Allegation #9: The nursing staff treat patients unnecessarily rough when performing hygiene.

Findings #9: During the investigation, record reviews and interviews with facility staff were completed.

One record was that of an 80 year old female that was admitted to the facility on 10/14/14, for care related to a stroke. The record included documentation by an RN, "She is not happy with nurse or cares. She accuses nurse of not being gentle. RN being very gentle with repositioning." An additional note by the RN documented the patient's affect was flat, and "irritable, does not like to be touched." The RN noted later in the shift "...gave enema. The patient didn't like it at all. She is angry. She keeps calling for her daughter. RN reassured her and did it as gently as possible. The daughter is in the hall and RN invited her to come in...This is a very angry and/or depressed patient." The RN documented another staff member assisted her with the procedure.

Patient and family members were interviewed during the investigation. The interviews with the patients and family members occurred individually, with no staff present in the room. The individuals who were interviewed stated their care was appropriate, and no one expressed concern that they were handled rough during their cares.

The allegation that the nursing staff was unnecessarily rough could not be substantiated.

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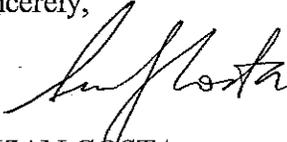
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Conclusion #9: Unsubstantiated. Lack of sufficient evidence.

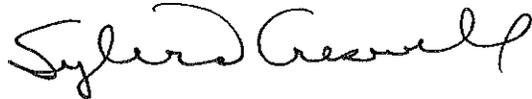
As only one of the allegations was substantiated, but was not cited, no response is necessary.

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,



SUSAN COSTA
Health Facility Surveyor
Non-Long Term Care



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/pmt