IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
OIVISION OF LICENSING & CERTIFICATION
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

October 23, 2015

Karl Keeler, Administrator
Saint Alphonsus Medical Center - Nampa
1512 Twelfth Avenue Road
Nampa, ID 83686

RE: Saint Alphonsus Medical Center - Nampa, Provider #130013

Dear Mr. Keeler:

This is to advise you of the findings of the complaint investigation, which was concluded at your facility on October 1, 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.

Whether you choose to provide a plan of correction or not, please sign and date the form and return it to our office by **November 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,

LAURA THOMPSON
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

LT/pmt
Enclosures

Saint Alphonsus Health System

RECEIVED
NOV - 6 2015
FACILITY STANDARDS

November 5, 2015

Laura Thompson
Sylvia Creswell
Idaho Department of Health and Welfare
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009

Dear Ms. Thompson and Ms. Creswell:

Enclosed please find Saint Alphonsus Medical Center-Nampa's plan of correction (PoC), which is intended to address deficiencies cited during a complaint investigation concluded on October 1, 2015.

The hospital does not admit or concede to a deficiency, but to the extent that an actual deficiency does exist, Saint Alphonsus Medical Center-Nampa is taking appropriate action to correct the deficiency, including the steps outlined in the attached PoC. This plan of correction addresses Medicare tags A395, A800 and A821.

We want to emphasize our absolute commitment to quality patient care and continued efforts to fulfill all regulatory requirements. Please contact either of us if you have questions or concerns regarding these documents.

Sincerely,

Clint Child
Vice President of Patient Care Services/CNO
(208) 463-5599

T. M. Watt RN BSN

Tracy M. Watt
Manager of Performance Improvement
(208) 463-5860

Enclosure

1512 12th Avenue Road, Nampa, Idaho 83686
Phone: (208) 465-5000 | Fax: (208) 465-5068
www.saintalphonsus.org

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130013	A. BUILDING _____ B. WING _____	C 10/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ALPHONSUS MEDICAL CENTER - NAMPA	1512 TWELFTH AVENUE ROAD NAMPA, ID 83686

(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 9/28/15 to 10/01/15. The surveyors conducting the investigation were: Laura Thompson RN, BSN, HFS - Team Leader Nancy Bax RN, BSN, HFS The following acronyms were used in this report: DM - Diabetes Mellitus DVT - Deep Vein Thrombosis ED - Emergency Department EMR - Electronic Medical Record H&P - History & Physical HTN - Hypertension ICU - Intensive Care Unit IV - Intravenous PICC - Peripherally Inserted Central Catheter RN - Registered Nurse SNF - Skilled Nursing Facility UTI - Urinary Tract Infection	A 000	This plan of correction does not constitute an admission of liability on the part of Saint Alphonsus Medical Center-Nampa, and such liability is hereby specifically denied. The submission of the plan does not constitute an agreement by Saint Alphonsus Medical Center-Nampa that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope of severity regarding any of the deficiencies cited are correctly applied. The following acronyms were used in this plan of correction: CNO – Chief Nursing Officer PoC – Plan of Correction SAMC-Nampa – Saint Alphonsus Medical Center- Nampa CNA – Certified Nursing Aide RN – Registered Nurse EMR – Electronic Medical Record	
A 395	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: Based on medical record review and staff interview, it was determined the hospital failed to ensure a comprehensive nutritional admission assessment was conducted by the RN for 2 out of 11 patients (Patient #3 and #8) whose records were reviewed. This failure had the potential to result in delayed patient healing and improvement. Findings include:	A 395	The CNO, Inpatient Nursing Director, Clinical Educator, Manager of Case Management, and Manager of Quality developed and will implement the action plan that delineates the requirements for supervision and evaluation of the nursing care for each patient.	10/27/15

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

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A 395	Continued From page 1 The National Institutes of Health website, accessed 10/05/15, stated "There are many factors that can affect wound healing which interfere with one or more phases in this process, thus causing improper or impaired tissue repair. Wounds that exhibit impaired healing, including delayed acute wounds and chronic wounds, generally have failed to progress through the normal stages of healing. Such wounds frequently enter a state of pathologic inflammation due to a postponed, incomplete, or uncoordinated healing process. Multiple factors can lead to impaired wound healing. Most obvious is that malnutrition or specific nutrient deficiencies can have a profound impact on wound healing after trauma and surgery. Patients with chronic or non-healing wounds and experiencing nutrition deficiency often require special nutrients. Energy, carbohydrate, protein, fat, vitamin, and mineral metabolism all can affect the healing process." 1. Patient #3 was a 75 year old female admitted to the hospital on 9/20/14, with a diagnosis of bacterial sepsis. Additional medical problems included recurrent left leg cellulitis, UTI, history of DVTs (blood clots in the leg), DM Type II, HTN, high cholesterol, and depression. Her record for her hospital admission from 9/20/14 to 9/27/14, was reviewed. Patient #3's record included an Admission Assessment, completed by an RN on 9/20/14 at 12:30 PM. The Admission Assessment included a section for a nutritional screening. The RN documented Patient #3 had a "decreased appetite and ... an open or unhealing wound."	A 395	Action and Implementation: 1. All patients will receive "Nutrition Screening" within 24 hours of admission by nursing staff. The screening, which is part of the patient's complete "Admit Profile" includes: • Recent weight loss without trying • Usual and current weight • Usual and/or specialty diet type • Appetite changes • Nutritional access device(s); tube feedings • Large open wounds or wounds that are not healing 2. Nursing staff (including CNAs, RNs and dietary aides) will document food intake including percent of meal consumed for each meal in the EMR. Education regarding documentation of food intake will be provided for nursing staff. 3. Education will be provided to inpatient managers/directors and case management staff re: clarification of nutrition policy and procedure, as it relates to consults vs. referrals, SAMC-Nampa Registered Dietitian.	10/2/15 11/30/15 11/30/15

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A 395	Continued From page 2 The Nursing Care Plan for Patient #3 did not include a plan, interventions, or goals related to her nutritional screening findings. Additionally, her meal intake was documented twice from 9/20/14 to 9/23/14. The first entry was documented on 9/23/14 at 9:00 AM, 3 days after her admission. The entry stated Patient #3 ate 0% of her meal. The second entry was documented on 9/23/14 at 6:00 PM, and stated Patient #3 had "bites of her meal." Patient #3's record included an order for a nutritional consult dated 9/20/14 at 4:13 PM. The order stated "Nutrition referral placed due to responses on nutrition screening: Decreased appetite. (Calculated Weight change is 0 kg.) Presence of open or unhealing wounds." The nutritional consult was not documented in Patient #3's record until 9/24/14, her fourth day of admission. The nutritional assessment was completed on 9/24/14 at 9:25 AM, by a Registered Dietician. The Registered Dietician documented Patient #3 stated she had no appetite and was requesting cream of wheat or oatmeal. Additionally, the Registered Dietician documented Patient #3's intake was poor and she had consumed less than 25% of her last 3 meals. During an interview on 9/30/15 at 4:40 PM, the Manager of Quality Performance and Improvement reviewed the record. She stated if the RN filling out the Admission Assessment answered yes to any of the questions for the nutritional screening, an order for a nutrition assessment was automatically generated in the EMR. The Manager of Quality Performance and	A 395	4. "Nutrition Care" policy reviewed and modified, as appropriate, by the SAMC-Nampa Registered Dietitian. • Surveyors used terms "referral" and "consult" interchangeably. • Referrals, triggered by nursing assessment, documentation and Malnutrition Screening Tool, are reviewed by dietitian and interdisciplinary team, including wound RN and Case Management team for appropriate referral and follow-up. Not all nutrition referrals require a nutrition consult, as was the case for survey patient #3. Nutrition consult(s) are ordered as deemed necessary based on interdisciplinary review. • All patients receive a nutrition consult, regardless of nutrition status, on or after hospital day 5, as was the case for survey patient #3. Monitoring and Tracking: 1. Audits for complete "Admit Profile" to include "Nutrition Screening" will be performed on 10 randomly selected charts per month X 6 months. Responsibility – Quality Department Manager.	10/29/15 5/1/16

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A 395	Continued From page 3 Improvement confirmed Patient #3's nutritional consultation by the Registered Dietician was not completed until her fourth day of admission. She further confirmed nutrition was not part of the Nursing Care Plan and Patient #3's food intake was not frequently assessed. The RN failed to provide interventions and reassess Patient #3's nutritional needs. 2. Patient #8 was a 50 year old female admitted to the hospital on 10/12/14, with complaints of abdominal pain, nausea and vomiting. Additional medical problems included DM, HTN, chronic kidney disease and depression. Her record for her hospital admission from 10/12/14 to 10/16/14, was reviewed. Patient #8's record included an Admission Assessment, completed by an RN on 10/12/14 at 9:08 PM. The Admission Assessment included a section for a nutritional screening. The RN documented Patient #8 did not have an open or unhealing wound. However, Patient #8's ED record stated she had a hysterectomy and tummy tuck 10 days prior to her ED visit. Additionally, it stated she had a long incision across her lower abdomen that was "reddened and draining purulent material." Patient #8 was initially ordered an NPO diet (no food or drink by mouth) on 10/12/14 at 8:24 PM, related to her nausea and vomiting. On 10/13/14 at 7:25 PM, a carbohydrate consistent diet, with no calorie level specified, was ordered for Patient #8. The American Academy of Family Physicians website, accessed 10/05/15, stated "Suboptimal glycemic control in hospitalized patients with type 2 diabetes mellitus can have adverse	A 395	2. Audits for percent of meal consumed documentation will be performed on 10 randomly selected charts per month X 6 months. Responsibility – Quality Department Manager. 3. Audits for appropriateness of nutrition consult vs referral based on RN assessment documentation. Responsibility – Registered Dietitian. 4. "Nutrition Care" will be updated and approved by Policy Review Committee, as recommended. Responsibility: Policy Review Committee Chair; Quality Department Manager.	5/1/16 10/29/15 12/8/15

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A 395	Continued From page 4 consequences, including increased neurologic ischemia, delayed wound healing and an increased infection rate." Additionally, it stated for patients who are not eating, insulin and some other non-oral source of calories are necessary. During an interview on 9/30/15 at 4:45 PM, the Manager of Quality Performance and Improvement reviewed the record. She confirmed the nutritional screening question related to wounds was answered inaccurately by the RN. The Manager of Quality Performance and Improvement stated a nutritional consultation was likely not ordered because the question was answered inaccurately, and Patient #8 was initially NPO. Patient #8's nutritional screening assessment was inaccurate and failed to generate the need for a consultation by a Registered Dietician. The hospital did not provide adequate RN supervision to ensure comprehensive patient care.	A 395		
A 800	482.43(a) CRITERIA FOR DISCHARGE EVALUATIONS The hospital must identify at an early stage of hospitalization all patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning. This STANDARD is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the hospital failed to ensure post-hospitalization discharge needs were identified early in the admission process. This failure placed patients at risk of adverse health events after discharge, due to lack of needed	A 800	The CNO, Inpatient Nursing Director, Clinical Educator, Manager of Case Management, and Manager of Quality developed and will implement the action plan that delineates the requirements for supervision and evaluation of the criteria for discharge evaluations.	10/27/15

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A 800	Continued From page 5 services. Findings include: A policy, "Discharge Planning," revised October 2013, stated "Registered Nurses complete the nursing admission assessment tool which includes discharge planning assessment questions. Referrals to Clinical Resource Management (CRM)/Case Management (CM) are made based on nursing assessment findings. Such referrals should be made based on, but not limited to initial assessment indicators, perceived need for ongoing community based assistance, request of the family for assistance beyond the scope of the frontline nurse, Licensed Independent Practitioner's (LIP) order, or circumstances involving such issues as current living situations, functional and mobility deficits and needs." The Admission Assessment tool was completed for each patient by the floor RN. The tool included a section, "Functional/Discharge Screening." The questions under this section were related to identifying any perceived or anticipated problems the patient was experiencing prior to or upon admission to the hospital. During an interview on 9/30/15 at 1:55 PM, an RN Case Manager was questioned about the discharge screening process. She stated the initial screening was completed by the floor RN at the time of her initial assessment. The RN Case Manager stated the Admission Assessment included a section for discharge planning. She stated when any of the questions under this section were answered with a yes, a referral was automatically generated for discharge planning in the EMR.	A 800	Action and implementation: 1. Nursing staff education provided: • During staff huddles • During staff meetings • During nursing orientation, regarding the importance of the admission and ongoing assessment of functional/ discharge planning and how that prompts/triggers messages to the physician and Case Manager's Inbox for further evaluation and planning.	12/31/15

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A 800	Continued From page 6 During an interview on 9/30/15 at 11:00 AM, an RN from the Medical/Surgical unit was questioned about the discharge screening process and evaluation of the patients' needs for discharge planning. She stated the evaluation was completed by the Case Manager. The RN stated if discharge questions or needs arise she contacted the Case Manager, or a Social Worker if the need was on an evening or weekend. She confirmed the floor nurses were responsible for completing the Admission Assessment. The RN stated she was not aware questions, related to the discharge screening, automatically generated a referral in the EMR to the Case Management Department. During an interview on 9/30/15 at 11:15 AM, an RN from the ICU was questioned about the discharge screening process and evaluation of the patients' needs for discharge planning. The RN stated discharge planning began at admission with Case Managers visiting the patient to talk with them about their needs. She confirmed floor nurses completed the Admission Assessment. The RN stated she was not aware questions, related to the discharge screening, automatically generated a referral in the EMR to the Case Management Department. During an interview on 9/28/15 at 2:30 PM, the Manager of Case Management stated Case Managers were RNs and were assigned to a specific physician each day. The Manager said Case Managers participated in patient rounds each morning, Monday through Friday, with their assigned physician, and an interdisciplinary team; to discuss patients and assess their needs. She stated the interdisciplinary team could include a	A 800	2. All patients will receive "Functional Screening/Discharge Planning" within 24 hours of admission by nursing staff. The screening, which is part of the patient's complete "Admit Profile" includes: • New difficulties with dressing, bathing, or household activities • Speech, memory, or communication problems within the last 6 months • Strength, balance, or walking problems, within the last 6 months • Chewing, swallowing, coughing, or drinking difficulties, within the last 6 months • Vision or hearing difficulties within the last 6 months • Durable medical equipment use/needs; current or anticipated • Assistive services, current or anticipated • Functional level of activities of daily living at home • Brief discharge plan 3. Develop an orientation process for new and/or graduate nurses to orient to the Case Management and Discharge Planning process by spending up to four hours with Case Management staff.	10/2/15 10/27/15

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A 800	Continued From page 7 Registered Dietician, Therapy Services representative, and a charge RN. The Manager of Case Management stated discharge planning evaluations were completed either by referral from a physician, by a family member request, or through daily rounding with the team. She stated the goal of the department was to see all patients through interdisciplinary rounding. The Manager of Case Management stated this "did not always happen." During an interview on 9/29/15 at 3:45 PM, a second RN Case Manager was questioned about the discharge screening process. She stated she performed discharge planning on "as many patients as we can." The RN Case Manager stated patients' discharge needs were determined through rounding with the interdisciplinary team. She stated a discharge screening was not completed on every patient for discharge planning needs. The Case Management team and floor RNs who completed the Admission Assessments, were not aware of the discharge planning process. Two RNs, 1 Case Manager, and the Manager of the Case Management Department, were not aware that by answering yes to any of the questions in the "Functional/Discharge Screening" section of the Admission Assessment, an order for referral to discharge planning was automatically generated in the EMR. As a result, patients' in need of discharge planning, may not have been identified. The hospital failed to ensure patients' discharge planning needs were identified early in the admission process.	A 800	Monitoring and Tracking: 1. Random live audit during scheduled Clinical Tracers in 2016: • Ask nursing staff how discharge planning process is prompted 2. Audits for complete "Admit Profile" to include "Functional Screening/Discharge Planning" will be performed on 10 randomly selected charts per month X 6 months. Responsibility – Quality Department Manager. 3. Random live audit during scheduled Clinical Tracers in 2017: • Ask nursing staff how discharge planning process is prompted	CY2016 5/1/2016 CY2017

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A 821 A 821	Continued From page 8 482.43(c)(4) REASSESSMENT OF A DISCHARGE PLAN The hospital must reassess the patient's discharge plan if there are factors that may affect continuing care needs or the appropriateness of the discharge plan. This STANDARD is not met as evidenced by: Based on medical record review and staff interview, it was determined the facility failed to ensure discharge plans were reassessed after changes in patient status for 1 out of 10 patients (Patient #8) who received discharge planning and whose record was reviewed. This had the potential to result in patients' post-hospitalization needs not being addressed and inappropriate placement after discharge. Findings include: Patient #8 was a 50 year old female admitted to the hospital on 10/12/14, with complaints of abdominal pain, nausea and vomiting. Additional medical problems included DM, HTN, chronic kidney disease and depression. Her record for her hospital admission from 10/12/14 to 10/16/14, was reviewed. Patient #8's ED record stated she had a hysterectomy and tummy tuck 10 days prior to her ED visit. Additionally, it stated she had a long incision across her lower abdomen that was reddened and draining purulent material. During an interview on 9/28/15 at 2:30 PM, the Manager of Case Management stated discharge planning was completed by the hospital's Case Managers, and documented in Case Management Progress Notes. Patient #8's record included a Case Management	A 821 A 821	The CNO, Inpatient Nursing Director, Clinical Educator, Manager of Case Management, and Manager of Quality developed and will implement the action plan that delineates the requirements for supervision and evaluation of the reassessment of a discharge plan.	

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SAINT ALPHONSUS MEDICAL CENTER - NAMPA	1512 TWELFTH AVENUE ROAD NAMPA, ID 83686

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A 821	Continued From page 9 Progress Note, dated 10/13/14. The note stated an initial assessment was completed. It stated Patient #8 lived in a SNF, and planned to return there following her discharge from the hospital. The note stated the SNF was updated regarding Patient #8's status. Additionally, it stated Patient #8 would be followed for further discharge needs. Patient #8's record did not include additional Case Management Progress Notes. Patient #8's record included a Wound Progress Note completed on 10/14/14, and signed by the wound care RN. The note stated a Wound VAC was placed on Patient #8's abdominal wound. (Wound VACs use foam dressings and a vacuum device to apply negative pressure to a wound for wound healing. The foam dressings are typically changed 3 times a week.) Patient #8's record included a discharge summary dated 10/17/14, signed by her physician. The summary stated she was discharged from the hospital, and returned to the SNF on 10/16/14. Her discharge summary stated she was to continue using the Wound VAC following discharge. Additionally, her discharge summary stated she was to continue intravenous antibiotic therapy through a PICC line for 2 weeks following discharge. Patient #8's record did not include documentation of an update to her discharge plan. Additionally, it did not include documentation of contact with the SNF to coordinate care related to her wound VAC and IV therapy. During an interview on 9/30/15 at 2:45 PM, the Manager of Case Management reviewed Patient #8's record and confirmed there was no	A 821	Action and Implementation: 1. Education for nursing staff caring for patients being discharged to another facility regarding: • Perform final nurse to nurse hand-off over telephone or face-to-face, when appropriate • Document face-to-face hand-off in patients EMR 2. Focused education provided for Case Management staff/Discharge Planners regarding complete discharge plans and evaluation of discharge plans. 3. Focused education regarding complete discharge planning and evaluation of discharge plans included in Case Management staff orientation process. Monitoring and Tracking: 1. Facility has an audit process in place to ensure completeness and reassessment of discharge plans for patients with status changes. Responsibility – Case Management Manager	11/30/15 10/2/15 10/2/15 10/2/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130013	A. BUILDING _____ B. WING _____	C 10/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ALPHONSUS MEDICAL CENTER - NAMPA	1612 TWELFTH AVENUE ROAD NAMPA, ID 83686

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A 821	Continued From page 10 documentation of contact with the SNF to inform them of her wound care and IV therapy needs. The hospital failed to provide updated discharge planning to ensure Patient #8's post-hospitalization needs were met.	A 821		

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
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November 9, 2015

Karl Keeler, Administrator
Saint Alphonsus Medical Center - Nampa
1512 Twelfth Avenue Road
Nampa, ID 83686

Provider #130013

Dear Mr. Keeler:

An unannounced on-site complaint investigation was conducted from September 28, 2015 to October 1, 2015 at Saint Alphonsus Medical Center - Nampa. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00006696

Allegation: The complainant stated she was transferred to a skilled nursing facility without her consent or approval. Consequently, prior to the transfer, she was not provided with a list of skilled nursing facilities from which to choose.

Findings: During the investigation, 10 medical records were reviewed, hospital policies and other hospital documents were reviewed, patients and family members were interviewed and staff was interviewed.

A policy, "Discharge Planning" revised October 2014, was reviewed. The policy stated "The CRM/CM (Clinical Resource Management/Case Manager) will provide discharge/transition planning to facilitate continuity of care for patients discharged or transferred from the hospital to a health care organization or agency to which the patient is discharged to (e.g. Home care, agency, extended care facility, acute care hospital, rehabilitation unit, foster care, assisted living facility, etc.).

When the discharge/transition assessment indicates a need for home care or extended agencies (home care and/or skilled nursing) that are available and serve the geographic are requested by the patient. In the cases where managed care is a factor, the plan identifies agencies that have a contract with the managed care organization. Freedom of choice must be provided to patients. "

During an interview on 9/29/15 at 3:45 PM, an RN Case Manager was questioned about the discharge screening process. The RN Case Manager stated patients' discharge needs were determined through visiting patients in their rooms with the interdisciplinary team. She stated patients were evaluated and, if needed, given a list of facilities to choose from for either home health agencies or skilled nursing facilities.

On 9/28/15, a list of hospital inpatient admissions, from August 2014 through December of 2014, was requested. From this list, 10 medical records were selected for review. Four of ten records included patients which were transferred to a skilled nursing facility upon discharge.

One of the medical records reviewed included a 52 year old female, who was admitted on 9/08/14, for paresis. The record stated the patient was discharged to a skilled nursing facility on 9/11/14. Initially, the patient was admitted for observation on 9/05/14. A Case Manager was assigned to her and met with the patient on 9/05/14. The Case Manager documented the patient lived with her daughter and was alone during the day, without access to a phone while her daughter worked.

On 9/09/14, the Case Manager documented the patient, and her family member, were given a list of skilled nursing facilities from which to choose. Additionally, a staff member, from one of the facilities included on the list, went to the patient's room and talked with her and her daughter. Documentation also said that after meeting with the patient and her daughter, they agreed the patient would be transferred to a skilled nursing facility of their choosing.

On 9/10/14, the Case Manager documented the patient changed her mind and stated she did not want to go to a skilled nursing facility, but wanted to return home, with home health services. The Case Manager also documented the patient was provided a list of home health agencies from which to choose.

The next morning, on 9/11/14, the Case Manager documented she met with the patient at 7:30 AM. Documentation indicated the patient changed her mind about home health services and stated she wanted to go to the skilled nursing facility. The Case Manager documented she made arrangements for transporting the patient by van, to the facility of her choice, on 9/11/14.

Additionally, the medical record included documentation of several discussions between the Case Manager, the patient, and the patient's daughter throughout her stay.
On 9/29/15, beginning at 1:15 PM, the adult surgical unit was visited for a patient interview regarding discharge planning and patient rights. One patient and her family member were interviewed.

The family member stated discharge planning was discussed early on during the admission of her mother. She stated home health services were discussed first, and they were given a list of agencies from which to choose. The daughter of the patient stated the Case Manager "came by a few times and she was very helpful."

On 9/30/15, beginning at 4:05 PM, the adult medical/surgical unit was visited. Patient interviews about discharge planning were conducted, and two patients were interviewed.

One patient stated she remembered hearing staff discuss patient rights, but she did not have an admission folder or paperwork at her bedside. She stated a discharge planner or Case Manager had not yet met with her to discuss discharge planning.

The other patient, who was interviewed, stated she received her admission folder and was aware of her patient rights. She stated the Case Manager came to her room and introduced herself, and left her name and phone number on a whiteboard, in the patient's room.

Each patient was asked about their rights as a patient and whether staff had discussed their pending discharge with them. Four of four patients interviewed stated they received their patient rights information upon admission to the hospital. Three of four patients interviewed stated they were aware of their pending discharge and were involved in their discharge plan. Two of the three patients with discharge plans stated discharge planning and discussion began soon after their admission. None of the patients interviewed expressed dissatisfaction with the hospital's discharge planning process.

It could not be verified that patients were discharged to facilities without their consent or knowledge. However, related deficiencies were cited at 42 CFR 482.43(a) and 42 CFR 482.43(c)(4), as they related to the failure of the hospital to ensure a discharge screening evaluation took place upon admission and patient discharge plans were reassessed according to their needs.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

Sylvia Creswell for

LAURA THOMPSON
Health Facility Surveyor
Non-Long Term Care

Sylvia Creswell

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

LT/pmt

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November 9, 2015

Karl Keeler, Administrator
Saint Alphonsus Medical Center - Nampa
1512 Twelfth Avenue Road
Nampa, ID 83686

Provider #130013

Dear Mr. Keeler:

An unannounced on-site complaint investigation was conducted from September 28, 2015 to October 1, 2015 at Saint Alphonsus Medical Center - Nampa. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00006691

Allegation #1: Patient IVs were not monitored appropriately which resulted in delays in the administration of ordered antibiotics.

Findings #1: During the investigation, 10 medical records were reviewed, hospital policies and other hospital documents were reviewed, 3 patients and 1 family member were interviewed and staff were interviewed.

On 9/28/15, a list of hospital inpatient admissions from August 2014 through December of 2014, was requested. From this list, 10 medical records were selected for review. Two of the records reviewed included patients who had PICC (Peripherally inserted central lines used for intravenous therapy for a prolonged period of time) lines placed for IV (intravenous) therapy.

* The record of a 50 year old female was reviewed. She was admitted to the hospital on 10/12/14, with complaints of abdominal pain, nausea and vomiting, and was discharged on 10/16/14. Her record included documentation a PICC line was inserted during her hospital stay.

The patient had a hysterectomy and tummy tuck 10 days previous to her admission. She had a lower abdominal incision which was red and had purulent drainage. An IV was inserted on 10/12/14, her first day of admission, and two antibiotics were ordered for IV administration.

The patient's record noted that at 10:15 PM on 10/14/14, the IV infusion was stopped for possible infiltration of the peripheral IV. At 12:43 AM on 10/15/14, the physician was called for placement of a central line because the peripheral IV had occluded and was no longer working. Additionally, the RN documented the IV fluid was stopped and the antibiotic, Vancomycin, was held.

On 10/15/14 at 8:41 AM, an order was placed for placement of a PICC line by Interventional Radiology. The documentation in the record stated the PICC line was placed at 8:44 AM on 10/15/14.

The patient's IV fluid was stopped and a dose of her antibiotics were missed due to occlusion of her PICC line, and the delay in reinserting a new PICC line.

* The record of a 75 year old female was also reviewed. The patient was admitted for bacterial sepsis on 9/20/14, and was discharged on 9/27/14. Her record included documentation of 2 peripheral IVs and the placement of a PICC line during her hospital stay.

The patient presented to the Emergency Department, on 9/20/14, with a peripheral line in her left wrist. On 9/20/14 at 10:00 AM, a second peripheral line was inserted into her right wrist. The patient's record included documentation the IVs were assessed at the beginning and end of each nursing shift for swelling, redness, and if normal saline would flush the line easily or if the line had resistance.

According to the documentation in her record, the first peripheral line, in her left wrist, was discontinued on 9/22/14 at 3:41 AM, due to an occlusion and the inability to flush the line with normal saline. The second peripheral line, in the patient's right wrist, was discontinued on 9/21/14 at 9:46 PM, for the same reason.

A PICC line was ordered on 9/21/14 at 5:02 PM, for placement by Interventional Radiology. It was ordered again on 9/22/14 at 3:34 PM. The PICC line was inserted on 9/22/14 at 6:45 PM, to her left upper arm. The record did not include documentation why the PICC line was not placed with the initial order, dated 9/21/14.

However, the patient's record included a Medication Administration Record (MAR) which included documentation the patient received her first dose of IV antibiotic, Meropenem, on 9/20/14 at 11:00 AM. At 11:10 AM on 9/20/14, the patient received a second IV antibiotic, Vancomycin. The MAR showed the patient received all of her antibiotic medications, as ordered by the physician, throughout her stay. If some fluid infused into the patient's tissue, it could not be determined if, or how much, medication was not administered to the patient.

During an interview on 9/29/15 at 2:30 PM, the Manager of the Medical/Surgical and Orthopedic units was questioned regarding delays in responding to orders for PICC line placement. He stated there were occasions when the Interventional Radiologist was unable to place a PICC line at the time of the order. The Manager stated usually the Radiologist would contact the floor and inform them of a possible delay, but the conversation was usually not documented in the record.

Based on the above information, the patient received her IV medications as ordered with no delays in treatment for her condition.

Two of the 10 patient records reviewed included patients who had PICC lines for antibiotic therapy. One of the 2 records noted there was a delay in treatment related to infiltration or occlusion of the PICC line. Therefore, the allegation was substantiated, as a result of delays in PICC line placement and delays in IV medication administration. However, no concerns regarding delayed medication administration were noted in the records of the other 8 patients reviewed. While one patient missed one dose of medication, there was insufficient evidence to verify a pattern of regulatory non-compliance. Therefore, no deficiencies were cited related to medication administration.

Conclusion #1: Substantiated. No deficiencies related to the allegation are cited.

Allegation #2: Needed medications are withheld without cause.

Findings #2: During the investigation, 10 medical records were reviewed, hospital policies and other hospital documents were reviewed, patient/family members and staff were interviewed.

The Medication Administration Record (MAR) was reviewed for the 10 patient records selected. Medications were given as ordered by their physicians and documented in the MAR. If a medication was not given, the records included an explanation in the documentation or there was a physician order to discontinue the medication. For example:

* The record of a 50 year old female was reviewed. She was admitted to the hospital on 10/12/14, with complaints of abdominal pain, nausea and vomiting, and was discharged on 10/16/14. Her record included documentation a PICC line was inserted during her hospital stay.

The patient had a hysterectomy and tummy tuck 10 days previous to her admission. She had a lower abdominal incision which was red and had purulent drainage. An IV was inserted on 10/12/14, her first day of admission, and two antibiotics were ordered for IV administration.

The patient's record noted that at 10:15 PM on 10/14/14, the IV infusion was stopped for possible infiltration of the peripheral IV. At 12:43 AM on 10/15/14, the physician was called for placement of a central line because the peripheral IV had occluded and was no longer working. Additionally, the RN documented the IV fluid was stopped and the antibiotic, Vancomycin, was held.

While the patient's medication was not administered, the reason was documented.

* The record of a 75 year old female was reviewed. The female was admitted for bacterial sepsis on 9/20/14, and was discharged on 9/27/14. The female patient's medical history included diabetes, hypertension, high cholesterol, and recurrent cellulitis (an infection which causes redness and swelling).

Upon admission to the hospital the physician ordered her home medications to be continued during her hospital stay, which included a blood pressure medication Candesartan. The Candesartan was given to the patient at 11:19 AM on 9/20/14. The following day, 9/21/14, the patient's blood pressure measurements were documented in the record as follows: 12:00 AM 124/54, 4:36 AM 127/65, 7:44 AM 106/51, 12:02 PM 118/56, 3:48 PM 107/60, 7:00 PM 116/49.

The medication was discontinued by the physician, on 9/21/14, related to her low blood pressure measurements. The medication was reordered by her physician on 9/26/14, when her blood pressure measurements elevated again.

During an interview on 9/29/15 at 2:05 PM, the Manager of the Medical/Surgical and Orthopedic units reviewed the patient's record. He confirmed the physician discontinued the blood pressure medication due to the patient's lower blood pressure measurements.

In this case, the physician decided a medication the patient was taking at home was not consistent with her medical needs during hospitalization, and temporaily discontinued the medication.

No concerns regarding medication administration were noted in the records of the other 8 patients reviewed.

I could not be verified that patients' medications were withheld without cause.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: Patients had wounds for which nursing staff failed to administer medication until prompted by family members.

Findings #3: On 9/28/15, a list of hospital, inpatient admissions, from August 2014 through December of 2014, was requested. From this list, 10 medical records were selected for review. Three of the patient records reviewed included patients with wounds which required wound care during their stay. All three of the patients' records included an order for a consultation visit and treatment recommendations by a certified wound care nurse.

Nursing Care Plans, completed and updated by an RN, included a section for assessment and interventions related to wounds and skin care.

A policy, "Wound/Ostomy Care," effective December 2003, stated "A wound/ostomy certified nurse (WOCN) is a RN who is a graduate of an WOCN-accredited WOC nursing education program and has successfully completed the written WOCNCB certification examination. The WOCN specializes in the prevention of pressure ulcers and the management and rehabilitation of patients with stomas, wounds and incontinence. Care also includes extensive education on skin care, nutrition and emotional support as well as methods of educating the patients and families regarding patient self-care and independent living. The WOCN is responsible for assessing the patient and determining treatment needs, necessary equipment and supplies, and patient specific education."

* The record of a 50 year old female was reviewed. The patient was admitted for abdominal pain, nausea, and vomiting on 10/12/14, and was discharged on 10/16/14. The patient had a hysterectomy and tummy tuck 10 days previous to her admission. She had a lower abdominal incision which was red and had purulent drainage upon admission.

On 10/13/14 at 1:14 PM, an order was placed for a wound care visit by the WOCN. The WOCN documented in the patient's record the assessment and findings related to her skin. The patient had 1 surgical wound to her lower abdomen. The WOCN documented the physician was at the bedside and he removed staples from the abdominal incision and opened it for assessment. The WOCN further documented moist gauze was placed into the opened area of the incisional wound and she would "likely place a wound VAC (###) tomorrow afternoon."

On 10/14/14 at 3:43 PM, the WOCN documented a second visit to the patient. She documented cleaning the incisional wound and placing a wound VAC over the opened area of the abdominal incision. The documentation also included measurements and a description of the surgical wound.

The patient's wound was identified, assessed, and wound treatment provided as ordered by the physician.

* The record of a 75 year old female was also reviewed. The female was admitted for bacterial sepsis on 9/20/14, and was discharged on 9/27/14. The patient had a chronic wound to her left lower leg in which the swelling and redness were worsening.

The Admission Assessment completed by an RN documented the patient had an unhealing wound to her left lower leg. Additionally, the Nursing Care Plan, completed by an RN, documented the patient had impaired skin integrity.

Upon admission to the hospital the physician ordered wound care for the left lower leg, which included daily assessment and dressing to contain drainage of the wound. On 9/22/14, an order was initiated for a consultation and evaluation by the WOCN.

The patient was evaluated by the WOCN on 9/22/14 at 2:59 PM. She documented the patient was known to her from previous hospitalizations and she had chronic venous insufficiency disease with a draining wound to the left lower leg. The WOCN documented her assessment and treatment of the wound. The WOCN documented 2 additional visits to the patient on 9/23/14 and 9/25/14. Additionally, the patient's record included documentation, by the RNs assigned to her care, of daily dressing changes and assessment of the wound.

The patient's wound was identified, assessed, and wound treatment provided as ordered by the physician.

* The third patient's record similarly noted wounds were identified, assessed, and wound treatment provided as ordered by the physician.

It could not be verified patients' wounds were not identified by staff or their wounds were not treated as ordered by the physician.

Conclusion #3: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: Nursing staff do not adequately address the patients' nutritional needs.

Findings #4: On 9/28/15, a list of hospital, inpatient admissions, from August 2014 through December of 2014, was requested. From this list, 10 medical records were selected for review. Two of the patient records reviewed documented the need for a nutritional consultation, which were delayed or not completed. Examples include:

* The record of a 75 year old female was reviewed. The female was admitted for bacterial sepsis on 9/20/14, and was discharged on 9/27/14.

Her record included an Admission Assessment, completed by an RN on 9/20/14 at 12:30 PM. The Admission Assessment included a section for a nutritional screening. The RN documented the patient had a "decreased appetite and ... an open or unhealing wound."

The Nursing Care Plan for the patient did not include a plan, interventions, or goals related to the patient's nutritional needs. Additionally, her meal intake was documented twice from 9/20/14 to 9/23/14. The first entry was documented on 9/23/14 at 9:00 AM, 3 days after her admission. The entry stated she ate 0% of her meal. The second entry was documented on 9/23/14 at 6:00 PM, and stated the patient only had "bites of her meal."

The patient's record included an order for a nutritional consult dated 9/20/14 at 4:13 PM. The order stated "Nutrition referral placed due to responses on nutrition screening: Decreased appetite. (Calculated Weight change is 0 kg.) Presence of open or unhealing wounds."

The nutritional consult was not documented in the patient's record until 9/24/14, her fourth day of hospitalization. The nutritional assessment was completed by a Registered Dietician. The Registered Dietician documented the patient stated she had no appetite and was requesting cream of wheat or oatmeal. Additionally, the Registered Dietician documented her intake was poor and she had consumed less than 25% of her last 3 meals.

During an interview on 9/30/15 at 4:40 PM, the Manager of Quality Performance and Improvement reviewed the record. She stated on the Admission Assessment, if the RN filling it out, answered yes to any of the questions for the nutritional screening, an order for a nutrition assessment was automatically generated in the electronic medical record. The Manager of Quality Performance and Improvement confirmed the patient's nutritional consultation by the Registered Dietician was not completed until her fourth day of hospitalization. She further confirmed nutrition was not part of the Nursing Care Plan and the patient's food intake was not frequently assessed.

* The record of a 50 year old female was reviewed. The female was admitted for abdominal pain, nausea, and vomiting on 10/12/14, and was discharged on 10/16/14.

Her record included an Admission Assessment, completed by an RN on 10/12/14. The Admission Assessment included a section for a nutritional screening. The RN documented the patient did not have an open or unhealing wound. However, her Emergency Department record stated she had a hysterectomy and tummy tuck 10 days prior to her hospital visit. Additionally, it stated she had a long incision across her lower abdomen that was "reddened and draining purulent material."

The patient was initially ordered an NPO diet (no food or drink by mouth) on 10/12/14, related to her nausea and vomiting. On 10/13/14, a carbohydrate consistent diet, with no calorie level specified, was ordered for the patient.

During an interview on 9/30/15 at 4:45 PM, the Manager of Quality Performance and Improvement reviewed the record. She confirmed the nutritional screening question related to wounds was answered inaccurately by the RN. The Manager of Quality Performance and Improvement stated a nutritional consultation was likely not ordered because the question was answered inaccurately, and the patient was initially not eating or drinking anything.

The RNs did not identify patients' nutritional needs or possible deficits after completing the Admission Assessment. Additionally, one patient's Nursing Care Plan did not include interventions for diet or nutritional interventions by nursing staff to address her needs.

Therefore, the allegation was substantiated and a deficiency was cited at 42 CFR 482.23 (b)(3), related to the failure of the hospital to ensure a comprehensive nutritional assessment by the RN which addressed patients identified needs.

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 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,

Sylvia Creswell for

LAURA THOMPSON
Health Facility Surveyor
Non-Long Term Care

Sylvia Creswell

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

LT/pmt