



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

November 20, 2015

James Elton, Administrator
Vibra Hospital Of Boise
2131 South Bonito Way
Meridian, ID 83642

RE: Vibra Hospital Of Boise, provider #132002

Dear Mr. Elton:

This is to advise you of the findings of the complaint investigation, which was concluded at your facility on November 4, 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.

Also enclosed is a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction.

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

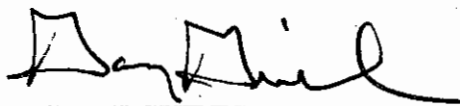
- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date 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.

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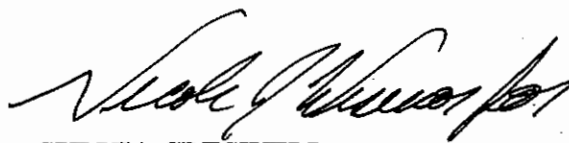
Please sign and date both of the forms and return them to our office by **December 3, 2015**. Keep a copy for your records. For your information, the Statement of Deficiencies is disclosable to the public under the disclosure of survey information provisions.

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,



GARY GUILLES
Health Facility Surveyor
Non-Long Term Care



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

GG/pmt
Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/20/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 132002	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/04/2015
NAME OF PROVIDER OR SUPPLIER VIBRA HOSPITAL OF BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 2131 SOUTH BONITO WAY MERIDIAN, ID 83642	
(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	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the complaint investigation survey of your hospital. The surveyors conducting the investigation were:</p> <p>Gary Guiles, RN Health Facility Surveyor, Team Leader Rebecca Lara, RN, BA, Health Facility Surveyor</p> <p>The following acronyms were used in this report:</p> <p>ADA - American Diabetes Association CCO - Chief Clinical Officer CEO - Chief Executive Officer CHF - Congestive Heart Failure COPD - Chronic Obstructive Pulmonary Disease DQM - Director of Quality Management EMR - Electronic Medical Record ICU - Intensive Care Unit IV - intravenous line NP - Nurse Practitioner PICC - Peripherally Inserted Central Catheter PRN - As Needed RN - Registered Nurse UTI - Urinary Tract Infection</p>	A 000	<p>RECEIVED</p> <p>DEC - 3 2015</p> <p>FACILITY STANDARDS</p>	
A 118	<p>482.13(a)(2) PATIENT RIGHTS: GRIEVANCES</p> <p>The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance.</p> <p>This STANDARD is not met as evidenced by: Based on interview with patients and/or their designees, staff interview, review of medical records, and review of grievance documentation, it was determined the hospital failed to identify grievances and/or respond to them for 5 of 6 patients (#8 - #12) whose medical records and/or</p>	A 118		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Sean McCarthy Regional VP / Kathy Kelly MSPM, MSN-Ed, RN CCO

TITLE
Regional VP / MSPM, MSN-Ed, RN CCO

(X6) DATE
12/3/2015

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 grievances were reviewed. This resulted in incomplete investigation and resolution of grievances. Findings include: 1. Patient #8 was a 74 year old female, who was admitted to the facility for care related to a diagnosis of acute, hypoxic respiratory failure. Patient #8 was also receiving treatment for complications related to a motor vehicle accident, when she sustained multiple rib fractures bilaterally, a T1 transverse process fracture (spinal fracture at the thoracic level,) a left tibial fracture and injury to the cervical spine. Additional diagnoses included severe sepsis with shock, which was resolved, clostridium difficile (bacteria in the large colon, causing infectious diarrhea,) which resulted in surgery and placement of a colostomy (a surgical procedure in which an opening is formed by pulling the healthy end of the large intestine through an incision in the abdominal wall and suturing it in place, providing an alternative channel for feces to leave the body,) acute renal failure, bacteremia (presence of bacteria in the blood,) a UTI, a chronic seizure disorder, protein-calorie malnutrition and a blood clot in the left leg. During the survey, patients and their designees were interviewed about their understanding of the hospital's grievance process. Patient #8's caregiver, her daughter, was interviewed on 10/30/15, beginning at 9:10 AM. Patient #8's daughter stated she was satisfied with the overall care her mother received but described an incident when her mother had complained of severe pain and requested medication to alleviate it. Patient #8's daughter said a nurse came to her mother's room with the pain medication and tried to scan her mother's hospital wrist band for the	A 118	A118-482.13(a)(2) Patient Rights – Grievances Action Plan: Accurate and complete notification of the patients, families/friends & staff members regarding the Complaint/Grievance facility process is essential to ensuring a responsive method of resolution. The following action items have already been put into place to achieve the goal education for both patients/families & staff: 1. The electronic patient admission packet is in the process of being updated to the mailing address for the Bureau of Facility Standards 2. The patient “Welcome Packet” has been updated and reviewed for final printing. This booklet contains additional information about patient rights and the complaint/grievance process as well as contact information. All clinical staff will be oriented to the information in the packet. 3. Case Managers will go over the booklet with the patient/family during their initial admission assessment. 4. Staff education related to the process has been initiated and is scheduled to be ongoing throughout the year. The following items have been completed: a. Clinical Staff Huddles twice a day for 2 weeks b. Department Managers will be covering specific pieces of	12/15/2015

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A 118	<p>Continued From page 2</p> <p>purpose of identification, but was unable to complete the scanning process. She stated the nurse left the room in an attempt to resolve the problem and did not return for 3 hours. Patient #8's daughter said she then went to the hospital's administration office and talked to someone about the problem. Afterward, she stated the RN Supervisor talked with her, and she relayed the details of the incident to him. Patient #8's daughter was unaware of the events that transpired after her discussion with the RN Supervisor. She was unable to recall the date the incident occurred.</p> <p>The Director of Quality Management was interviewed on 10/30/15, beginning at approximately 1:55 PM. She stated the complaint voiced by Patient #8's daughter was not recognized or investigated as a grievance.</p> <p>The policy titled, "Patient Complaint and Grievance Process" was reviewed during the survey. The policy included the following definition:</p> <p>"Patient complaint: Grievance: Any expression of the dissatisfaction (written or verbal) related to an occurrence within [Name of Hospital], which is of such severity that it is not able to be resolved to the satisfaction of the complainant at a departmental level by the staff present. Complaints that require further investigation, further actions for resolution, or are postponed for later resolution are considered grievances. Complaint type examples include but are not limited to: ...Patient care: coordination of care, quality of care, department-to-department communication, etc..."</p>	A 118	<p>a. Clinical Staff Huddles twice a day for 2 weeks</p> <p>b. Department Managers will be covering specific pieces of complaint/grievances at staff meetings.</p> <p>c. The November VHB Newsletter contained a full page article addressing processes, definitions & documentation. (See Attachment 2)</p> <p>d. The complaint/grievance education has been added as a standing agenda item at all scheduled Employee Forums.</p> <p>e. Updated complaint/grievance processed has been added to the General Hospital Orientation Materials.</p> <p>Monitoring & Tracking:</p> <ol style="list-style-type: none"> Our monitoring data will be based on; Denominator - # of Admissions, Numerator - # of Packets received by the patients. Both the Case Manager and the patient Ambassadors will be checking with the patient and the family on their first visit to determine if the packet has been provided. <p>Responsible Person(s):</p> <p>The Chief Clinical Officer & Director of Case Management will be responsible for the monitoring of compliance. Education activities have been completed by the Senior Leadership Team.</p>	11/15/2015	11/30/2015	11/10/2015	11/10/2015	12/01/2015

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A 118	<p>Continued From page 3</p> <p>On 10/30/15, beginning at approximately 8:40 AM, the RN Supervisor on duty was interviewed regarding the hospital's grievance process. He stated patients and family members could file a grievance using a complaint form that was included in their admission packets. The RN Supervisor also stated every patient in the hospital was assigned an "ambassador." He defined an ambassador as a patient representative from hospital administration. The RN Supervisor stated patients' ambassadors checked in weekly with patients and family members in an attempt to address any concerns they might have. When asked to explain his understanding of the difference between complaints and grievances, the RN Supervisor said the severity of a complaint determined whether the complaint was addressed as a grievance.</p> <p>On 11/04/15, beginning at approximately 8:45 PM, a different RN Supervisor who was on duty, was interviewed regarding the complaint voiced by Patient #8's daughter. The RN Supervisor presented a document, titled "PATIENT COMPLAINT RESOLUTION." He stated he had completed the document. The document described a grievance voiced by Patient #8, to her daughter, who then relayed the grievance to the RN Supervisor. The document included the date the grievance was received and resolved as 10/26/15. However, the document was not completed, signed and dated by the RN Supervisor, until 11/03/15. The RN Supervisor stated the grievance was not filed at the time of the event.</p> <p>The "PATIENT COMPLAINT RESOLUTION" form documented Patient #8 was awakened at 4:00</p>	A 118			

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A 118	<p>Continued From page 4</p> <p>AM for vital signs and assessment, and was unable to get back to sleep because of discomfort. According to the documentation, Patient #8 complained to her daughter that staff did not come in her room between the hours of 4:00 AM and 7:00 AM, though she had her call light on during that time. Under the section, "Desired Resolution...", the form then indicated Patient #8's medical record showed a nurse administered pain medication, for back and neck pain, at 5:49 AM. The form also included that the record showed Patient #8 was repositioned. Under the heading "Actions Taken to bring Resolution," the form included that the RN Supervisor instructed the nursing staff to try not to wake the patient when she was sleeping, if possible. Also, the nursing staff was instructed to be more attentive to Patient #8's pain medication regime. The form did not include evidence that the RN Supervisor followed up with the nurse who was caring for the patient, or the patient and daughter. Though the complaint required investigation and involved the care of Patient #8, the RN Supervisor stated he did not believe the documented complaint was a grievance.</p> <p>Facility staff did not adequately understand the hospital's policy related to the grievance process. Hospital staff was unable to accurately explain the difference between the facility's definition of a complaint, versus the facility's definition of a grievance.</p> <p>The facility failed to ensure the process for grievance identification and resolution had been thoroughly developed and implemented.</p> <p>2. The policy "Patient Complaint and Grievance Process," not dated, stated "A written complaint is</p>	A 118		

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A 118	<p>Continued From page 5</p> <p>always considered a grievance." The policy also stated "A written response is sent to the complainant upon resolution of the grievance."</p> <p>a. A "PATIENT COMPLAINT RESOLUTION" form regarding Patient #9, dated 10/07/15, alleged a nurse "...yelled at [Patient #9] for one hour for not getting up for breakfast at 7:30." The form stated a family member requested a different nurse care for Patient #9. Under the heading "Actions taken to bring Resolution:" the form stated the author verified a different nurse was assigned and the charge nurse was interviewed. No other investigation or findings were documented and the form did not state if the allegation was substantiated. A written response to the patient was not documented.</p> <p>The DQM was interviewed on 10/30/15 beginning at 1:55 PM. She stated documentation of an investigation of Patient #9's grievance was not present. She stated no written response was sent to the complainant.</p> <p>The hospital failed to investigate and respond to Patient #9's grievance.</p> <p>b. A "PATIENT COMPLAINT RESOLUTION" form regarding Patient #10, dated 9/09/15, included a written grievance, dated 9/08/15. The form alleged there were care issues involving an allergic reaction, a fluid restriction, and therapy scheduling. The form listed some actions that had been taken in response to the grievance but it did not document an investigation of the allegations. A response to the complainant was not documented.</p> <p>The DQM was interviewed on 10/30/15 beginning</p>	A 118			

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A 118	<p>Continued From page 6</p> <p>at 1:55 PM. She stated documentation of an investigation of Patient #10's grievance was not present. She stated no written response was sent to the complainant.</p> <p>The hospital failed to investigate and respond to Patient #10's grievance.</p> <p>c. A "PATIENT COMPLAINT RESOLUTION" form regarding Patient #11, dated 9/03/15, stated a family member complained that a nurse failed to perform appropriate hand hygiene and failed to wear gloves when needed. The form stated staff discussed the allegations with the complainant but an interview with the nurse was not documented. The form stated there was a delay in the investigation due to a decline in the patient's condition and staffing issues. A determination of the validity of the allegations was not documented. Actions to resolve the complaints were not documented. A written response to the complainant was not documented.</p> <p>The DQM was interviewed on 10/30/15 beginning at 1:55 PM. She stated documentation of an investigation of Patient #11's grievance was not present. She stated no written response was sent to the complainant.</p> <p>The hospital failed to investigate and respond to Patient #11's grievance.</p> <p>d. A "PATIENT COMPLAINT RESOLUTION" form regarding Patient #12, dated 9/08/15, included allegations of delays in answering call lights, showers not being given, delays in turning, and not receiving medications. An accompanying email, dated 9/09/15, was attached. The form</p>	A 118			

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A 119	<p>Continued From page 8</p> <p>grievance process. This resulted in the inability of the hospital to maintain an effective grievance process. Findings include:</p> <p>1. Patient #8 was a 74 year old female, who was admitted to the facility for care related to a diagnosis of acute, hypoxic respiratory failure. Patient #8's caregiver, her daughter, was interviewed on 10/30/15, beginning at approximately 9:10 AM. Patient #8's daughter stated she was satisfied with the care her mother had received overall, but described an incident when her mother had complained of severe pain and requested medication to alleviate the pain. Patient #8's daughter said a nurse came to her mother's room with the pain medication and tried to scan her mother's hospital wrist band for the purpose of identification, but was unable to complete the scanning process. She stated the nurse left the room in an attempt to resolve the problem and did not return for 3 hours. Patient #8's daughter said she was not aware of who to contact to file a grievance. She stated she did not remember receiving information from the hospital regarding grievances.</p> <p>Additionally, 7 patient medical records (Patients #1, #2, #4, #5, #6, #7, and #8) did not contain evidence that patients or their representatives were informed of who to notify to file a grievance.</p> <p>The CCO was interviewed on 10/30/15 beginning at 3:15 PM. She stated on admission patients were given a booklet with helpful information which included the grievance procedure and whom to notify to file a grievance. She stated the hospital had run out of these booklets 6-8 months ago and had not provided the grievance information to patients since that time.</p>	A 119	<p>3. Any complaint that can not be resolved at the time will be immediately forwarded to the Nursing Supervisor who will notify someone from the Senior Leadership Team during office hours or the Administrator on Call after hours.</p> <p>4. The documentation of the complaint/grievance will be forwarded to the Director of Quality/Risk Management or Chief Clinical Officer and the event will be evaluated by the Grievance Committee within 24-48 hours.</p> <p>5. All complaints will be maintained in the complaint/grievance log with all intervention and resolution documentation including response letters if determined appropriate.</p> <p><u>Monitoring & Tracking:</u></p> <p>Reporting/reviewing complaint/grievances is now a standing agenda item for the Senior Leadership Team Meetings & all review & intervention will be reflected in their meeting minutes (when appropriate),</p> <p>Monitoring of the Complaint Grievance log will also demonstrate the timeliness & follow up of complaints/grievances will be reported to the Quality Assessment Performance Improvement Committee, Medical Executive Committee and to the Governing Board on a regularly scheduled basis. Reports will track the data by types of complaints/services or disciplines</p>	

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A 119	Continued From page 9	A 119		
A 123	<p>Patients were not informed of the hospital's grievance process.</p> <p>2. The CEO was interviewed on 11/02/15 beginning at 8:20 AM. He stated at Governing Body meetings the Board was informed of grievance statistics such as the number of grievances and the number of responses to complainants. He stated he could not think of any meetings since 1/01/15 where the Board had discussed the grievance process or reviewed any grievances in order to determine whether procedures were followed. He stated Board minutes did not contain documentation that the process had been reviewed.</p> <p>The hospital's Governing Body did not maintain responsibility for the grievance process.</p> <p>482.13(a)(2)(iii) PATIENT RIGHTS: NOTICE OF GRIEVANCE DECISION</p> <p>At a minimum: In its resolution of the grievance, the hospital must provide the patient with written notice of its decision that contains the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion.</p> <p>This STANDARD is not met as evidenced by: Based on policy review and staff interview, it was determined the hospital failed to ensure patients were provided with written notice of grievance investigations, including the name of the hospital contact person for 27 of 28 grievances filed in 2015. This resulted in a lack of information being</p>	A 123	<p><u>Responsible Person(s):</u></p> <p>The Director of Quality/Risk Management will be responsible for collecting the data and presenting it at all committee meetings including the "SLT Grievance Committee Meetings". The DQRM will also be responsible for ensuring letter distribution and reporting of that data during Committee Meetings.</p> <p><u>A123-482.13(a)(2) Patient Rights Review of Grievances</u></p> <p><u>Action Items</u></p> <p>1. As per action items for A119 - 482.13(a)(2) all complaints and grievances will be reviewed by the Complaints/Grievance Committee. Content of response letters will be generated through this committee and letter mailed or hand-delivered (if patient is still in the hospital) within 7-10 days of the initial complaint/grievance</p> <p><u>Monitoring & Tracking:</u></p> <p>The denominator for monitoring is total number of grievances & the numerator is the number of letters sent within the defined time frame.</p>	

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A 123	Continued From page 10 provided to patients. Findings include: The policy "Patient Complaint and Grievance Process," not dated, stated "A written response is sent to the complainant upon resolution of the grievance." The DQM was interviewed on 10/30/15 beginning at 1:55 PM. She stated 28 grievances had been filed since 1/01/15. Of these 28 grievances she stated only 1 written response had been provided to the complainant. She stated most complainants had been provided verbal responses. The hospital failed to provide complainants with written notification of grievance decisions and the name of the hospital contact person.	A 123	<u>Responsible Person(s):</u> The Director of Quality/Risk Management will be responsible for collecting the data and presenting it at all committee meetings including the "SLT Grievance Committee Meetings". The DQRM will also be responsible for	
A 164	482.13(e)(2) PATIENT RIGHTS: RESTRAINT OR SECLUSION Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm. This STANDARD is not met as evidenced by: Based on observation, staff interview, and review of medical records, it was determined the hospital failed to ensure restraints were used only after a comprehensive risk assessment and when less restrictive interventions were determined to be ineffective to protect 2 of 3 restrained patients (#1 and #3) from harm. This resulted in the unnecessary use of restraints. Findings include: 1. Patient #3 was an 81 year old male admitted to the hospital on 7/15/14 and discharged on	A 164		

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A 164	<p>Continued From page 11</p> <p>8/14/14. His diagnoses included a history of aortic valve replacement in February 2014 and prostate surgery in June 2014. He developed an infection and was admitted to the hospital for long term IV antibiotic therapy. Other diagnoses included protein calorie malnutrition and dementia. He had a urinary catheter. On 7/22/14 he began bleeding from his urinary tract. A continuous bladder irrigation was started.</p> <p>A "Restraint Order and Flow Record, Medical" form stated bilateral wrist restraints were ordered for Patient #3. The time they were applied was not documented but the form stated the physician was notified of their use at 9:47 AM on 7/23/14. The form included checked boxes stating "Reason for Restraint Use...Pulling at tubing/dressing [and] Unable to follow safety instructions." Another section stated "Less restrictive intervention used/considered that are ineffective [were] Pain relief/comfort measures...re-orientation, verbal reminders [and] Limit setting." A comprehensive assessment of Patient #3's need for restraint was not documented.</p> <p>A progress note by the NP and authenticated by the physician, was dated 7/23/15 at 4:09 PM. The note did not mention restraints. Also, except for the boxes checked on the "Restraint Order and Flow Record, Medical" form, dated 7/23/14, no documentation of a nursing assessment of the need for restraints was present on 7/23/14 or 7/24/14.</p> <p>A "Restraint Order and Flow Record, Medical" form, dated 7/24/14 was signed by Patient #3's physician on 7/24/15 but was not timed. The form continued the order for wrist restraints. The</p>	A 164	<p><u>A 164 – 482.13 (e)(2) Patient Rights - Restraint or Seclusion</u></p> <p><u>A 165 – 482.13 (e)(3) Patient Rights - Restraint or Seclusion</u></p> <p><u>A 186 – 482.13 (e)(16)(iii) Patient Rights -Restraint or Seclusion</u></p> <p><u>A 188 – 482.13 (e)(16)((v) Patient Rights -Restraint or Seclusion</u></p> <p>Accurate, appropriate & complete assessments & documentation are essential to ensure a safe environment for all of our patients at VHB. Particular care needs to be taken when determining the need for utilization of any form of restraint for their protection. This process is multi-disciplinary and therefore we have included all levels of care in the action plans.</p> <p><u>Action Plan:</u> As per our policy restraints are ordered and applied by trained personnel in response to an urgent, emergent, or dangerous situation as an adjunct to planned care. VHB does not use seclusion. We have developed an action plan to improve our assessments and documentation related to restraints.</p> <p>1. Continue utilization of the Restraint Order & Flow Record, Medical Restraints & monitor it real time.</p>	11/05/2015	

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A 164	<p>Continued From page 12</p> <p>form included checked boxes stating "Reason for Restraint Use...Pulling at tubing/dressing [and] Unable to follow safety instructions." Another section stated "Less restrictive intervention used/considered that are ineffective [were] Pain relief/comfort measures...Environmental modifications...re-orientation, verbal reminders...Diversional activities [and] Limit setting." None of the checked boxes were explained. Again a comprehensive assessment of Patient #3's need for restraint was not documented.</p> <p>Patient #3's record contained another progress note by the NP and authenticated by the physician, dated 7/24/15 at 4:39 PM. This note also did not mention restraints.</p> <p>At some point on 9/24/14 or 9/25/14, Patient #3's restraints were discontinued. The record did not document when this took place and did not contain an assessment stating restraints were no longer needed.</p> <p>On 7/23/14 at 5:32 AM and 5:35 AM, orders were documented to give Patient #3 0.5 mg IV Lorazepam, an anti-anxiety drug, and 0.5 mg IV Haldol, an antipsychotic drug. The orders did not state why the medications were ordered. A second set of orders for 1 mg IV Lorazepam and 1 mg IV Haldol was dated 7/23/14 at 9:20 AM. This time, the orders stated the medications were ordered for delirium. The medications were administered as ordered.</p> <p>Progress notes by the NP and signed by the physician for 7/22/14 and 7/23/14 did not mention delirium and Patient #3's diagnoses did not include delirium. A Neuropsychiatric Evaluation</p>	A 164	<p>2. Staff was re-educated on the need for additional assessment documentation in the patient care notes regarding continued need for restraints by the nurse at least once per shift and with any change in mentation or behavior.</p> <p>3. Patients who are being monitored by a sitter will have the 1:1 Sitter Protocol implemented & a "Sitter Documentation Form" initiated. The nurse assigned to the patient will be reviewing the sitter documentation and signing off at least once per shift.</p> <p>4. Alternative measures attempted will be documented in the narrative at that time.</p> <p>5. Re-Education is conducted on an ongoing basis by the Nursing Supervisors as they are completing their concurrent monitoring see below.</p> <p>6. Restraints, including chemical have been added to the IDT forms for Nursing & Pharmacy & will be addressed weekly by the entire Interdisciplinary Team. This will assist in the assessment and determination of what type of restraint would be most appropriate for the patient.</p> <p>7. In addition a discussion reminder has been added to all team forms for review of Patient Care Plans & Initiation of a plan for patient's determined to need restraining of any kind.</p>	<p>11/30/2015</p> <p>12/02/2015</p> <p>12/02/2015</p> <p>12/02/2015</p>

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A 164	<p>Continued From page 14</p> <p>A "Restraint Order and Flow Record, Medical" form, dated 7/29/14 at 7:00 AM, stated bilateral wrist restraints were ordered for Patient #3. The form included checked boxes stating "Reason for Restraint Use...Pulling at tubing/dressing [and] Unable to follow safety instructions." The section stated Patient #3 pulled his PICC line out. Another section stated "Less restrictive intervention used/considered that are ineffective [were] re-orientation, verbal reminders [and] Diversional activities." A comprehensive assessment of Patient #3's need for restraint was not documented.</p> <p>A nursing progress note on 7/29/14 at 12:36 PM, stated Patient #3 was sitting up in bed with his daughter at the bedside. The note stated "Restraints are off with family at bedside." An assessment of the need for restraints at this time was not documented. It appeared the restraints were not reapplied but the time restraints were discontinued was not clearly documented. An order for "sitter to bedside 24 [hours]" was dated 7/29/14 but was not timed.</p> <p>The DQM was interviewed on 10/29/15 beginning at 1:25 PM. She confirmed the episodes of physical restraints for Patient #3 on 7/29/14. She stated an assessment of the need for restraints was not documented except for the boxes checked on the restraint order forms. She stated the use of less restrictive interventions was not documented except for the checked boxes on the orders. She stated documentation was not present to show specifically when restraints were applied and when they were removed.</p> <p>The hospital did not conduct a comprehensive assessment for Patient #3 to determine that the</p>	A 164	<p>The monitoring tool will include documentation in the patient's care plan as well as physician documentation and signatures/dates/times on the Restraint Order Form and progress notes.</p> <p>Real time intervention will occur for completion.</p> <p>All audits will be forwarded to the Falls/Restraints Committee for review</p> <p>Due to the importance of this process and our low patient restraint day volume this monitoring will be completely daily.</p> <p>Responsible Person(s): The Nursing Supervisor will be responsible for completing the auditing and to implement real time education and ensure appropriate documentation is occurring.</p> <p>The Director of Pharmacy will be responsible for educating the pharmacy staff and monitoring the events related to chemical restraint medication orders.</p> <p>The Falls/Restraints Committee will review all of the restraint auditing & make recommendations to the Chief Clinical officer.</p> <p>The Chief Clinical Officer and the Director of Quality/Risk will be responsible for the data analysis, reporting</p>	

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A 164	<p>Continued From page 15</p> <p>risks associated with the use of the restraints were outweighed by the risks of not using the restraints.</p> <p>2. Patient #1 was an 84 year old male who was admitted to the hospital on 10/23/15. He was currently a patient as of 11/03/15. His diagnoses included stroke with left hemiplegia and diabetes type II.</p> <p>Patient #1 was observed in bilateral restraints on 10/29/15 at 9:20 AM. He appeared to be sleeping and was not moving. He had a nasogastric tube and a PICC line with IV fluids running.</p> <p>Bilateral wrist restraint orders for Patient #1 were dated 10/23/15 at 8:30 PM. The "Restraint Order and Flow Record, Medical" order form indicated the restraints were applied at 8:00 PM on that date. The form included checked boxes stating "Reason for Restraint Use...Pulling at tubing/dressing [and] Unable to follow safety instructions." Another section stated "Less restrictive intervention used/considered that are ineffective [were] Pain relief/comfort measures...Environmental modifications...Visual Supervision [and] Medication/Sedation."</p> <p>A comprehensive assessment of Patient #1's need for restraint was not documented. The "Nursing ICU Admission Assessment," dated 10/23/15 at 7:35 PM, stated Patient #3 was non-verbal and had "Light sedation (Briefly awakens with eye contact to voice less than 10 seconds)." The assessment also stated he responded "...only to painful stimuli." The assessment did not contain any information that Patient #3 required restraints.</p>	A 164	and intervention when goals are not achieved.		

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A 164	<p>Continued From page 16</p> <p>The History and Physical, dated 10/24/15 at 8:43 AM, stated Patient #1 was not moving his left arm but said he did move his right leg. Restraints and the need for them were not documented.</p> <p>Further restraint orders for Patient #1 were documented on 10/24/15 at 7:00 AM, 10/27/15 at 7:00 AM, and 10/28/15 when no time was documented. The record showed Patient #1 was restrained on these dates.</p> <p>There was no documentation Patient #1 was restrained on 10/25/15 or 10/26/15. An assessment indicating Patient #1 required restraints on 10/27/15 and 10/28/15 was not documented.</p> <p>Daily provider progress notes dated 10/25/15 - 10/29/15 did not mention restraints.</p> <p>Except for checked boxes, only 1 nursing progress note addressed restraints. A "Patient Care Note" by the RN, dated 10/29/15 at 12:46 AM, stated "Pulls at gown tubings and anything placed in his hands. Remains restrained bilateral hands at this time."</p> <p>The RN caring for Patient #1 was interviewed on 10/29/15 beginning at 10:15 AM. He stated Patient #1 occasionally pulled at tubes but stated these were not purposeful movements. He stated since Patient #1's movements were not purposeful, mitts instead of restraints might be sufficient to protect the tubes.</p> <p>After observing Patient #1, his medical record was reviewed with the CCO on 10/29/15 beginning at 9:20 AM. She confirmed the documentation and stated a comprehensive</p>	A 164			

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A 164	Continued From page 17 assessment of the need for restraints was not included in Patient #1's medical record.	A 164			
A 165	<p>The hospital did not conduct a comprehensive assessment for Patient #1 to determine that the risks associated with the use of the restraints was outweighed by the risks of not using the restraints.</p> <p>482.13(e)(3) PATIENT RIGHTS: RESTRAINT OR SECLUSION</p> <p>The type or technique of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the patient or others from harm.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview, and review of medical records, it was determined the hospital failed to ensure the least restrictive restraint was used to protect 1 of 3 restrained patients (#1) from harm. This resulted in a patient's ability to move being more restricted than necessary. Findings include:</p> <p>Patient #1 was an 84 year old male who was admitted to the hospital on 10/23/15. He was currently a patient as of 11/03/15. His diagnoses included stroke with left hemiplegia and diabetes type II.</p> <p>Patient #1 was observed in bilateral restraints on 10/29/15 at 9:20 AM. He appeared to be sleeping and was not moving. He had a nasogastric tube and a PICC line with IV fluids running.</p> <p>The "Restraint Order and Flow Record, Medical" order form stated bilateral wrist restraints were</p>	A 165			

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A 165	<p>Continued From page 18 applied at 8:00 PM on 10/23/15. The form included checked boxes stating "Reason for Restraint Use...Pulling at tubing/dressing [and] Unable to follow safety instructions."</p> <p>A comprehensive assessment including the type of restraints needed to protect Patient #1 was not documented. The "Nursing ICU Admission Assessment," dated 10/23/15 at 7:35 PM, stated Patient #3 was non-verbal and had "Light sedation (Briefly awakens with eye contact to voice less than 10 seconds)." The assessment also stated he responded "...only to painful stimuli." The assessment did not contain any information that Patient #3 required restraints.</p> <p>Further restraint orders for Patient #1 were documented on 10/24/15 at 7:00 AM, 10/27/15 at 7:00 AM, and 10/28/15 when no time was documented. The record showed Patient #1 was restrained on these dates.</p> <p>After observing Patient #1, his medical record was reviewed with the CCO on 10/29/15 beginning at 9:20 AM. She confirmed the documentation and stated a comprehensive assessment including the type of restraints needed to protect Patient #1 was not included in his medical record.</p> <p>The RN caring for Patient #1 was interviewed on 10/29/15 beginning at 10:15 AM. He stated Patient #1 occasionally pulled at tubes but stated these were not purposeful movements. He stated since Patient #1's movements were not purposeful, mitts instead of restraints might be sufficient to protect the tubes.</p> <p>The hospital did not conduct a comprehensive</p>	A 165		

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A 165	Continued From page 19	A 165			
A 186	<p>assessment for Patient #1 to determine that the least restrictive restraints were used.</p> <p>482.13(e)(16)(iii) PATIENT RIGHTS: RESTRAINT OR SECLUSION</p> <p>[there must be documentation in the patient's medical record of]</p> <p>Alternatives or other less restrictive interventions attempted (as applicable);</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview, and review of medical records, it was determined the hospital failed to ensure less restrictive interventions were clearly documented prior to the use of restraints for 2 of 3 patients (#1 and #3) reviewed, for whom restraints were used. This resulted in the inability of the hospital to justify the use of restraints. Findings include:</p> <p>1. Patient #3 was an 81 year old male admitted to the hospital on 7/15/14 and discharged on 8/14/14. His diagnoses included a history of aortic valve replacement in February 2014 and prostate surgery in June 2014. He developed an infection and was admitted to the hospital for long term IV antibiotic therapy. Other diagnoses included protein calorie malnutrition and dementia.</p> <p>A "Restraint Order and Flow Record, Medical" form stated bilateral wrist restraints were ordered for Patient #3. The time they were applied was not documented but the form stated the physician was notified of their use at 9:47 AM on 7/23/14. The form included checked boxes stating "Less restrictive interventions used/considered that are</p>	A 186			

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A 186	<p>Continued From page 20</p> <p>ineffective [were] Pain relief/comfort measures...re-orientation, verbal reminders [and] Limit setting."</p> <p>A nursing shift assessment report by the RN, dated 7/23/14 at 9:30 AM, stated Patient #3 had bladder pain and was medicated and repositioned. The report stated "in the absence of patient self report, nursing assessment of possible pain-Nonverbal sounds (crying, gasping, moaning, or groaning) Vocal complaints of pain (e.g.. that hurts, ouch stop) Protective movements or postures." The report did not state which of these behaviors Patient #3 exhibited.</p> <p>RN Patient Care Notes dated 7/23/14 at 4:22 AM stated Patient #3 had been transferred to a local emergency department and returned to the hospital at that time with a continuous bladder irrigation. The note stated Patient #3 was "...anxious and irritable reporting pain and discomfort. A PRN Norco was given." The next nursing note documenting his behavior was dated 7/24/14 at 5:38 PM. No nursing notes specifically addressed the other less restrictive interventions including "...re-orientation, verbal reminders [and] Limit setting." In addition, verbal reminders and limit setting were not defined.</p> <p>A progress note by the NP and authenticated by the physician, was dated 7/23/15 at 4:09 PM. The note did not mention restraints or less restrictive measures.</p> <p>A "Restraint Order and Flow Record, Medical" form, dated 7/24/14 was signed by Patient #3's physician on 7/24/15 but was not timed. The form continued the order for wrist restraints. The form included checked boxes stating "Less</p>	A 186			

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A 186	<p>Continued From page 21</p> <p>restrictive intervention used/considered that are ineffective [were] Pain relief/comfort measures...Environmental modifications...re-orientation, verbal reminders...Diversional activities [and] Limit setting." None of the checked boxes were explained. Again, less restrictive measures were not defined and specifics were not documented.</p> <p>The DQM was interviewed on 10/29/15 beginning at 1:25 PM. She stated the use of less restrictive interventions was not documented except for the checked boxes on the orders.</p> <p>The hospital did not document less restrictive interventions than restraints for Patient #3.</p> <p>2. Patient #1 was an 84 year old male who was admitted to the hospital on 10/23/15. He was currently a patient as of 11/03/15. His diagnoses included stroke with left hemiplegia and diabetes type II.</p> <p>Patient #1 was observed in bilateral restraints on 10/29/15 at 9:20 AM. He appeared to be sleeping and was not moving. He had a nasogastric tube and a PICC line with IV fluids running.</p> <p>Bilateral wrist restraint orders for Patient #1 were dated 10/23/15 at 8:30 PM. The "Restraint Order and Flow Record, Medical" order form indicated the restraints were applied at 8:00 PM on that date. The form included checked boxes stating "Reason for Restraint Use...Pulling at tubing/dressing [and] Unable to follow safety instructions." Another section stated "Less restrictive intervention used/considered that are ineffective [were] Pain relief/comfort measures...Environmental modifications...Visual</p>	A 186			

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A 186	<p>Continued From page 22 Supervision [and] Medication/Sedation."</p> <p>A comprehensive assessment of Patient #1's need for restraint was not documented. A Nursing Admission Assessment, dated 10/23/15 at 7:35 PM stated Patient #1's "Best motor response" was "Purposeful movement to painful stimuli." The assessment also stated his neurological status was "Light sedation (Briefly awakens with eye contact to voice, less than 10 seconds)." No RN Patient Care Notes dated 10/23/15 documented specific less restrictive interventions. The "Less restrictive interventions used/considered that are ineffective" noted above were not defined.</p> <p>The History and Physical, dated 10/24/15 at 8:43 AM, stated Patient #1 was not moving his left arm but said he did move his right leg. Restraints and less restrictive interventions were not documented.</p> <p>Further restraint orders for Patient #1 were documented on 10/24/15 at 7:00 AM. The order form stated "Less restrictive intervention used/considered that are ineffective [were] Pain relief/comfort measures...Environmental modifications...Visual Supervision [and] Medication/Sedation." These less restrictive measures were not defined in Patient #1's medical record.</p> <p>After observing the Patient #1, his medical record was reviewed with the CCO on 10/29/15 beginning at 9:20 AM. Except for the order forms, she stated less restrictive interventions were not documented.</p> <p>The hospital did not document less restrictive</p>	A 186			

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A 186	Continued From page 23	A 186			
A 188	<p>interventions than restraints for Patient #1.</p> <p>482.13(e)(16)(v) PATIENT RIGHTS: RESTRAINT OR SECLUSION</p> <p>[there must be documentation in the patient's medical record of the following:]</p> <p>The patient's response to the intervention(s) used, including the rationale for continued use of the intervention.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview, and review of medical records, it was determined the hospital failed to ensure 2 of 3 restrained patients' medical records (#1 and #3) contained documentation of their response to the restraints and the rationale for the continued use of those restraints. This resulted in the inability of the hospital evaluate the efficacy of the restraint use. Findings include:</p> <p>1. Patient #3 was an 81 year old male admitted to the hospital on 7/15/14 and discharged on 8/14/14. His diagnoses included a history of aortic valve replacement in February 2014 and prostate surgery in June 2014. He developed an infection and was admitted to the hospital for long term IV antibiotic therapy.</p> <p>A "Restraint Order and Flow Record, Medical" form stated bilateral wrist restraints were ordered for Patient #3. The time they were applied was not documented but the form stated the physician was notified of their use at 9:47 AM on 7/23/14. The form included checked boxes stating "Reason for Restraint Use...Pulling at tubing/dressing [and] Unable to follow safety instructions." A comprehensive assessment of</p>	A 188			

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A 188	<p>Continued From page 24</p> <p>Patient #3's need for restraint was not documented.</p> <p>A "Restraint Order and Flow Record, Medical" form, dated 7/24/14 was signed by Patient #3's physician on 7/24/15 but was not timed. The form continued the order for wrist restraints. The form included checked boxes stating "Reason for Restraint Use...Pulling at tubing/dressing [and] Unable to follow safety instructions." Another section stated "Less restrictive intervention used/considered that are ineffective [were] Pain relief/comfort measures...Environmental modifications...re-orientation, verbal reminders...Diversional activities [and] Limit setting." None of the checked boxes were explained. A comprehensive assessment of Patient #3's need for continued restraint was not documented.</p> <p>Patient #3's record contained another progress note by the NP and authenticated by the physician, dated 7/24/15 at 4:39 PM. This note did not mention restraints.</p> <p>At some point on 9/24/14 or 9/25/14, Patient #3's restraints were discontinued. The record did not document when this took place and did not contain an assessment stating restraints were no longer needed. Nursing notes did not include Patient #3's response to the restraints. Nursing notes also did not include assessments that justified the continued use of restraints.</p> <p>The DQM was interviewed on 10/29/15 beginning at 1:25 PM. She confirmed the episodes of physical restraints for Patient #3. She stated except for the boxes checked on the daily restraint order forms, the justification for the</p>	A 188			

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A 188	<p>Continued From page 25</p> <p>continued use of restraints for Patient #3 and his response to the restraints was not documented in nursing or provider notes.</p> <p>The hospital did not document Patient #3's response to restraints or the rationale for the continuation of restraints.</p> <p>2. Patient #1 was an 84 year old male who was admitted to the hospital on 10/23/15. He was currently a patient as of 11/03/15. His diagnoses included stroke with left hemiplegia and diabetes type II.</p> <p>Patient #1 was observed in bilateral restraints on 10/29/15 at 9:20 AM. He appeared to be sleeping and was not moving. He had a nasogastric tube and a PICC line with IV fluids running.</p> <p>Bilateral wrist restraint orders for Patient #1 were dated 10/23/15 at 8:30 PM. The "Restraint Order and Flow Record, Medical" order form indicated the restraints were applied at 8:00 PM on that date.</p> <p>A comprehensive assessment of Patient #1's need for restraint was not documented. The "Nursing ICU Admission Assessment," dated 10/23/15 at 7:35 PM, stated Patient #3 was non-verbal and had "Light sedation (Briefly awakens with eye contact to voice less than 10 seconds)." The assessment also stated he responded "...only to painful stimuli." The assessment did not contain any information that Patient #3 required restraints.</p> <p>The History and Physical, dated 10/24/15 at 8:43 AM, stated Patient #1 was not moving his left arm but said he did move his right leg. Restraints and</p>	A 188		

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A 188	Continued From page 26 the need for them were not documented. Further restraint orders for Patient #1 were documented on 10/24/15 at 7:00 AM, 10/27/15 at 7:00 AM, and 10/28/15 when no time was documented. The record showed Patient #1 was restrained on those dates. There was no documentation stating Patient #1's response to restraints or the rationale for the continuation of restraints. Daily provider progress notes dated 10/25/15 - 10/29/15 did not mention restraints. Except for checked boxes, only 1 nursing progress note addressed restraints. A "Patient Care Note" by the RN, dated 10/29/15 at 12:46 AM, stated "Pulls at gown tubings and anything placed in his hands. Remains restrained bilateral hands at this time." After observing Patient #1, his medical record was reviewed with the CCO on 10/29/15 beginning at 9:20 AM. She stated except as noted above, Patient #1's medical record did not document his response to restraints or the rationale for the continuation of restraints.	A 188	A396-482.23(b)(4) – Nursing Care Plans BB175 – 16.03.14.310.03 – Patient Care Plans The patient's plan of care developed through the Interdisciplinary Team process is the guidebook & communication tool to address patient and/or needs & their progress during their stay. Accurate and timely posting of the initial as well as ongoing patient care plan information is essential to ensure the delivery of safe/quality care. VHB has implemented the following action plans to ensure this process is complete & successful: Action Plan: 1. Continue to utilize the electronic Patient Care Plan in the EMR. All members of the VHB clinical staff have access to the screen. 2. Care Plan Review triggers have been added to each of the discipline's IDT reporting forms. Updates to the Care Plans will occur concurrently with the IDT review. The following areas to be addressed include but are not limited to:	11/15/2015	
A 396	482.23(b)(4) NURSING CARE PLAN The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. The nursing care plan may be part of an interdisciplinary care plan	A 396		11/15/2015	

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A 396	<p>Continued From page 27</p> <p>This STANDARD is not met as evidenced by: Based on medical record review and staff interview, it was determined the facility failed to ensure thorough nursing care plans were developed, and/or followed, for 3 of 7 patients (#2, #5, and #6) whose care plans were reviewed. Lack of a complete care plan and failure to follow care plan interventions had the potential to result in patient care needs that were not addressed and interfered with coordination of patient care among disciplines. Findings include:</p> <p>1. Patient #5 was a 37 year old female who was admitted to the facility on 9/18/15 for care related to a history of a multidrug-resistant UTI, acute renal failure secondary to sepsis and possible protein calorie malnutrition. She was currently a patient as of 11/03/15. Her diagnoses included dyslipidemia (abnormal amount of lipids in the blood), hypertension, chronic pain, anxiety and depression, osteoarthritis, obstructive sleep apnea and debility. She was morbidly obese, had been intubated prior to arrival at the facility, and on 9/11/15, a tracheotomy was performed. Patient #5 also had wounds on her back, around the buttocks area.</p> <p>Patient #5's care plan ***dated**** did not include information related to her skin integrity and/or prevention of further skin breakdown.</p> <p>Patient #5's record was reviewed with the CCO on 10/30/15, beginning at approximately 9:10 AM. Patient #5's care plan was reviewed. The CCO confirmed a problem related to skin integrity, and/or prevention of further skin breakdown, should have been identified on the care plan, but was not.</p>	A 396	<p>a. Infection/Isolation b. Wounds and Skin Integrity c. Restraints/Falls/Safety Risks d. Antibiotics/Medications e. Mobility/ADL's f. Short Term and Long Term goals. g. Psychosocial needs</p> <p>3. Re-education of Interdisciplinary Team has occurred related to utilization of electronic patient care plan.</p> <p>4. Each Discipline is responsible for moving problems identified in IDT to the EMR Care Plan & ensuring documentation in the medical record of interventions related to action items.</p> <p>5. Instructions have been provided regarding the triggers on the IDT forms and documentation of the discussion and updates in the electronic care plan at the weekly IDT meeting.</p> <p>Monitoring & Tracking: Current Medical Record Review audits include a section for auditing patient care plans.</p> <p>The indicators include:</p> <p>1. Care Plans are individualized within 24 hrs. of admission</p> <p>2. Care Plan updated weekly</p>	12/02/2015	11/30/2015

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A 396	<p>Continued From page 28</p> <p>The nursing care plan did not thoroughly reflect the individual needs of Patient #5.</p> <p>2. During an interview on 10/29/15 at ****, the CCO stated a dietician completed a nutritional assessment, including dietary orders and a nutritional plan, for every patient in the facility. The CCO said information from the nutritional assessment should then be identified on the nursing care plan, and appropriate interventions should be entered on the care plan and followed by nursing staff.</p> <p>However, nursing interventions were not consistently documented, as follows:</p> <p>a. Patient #5's care plan ***dated*** identified a problem related to alteration in nutritional status. Under the problem related to altered nutritional status, there were interventions which included, but were not limited to, monitoring intake of meals, offering supplements if she ate less than 50% of a meal, and dietary supplements or snacks.</p> <p>A page in Patient #5's EMR, titled "Intakes/Outputs," included daily documentation for fluid intake and consumption of meals and supplements/snacks. There was no documentation of the percentage of dinner consumed or supplements/snacks for 10/26/15, 10/28/15, or 10/29/15 and there was no documentation of the percentage of lunch consumed or supplements/snacks for 10/27/15.</p> <p>Patient #5's record was reviewed with the CCO on 10/30/15, beginning at approximately 9:10 AM. Patient #5's care plan was reviewed. The CCO confirmed documentation of meals and snacks</p>	A 396	<p>3. Care Plan updated with any change in condition</p> <p>Denominator - number of admissions Numerator -- Completion of each of the indicators</p> <p>4. Appropriate interventions are documented in the patient's medical record based on Patient Care Plan action items.</p> <p>We will continue to do the 30 cases a quarter review with an emphasis on the care plan indicators & we have added 100% of new admissions for 30 days.</p> <p>We will continue to monitor for maintenance of benchmark and decrease volume of reviews sequentially to the 30 per quarter reviews unless the indicators fall below benchmark.</p> <p><u>Responsible Person(s):</u></p> <p>The Chief Clinical Officer & Director of Case Management are responsible for ensuring the IDT members are discussing and updating care plans at the time of the IDT.</p> <p>The Director of Quality/Risk Management is responsible for evaluating and analyzing data and reporting the outcomes at the Quality Assessment</p>	

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A 396	<p>Continued From page 29</p> <p>should have been accurately entered each shift, by nursing staff.</p> <p>b. Patient #2 was an 81 year old female, who was admitted to the hospital on 10/21/15, for care related to encephalopathy (general term describing a disease that affects the function or structure of the brain), UTI with possible urosepsis (septic poisoning resulting from retained and absorbed urinary substances), hypotension and hypoglycemia. Additional diagnoses included diabetes mellitus, hyperlipidemia, dementia, hallucinations, debility and protein calorie malnutrition.</p> <p>Patient #2's medical record included a document titled, "Nutritional Assessment." The assessment was dated 10/22/15 and identified Patient #2 as at a "...moderate risk due to 30 lb. weight loss in 4 months, need for therapeutic diet..." Also included on the assessment was an order for a 2 gram sodium diet with no concentrated sweets, and a diet plan. The diet plan included orders for snacks 3 times daily, as well as a liquid protein supplement with meals.</p> <p>Patient #2's care plan identified a problem related to alteration in nutritional status. Under the problem related to altered nutritional status, there were interventions, which included, but were not limited to, monitoring intake of meals and dietary supplements or snacks.</p> <p>A page in Patient #2's EMR, titled "Intakes/Outputs," included daily documentation for fluid intake and consumption of meals and supplements/snacks. There was no documentation of the percentage of breakfast or dinner consumed or supplements/snacks for</p>	A 396		

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A 396	<p>Continued From page 30</p> <p>10/22/15, there was no documentation of the percentage of dinner consumed or supplements/snacks for 10/23/15, 10/27/15, and 10/28/15 and there was no documentation of the percentage of lunch consumed or supplements/snacks for 10/24/15 and 10/25/15.</p> <p>Patient #2's record was reviewed with the DQM on 10/29/15, beginning at approximately 9:30 AM. She confirmed the care plan was not followed and that documentation of meals and snacks should have been accurately entered each shift by nursing staff.</p> <p>c. Patient #6 was an 86 year old female admitted to the hospital on 7/22/14, for care related to acute onset, chronic respiratory failure. Other diagnoses included COPD exacerbation, possible CHF exacerbation, community acquired pneumonia, acute renal failure, acute blood loss anemia, hypertension, recent UTI and decubitus ulcer(s) on right foot and right buttock.</p> <p>Patient #6's medical record included a document titled, "Nutritional Assessment." The assessment was dated 7/24/14 and identified Patient #6 as at "...high nutritional risk due to wounds, need for renal/ADA diet, edema..." Also included on the assessment was an order for a renal diet, and a diet plan. The diet plan included orders for a liquid, protein supplement 3 times daily.</p> <p>Patient #6's care plan ***dated*** identified a problem related to alteration in nutritional status. Under the problem related to altered nutritional status, there were interventions, which included, but were not limited to, monitoring intake of meals and dietary supplements or snacks.</p>	A 396			

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A 396	<p>Continued From page 31</p> <p>A page in Patient #6's EMR, titled "Intakes/Outputs," included daily documentation for fluid intake and consumption of meals and supplements/snacks. There was no documentation of the percentage of breakfast, lunch or supper consumed, and no documentation of protein supplement on 8/01/14, there was no documentation of the percentage of breakfast consumed for 7/25/14, there was no documentation of the percentage of dinner consumed on 7/28/14, 7/31/14, 8/02/14, and 8/03/14, there was no documentation for the protein supplement for 7/25/14, 7/28/14, and 8/03/14.</p> <p>Patient #6's record was reviewed with the CCO on 11/02/15, beginning at approximately 1:30 PM. She confirmed the care plan was not followed and that documentation of meals and supplements should have been accurately entered each shift by nursing staff.</p> <p>The hospital failed to ensure documentation of nursing interventions was completed.</p>	A 396		
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Bureau of Facility Standards

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B 000	16.03.14 Initial Comments The following deficiency was cited during the complaint investigation survey of your hospital. The surveyors conducting the investigation were: Gary Guiles, RN Health Facility Surveyor, Team Leader Rebecca Lara, RN, BA, Health Facility Surveyor	B 000		
BB175	16.03.14.310.03 Patient Care Plans 03. Patient Care Plans. Individual patient care plans shall be developed, implemented and kept current for each inpatient. Each patient care plan shall include but is not limited to: (10-14-88) a. Nursing care treatments required by the patient; and (10-14-88) b. Medical treatment ordered for the patient; and (10-14-88) c. A plan devised to include both short-term and long-term goals; and (10-14-88) d. Patient and family teaching plan both for hospital stay and discharge; and (10-14-88) e. A description of socio-psychological needs of the patient and a plan to meet those needs. (10-14-88) This Rule is not met as evidenced by: Refer to A396:	BB175		

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IDAHO DEPARTMENT OF
HEALTH & WELFARE

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DIVISION OF LICENSING & CERTIFICATION
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December 23, 2015

Stephanie Lawrence, Administrator
Vibra Hospital Of Boise
2131 South Bonito Way
Meridian, ID 83642

Provider #132002

Dear Ms. Lawrence:

An unannounced on-site complaint investigation was conducted from October 29, 2015 to November 4, 2015 at Vibra Hospital Of Boise. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006669

Allegation #1: The hospital did not have enough nurses to care for patients and there was poor communication between physicians.

Findings #1: The hospital employed 3 physician hospitalists who provided care for patients. Patients were also seen by physician specialists as needed. The hospitalists each worked a rotation of several days in a row. When they were on rotation, they stayed at the hospital and were available 24 hours a day. The hospital also employed 2 nurse practitioners who assisted the hospitalists. Patients were seen daily by either a physician or nurse practitioner. They met daily with nursing staff.

The hospitalist on duty was interviewed on 11/02/15 beginning at 12:10 AM. He stated physicians reported to each other when they transferred care. He stated the nurse practitioners also provided continuity because they were more steadily present.

Stephanie Lawrence, Administrator
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The hospital's as-worked staffing and census counts were reviewed for the past 3 months. The Intensive Care Unit (ICU) was staffed at a ratio of 1 nurse to 2-3 patients. The nursing unit had up to 1 nurse to 6 patients. The hospital had aides to assist the nurses with cares. Nurses on both units stated they felt staffing levels were sufficient. They also stated if it was very busy the RN House Supervisor assisted to care for patients and other nurses were available to call in.

Four current patients were interviewed during the investigation. They all stated staff were punctual and attentive. They all stated staff answered their call lights promptly. They stated they felt their needs were met. They stated they felt well informed about their condition and their care.

Eight medical records were reviewed. The records did not include evidence of patient care concerns due to a lack of physician communication. Nursing care was documented to all patients. None of the records indicated problems due to inadequate staffing levels and one patient record, documented environmental changes were made to accommodate increased monitoring. The medical record documented an 81 year old male who was a patient from 7/15/14 to 8/14/14. He was transferred from the nursing unit to the ICU on 7/23/14 following a urological procedure. He required increased nursing care due to continuous bladder irrigation and was placed where he was more easily observed from a nursing station. The medical record documented the patient was up and ambulated but did not document the specific amount of care and assistance provided. Surveyors were not able to verify if the patient needed more personal assistance than was provided.

It could not be determined that the hospital did not have enough nurses to care for patients or that there was poor communication between physicians.

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: Patients were prescribed inappropriate medications and incorrect prescriptions were called to pharmacies when patients were discharged.

Findings #2: The Director of Pharmacy was interviewed on 10/31/15 beginning at 10:00 AM. The Director stated pharmacy services were available 24 hours a day and a medication profile was maintained for each patient. The Director stated pharmacists reviewed all medication orders, checking for drug interactions and inappropriate medications.

Eight medical records were reviewed. The records documented physicians changed medication orders as appropriate and the medication changes were reviewed by the hospital's pharmacists. The hospital's electronic medical record checked for drug interactions and inappropriate medications. Pharmacists were automatically notified of any interactions.

For example, one medical record documented an 81 year old male who was a patient from 7/15/14 to 8/14/14. He was admitted to the hospital on Lovenox, a blood thinner, for a mitral valve diagnosis. He also had a history of prostate surgery one month prior to admission. On 7/22/15, the patient developed bleeding from his urinary tract. The Lovenox was discontinued on that date. He had frequent blood tests. When his blood tests showed he was stable, the Lovenox was restarted on 8/04/14. The decision to restart the Lovenox was a medical judgement which weighed the risk of bleeding against the risk of developing blood clots. The pharmacy reviewed the Lovenox order.

The patient's records also documented he was discharged home with home health services. His record stated the Case Manager reviewed the patient's discharge medications with his caregiver and then faxed the orders per the caregiver's request to her pharmacy of choice.

The Chief Clinical Officer was interviewed on 11/03/15 beginning at 9:35 AM. She stated the hospital did not call in prescriptions to pharmacies when patients were discharged. She stated the hospital did not have staff or procedures to do so. She stated physicians wrote prescriptions and caregivers filled the prescriptions at a pharmacy of their choice.

It could not be determined that patients were prescribed inappropriate medications or that incorrect prescriptions were completed when patients were discharged. The hospital monitored patients' medications and changed orders as needed. No concerns with discharge medications were identified during the investigation.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: The hospital experienced computer problems which resulted in delays in placing intravenous (IV) lines and repeated blood draws.

Findings #3: The hospital used an electronic record keeping system (EMR). The administrator was interviewed regarding the EMR. He described back up systems that were in place in case the EMR went down for any length of time. The hospital had a paper back up system that was utilized until the EMR was up and running.

Eight medical records were reviewed. None of the records indicated the hospital had experienced problems with the electronic record keeping system. All of the records contained documentation that laboratory work was conducted as ordered. None of the records indicated difficulty obtaining blood or that repeat blood draws had been done as a result of the electronic system being down. Additionally, a log of incidents/ issues for the laboratory for 2015 was reviewed. No difficulty with computerized orders or with obtaining blood was documented.

One medical record documented an 81 year old male who was a patient from 7/15/14 to 8/14/14. The record documented the patient accidentally pulled his central IV line out at 1:53 AM on 7/29/14. His physician was contacted and ordered the line replaced. The line needed to be replaced by a physician with privileges to perform the procedure. The line was replaced at 2:30 PM that day. The patient was receiving IV antibiotics through the central line since his admission. The antibiotics were interrupted for approximately 13 hours and one dose was missed.

The Chief Clinical Officer was interviewed on 11/02/15 beginning at 9:15 AM. She stated the central line was replaced as soon as was practical.

The central line was replaced as soon as it was practical to do so. The physician was aware of the interruption in antibiotic administration and the length of time the antibiotic was interrupted did not pose a threat to his health.

No other interruption to intravenous medications was documented in the other 7 medical records reviewed. Additionally, four current patients were interviewed during the investigation. None of the patients interviewed expressed concerns about their services, including laboratory services. They all stated they felt their needs were met.

It could not be determined that the hospital experienced computer problems which resulted in delays in placing intravenous (IV) lines and repeated blood draws.

Conclusion #3: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: Patients received food inconsistent with their health status and snacks were not provided as ordered.

Findings #4: During an interview on 10/29/15 at 3:30 PM, the Chief Clinical Officer (CCO) stated a dietician completed a nutritional assessment, including dietary orders and a nutritional plan, for every patient in the facility. The CCO said information from the nutritional assessment should then be identified on the nursing care plan, and appropriate interventions should be entered on the care plan and followed by nursing staff.

The dietician was interviewed on 11/02/15 beginning at 10:00 AM. She stated she oversaw all diets. She stated some diets may appear incorrect but met the requirements for the ordered diet. For example, she stated a patient on a cardiac diet might receive chicken strips if they were baked and not fried.

The diet orders of 3 patients were reviewed and compared with the patients' meal trays for lunch on 10/30/15. All observed meal trays complied with dietary orders and snacks were observed to be appropriate to patients' needs.

Stephanie Lawrence, Administrator

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Four current patients were interviewed during the investigation. They all stated they received appropriate meals and snacks.

Eight medical records were reviewed. The patients' records included a document titled "Intakes/Outputs," which included daily documentation for fluid intake and consumption of meals and supplements/snacks. Three of the 8 records did not include complete documentation, as follows:

One patient's "Intakes/Outputs" record did not include documentation of the percentage of dinner consumed or supplements/snacks for 10/26/15, 10/28/15, or 10/29/15 and there was no documentation of the percentage of lunch consumed or supplements/snacks for 10/27/15.

The patient's record was reviewed with the CCO on 10/30/15, beginning at approximately 9:10 AM. The CCO confirmed documentation of meals and snacks should have been accurately entered each shift, by nursing staff.

A second patient's medical record did not include documentation of the percentage of breakfast or dinner consumed or supplements/snacks for 10/22/15, there was no documentation of the percentage of dinner consumed or supplements/snacks for 10/23/15, 10/27/15, and 10/28/15 and there was no documentation of the percentage of lunch consumed or supplements/snacks for 10/24/15 and 10/25/15.

The patient's record was reviewed with the Director of Quality Management on 10/29/15, beginning at approximately 9:30 AM. She confirmed that documentation of meals and snacks should have been accurately entered each shift by nursing staff.

A third patient's record did not include documentation of the percentage of breakfast, lunch or dinner consumed, and documentation of an ordered protein supplement on 8/01/14 was not present. There was no documentation of the percentage of breakfast consumed for 7/25/14, there was no documentation of the percentage of dinner consumed on 7/28/14, 7/31/14, 8/02/14, and 8/03/14, and there was no documentation for an ordered protein supplement for 7/25/14, 7/28/14, and 8/03/14.

The patient's record was reviewed with the CCO on 11/02/15, beginning at approximately 1:30 PM. She confirmed that documentation of meals and supplements should have been accurately entered each shift by nursing staff.

The hospital failed to ensure patient records included consistent documentation of meals and snacks. A deficient practice was cited at 42 CFR 482.23(b)(4).

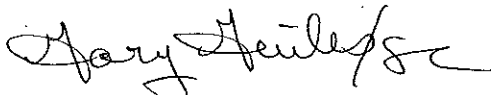
Conclusion #4: Substantiated. Federal and State deficiencies related to the allegation are cited.

Stephanie Lawrence, Administrator
December 23, 2015
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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,



GARY GILES
Health Facility Surveyor
Non-Long Term Care



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

GG/pt