

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Western Division of Survey and Certification
Seattle Regional Office
701 Fifth Avenue, Suite 1600, MS RX-400
Seattle, WA 98104



**THIS SERVES AS OFFICIAL NOTICE SENT VIA FACSIMILE PURSUANT TO 42 CFR
§488 NO HARD COPY TO FOLLOW
IMPORTANT NOTICE – PLEASE READ CAREFULLY**

December 4, 2015

Doug Crabtree, CEO
Eastern Idaho Regional Medical Center (CCN: 13-0018)
3100 Channing Way
Idaho Falls, ID 83404

**Re: Notice of CMS Enforcement Action
Complaint Investigation Completed November 20, 2015
Conditions of Participation Not Met
Placed on 90-day Termination Track
Deemed Status Temporarily Removed**

Dear Mr. Crabtree:

After careful review of the facts, the Centers for Medicare and Medicaid Services (CMS) has determined that **Eastern Idaho Regional Medical Center** no longer meets the requirements for participation as a provider of services in the Medicare program established under Title XVIII of the Social Security Act. **This is to notify you that effective February 19, 2016, the Secretary of the Department of Health and Human Services intends to terminate its provider agreement with Eastern Idaho Regional Medical Center.** This letter also notifies that your deemed status through The Joint Commission is temporarily removed and you are placed under the State's survey jurisdiction.

BACKGROUND

To participate as a provider of services in the Medicare and Medicaid Programs, a hospital must meet all the Conditions of Participation established by the Secretary of Health and Human Services. When a hospital is found to be out of compliance with the Medicare Conditions of Participation, the facility no longer meets the requirements for participation as a provider of services in the Medicare program.

The Social Security Act Section 1866(b)(2) authorizes the Secretary to terminate a hospital's Medicare provider agreement if the hospital no longer meets the regulatory requirements. Regulations at 42 CFR § 489.53 authorize the Centers for Medicare and Medicaid Services to Terminate Medicare provider agreements when a provider no longer meets the Conditions of Participation.

On **November 20, 2015**, a complaint investigation was completed at **Eastern Idaho Regional Medical Center** by the Idaho Bureau of Facility Standards (State survey agency) to determine compliance with Federal requirements for hospitals participating in the Medicare and Medicaid programs. The investigation found that the following Medicare Condition of Participation (CoP) was not met:

42 CFR 482.13 Patient's Rights

The deficiencies limit the capacity of **Eastern Idaho Regional Medical Center** to provide services of an adequate level and quality. The details of the above deficiencies are listed on the enclosed Statement of Deficiencies and Plan of Correction (Form CMS 2567).

PUBLIC NOTICE OF TERMINATION AND OPPORTUNITY TO CORRECT

In accordance with 42 CFR § 489.53(d), legal notice of our action will be published in the local newspaper **15 days** before the termination date.

The 90-day termination action can be avoided by correcting the deficiencies. CMS must receive and approve a credible allegation of compliance in the form of a Plan of Correction. An acceptable plan must be verified by an unannounced revisit by the State survey agency, verifying evidence that that Plan of Correction is implemented and that the deficiencies have been corrected. **Please complete your Plan of Correction in the space provided on the CMS-2567 within 10 calendar days** from the date of this letter. An acceptable Plan of Correction must include acceptable completion dates and the following elements:

- Plan of Correction for each specific deficiency cited.
- Procedure/process for implementing the acceptable plan of correction for each deficiency cited.
- Monitoring and tracking procedures to ensure the plan of correction is effective and that specific deficiencies cited remain corrected and/or in compliance with the regulatory requirements.
- Address process improvement and demonstrate how the hospital has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address systems improvement to prevent the likelihood of re-occurrence of the deficient practice.
- A completion date for correction of each deficiency cited.
- Identify the individual responsible for implementing the acceptable plan of correction with signature and title.

Please send your plan of correction to the State survey agency and to CMS in care of:

CMS – Division of Survey and Certification
Attention: Fe Yamada
701 Fifth Avenue, Suite 1600, M/S 400
Seattle, WA 98104

Or by email marie.yamada@cms.hhs.gov

If you disagree with this determination, you have the right to appeal this determination by requesting a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). The regulations governing this process are set out in 42 CFR § 498.40 et seq. You will find the DAB's e-filing procedures on the internet at the following URL: <http://www.hhs.gov/dab/divisions/civil/Procedures/filing-and-service.html>

A request for a hearing should identify the specific issues, and the findings of fact, and conclusions of law with which you disagree. The request should also specify the basis for contending that the findings and conclusions are incorrect. Evidence and arguments may be presented at the hearing and you may be represented by legal counsel at your own expense. A hearing request must be filed not later than **60 days** after the date you receive this letter.

The DAB requires you to e-file your appeal request unless you do not have access to a computer or internet service. In such circumstances, you may file in writing, but must provide an explanation as to why you cannot file submissions electronically and request a waiver from e-filing in the mailed copy of your request for a hearing. If you seek a waiver from e-filing, you must also file a written request for appeals no later than sixty (60) calendar days from the date you receive this notice. You must submit it to the following address:

Chief, Civil Remedies Division Departmental Appeals Board MS 6132 Cohen Building, Room 637-D 330 Independence Avenue, SW Washington, D.C. 20201	Please also send a copy to:	Chief Counsel, DHHS Office of General Counsel 701 Fifth Avenue, Suite 1620 M/S RX-10 Seattle, WA 98121-2500
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If you have any questions regarding this letter, please contact Fe Yamada of my staff at (206) 615-2381 or email marie.yamada@cms.hhs.gov.

Sincerely,



Patrick Thrift, Manager
Division of Survey, Certification & Enforcement
CMS Regional Office - Seattle

Cc: Bureau of Facility Standards
DHHS – OGC
ID Medicaid
The Joint Commission

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130018	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/20/2015
NAME OF PROVIDER OR SUPPLIER EASTERN IDAHO REGIONAL MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 CHANNING WAY IDAHO FALLS, ID 83404	
(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 a CMS complaint investigation conducted 11/16/15 to 11/20/15. The surveyors conducting the complaint investigation were: Gary Guiles, RN, HFS, Team Lead Nancy Bax, RN, HFS The following acronyms were used in this report: CNO - Chief Nursing Officer IM - Intramuscular LIP - Licensed Independent Practitioner MD - Medical Doctor mg - milligrams RN - Registered Nurse	A 000	<p style="text-align: center;">RECEIVED</p> <p style="text-align: center;">JAN - 6 2016</p> <p style="text-align: center;">FACILITY STANDARDS</p>	
A 115	482.13 PATIENT RIGHTS A hospital must protect and promote each patient's rights. This CONDITION is not met as evidenced by: Based on observation, review of patient rights information, review of medical records and hospital policies, and patient and staff interview, it was determined the hospital failed to ensure patients' rights were protected and promoted. This resulted in the failure of the hospital to ensure each patient received care in a safe setting, and restraints were used safely and appropriately by qualified staff to protect the patient or others from harm. Findings include: 1. Refer to A117 as it relates to the failure of the hospital to ensure all patient were informed of their rights.	A 115		Please refer to A-117, A-118, A-144, A-167, A-168, A-171, A-175, A-178, and A-194

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

[Signature]

TITLE

CEO

(X6) DATE

1/6/16

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 115	Continued From page 1 2. Refer to A118 as it relates to the failure of the hospital to ensure all patient were informed of whom to contact to file a grievance. 3. Refer to A144 as it relates to the failure of the hospital to ensure care was provided to patients in a safe setting. 4. Refer to A167 as it relates to the failure of the hospital to ensure the use of restraints was implemented in accordance with safe and appropriate techniques as determined by hospital policy. 5. Refer to A168 as it relates to the failure of the hospital to ensure restraints were implemented in accordance with current, clear, and complete orders of physicians or other LIPs who were authorized to order restraints. 6. Refer to A171 as it relates to the failure of the hospital to ensure orders for restraints used to manage violent or self-destructive behavior were renewed in accordance with hospital policy. 7. Refer to A175 as it relates to the failure of the hospital to ensure the condition of patients who were restrained was monitored by trained staff. 8. Refer to A178 as it relates to the failure of the hospital to ensure a face-to-face meeting by a physician or LIP was conducted within 1 hour of the application of restraints used to manage violent or self-destructive behavior. 9. Refer to A194 as it relates to the failure of the hospital to ensure security staff had education, training, and demonstrated knowledge to manage violent or aggressive patients.	A 115			

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A 115	Continued From page 2	A 115		
A 117	<p>The cumulative effects of these negative systemic practices seriously impeded the ability of the hospital to protect patient rights and provide services in a safe setting.</p> <p>482.13(a)(1) PATIENT RIGHTS: NOTICE OF RIGHTS</p> <p>A hospital must inform each patient, or when appropriate, the patient's representative (as allowed under State law), of the patient's rights, in advance of furnishing or discontinuing patient care whenever possible.</p> <p>This STANDARD is not met as evidenced by: Based on observation, review of patient rights information, and staff and patient interview, it was determined the hospital failed to ensure 3 of 4 current patients (#11, #12, and #13), who were interviewed, were informed of their rights. This prevented patients from exercising their rights. Findings include:</p> <p>1. Patients were not aware of their rights. Examples include:</p> <p>a. Patient #11 was interviewed on 11/18/15 between 11:30 AM and 12:15 PM. She was a current patient who was admitted on 11/16/15. She stated she was not given a copy of the patient rights and had not been informed of her rights by staff.</p> <p>b. Patient #12 was interviewed on 11/18/15 between 11:30 AM and 12:15 PM. He was a current patient who was admitted on 11/16/15. He stated he was not given a copy of the patient rights and had not been informed of his rights by</p>	A 117	<p>Plan of Correction: Hospital will reinforce the standard process for notification of patient rights to all patients.</p> <p>Procedure/Process for implementing: The hospital has a published brochure that outlines the patient rights and is currently being used. Admission staff are being re-educated on the importance of providing this brochure and explaining the purpose and content with each patient or their family. Standardized scripting is being taught to assure that the message is clear, precise and consistent.</p> <p>Monitoring and tracking: Periodic interviews will be conducted with patients to determine if they were informed of their rights.</p> <p>QA/PI: Investigation into an electronic checklist in the EMR in order to verify each discussion that is had with the patient will be conducted to determine feasibility.</p> <p>Individual Responsible: Julie Hogue, Director of Quality Management</p>	2/19/16

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A 117	<p>Continued From page 3 staff.</p> <p>c. Patient #13 was interviewed on 11/18/15 between 11:30 AM and 12:15 PM. He was a current patient who was admitted on 11/16/15. He stated he was not given a copy of the patient rights and had not been informed of his rights by staff.</p> <p>Patients were not informed of their rights.</p> <p>2. The 3 current patients noted above each had a folder that contained information from the hospital but did not contain a copy of patient rights.</p> <p>The Unit Secretary was interviewed on 11/18/15 beginning at 12:15 PM. She had folders of patient information she was preparing at the nursing station on the Medical/Oncology Unit. She stated the folders included a brochure outlining patient rights. The folders she was preparing did not include a copy of patient rights. She went into a back room and retrieved a box of patient rights brochures and placed them in the folders. The rights brochures were not in the folders in the rooms of the above patients.</p> <p>The Nursing Director of the Medical/Oncology Unit was interviewed on 11/18/15 beginning at 2:05 PM. He stated the hospital did not use the patient rights brochures any more. He presented a bound patient handbook and stated the hospital kept one in each patient room. He took the surveyor into an empty room and there was a 3 ring binder in a drawer. This was different from the handbook presented earlier. The binder contained approximately fifty pages of material including the rights.</p>	A 117			

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A 117	Continued From page 4	A 117			
A 118	<p>Staff members were not clear about a consistent method of informing patients of their rights. If booklets were placed in patient rooms, patients were not aware of this. The hospital failed to ensure patients were informed of their rights.</p> <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 staff and patient interview, it was determined the hospital failed to ensure 3 of 4 current patients (#11, #12, and #13), who were interviewed, were informed of whom to contact to file a grievance. This prevented patients from exercising their rights and prevented the hospital from identifying care issues. Findings include:</p> <p>1. Patients were not aware of whom to contact to file a grievance, as follows:</p> <p>a. Patient #11 was interviewed on 11/18/15 between 11:30 AM and 12:15 PM. She was a current patient who was admitted on 11/16/15. She stated she had not been given a copy of the patient rights, including her right to file grievances. She also stated she had not been informed of whom she could contact to file a grievance.</p> <p>b. Patient #12 was interviewed on 11/18/15 between 11:30 AM and 12:15 PM. He was a current patient who was admitted on 11/16/15. He stated he had not been given a copy of the patient rights, including his right to file grievances.</p>	A 118	<p>Plan of Correction: Grievance is addressed in the patient rights and included in the brochure that is provided on admission. The information is being updated to include all of the required elements and contact information. Staff are being reeducated on this information and the process to file a grievance so they can be a resource and direct the patient as needed.</p> <p>Procedure/Process for implementing: Patients will be presented upon admission to the hospital with a brochure that contains the contact information for whom handles grievances and the process of how to file a grievance. Scripting is being taught to admission staff to emphasize the grievance process with each patient.</p> <p>Monitoring and tracking: Periodic interviews will be conducted with patients to determine if the patient understands who to contact to file a grievance.</p> <p>QA/PI: Investigation into an electronic checklist in the EMR in order to verify each brochure is handed out and a discussion was had with the patient will be conducted to determine feasibility.</p>	2/19/16	

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A 118	Continued From page 5 He also stated he had not been informed of whom he could contact to file a grievance. c. Patient #13 was interviewed on 11/18/15 between 11:30 AM and 12:15 PM. He was a current patient who was admitted on 11/16/15. He stated he had not been given a copy of the patient rights, including his right to file grievances. He also stated he had not been informed of whom he could contact to file a grievance. The Nursing Director of the Medical/Oncology Unit was interviewed on 11/18/15 beginning at 2:05 PM. He stated the hospital kept bound patient handbooks in rooms. He took the surveyor into an empty room and there was a 3 ring binder in a drawer. The binder contained approximately fifty pages of material including the rights. The Director looked at the binder but was not immediately able to find the grievance information. He eventually located it on page 12. Patients were not informed of where to find grievance information, including who to contact to file a grievance. Additionally, the information in the patient room handbooks was not readily identifiable.	A 118	Individual Responsible: Julie Hogue, Director of Quality Management	
A 144	482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: Based on medical record review, staff interview	A 144	Plan of Correction: All licensed staff and security personnel have been assigned a required read of the restraint policy in our electronic policy manager system. This will remain and be an annual required read.	2/19/16

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A 144	<p>Continued From page 6</p> <p>and review of hospital policies, it was determined the hospital failed to provide a safe environment for 1 of 2 patients (#3) who were restrained for violent or self destructive behavior and whose records were reviewed. This failed practice had the potential to result in negative patient outcomes and interfere with the safety of all patients. Findings include:</p> <p>1. Patient #3 was a 72 year old male admitted to the hospital on 10/16/15, with diagnoses of bilateral lower extremity cellulitis and end stage Alzheimer's disease. He was discharged on 10/19/15.</p> <p>The hospital failed to ensure policies were followed to provide for Patient #3's safety. Examples include:</p> <p>a. The hospital's policy #491, Code "5" - Request for Assistance, effective 3/14/12, stated "Upon "Code 5" notification, all available personnel will report to the area. The charge nurse/clinical team leader, department director or house supervisor will act as "Code 5" leader and assume responsibility for evaluating the need for assistance. The Code 5 leader will inform those present of the situation and identify those needed to assist."</p> <p>Patient #3's record included a Nurses' Note dated 10/16/15 at 9:45 PM. The note stated "Code 5 (all available male assistance/security) called in response to patient's escalating aggression and threat to self and staff." The note further stated "Officers restrained patient with bed sheets for patient's and staff's safety." There was no documentation in Patient #3's record stating how the security officers were informed or directed, or</p>	A 144	<p>The Code 5 policy will be assigned to House Supervisors, Clinical Supervisors, Charge Nurses and Directors to reinforce their knowledge of the role they play as "leader" when a Code 5 is initiated. This will include their responsibility in documenting the event.</p> <p>Procedure/Process for implementing: A HealthStream education course will be assigned to each licensed staff members to reinforce the restraint policy.</p> <p>Monitoring and tracking: Policy manager and HealthStream reports on completion will be monitored to ensure staff assigned complete the assignments. Annual HealthStream education will continue for reinforcement of policy.</p> <p>QA/PI: Utilization of Healthstream reports for tracking compliance will be completed by unit Directors and will be reviewed during the Restraint Committee.</p> <p>Individual Responsible: Renae Oswald, MSN, NHA, NE-BC; Assistant Chief Nursing Officer</p>	

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A 144	<p>Continued From page 7 who acted as the Code 5 leader.</p> <p>Patient #3's record included a Nurses' Note dated 10/16/15 at 11:35 PM. It stated security officers were in Patient #3's room, and he was released from the sheet restraints placed by the officers.</p> <p>During an interview on 11/18/15 at 11:10 AM, the Assistant CNO reviewed Patient #3's record. She stated it was not the hospital's practice to restrain patients with sheets.</p> <p>The Director of ICU was interviewed on 11/19/15 at 11:15 AM. He stated he was the chair of the Restraint Committee for the hospital. When asked if the hospital used sheets to restrain patients, he stated "No, never."</p> <p>A hospital security office was interviewed on 11/19/15 at 8:40 AM. He stated security officers responded to Code 5 situations. He stated in most cases the nurse in charge deferred to the security officers in situations where a patient was exhibiting aggressive behavior and required restraint. He described sheet restraints as rolled sheets applied over the patient's chest and/or legs, tied to one side of the bed and held down by a security officer on the other side of the bed. He reviewed Patient #3's record and stated he did not believe the officers stayed with him for the 1 hour and 50 minutes he was in sheet restraints and stated they probably tied the sheets to both sides of the bed. It was unclear how the sheet would be quickly released in case of an emergency.</p> <p>Patient #3 was restrained with sheets applied by the hospital's security officers.</p>	A 144			

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A 144	<p>Continued From page 8</p> <p>b. The hospital's policy #391, Patient Restraint/Seclusion, effective 9/30/14, stated "An order for restraint or seclusion must be obtained from an LIP/physician who is responsible for the care of the patient prior to the application of restraint or seclusion. The order must specify clinical justification for the restraint or seclusion, the date and time ordered, the duration of use, the type of restraint to be used and behavior-based criteria for release." Additionally, it stated "When a LIP/physician is not available to issue a restraint or seclusion order, an RN with demonstrated competence may initiate restraint or seclusion use based upon face-to-face assessment of the patient. In these emergency situations, the order must be obtained during the emergency application or immediately (within minutes) after the restraint or seclusion is initiated."</p> <p>Patient #3's record included a Nurses' Note dated 10/16/15 at 9:45 PM, at the time sheet restraints were applied. The note stated "MD contacted and orders received to give IM Geodon 20 mg now and notify him of effectiveness." A Nurses' Note dated 10/16/15 at 9:53 PM, stated Patient #3's physician was notified of his behavior. The note documented the physician instructed the nurse to administer Geodon and call back if it did not work, to discuss restraints. However, sheet restraints were in place. Patient #3's record did not include a physician's order for the sheet restraints applied on 10/16/15 at 9:45 PM, and removed 1 hour and 50 minutes later.</p> <p>During an interview on 11/18/15 at 11:10 AM, the Assistant CNO reviewed Patient #3's record and confirmed there was not a physician's order for the sheet restraints.</p>	A 144			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130018	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/20/2015
NAME OF PROVIDER OR SUPPLIER EASTERN IDAHO REGIONAL MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 CHANNING WAY IDAHO FALLS, ID 83404		
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A 144	<p>Continued From page 9</p> <p>Patient #3 was placed in restraints without a physician's order.</p> <p>c. The hospital's policy #391, Patient Restraint/Seclusion, effective 9/30/14, included a section titled "Second Tier of Review" which stated "A member of nursing administration/management (e.g., nursing supervisor, manager/director, CNO, etc.) will review the need for restraint or seclusion with the RN who has determined that the patient requires restraint or seclusion. The second tier of review will occur with the initial application or restraint or seclusion."</p> <p>Patient #3's record did not include documentation of a Second Tier of Review during the 1 hour and 50 minutes he was restrained with sheets.</p> <p>During an interview on 11/19/15 at 11:15 AM, the Director of ICU, who is the chair of the Restraint Committee, reviewed Patient #3's record and confirmed there was no Second Tier of Review after sheet restraints were applied.</p> <p>Patient #3's need for restraint was not reviewed, to determine if policies were followed and restraints were appropriate.</p> <p>d. The hospital's policy #391, Patient Restraint/Seclusion, effective 9/30/14, stated "A face-to-face assessment by a physician or LIP, RN or physician assistant with demonstrated competence, must be done within one hour of restraint or seclusion initiation...to manage violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others."</p>	A 144			

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A 144	<p>Continued From page 10</p> <p>Patient #3's record did not include documentation of a face-to-face evaluation by a physician or other trained professional within 1 hour of the placement of restraints for violent/self destructive behavior, to complete a physical and behavioral evaluation, assess the safety of the patient, and determine the need to continue or terminate the restraint.</p> <p>During an interview on 11/18/15 at 11:10 AM, the Assistant CNO reviewed Patient #3's record and confirmed there was no documentation of a face-to-face evaluation by a physician or other trained professional within 1 hour of the implementation of restraints.</p> <p>Patient #3 did not receive a face-to-face evaluation after being restrained.</p> <p>e. The Director of ICU was interviewed on 11/19/15 at 11:15 AM. He stated he was the chair of the Restraint Committee for the hospital. He stated the hospital's unit Directors were members of the Restraint Committee which met monthly. He stated at each meeting he asked the Directors if they were aware of any problems on their units related to restraints, then gave each Director the names of patients on their unit who were restrained within the last month. They returned to their units to complete audits of restraint records. He stated the hospital had an audit tool and it was the responsibility of each Director to monitor and audit restraint records on their unit.</p> <p>Documentation of an audit of Patient #3's restraint record was requested. On 11/19/15 at 11:50 AM, the Director of Risk Management stated he spoke to the Unit Director who stated</p>	A 144		

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A 144	Continued From page 11 no audit of Patient #3's restraint record was completed. Therefore, there was no evaluation of the appropriateness of the restraint and the safety of the patient. Minutes of the Restraint Committee monthly meetings in 2015 were requested. In a letter faxed to surveyors on 11/20/15, the Director of Risk Management stated "In response to your request for restraint committee minutes; please be advised the committee did not meet in 2015, therefore there are no minutes."	A 144		
A 167	The hospital failed to review restraint records to ensure the safety of patients was not jeopardized. 482.13(e)(4)(ii) PATIENT RIGHTS: RESTRAINT OR SECLUSION [The use of restraint or seclusion must be--] (ii) implemented in accordance with safe and appropriate restraint and seclusion techniques as determined by hospital policy in accordance with State law. This STANDARD is not met as evidenced by: Based on patient record review, policy review and staff interview, it was determined the hospital failed to ensure the use of restraints was implemented in accordance with safe and appropriate techniques as determined by hospital policy for 1 of 2 patients (#3) who were restrained for violent or self destructive behavior and whose records were reviewed. This resulted in an inability of the hospital to ensure restraints were implemented in a safe and effective manner. The findings include: 1. The hospital's policy #391, Patient	A-167	Plan of Correction: The deficient practice found with patient #3 occurred due to the nursing staff relinquishing oversight of restraining patient #3 to EIRMC security (off duty IFPD). Accomplishing the POC to A-144 will result in more complete understanding of the policy. As a result, a behavioral restraint will be identified. 2 nd tier review is expected with each restraint applied. Procedure/Process for implementing: House Supervisors are being trained (per our Behavioral Health Services standards) to be the qualified RN to do the face to face and they are on the premises 24/7. Each restraint is to be 2 nd tiered by RN trained in restraints and our House Supervisor will be notified of each patient that is put in to, or who is presently in, a restraint. Automatic EHR reporting to House Supervisor will also assist with this process.	2/19/16

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A 167	<p>Continued From page 12</p> <p>Restraint/Seclusion, effective 9/30/14, included a section titled "Second Tier of Review" which stated "A member of nursing administration/management (e.g., nursing supervisor, manager/director, CNO, etc.) will review the need for restraint or seclusion with the RN who has determined that the patient requires restraint or seclusion. The second tier of review will occur with the initial application of restraint or seclusion."</p> <p>Patient #3's record included a Nurses' Note dated 10/16/15 at 9:45 PM. The note stated all available male assistance/security officers were called due to his escalating aggression. The note further stated "Officers restrained patient with bed sheets for patient's and staff's safety."</p> <p>Patient #3's record included a Nurses' Note dated 10/16/15 at 11:35 PM. It stated security officers were in Patient #3's room, he was released from the sheet restraints placed by the officers.</p> <p>Patient #3's record did not include documentation of a Second Tier of Review during the 1 hour and 50 minutes he was restrained with sheets.</p> <p>During an interview on 11/19/15 at 11:15 AM, the Director of ICU, who is the chair of the Restraint Committee, reviewed Patient #3's record and confirmed there was no Second Tier of Review after sheet restraints were applied.</p> <p>Patient #3's need for restraint was not reviewed per hospital policy.</p> <p>2. Refer to A166 as it relates to the failure of the hospital to ensure restraints were implemented in accordance with current, clear, and complete</p>	A 167	<p>Monitoring and tracking: The restraint committee will run the EMR report monthly to identify which patients were restrained and a 100% audit will be conducted to assure the policy was followed. This will be reported to MEC on a monthly basis.</p> <p>QA/PI: Audit and policy compliance results will be placed on Scorecards for tracking and trending behavior through the use of our performance improvement computer software program.</p> <p>Individual Responsible: Renae Oswald, MSN, NHA, NE-BC; Assistant Chief Nursing Officer</p>

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A 167	Continued From page 13 orders of physicians or other LIPs who were authorized to order restraints. 3. Refer to A171 as it refers to the failure of the hospital to ensure orders for restraint used to manage violent or self-destructive behavior were renewed every 4 hours in accordance with hospital policy. 4. Refer to A175 as it relates to the failure of the hospital to ensure the condition of patients who were restrained was monitored by trained staff. 5. Refer to A178 as it relates to the failure of the hospital to ensure a face-to-face meeting by a physician or LIP was conducted within 1 hour of the application of restraints used to manage violent or self-destructive behavior. The hospital failed to ensure policies related to safe and appropriate use of restraints were followed.	A 167			
A:168	462.13(e)(5) PATIENT RIGHTS: RESTRAINT OR SECLUSION The use of restraint or seclusion must be in accordance with the order of a physician or other licensed independent practitioner who is responsible for the care of the patient as specified under §482.12(c) and authorized to order restraint or seclusion by hospital policy in accordance with State law. This STANDARD is not met as evidenced by: Based on medical record review, policy review, and staff interview, it was determined the use of restraints was not implemented in accordance with current, clear, and complete orders of	A 168	Plan of Correction: House Supervisors (HS) are being trained to do face to face assessment and are the subject matter experts (SME) on restraints and the policy. Procedure/Process for implementing: HS will follow our policy of contacting the primary physician themselves as soon as possible for behavioral restrains. The HS will serve as SME to direct Clinical Supervisors or charge nurses to call receive an order for restraint when they are notified of restraint placement to assure that the policy was followed, if this has not already been completed.	2/19/16	

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A 168	<p>Continued From page 14</p> <p>physicians or other LIPs for 1 of 2 patients (#3) who were restrained for violent or self destructive behavior and whose records were reviewed. This resulted in missing or incomplete orders and restraint use that was not consistent with the orders of a physician or other LIP. This had the potential to result in unsafe care of restrained patients. Findings include:</p> <p>The hospital's policy #391, Patient Restraint/Seclusion, effective 9/30/14, stated "An order for restraint or seclusion must be obtained from an LIP/physician who is responsible for the care of the patient prior to the application of restraint or seclusion. The order must specify clinical justification for the restraint or seclusion, the date and time ordered, the duration of use, the type of restraint to be used and behavior-based criteria for release." Additionally, it stated "When a LIP/physician is not available to issue a restraint or seclusion order, an RN with demonstrated competence may initiate restraint or seclusion use based upon face-to-face assessment of the patient. In these emergency situations, the order must be obtained during the emergency application or immediately (within minutes) after the restraint or seclusion is initiated."</p> <p>Patient #3 was a 72 year old male admitted to the hospital on 10/16/15, with diagnoses of bilateral lower extremity cellulitis and end stage Alzheimer's disease. He was discharged on 10/19/15.</p> <p>Patient #3's record included a Nurses' Note dated 10/16/15 at 9:45 PM. The note stated all available male assistance/security officers were called due to Patient #3's escalating aggression.</p>	A 168	<p>Monitoring and tracking: Restraint committee will do a 100% review of all restraints documented in EMR to assure policy elements were followed. If they weren't remedial action will be taken to assure the events do not reoccur.</p> <p>QA/PI: Audit and policy compliance results will be placed on Scorecards for tracking and trending behavior through the use of our performance improvement computer software program.</p> <p>Individual Responsible: Renae Oswald, MSN, NHA, NE-BC; Assistant Chief Nursing Officer</p>	

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A 168	Continued From page 15 The note further stated "Officers restrained patient with bed sheets for patient's and staff's safety. MD contacted and orders received to give IM Geodon 20 mg now and notify him of effectiveness." A Nurses' Note dated 10/16/15 at 9:53 PM stated Patient #3's physician was notified of his behavior. The note documented the physician instructed the nurse to administer Geodon and call back if it did not work, to discuss restraints. Patient #3's record included a physician's order for bilateral soft wrist restraints, dated 10/16/15 at 11:04 PM. His record included a Nurses' Note dated 10/16/15 at 11:35 PM. It stated security officers were in Patient #3's room, he was released from the sheet restraints placed by the officers and placed in bilateral upper extremity soft restraints. Patient #3's record did not include a physician's order for the sheet restraints applied on 10/16/15 at 9:45 PM, and removed 1 hour and 50 minutes later. During an interview on 11/18/15 at 11:10 AM, the Assistant CNO reviewed Patient #3's record and confirmed there was not a physician's order for the sheet restraints.	A 168			
A 171	Patient #3 was placed in restraints without a physician's order. 482.13(e)(8) PATIENT RIGHTS: RESTRAINT OR SECLUSION Unless superseded by State law that is more restrictive— (i) Each order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical	A 171	Plan of Correction: As referred to in POC for A-144, the policy will be re-taught to staff.	2/19/16	

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A 171	<p>Continued From page 16</p> <p>safety of the patient, a staff member, or others may only be renewed in accordance with the following limits for up to a total of 24 hours: (A) 4 hours for adults 18 years of age or older; (B) 2 hours for children and adolescents 9 to 17 years of age; or (C) 1-hour for children under 9 years of age;</p> <p>This STANDARD is not met as evidenced by: Based on medical record review, policy review, and staff interview, it was determined the hospital failed to ensure orders for restraint used to manage violent or self-destructive behavior were renewed every 4 hours for 1 of 2 patients (#3) who were restrained for more than 4 hours to manage violent or self-destructive behavior and whose records were reviewed. This resulted in lack of oversight by a physician or qualified LIP and had the potential to interfere with patient safety. Findings include:</p> <p>The hospital's policy #391, Patient Restraint/Seclusion, effective 9/30/14, included guidelines for restraints for violent or self-destruction behavior. It stated physician orders for restraints must not exceed 4 hours for adults 18 and older.</p> <p>Patient #3 was a 72 year old male admitted to the hospital on 10/16/15, with diagnoses of bilateral lower extremity cellulitis and end stage Alzheimer's disease. He was discharged on 10/19/15.</p> <p>Patient #3's record included a physician's order for bilateral soft wrist restraints, dated 10/16/15 at 11:04 PM.</p> <p>Patient #3's record included a restraint monitor</p>	A 171	<p>Procedure/Process for implementing: House Supervisors will be SME and are on premises 24/7, they will be notified of any restraint present or place and will oversee following of policy including appropriate orders and assessment. Refer to A 168 POC as well.</p> <p>Monitoring and tracking: Refer to A-168 plan</p> <p>QA/PI: Refer to A-168 plan</p> <p>Individual Responsible: Renae Oswald, MSN, NHA, NE-BC; Assistant Chief Nursing Officer</p>	

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A 171	Continued From page 17 note dated 10/16/15 at 11:35 PM. The note stated bilateral soft wrist restraints were implemented due to violent/self destructive behavior. Nurses' Notes in Patient #3's clinical record dated 10/17/15 at 2:00 AM, 3:52 AM, 5:30 AM, 7:37 AM, 8:10 AM, 8:28 AM, and 10:00 AM, documented restraints were in place due to violent/self destructive behavior. A Nurses' Note dated 10/17/15 at 11:00 AM stated Patient #3's restraints were removed. Patient #3's record included a physician's order for bilateral soft wrist restraints, dated 10/16/15 at 11:04 PM. The order expired at 3:04 AM on 10/17/15. His record did not include physician orders for restraints used from 3:04 to 11:00 AM on 10/17/15. During an interview on 11/18/15 at 11:10 AM, the Assistant CNO reviewed Patient #3's record and confirmed the physician's restraint order was not renewed every 4 hours.	A 171			
A 175	482.13(e)(10) PATIENT RIGHTS: RESTRAINT OR SECLUSION The condition of the patient who is restrained or secluded must be monitored by a physician, other licensed independent practitioner or trained staff that have completed the training criteria specified in paragraph (f) of this section at an interval determined by hospital policy.	A 175	Plan of Correction: House Supervisors are undergoing training to be qualified to assess for behavioral restraints.	2/19/16	

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A 175	<p>Continued From page 18</p> <p>This STANDARD is not met as evidenced by: Based on medical record review, policy review, and staff interview, it was determined the hospital failed to ensure the condition of patients who were restrained was monitored by trained staff for 1 of 2 patient (#3) who were restrained for violent or self destructive behavior and whose records were reviewed. This resulted in a lack of oversight and had the potential to interfere with patient safety. Findings include:</p> <p>The hospital's policy #391, Patient Restrain/Seclusion, effective 9/30/14, included a section on monitoring patients in restraint. It stated "An RN will assess the patient at least every 2 hours." The policy stated the assessment would include signs of injury associated with the restraint, including circulation of affected extremities, respiratory and cardiac status, psychological status, needs for range of motion, hydration and nutritional needs, hygiene and elimination needs, and consideration of less restrictive alternatives to restraint.</p> <p>Patient #3 was a 72 year old male admitted to the hospital on 10/16/15, with diagnoses of bilateral lower extremity cellulitis and end stage Alzheimer's disease. He was discharged on 10/19/15.</p> <p>Patient #3's record included a Nurses' Note dated 10/16/15 at 9:45 PM. The note stated all available male assistance/security officers were called due to his escalating aggression. The note further stated "Officers restrained patient with bed sheets for patient's and staff's safety."</p> <p>Patient #3's record included a physician's order for bilateral soft wrist restraints, dated 10/16/15 at</p>	A 175	<p>Procedure/Process for Implementing: The training will be provided by a clinician with experience in in-patient psychiatric care and education/training in medical and behavioral assessment of patients. This training will include how to complete the face to face assessment; identifying pre-existing conditions; documentation requirements; assessing the patient's immediate situation and their reaction to the intervention; complete review of systems; risk assessment; review of health information and history; identification of interventions and measurable behavioral release criteria. Training packet included, see attachment A.</p> <p>The House Supervisor will be expected to pass the post-test and will be proctored twice by EIRMC Behavioral Health Center Clinical Supervisors. Proctor form included, see attachment B. This documentation will be present for all House Supervisors and be expected with House Supervisor orientation as part of their basic competencies. Refer to A-144, A-168, and A-171.</p> <p>Monitoring and tracking: Refer to A-168</p> <p>QA/PI: Refer to A-168</p> <p>Individual Responsible: Renae Oswald, MSN, NHA, NE-BC; Assistant Chief Nursing Officer</p>		

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A 175	<p>Continued From page 19</p> <p>11:04 PM. His record included a Nurses' Note dated 10/16/15 at 11:35 PM. It stated security officers were in Patient #3's room, he was released from the sheet restraints placed by the officers and placed in bilateral upper extremity soft restraints due to violent/self destructive behavior. Patient #3's record did not include documentation of an RN assessment during the 1 hour and 50 minutes he was restrained by sheets.</p> <p>Patient #3's record included a "Restraints Monitor" note dated 10/17/15 at 2:00 AM, 2 hours and 25 minutes after his bilateral upper extremity soft restraints were applied. However, the entry did not include an assessment of his status and needs, or consideration of alternatives to restraint.</p> <p>Patient #3's record included an RN assessment related to his restraints dated 10/17/15 at 3:52 AM, 4 hours and 17 minutes after restraints were applied to his upper extremities.</p> <p>Patient #3's record included an RN assessment related to his restraints dated 10/17/15 at 5:30 AM. However, the next RN assessment related to restraints was documented at 8:10 AM, 2 hours and 40 minutes after the previous assessment. An additional RN assessment related to restraints was documented at 11:00 AM, 2 hours and 50 minutes after the previous assessment. The restraints were discontinued at that time.</p> <p>During an interview on 11/18/15 at 11:10 AM, the Assistant CNO reviewed Patient #3's record and confirmed his status and needs related to restraints were not assessed by an RN every 2 hours.</p>	A 175		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 175	Continued From page 20	A 175		
A 178	<p>Patient #3's condition was not monitored frequently while he was in restraints.</p> <p>482.13(e)(12) PATIENT RIGHTS: RESTRAINT OR SECLUSION</p> <p>When restraint or seclusion is used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others, the patient must be seen face-to-face within 1-hour after the initiation of the intervention --</p> <p>o By a--</p> <ul style="list-style-type: none"> - Physician or other licensed independent practitioner; or - Registered nurse or physician assistant who has been trained in accordance with the requirements specified in paragraph (f) of this section. <p>This STANDARD is not met as evidenced by: Based on medical record review, policy review, and staff interview, it was determined the hospital failed to ensure a face-to-face meeting by a physician or LIP was conducted within 1 hour of the application of behavioral restraints for 1 of 2 patients (#3) who were restrained to manage violent or self-destructive behavior and whose records were reviewed. This prevented the hospital from evaluating the causes and appropriateness of the need for restraint. Findings include:</p> <p>The hospital's policy #391, Patient Restraint/Seclusion, effective 9/30/14, stated "A face-to-face assessment by a physician or LIP, RN or physician assistant with demonstrated competence, must be done within one hour of</p>	A 178	Please refer to A 175	2/19/16

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

PRINTED: 12/04/2015
FORM APPROVED
OMB NO. 0938-0391

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A 178	<p>Continued From page 21</p> <p>restraint or seclusion initiation...to manage violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others."</p> <p>Patient #3 was a 72 year old male admitted to the hospital on 10/16/15, with diagnoses of bilateral lower extremity cellulitis and end stage Alzheimer's disease. He was discharged on 10/19/15.</p> <p>Patient #3's record included a Nurses' Note dated 10/16/15 at 9:45 PM. The note stated all available male assistance/security officers were called due to Patient #3's escalating aggression. The note further stated "Officers restrained patient with bed sheets for patient's and staff's safety."</p> <p>Patient #3's record included a physician's order for bilateral soft wrist restraints dated 10/16/15 at 11:04 PM. His record included a Nurses' Note dated 10/16/15 at 11:35 PM. It stated security officers were in Patient #3's room, he was released from the sheet restraints placed by the officers and placed in bilateral upper extremity soft restraints due to violent/self destructive behavior. A Nurses' Note date 10/17/15 at 11:00 AM stated his wrist restraints were removed.</p> <p>Patient #3 was in sheet restraints for 1 hour and 50 minutes. He was in soft wrist restraints for 11 hours and 25 minutes. However, Patient #3's record did not include documentation of a face-to-face evaluation by a physician or other trained professional within 1 hour of the placement of restraints for violent/self destructive behavior.</p>	A 178		

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A 178	Continued From page 22 During an interview on 11/18/15 at 11:10 AM, the Assistant CNO reviewed Patient #3's record and confirmed there was no documentation of a face-to-face evaluation by a physician or other trained professional within 1 hour of the implementation of restraints.	A 178		
A 194	Patient #3 did not receive a face-to-face evaluation after being restrained. 482.13(f) PATIENT RIGHTS: RESTRAINT OR SECLUSION Restraint or Seclusion: Staff Training Requirements. The patient has the right to safe implementation of restraint or seclusion by trained staff. This STANDARD is not met as evidenced by: Based on review of restraint education information, medical record review, and staff interview, it was determined the hospital failed to ensure security officers had education, training, and demonstrated knowledge to manage patients exhibiting out-of-control and/or aggressive behavior. This resulted in inappropriate use of restraint to manage the aggressive behavior of 1 of 2 patients (#3) who were restrained to protect the safety of self and others. This failure placed all patients experiencing behavioral and psychiatric challenges at risk of physical and/or mental harm. Findings include: Patient #3's record documented he was a 72 year old male admitted to the hospital on 10/16/15, with diagnoses of bilateral lower extremity cellulitis end end stage Alzheimer's disease. He was discharged on 10/19/15.	A 194	Plan of Correction: EIRMC education department will provide train the trainer for EIRMC security leadership who will then provide education and training to security personnel via HeathStream. Procedure/Process for Implementing: The restraint policy and the Code 5 policy in Policy Manager will be a required read for all security staff. Competency on restraints will be documented in the employee record and be a basic competency for EIRMC employment for the security personnel. This will include them having knowledge that the RN maintains responsibility for the POC for the patient at all times. In addition, their training will include articulating the differences in restraining patients in a healthcare setting vs law enforcement. Monitoring and tracking: Policy manager and HealthStream reports on competency completion will be monitored to ensure all security staff assigned complete the assignments. Annual HealthStream education will continue for reinforcement of the policy.	2/19/16

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A 194	<p>Continued From page 23</p> <p>Patient #3's record included a Nurses' Note dated 10/16/15 at 9:45 PM. The note stated all available male assistance/security officers were called due to Patient #3's escalating aggression. The note further stated "Officers restrained patient with bed sheets for patient's and staff's safety." Patient #3's record included a Nurses' Note dated 10/16/15 at 11:35 PM. It stated security officers were in Patient #3's room, and he was released from the sheet restraints placed by the officers.</p> <p>During an interview on 11/18/15 at 11:10 AM, the Assistant CNO reviewed Patient #3's record. She stated it was not the hospital's practice to restrain patients with sheets.</p> <p>The Director of ICU was interviewed on 11/19/15 at 11:15 AM. He stated he was the chair of the Restraint Committee for the hospital. When asked if the hospital used sheets to restrain patients, he stated "No, never."</p> <p>The hospital utilized off duty Police Officers as hospital security officers. Training records for 3 Security Officers scheduled for duty on 11/19/15 were requested, including records for the Security Officer who restrained Patient #3 noted above. The hospital provided documents titled "Idaho Peace Officer Standards and Training," dated 1/01/15, for all 3 Security Officers. The documents included a record of training such as firearms training, stalking investigations, and arrest techniques. No training specific to hospital duties, including hospital restraint training, was included in training reports.</p> <p>The Director of Risk Management was interviewed on 11/19/15 beginning at 12:00 noon.</p>	A 194	<p>QA/PI: Utilization of Healthstream reports for tracking compliance of the security officers will be completed and will be reviewed during the Restraint Committee.</p> <p>Individual Responsible: Grant Gohr, Director of Plant Operations</p>	

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A 194	Continued From page 24 He stated there was no record of hospital training for Security Officers, including restraint training. The hospital used a system for the management of behavior called "Non Violent Crisis Intervention (NVCI)." The on duty Security Officer was interviewed on 11/19/15 beginning at 8:40 AM. He stated Security Officers participated in the placement of restraints for patients with violent or self destructive behavior. The Security Officer stated he had not received restraint training at the hospital. He stated he did not know what behavior management system the hospital used. He stated he did not know what the acronym NVCI stood for. He stated he did not use the hospital's behavior management system. He stated, if Security Officers responded to a call regarding patients' acting out, then the nurses deferred to the officers to help things calm down. Staff members who restrained patients were not trained by the hospital.	A 194		



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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December 14, 2015

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

Provider #130018

Dear Mr. Crabtree:

An unannounced on-site complaint investigation was conducted from November 16, 2015 to November 20, 2015 at Eastern Idaho Regional Medical Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00007192

Allegation #1: Patients were not provided with information regarding who to submit grievances to.

Findings #1: Five inpatients were interviewed on 11/17/15 and 11/18/15, including 1 former patient and 4 current patients. Four of the 5 stated they were not informed, either in writing or verbally, of whom to contact to file a grievance. The fifth patient was getting ready for discharge. She stated she thought she might have been informed in writing but she had packed her hospital paperwork and she was not sure.

Three different sets of patient rights information appeared to be used on the medical/oncology unit where the interviews occurred. On 11/18/15 at 12:15 PM, the Unit Secretary was preparing patient rights folders at the nursing station on the Medical/Oncology Unit. She stated the folders included a brochure outlining patient rights. The folders she was preparing did not include a copy of patient rights. When asked, she went into a back room and retrieved a box of patient rights brochures and placed them in the folders. The rights brochures were not in the folders in the rooms of the above patients.

The Nursing Director of the Medical/Oncology Unit was interviewed on 11/18/15 beginning at 2:05 PM. He stated the hospital did not use the patient rights brochures any more. He presented a bound patient handbook and stated the hospital kept one in each patient room. He took the surveyor into an empty room and there was a 3 ring binder in a drawer. This was different from the handbook presented earlier. The binder contained approximately fifty pages of material including the rights. The Director looked at the binder but was not immediately able to find the grievance information. He eventually located it on page 12.

The system to disseminate patient rights information, including information regarding the hospital's grievance process, was not consistent. Patients were not able to identify contact persons for the hospital's grievance process. If the handbooks were present in the room, it was not immediately apparent where the grievance information was. A deficiency related to lack of grievance information provided to patients was cited at 42 CFR Part 482.13(a)(2).

Conclusion #1: Substantiated. Federal deficiencies related to the allegation are cited.

Allegation #2: Patients did not receive safe radiological services.

Findings #2: For the first 3 quarters of 2015, 13 incident reports were documented related to the radiology department. All of the incidents were investigated and action was taken.

One incident report, dated 8/30/15, stated during Magnetic Resonance Imaging (MRI), a patient complained of a hot sensation on the left side of his abdomen. The report stated the technician examined the patient. It said no metal, wires, or electrocardiogram patches were on the patient during the scan. It said a sheet was placed between the patient's arm and abdomen and the scan was finished. It stated the cause of the "REDNESS/HEATING DURING THE SCAN" was unknown.

The technician who performed the scan for the patient was interviewed on 11/17/15 beginning at 9:35 AM. She stated she examined the patient for metal, wires, etc. before performing the scan. She stated the patient complained of a hot sensation during the test. She stated his left arm and chest were red where the skin touched. She stated she could not find a reason for the redness. She stated the test was finished without difficulty.

The patient's record contained a "MRI SCREENING FORM," not dated, which showed an examination for metal and foreign objects. Nothing was found.

A second incident report for the same patient, dated 8/31/15, stated a brown wrap around oxygen saturation monitor probe was on the patient's right index finger and a large blister was noted on his index finger. The incident report documented an investigation but it did not identify the cause of the blister.

Doug Crabtree, Administrator
December 14, 2015
Page 3 of 3

The patient was hospitalized from 8/30/15 to 9/04/15. A physician Discharge Summary, dated 9/04/15, stated during an MRI, the patient received burns and a plastic surgeon was consulted.

The plastic surgeon was interviewed on 11/18/15 beginning at 1:45 PM. He stated the patient had a third degree burn on his right index finger and second degree on his left chest and arm. He stated the second degree burns had healed but the finger was still being treated.

During a tour of the radiology department on the morning of 11/19/15, hospital oxygen saturation probes were observed. These were white and approximately 24 inches long.

The Nursing Director of the Medical/Oncology Unit was interviewed on 11/18/15 beginning at 2:05 PM. He stated oxygen saturation probes used by the local ambulance were brown and shorter.

The patient was interviewed on the morning of 11/17/15. He stated he was transported from home to the hospital by ambulance. He stated a wire about 8 to 10 inches long was taped to his right index finger. He stated the wire was left on during the MRI and he received burns to his right index finger and his left chest and arm.

Both radiology staff and physicians stated the burns were an extremely atypical event. The hospital had systems in place to check patients for metal and foreign objects prior to testing. No other burns had occurred. Radiology staff did not identify a wire probe attached to the patient's finger resulting in burns. This was an isolated incident and no systemic deficient practices were identified. The incident did occur but no deficiencies were cited.

Conclusion #2: Substantiated. No deficiencies related to the allegation are cited.

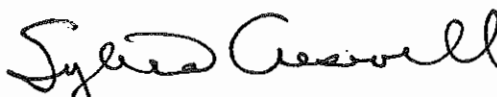
Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it will be addressed in the Plan of Correction.

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

Sincerely,



GARY GUILLES
Health Facility Surveyor
Non-Long Term Care



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

GG/pmt