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 25, 2015

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

RE: West Valley Medical Center, provider #130014

Dear Ms. Hunsicker:

This is to advise you of the findings of the complaint investigation, which was concluded at your facility on November 23, 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.

Please sign and date both of the forms and return them to our office by **December 7, 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,

Teresa Hamblin

TERESA HAMBLIN
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

TH/pmt
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130014	A. BUILDING _____ B. WING _____	C 11/23/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS The following deficiencies were cited during a CMS complaint investigation conducted 11/18/15 to 11/23/15/15. The surveyors conducting the complaint investigation were: Teresa Hamblin, RN, MS, HFS, Team Lead Susan Costa, RN, HFS The following acronyms were used in this report: BERT- Behavioral Emergency Response Team EMR - Electronic Medical Record LIP - Licensed Independent Practitioner MD - Medical Doctor prn - as needed pt- Patient RN - Registered Nurse	A 000		
A 123	482.13(a)(2)(iii) PATIENT RIGHTS: NOTICE OF GRIEVANCE DECISION 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. This STANDARD is not met as evidenced by: Based on review of hospital policy and grievance documentation, it was determined the hospital failed to ensure written notice was provided to patients or their legal representatives that included the steps taken to investigate the grievance and the results of the grievance process for 1 of 2 patients (#4) whose grievances	A 123		

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

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A 123	Continued From page 1 were reviewed. This resulted in an incomplete resolution to the grievance process. Findings include: The hospital policy "Patient/Family Complaint and Grievance Policy," dated 8/06/15, was reviewed. It stated "In resolution of the grievance, a written notice of the decision must be provided to the complainant that contains the name of the facility contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance investigation, and the date of completion." Two grievances were reviewed. Complaint documentation indicated a complaint was received on 9/15/15 by a legal guardian of Patient #4. The complainant alleged he was not included in treatment team meetings, that Patient #4's medications were being changed without his approval, and that he was not notified of Patient #4's impending transfer to another facility. The written notice of response, dated 10/09/15, did not include the steps taken to investigate the grievance and the results of the grievance process. This was confirmed by the Patient Advocate on 11/18/15 at 2:28 PM. She stated the complaint had been investigated and the complainant had not responded to telephone calls and she expected him to contact her after receipt of the letter. In its resolution of a grievance, the hospital did not provide Patient #4 or her legal representative with written notice that included the steps taken to investigate the grievance and the results of the grievance process.	A 123		

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A 168	Continued From page 2	A 168		
A 168	482.13(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 physicians or other LIPs for 1 of 5 patients (#12) who were physically restrained and whose medical 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: A hospital policy titled "Patient Restraint/Seclusion," approved 7/08/14, 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." The facility failed to ensure the staff followed the policy in the following examples: 1. Patient #12 was a 25 year old male who was	A 168		

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A 168	Continued From page 3 admitted to the Behavioral Health Unit on 10/26/15, for psychiatric services related to depression. He was discharged on 11/04/15. His record included documentation he was placed in restraints on two occasions. a. Patient #12's record included a verbal order for "Seclusion/Restraint" on 10/29/15 at 1:02 PM. However, the order was not clear and specific as follows: The order did not specify the type of restraints, such as leather restraints or the limbs to be restrained, such as all 4 extremities. Patient #12's record documented he was placed in leather restraints on all four extremities. A note entered by the RN caring for Patient #12 at that time read "Patient stated he was hearing voices but would not reveal what they were saying. Stated he could not remain safe. Staff offered 1:1 to help him stay safe and he began to strike himself in the head. Patient agreed to lie down for restraints. Restraints safely applied while pt was very cooperative." Patient #12's record did not include documentation he was placed in seclusion in accordance with the order. b. Patient #12's record included a verbal order for "Seclusion/Restraint" on 10/30/15 at 7:12 PM. However, the order was not clear and specific as follows: The order did not specify the type of restraints, such as leather restraints or the limbs to be restrained, such as all 4 extremities. Patient #12's record documented he was placed in leather restraints on all four extremities. A note entered by the RN caring for Patient #12 at 7:20 PM read "Due to prior amount of prn's no	A 168		

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A 168	Continued From page 4 additional meds were ordered and order received for seclusion and restraints now. BERT team called and restraints were placed [4 points]. 1:1 sitter placed outside door." During an interview on 11/20/15 beginning at 11:00 AM, an RN from the Behavioral Health Unit reviewed Patient #12's record and stated "A restraint order means 4 point hard restraints." He further demonstrated how restraint orders were entered in the EMR. The RN stated the drop down screen did not allow the user to select the type of restraint or the limbs to be restrained. The RN stated they did not seclude patients on the Behavioral Health Unit, and the room Patient #12 was placed in was used as a quiet room, it had video monitoring, and the patient had a one-to-one sitter. The RN confirmed the nursing note entered on 10/30/15 at 7:20 PM documented Patient #12 was placed in seclusion. Additionally, he confirmed the EMR orders for Patient #12 did not specify the type and amount of restraints to be used. The hospital failed to ensure physician orders for restraint and seclusion were complete and clear.	A 168		
A 171	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 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;	A 171		

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A 171	Continued From page 5 (B) 2 hours for children and adolescents 9 to 17 years of age; or (C) 1-hour for children under 9 years of age; 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 1 patients (#12) who was restrained for more than 4 hours to manage violent or self-destructive behavior and whose record was reviewed. This resulted in lack of oversight by a physician or qualified LIP and had the potential to interfere with patient safety. Findings include: The hospital's policy titled "Patient Restraint/Seclusion," approved 7/08/14, stated "Physician orders for restraint or seclusion must be time limited, and must specify clinical justification for the restraint or seclusion, the date and time ordered, the duration of restraint or seclusion use, the type of restraint, and behavior-based criteria for release. Orders for restraint or seclusion must not exceed 4 hours for adults." Additionally, the policy stated "To continue restraint or seclusion beyond the initial order duration, the RN determines that the patient is not ready for release and calls the ordering physician to obtain a renewal order." 1. Patient #12 was a 25 year old male who was admitted to the Behavioral Health Unit on 10/26/15, for psychiatric services related to depression. He was discharged on 11/04/15. Patient #12's record included a verbal order on 10/30/15 at 7:12 PM, for "Seclusion/Restraint" for	A 171		

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A 171	Continued From page 6 "Violent/Self Destructive" behavior. The order was written for 4 hours, which would have expired at 11:12 PM. However, he was released from seclusion and restraint on 10/31/15 at 1:10 AM, which was a total of 5 hours and 58 minutes. Patient #12's record did not include additional orders for further restraint and seclusion beyond 11:12 PM. During an interview on 11/20/15 beginning at 11:00 AM, an RN from the Behavioral Health Unit reviewed Patient #12's record and confirmed he was in 4 point leather restraints and seclusion for greater than four hours. The hospital failed to ensure orders for restraint and seclusion were renewed after four hours.	A 171		

Bureau of Facility Standards

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B 000	16.03.14 Initial Comments The following deficiencies were cited during a complaint investigation conducted 11/18/15 to 11/23/15. The surveyors conducting the complaint investigation were: Teresa Hamblin, RN, MS, HFS, Team Lead Susan Costa, RN, HFS	B 000		
BB458	16.03.14.470.05 Patient's Rights 05. Patient's Rights. Written Policies and procedures shall be developed regarding patient's rights. (10-14-88) a. Use of any form of physical restraint, forced treatment, chemical restraint or seclusion shall only occur in circumstances where there is established written policy and approved procedures to warrant such action and/ or is ordered by a physician; and (10-14-88) b. Each patient shall be allowed to communicate with persons outside the facility, except where excluded or limited in accordance with his comprehensive treatment plan. (10-14-88) c. Each patient shall be apprised of his rights. (10-14-88) This Rule is not met as evidenced by: Refer to A-168 and A-171 as it relates to restraints.	BB458		

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

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T. – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

December 1, 2015

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

Provider #130014

Dear Ms. Hunsicker:

An unannounced on-site complaint investigation was conducted from November 18, 2015 to November 23, 2015 at West Valley Medical Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00007191

Allegation #1: Patients were overmedicated, resulting in increased confusion.

Findings #1: An unannounced visit was made to the hospital for a complaint investigation on 11/18/15 to 11/23/15. During the investigation, 11 client records, policies, procedures, grievances, patient rights information, and restraint logs, were reviewed. Staff from the Behavioral Health Unit were interviewed, including a psychiatrist, psychiatric technicians, and nursing staff. Two current patients from the Behavioral Health Unit were also interviewed.

One patient record of a 79 year old male, admitted on 2/20/14, was reviewed. He was admitted upon the recommendation of a family physician due to family concerns about his increasing violent and aggressive behavior. The initial nursing assessment, dated 2/20/14, that occurred between 11:58 AM and 8:58 PM, indicated the patient was able to answer questions upon arrival and had some confusion about the date and the medications he was taking. The record indicated he became quite sedated after administration of medications ordered by the psychiatrist on 2/21/15, in response to an incident of violent and aggressive behavior toward staff. In addition to medication administered on an "as needed" basis, he was also administered regularly scheduled medications. A sample of nursing notes described the sedation, as follows:

2/21/14 12:15 PM - Patient is "quite sedated from earlier medications"

2/21/14 04:31 PM - Patient "continues to be sedated throughout the day... He remains disoriented to place, time, and situation."

2/22/14 09:26 AM - "Unable to assess at this time. Pt will not wake enough to answer questions."

2/22/14 04:02 PM - "Patient has been sleeping all day..."

2/22/14 09:30 PM - "Unable to assess at this time. Pt will not wake enough to answer questions."

2/23/14 10:00 AM - "Unable to assess at this time. Pt will not wake enough to answer questions."

2/23/14 11:22 PM - Patient "was unable to answer questions tonight. Pt has a sitter and became confused. Disoriented. And somewhat combative. Not wanting to follow instruction. Pt was attempting to get out the door. But could not figure out how. So sat down on the floor. Pt had a HAB {Haldol, Ativan, and Benadryl} on day shift & was given scheduled medication."

2/24/14 09:00 AM - Patient "extremely drowsy this am and unable to answer questions. He was unable to tell me where he is and the day/month."

2/24/14 4:46 PM - "Unable to assess pt this morning due to sedation level."

The Director of Nursing for the Behavioral Health Unit was interviewed on 11/19/15 at 12:51 PM. She stated she did not specifically recall the patient in question, but that it was never the intention of staff to over-sedate patients. She stated over-sedation is not considered a desirable outcome, that people react differently to medications, and staff communicate patient responses to medications to physicians. She also stated patients were seen daily by psychiatrists. They are also seen by a general medical doctor for a history and physical examination and on an "as needed" basis for medical issues that might arise.

The psychiatrist who cared for the patient was interviewed on 11/20/15 at 8:11 AM. He stated he had a specialty in neuropsychiatry and had been treating patients for over 30 years. He stated the patient was psychotic and violent as a result of his medical condition, an auto immune encephalitis. Medications were used to treat his condition and it could not always be predicted how a patient would respond to specific medications or dosages of medication. He stated the medications that were ordered were standard practice and were never intended to over-sedate him. He stated the patient had not slept well prior to his admission and the medications allowed him to get much needed sleep.

An RN who provided care for the patient was interviewed on 11/19/15 at 2:15 PM. He stated staff try to make sure patients are not over-sedated and he could not think of a patient in recent times who became over-sedated. He stated overuse of medications is discouraged.

Ten additional patient records were reviewed. They did not show evidence patients were over-sedated.

The Behavioral Health Unit was toured on 11/19 between 2:00 PM and 3:00 PM. There were 18 patients present at the time of the tour. None were observed to appear over-sedated. Two patients were interviewed during this time. They were able to answer questions and expressed satisfaction with the care they had been receiving.

While, one patient from February of 2014 did appear to be over-sedated, there was no evidence current patients on the Behavioral Health Unit were being over-sedated or that there was any pattern of over-sedating patients on the Behavioral Health Unit. Therefore, no deficiencies were cited.

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

Allegation#2: Patients developing bruising from staff abuse and inappropriate use of physical restraints.

Findings #2: The hospital's "Abuse," policy dated 6/12/13, was reviewed. The policy addressed criteria for suspicion of abuse, reporting procedures, and investigation of alleged abuse.

Eleven patient records were reviewed. One patient record of a 79 year old male, admitted on 2/20/14, was reviewed. He was admitted upon the recommendation of a family physician due to family concerns about his increasing violent and aggressive behavior. There was no documentation to indicate the patient was physically restrained during his hospital stay. There was documentation he was in seclusion between 7:30 AM and 8:30 AM on 2/27/14 in order to protect staff from the patient's thrusting fist.

The initial nursing assessment, dated 2/20/14 at 1:50 PM, indicated the patient did not have bruises or wounds at the time of admission on 2/20/14. Subsequent nursing notes, beginning on 2/23/14 at 11:22 PM, included documentation of upper extremity bruising and on 2/24/14 at 9:00 PM of skin tears and upper bruising. There was no explanation documented in the medical record for the bruising and skin tears.

It was requested of the Director of Quality and Risk Management whether there had been any grievances or incident reports, such as falls or injuries, filed related to the patient. He stated there had not been any variance reports or grievances but there had been one employee injury report from an incident that had occurred on 2/21/14.

The employee injury report, dated 2/21/14, was reviewed. It stated a staff member injured her back while trying to help an extremely agitated patient (the same patient referenced above) to keep him from falling. The event occurred on 2/21/14 at 01:10 AM. "He slipped, caught himself on my arms and sat back on the bed, pulling me on top of him. He continued to fight (hit, kick, try to bite) for another 30+ minutes. Pt (patient) also kicked me in the face." The employee involved with the incident was not available for interview.

A Psychiatric Technician who provided care for the patient was interviewed on 11/19/15 at 1:42 PM. When asked what she remembered about the patient, she stated she remembered him to be "antsy and agitated." She stated he had a one-to-one sitter with him continuously and additional staff monitored him every 15 minutes. When asked if she recalled any injuries the patient might have sustained during the hospitalization, she stated she remembered him having scratches on his lower arms from flailing his arms and hitting himself on something in the room. She could not recall any other injuries.

A second Psychiatric Technician who provided care for the patient was interviewed on 11/19/15 at 2:38 PM. She could not specifically remember the patient. She stated she had worked in the Behavioral Health Unit for over 6 years and had not known of any allegations of staff abuse of a patient on her unit.

An RN who provided care for the patient was interviewed on 11/19/15 at 2:15 PM. When asked what he remembered about the patient, he stated he was an older male who was "confused" and had "difficulty communicating" and he "hit staff a lot." He did not recall any falls or injuries the patient sustained during his stay. When asked how he would respond if he observed new bruising on a patient, he stated he would document it in the medical record and on a variance report, and he would report it to the charge nurse and physician.

The Chief Nursing Officer was interviewed on 11/23/15 at 11:30 AM. She stated the patient likely developed bruising from the incident that occurred where the employee was injured. She confirmed there was no specific documentation the patient's bruising had been investigated.

Evidence of unexplained bruising or other injuries was not present in the other 10 patient records.

The Director of the Behavioral Health Unit was interviewed on 11/18/15 beginning at 1:00 PM. She stated that since January of 2015 all staff were trained in how to assess patients for the potential for violence and how to calm patients down with techniques other than restraints or seclusion. She stated none of the current 18 patients on the Behavioral Health Unit had required restraint or seclusion since their admissions. There had been only one incident of restraint since August, 2015.

The Behavioral Health Unit was toured on 11/19 between 2:00 PM and 3:00 PM. There were 18 patients present at the time of the tour. Two patients were interviewed during this time. They were able to answer questions and expressed satisfaction with the care they had been receiving.

There was evidence of unexplained and uninvestigated patient bruises in 2014. There was no evidence of staff abuse or inappropriate restraint. The hospital had a process to identify, report, and investigate allegations of abuse. Therefore, no deficiencies were cited.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

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

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

Sincerely,

TERESA HAMBLIN
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

TH/pmt