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

February 19, 2016

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

RE: Eastern Idaho Regional Medical Center, Provider #130018

Dear Mr. Crabtree:

On February 2, 2016, a follow-up visit of your facility, Eastern Idaho Regional Medical Center, was conducted to verify corrections of deficiencies noted during the survey of 11/20/2015.

We were able to determine that the Condition of Participation of Patient Rights (42 CFR 482.13) is now met.

Your copy of a Post-Certification Revisit Report, Form CMS-2567B, listing deficiencies that have been corrected is enclosed.

Also enclosed is a Statement of Deficiencies/Plan of Correction form, CMS-2567, listing Medicare deficiencies. The hospital is under no obligation to provide a plan of correction for Medicare deficiencies. If you do choose to submit a plan of correction, provide it in the spaces provided on the right side of each sheet.

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

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

- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the PoC is effective in bringing the Hospital into compliance, and that the Hospital remains in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
- The administrator's signature and the date signed on page 1 of the Form CMS-2567.

Whether you choose to provide a plan of correction or not, please sign and date the form and return all pages of the form to our office by **February 29, 2016.** Also, please keep a copy for your records. For your information, the Form CMS-2567 Statement of Deficiencies is disclosable to the public under the disclosure of survey information provisions.

Thank you for the courtesies extended to the surveyors during their visit. If we can be of any help to you, please call us at (208) 334-6626, option 4.

Sincerely,

GARY GUILES
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/pt
Enclosures

ec: Debby Ransom, Bureau Chief, Bureau of Facility Standards
Aileen Renolayan, CMS Region X Office
Carroll Wyble, CMS Region X Office

Eastern Idaho REGIONAL MEDICAL CENTER
ADMINISTRATION

3100 Channing Way
Idaho Falls, Idaho 83404

Phone: (208) 529-6210
Fax (208) 529-7021

February 25, 2016

Centers for Medicare and Medicaid Services
Attention: Sylvia Creswell
Survey, Division of Survey and Certification

Dear Ms. Creswell,

In regards to our recent follow-up visit, please see the enclosed plan of correction related to our Medicare deficiencies. Although we were under no obligation to provide a plan of correction, we felt it important for you to be aware that we have put process in place to address the deficiencies. Thank you for your oversight and your team's assistance in helping us to improve the care we provide to our patients. Please contact me if you have any questions or require clarification.

Sincerely,

Doug Crabtree, CEO
Eastern Idaho Regional Medical Center

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130018	A. BUILDING _____ B. WING _____	R-C 02/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN IDAHO REGIONAL MEDICAL CENTER	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 the Medicare follow-up survey conducted from 2/01/16 to 2/02/16. The surveyors conducting the follow-up survey were: Gary Guiles, RN, HFS, Team Lead Teresa Hamblin, RN, MS, HFS The following acronyms were used in this report: ACNO - Assistant Chief Nursing Officer ED - Emergency Department LIP - Licensed Independent Practitioner ICU - Intensive Care Unit RN - Registered Nurse	{A 000}	RECEIVED FEB 25 2016 FACILITY STANDARDS	
{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 hospital failed to ensure the use of restraint was in accordance with the order of a physician and hospital policy for 2 of 4 patients (#1 and #2) who were restrained and whose medical records were reviewed. This had the potential to result in the unnecessary use of restraints. Findings include: The policy "Restraint/Seclusion," dated 11/23/15,	{A 168}	Plan of correction: House supervisors (HS) have been trained to do face to face assessment (for behavioral restraint) and are subject matter experts (SME) on restraints and our restraint policy. All clinical areas have been informed to notify HS when an assessment of a patient indicates the need for a restraint (any type). The HS will provide oversight of the process. Procedure/Process for implementing: Once the HS is notified of the assessment warranting a restraint, they will perform a "real time" audit to assure that the appropriate order has been received and is being executed as ordered. This will include type of restraint as well as documentation of order. Monitoring and tracking: Restraint committee will do a retrospective audit of 100% of any ordered restraint. This will include all elements of the policy, including orders. Remedial action will be taken (education, any physician follow up) to assure compliance. QA/PI: Audit and policy compliance results will be reported at restraint committee and also included on individual performance scorecards. Tracking and trending will occur through restraint committee.	2/24/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: CEO | (X6) DATE: 2/25/16

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 168}	Continued From page 1 was reviewed. It included, but was not limited to, the following information: - "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." - "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." The policy was not followed. Examples include: 1. Patient #2 was a 58 year old female whose medical record indicated application of soft bilateral wrist restraints in the ED on 1/27/16 at 1:00 PM. Physician documentation, dated 1/27/16 at 4:13 PM, included an order for bilateral soft wrist restraints for Patient #2 due to "pulling at lines." The time of the physician's order was greater than 3 hours after the application of restraints. The Director of the ED was interviewed on 2/02/16 at 9:52 AM. He stated he knew a verbal order for restraints had been received by nursing staff at the time of restraint application. He stated the medical record did not include documentation a verbal order had been received. Patient #2 was restrained without a timely order.	{A 168}	Person Responsible: Renae Oswald, ACNO	

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{A 168}	Continued From page 2 2. Patient #1 was a 64 year old female who was admitted to the hospital on 1/20/16 after a 35 foot fall. She suffered an open fracture of her right femur and fractures of her right elbow, jaw, face, right hip, and pelvis. A ventilator flow sheet stated Patient #1 was intubated at 1:20 PM on 1/20/16. A nursing progress note, dated 1/20/16 at 1:06 PM, stated soft restraints were applied on all 4 extremities. Another nursing progress note by another RN, titled "Restraints Evaluation/2nd Tier Review and dated 1/20/16 at 1:09 PM, stated Patient #1 had restraints applied to both upper extremities and to her left lower extremity. The physician order for the restraints was dated 1/20/16 at 1:06 PM. The order was for bilateral soft wrist restraints. The ED Director reviewed Patient #1's medical record on 2/02/16 beginning at 9:30 AM. He stated the restraint orders did not match the restraints that were applied according to the nursing progress notes. Restraints were not applied to Patient #1 in accordance with physician orders.	{A 168}		
A 173	482.13(e)(8) PATIENT RIGHTS: RESTRAINT OR SECLUSION [Unless superseded by State law that is more restrictive,] (iii) Each order for restraint used to ensure the physical safety of the non-violent or non-self-destructive patient may be renewed as authorized by hospital policy. This STANDARD is not met as evidenced by: Based on review of medical records, hospital	A 173	Plan of correction: Concurrent auditing is occurring on all ordered restraints in the ICU to prevent this from reoccurring. Procedure/Process for Implementing: The shift responsibilities for the ICU charge nurse includes reviewing all orders, reassessments and need for order renewal. The charge nurse collaborates with the primary care nurse and assures that orders are renewed per policy. Monitoring and tracking: Restraint committee will do a retrospective audit of 100% of any ordered restraint. This will include all elements of the policy, including orders. Remedial action will be taken (education, any physician follow up) to assure compliance. QA/PI: Audit and policy compliance results will be reported at restraint committee and also included on individual performance scorecards. Tracking and trending will occur through restraint committee. Physician order issues will be reported at MEC.	2/24/16

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A 173	Continued From page 3 policy, and staff interview, it was determined the hospital failed to ensure each order for restraint used to ensure the physical safety of the non-violent or non-self-destructive patient was renewed as authorized by hospital policy for 2 of 4 patients who were restrained (#3 and #4) and whose medical records were reviewed. This resulted in unauthorized restraint use. Findings include: The hospital policy "Restraint/Seclusion," dated 11/23/15, was reviewed. The policy included, but was not limited to, the following information: - "Duration of order for restraint use must not exceed twenty-four (24) hours for the initial order..." - "If reassessment indicates an ongoing need for restraint, a new order must be written each calendar day..." The policy was not followed. Examples include: 1. Patient #3 was a 53 year old female who was admitted to the hospital on 12/26/16. Restraint orders were reviewed from 1/15/16 through 1/25/16. Restraint orders included, but were not limited to, the following dates and times: - 1/15/16 12:05 AM (Initial) - 1/15/16 11:42 AM (renewal) - 1/17/16 2:30 PM (renewal) There were no documented restraint orders on 1/16/16.	A 173	Person Responsible: Renae Oswald, ACNO	

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A 173	Continued From page 4 Medical record documentation indicated Patient #3 was restrained continously from 1/15/16 through 1/17/16. The ACNO was interviewed on 2/02/16 at 10:09 AM. She reviewed Patient #3's medical record and confirmed Patient #3 continued in restraints on 1/16/16 without a renewal order for 1/16/16. Restraint orders were not renewed in accordance with hospital policy. 2. Patient #4 was a 78 year old male who was admitted to the hospital on 1/21/16 and died on 1/24/16 at 7:00 PM. Patient #4's medical record documented an order for bilateral wrist restraints in the ICU on 1/23/16. The order was dated 1/23/16 at 3:30 PM and stated "Utilize restraints for the next 24 hours (not to exceed 24 hours)." The medical record documented Patient #4 remained in restraints until his death. The order for wrist restraints was renewed on 1/24/16 at 6:38 PM, 27 hours after the initial restraint order. Patient 4's medical record was reviewed with the ACNO on 2/02/16 beginning at 10:05 PM. She confirmed the restraint order was not reviewed within the 24 hours prescribed by the order and hospital policy. Patient #4's restraint order was not renewed in accordance with hospital policy.	A 173		
A 187	482.13(e)(16)(iv) PATIENT RIGHTS: RESTRAINT OR SECLUSION [there must be documentation in the patient's	A 187		

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A 187	Continued From page 5 medical record of the following:] The patient's condition or symptom(s) that warranted the use of the restraint or seclusion. 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 there was medical record documentation of the condition or symptom(s) that warranted the use of restraints for 2 of 4 patients (#1 and #3) whose medical records were reviewed. This resulted in a lack of clarity as to whether the least restrictive restraints were utilized. Findings include: Patient #3 was a 53 year old female who was admitted to the hospital on 12/26/16 for care in the ICU related to vascular disease, necrotric muscle, and related complications. Physician documentation included restraint orders, dated 1/25/16 6:30 AM, for 4 point soft restraints for 24 hours for "pulling at line(s)." There was no documentation that explained how pulling at lines justified leg restraints. Review of nursing notes documentation for 1/25/16 did not include an explanation as to why it was necessary to restrain Patient #3's legs. The ACNO and Director of Respiratory/ICU were interviewed together on 2/02/16 at 10:23 AM. The Director of Respiratory/ICU explained the reason Patient #3 needed leg restraints was because she had a large groin wound with a wound vac and leg movement was interfering with her medical care. The ACNO and the Director of Respiratory/ICU confirmed documentation did not clearly explain the reason	A 187	Plan of Correction: Each patient will be assessed for least restrictive device to be used if a restraint is to be placed. Documentation will include symptoms that warranted the use of restraints. Procedure/Process for implementing: Clinical staff will be educated on the expectation that least restrictive device will be chosen based on the symptoms exhibited by the patient. Symptoms will be documented in the restraint assessment screen within the EHR to include what "line" is at risk and why the type of restraint identified was chosen. Monitoring and tracking: Concurrent auditing is being done in the ICU and ED by the charge nurse. Assessments will be audited to assure they include the required documentation. In addition, the restraint committee will do a retrospective audit of 100% of any ordered restraint. This will include all elements of the policy, including least restrictive device. Remedial action will be taken, if necessary, to assure compliance. QA/PI: Audit and policy compliance results will be reported at restraint committee and also included on individual performance scorecards. Tracking and trending will occur through restraint committee. Person Responsible: Renae Oswald, ACNO	2/24/16

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A 187	Continued From page 6 for the leg restraints. The hospital policy "Restraint/Seclusion," dated 11/23/15, was reviewed. The policy did not specifically address the requirement to document the patient's condition or symptom(s) that warranted the use of restraints. The policy was limited to the following documentation requirements: "The medical record contains documentation of: a. Assessment of risk for restraint or seclusion b. Restraint or seclusion alternatives employed c. Determination of effectiveness/ineffectiveness of restraint or seclusion alternatives d. Second tier review of need for restraint or seclusion e. Order for restraint or seclusion and any renewal orders for restraint or seclusion f. Restraint or seclusion application/initiation g. Family notification of restraint or seclusion use h. Patient and family education regarding restraint or seclusion use i. Assessment of the patient in restraint or seclusion j. Monitoring of the patient in restraint or seclusion k. Medical and behavioral evaluation for restraint or seclusion management of violent or self-destructive behavior l. Modifications of the plan of care m. Physician notification of changes in patient condition n. Restraint or seclusion removal/termination o. Document requirements related to deaths of patients..." Patient #3's medical record did not include clear documentation as to the patient's condition or	A 187		

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A 187	Continued From page 7 symptoms that warranted the use of leg restraints. 2. Patient #1 was a 64 year old female who was admitted to the hospital on 1/20/16 after a 35 foot fall. She suffered an open fracture of her right femur and fractures of her right elbow, jaw, face, right hip, and pelvis. A ventilator flow sheet stated Patient #1 was intubated at 1:20 PM on 1/20/16. A nursing progress note, dated 1/20/16 at 1:06 PM, stated soft restraints were applied on all 4 extremities. Another nursing progress note by another RN, titled "Restraints Evaluation/2nd Tier Review and dated 1/20/16 at 1:09 PM, stated Patient #1 had restraints applied to both upper extremities and to her left lower extremity. Nursing progress notes documented Patient #1 remained restrained until 8:40 PM on 1/20/16. None of the progress notes documented the symptoms that required the use of restraints. A nursing progress note, dated 1/20/16 at 1:07 PM, stated "Behavior - Attempts to remove device. The note did not state which device Patient #1 was trying to remove or how she could use her right arm or leg to remove a device given the nature of her fractures. The ED Director reviewed Patient #1's medical record on 2/02/16 beginning at 9:30 AM. He agreed the specific symptoms that required the use of restraints were not documented. The symptoms that warranted the use of restraints for Patient #1 were not documented.	A 187		