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February 1, 2012

Greg Maurer, Administrator  
Elmore Medical Center  
PO Box 1270  
Mountain Home, ID 83647

Provider #131311

Dear Mr. Maurer:

On **January 5, 2012**, a complaint survey was conducted at Elmore Medical Center. The complaint allegations, findings, and conclusions are as follows:

**Complaint #ID00005323**

**Allegation #1:** Emergency Department (ED) staff inaccurately described information in medical records for patients who were in pain as drug-seeking patients, rather than taking their pain seriously.

**Findings #1:** An unannounced visit was made to the hospital on 1/04/12. During the complaint investigation, surveyors interviewed staff and reviewed the ED visit log, ten patient records, hospital case management records, and complaint files.

The ED Nurse Manager was interviewed on 1/04/12. When asked if the ED or hospital kept a file of patients who were identified as drug-seeking patients, she explained they did keep a file of patients with known drug problems identified by the Board of Pharmacy. She showed the surveyor the file which contained the name of 3 patients and supporting documentation from the Board of Pharmacy. When asked if they kept a file of patients who were frequent visitors to the ED, she explained the hospital kept a file of ED patients who had been referred for Care Management. She showed the surveyor the file which contained the names of several patients. She provided a policy, "Care Management Program," which outlined the criteria for referral to the Care Management Program, including:

- Physician referral
- Licensed staff recommendation to treating physician for referral
- Three or more visits to the ED within a three month period
- Patients coming to the ED for medication refills
- Repeat visits for pain
- Repeat visits for drug and/or alcohol related complaints
- Prescription drug overdose
- Multiple patients from one family being seen in the ED at the same time
- Patients presenting fraudulent information to obtain narcotics
- Chronically mentally ill with no primary care provider
- Patients using the ED as a primary care provider
- Existing Contract/Care Plan with primary care provider or other physicians

Medical records for surveyor review were selected from the hospital's list of patients with known drug problems, the list of patients in the Care Management file, same-day patients, and from the general ED visit log.

Of the ten records reviewed, all of the ED notes described assessment and treatment of patients' pain followed by individualized treatment. None of the records described dismissing patients' reports of pain as not valid or identifying patients as "drug-seeking." However, some patient records contained documentation of physician decisions to not treat patients' pain with narcotic medication because of patients' documented or stated past history of drug overuse or drug abuse.

One patient record, selected from the Care Management file, documented an ED visit on 11/18/11 by a 51 year old female who reported back pain after lifting items in preparation for a garage sale. She also reported having chronic back pain. She requested a shot of Toradol to help relieve her pain so she could sleep. The report documented she was given a shot of Toradol and the physician told her he would not give her any narcotics because of her past history of narcotic overuse and over-sedation. There was no documentation the patient had asked for a narcotic during the visit. The patient was not in the hospital's file of patients with known drug problems.

The patient's record documented 11 ED visits in 2011, 16 ED visits in 2010, and 13 ED visits in 2009. The visit records prior to 2009 were not reviewed. Of the ED visits, there was only one visit (5/13/10) that documented the patient asked for a narcotic (Vicodin) stating she only had one pill left from her prescription from her primary doctor. During the ED visit, she was given a prescription for 16 Vicodin tablets. The patient had a second visit to the ED, after being transported by ambulance, later the same day (5/13/10). The ED record described the patient as arriving unresponsive. She was treated successfully with Narcan (a medication to counteract the effect of narcotics). It was determined the patient had a probable overdose of narcotics.

The physician who provided care to the above referenced patient on 11/18/11 was interviewed on 1/05/12. When asked if the patient asked for narcotics during her visit on 11/18/11, he said she asked for Toradol, a non-narcotic pain medication. When asked why he told her he would not give her narcotics, he stated she had been on narcotics for pain in the past. He feared, because of her mental health issues, she would overuse them if he prescribed them.

During a telephone interview on 1/05/12, the Chief Nursing Officer was asked if the hospital had a policy to address patient concerns that information in their medical records was inaccurate. She provided a copy of a hospital policy, "Patient Request for Amendment to Protected Health Information." The policy stated patients are allowed to amend their medical record, with some exceptions. If, after reviewing the request and the record, the hospital determines the information in the record is accurate and complete as recorded, then the record would not be amended.

There was lack of sufficient evidence to determine patients were being described inaccurately in medical records as drug-seeking patients or that their pain was not being taken seriously. Therefore, there were no deficiencies cited.

**Conclusion:** Unsubstantiated. Lack of sufficient evidence.

**Allegation #2:** ED staff violated patients' privacy by talking about patients by name within hearing distance of other patients.

**Findings #2:** During the complaint investigation on 1/04/12, surveyors reviewed patient rights information and a grievance log. They also interviewed staff and observed services being provided to three patients in the Emergency Department.

The surveyor requested copies of the hospital's patient rights and privacy information given to patients. A "Patient Rights" document that was attached to a "Patient Signature Statement" was provided for review. The document concerning patient rights included, but was not limited to the following information:

- The facility employees and health care providers will show the patient respect, maintain dignity and make the patient feel as comfortable as possible while receiving care.
- The staff will identify themselves by name and call the patient by name.
- When being examined, the patient may ask that the staff close the door, close the curtains, or ask patient visitors to leave the room during exam. If healthcare students are present or involved, the patient has the right to know.
- Information about the patient and care being provided will be kept completely private. The patient has the right to see their records if a request is submitted in writing.

- No matter race, color, national origin, religion, age, sex, sexual orientation, medical condition, or ability to pay for your care, you will receive the care you need and everything that is ordered by your physician.
- The facility and staff want the patients to be as comfortable as possible. The staff will work with the patient to control their pain.
- If a patient is not satisfied with the way their concerns are addressed, they can contact the Chief Nursing Officer at ext. 133, or the Risk Manager at ext. 163 and they will look into your concerns. The patient will be contacted within 30 days and can expect a written answer and/or solution to the problem within 60 days. The patient may also file their concern with the Bureau of Facility Standards at 334-6626, P.O. Box 83720, Boise, Idaho 83720-0036.

The surveyor also reviewed a "Patient and Visitor Comment Card." The directions on the card encouraged patients to write down their comments, concerns and compliments on the card and return to any staff member.

The facility grievance log was reviewed as well. One patient grievance, selected from the grievance log and dated 11/28/11, indicated a grievance related to privacy concerns was filed by a patient who was seen in the ED for treatment on 11/18/11. The patient stated she heard the nurses at the nurses station and hallway talking about her while using her full name and speaking loud enough for others to hear. The patient also stated the nurses were unprofessional. The hospital investigated the grievance and concluded that a breach in privacy had not occurred. The facility found the conversation that took place about the patient filing the complaint was found to have been in the course of treatment and therefore an incidental disclosure.

The physician who provided treatment for the patient who filed the grievance on 11/18/11 was interviewed on 1/05/12. He did not recall that the staff spoke in loud tones about the patient. He also stated the ED staff made efforts to maintain confidentiality and privacy for all patients, but that it was challenging given the small treatment space. He said it was possible for a conversations to have been overheard.

The surveyor observed ED staff for approximately 3 hours on 1/04/12. During that time, the ED staff provided treatment to 3 patients, 2 of whom were treated in the same treatment area, with only a curtain to provide separation and privacy. Though the physical space in the ED was small and conversations were easily overheard, the staff behaved in a professional manner, treated all patients with respect and made every effort to maintain privacy for each patient.

The Medical Director for the ED was interviewed on 1/04/12. He stated it was difficult to maintain privacy in the ED due to the small space available for treatment of patients. The Medical Director also said every effort was and is made to respect the the privacy and confidentiality of each patient, including the use of a bed number in place of a patient's name,

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and when necessary, the use of a patient's first name only. The Medical Director also stated, "It is a trade off as it relates to medical errors when providing medication and treatment to a patient." He said it was sometimes necessary when providing medications and treatment, for purposes of safety, to use a patient's full name for identification.

While it was possible for conversations to be overheard in a small ED where patients were receiving treatment in close proximity to one another, there was lack of sufficient evidence to determine patients were being discussed within hearing distance of other patients. Therefore, there were no deficiencies cited.

**Conclusion:** Unsubstantiated. Lack of sufficient evidence.

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

Sincerely,



TERESA HAMBLIN  
Health Facility Surveyor  
Non-Long Term Care



SYLVIA CRESWELL  
Co-Supervisor  
Non-Long Term Care

TH/srm