



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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February 25, 2013

Julie Taylor, Administrator
West Valley Medical Center
1717 Arlington Street
Caldwell, ID 83605

Provider #130014

Dear Ms. Taylor:

On **February 6, 2013**, a complaint survey was conducted at West Valley Medical Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00005863

ALLEGATION #1: Patients were not provided assistance when entering the Emergency Department.

FINDINGS #1: An unannounced visit was made to the hospital on 2/04/13 to 2/06/13. Eleven medical records of patients, who presented to the Emergency Department (ED) with complaints of chest pain, were reviewed. Staff and patients were interviewed.

All 11 medical records that were reviewed documented patients were triaged by a registered nurse (RN) within a few minutes of presenting to the ED. All of the records documented patients were assessed and treated.

For example, one medical record documented a 73 year old female who presented to the ED on 10/08/12 at 4:32 PM. She complained of chest pain. The triage note was written at 4:37 PM by an RN. The triage note stated the patient appeared in no acute distress and her respirations were not labored. The hospital had a chest pain protocol. Oxygen was started for the patient. An intravenous line (IV) was started. The patient was given aspirin and nitroglycerine. She was examined by a physician. Laboratory tests were drawn and an electrocardiogram were

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performed. The patient was evaluated and treated. She was admitted to the medical/telemetry unit for observation.

Three patients from the medical/telemetry unit were interviewed. All 3 had come through the ED. All 3 stated they were well cared for from the time they entered the ED. They all stated staff were attentive to their needs.

No problems with care in the ED were identified.

CONCLUSION #1: Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2: Patients were not provided food and water.

FINDINGS #2: Three medical records of patients who were admitted from the ED for further care, were reviewed. Nursing notes documented all 3 received the diet that was ordered for them.

One medical record documented a 73 year old female who presented to the ED on 10/08/12 at 4:32 PM. She was discharged after 6:12 PM on 10/09/12. She received IV fluids in the ED. She was treated in the ED until 10:47 PM when she was transferred to the medical/telemetry unit. She did not have a diet order written in the ED. Patients are typically not fed in the ED until a course of treatment is determined. Admission orders to the medical/telemetry unit, dated 10/8/12, stated the patient was not to eat or drink anything after midnight on 10/09/12. The order form included a cardiology consult the following day and anticipated a cardiac stress test would be ordered. Patients are typically not allowed to eat or drink before this type of test. A nursing note, dated 10/09/12 at 12:55 PM, stated the patient complained of being very hungry and thirsty and threatened to leave against medical advice. A cardiac diet was ordered at that time. The patient ate all of the meal. An echocardiogram was then conducted instead of the stress test. It was also documented the patient ate all of her evening meal.

Four current inpatients were interviewed on the medical/telemetry unit on the afternoon of 2/05/13. All 4 patients stated they had received plenty of food and fluids.

Patients were provided food and fluids in compliance with physician orders.

CONCLUSION #2: Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3: Patients were ignored by nursing staff and call lights were not answered in a timely manner.

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FINDINGS #3: Four medical records were reviewed of patients who were hospitalized on the medical/telemetry unit between 10/08/12 and 1/11/13. All of these records documented nursing staff had frequent contact with patients and provided nursing services.

One medical record documented a 73 year old female who presented to the ED on 10/08/12 at 4:32 PM. She was discharged after 6:12 PM on 10/09/12. Her room was located next to the nursing station. Nursing notes documented interaction with the patient at least 8 times between her arrival on the medical/telemetry unit at 11:00 PM on 10/08/12 and 7:00 AM on 2/09/12 when shift change occurred. Nursing notes documented interaction with the patient at least 10 times between 7:00 AM and 6:02 PM on 2/09/12, shortly before discharge.

Four patients from the medical/telemetry unit were interviewed. All 4 stated the hospital appeared to have sufficient nursing staff on duty and their call lights had been responded to in a timely manner.

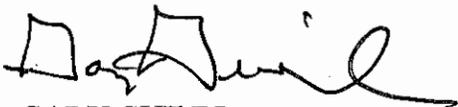
No instances were identified where staff failed to respond to patients' needs .

CONCLUSION #3: Unsubstantiated. Lack of sufficient evidence.

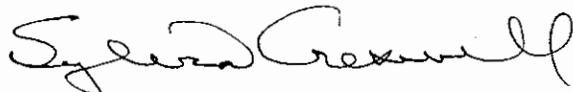
As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

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Sincerely,



GARY GUILLES
Health Facility Surveyor
Non-Long Term Care



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

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