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June 5, 2012

Curtis Maier, Administrator
St Benedicts Family Medical Center
PO Box 586
Jerome, ID 83338

Provider #131310

Dear Mr. Maier:

On **May 22, 2012**, a complaint survey was conducted at St Benedicts Family Medical Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00005481

Allegation #1: The physician did not do a physical exam, such as listening to lungs, on a patient who came to the Emergency Department (ED) with symptoms of a respiratory infection. The physician did not give him any medication for his condition.

Findings #1: An unannounced visit was made to the hospital on May 21, 2012 - Tuesday, May 22, 2012. Staff were interviewed and ten records of patients who came to the ED in March 2012 with respiratory symptoms were reviewed. ED hospital policies, protocols, and summary information related to follow-up telephone calls to patients seen in the ED were reviewed.

Ten of ten patient records reviewed documented physician assessment and treatment. For example, one patient record documented a 65 year old male who came to the ED on 3/18/12, reporting difficulty breathing for two weeks. The nursing note documented the patient was a smoker and had a medical history of chronic obstructive pulmonary disease (COPD) and a myocardial infarction (MI),

The following information summarizes the course of care:

- At 12:15 PM, an RN documented an initial evaluation. At the time of triage, the patient's blood pressure was 152/76; his heart rate was 68; his respirations were 20, and his temperature was 96.5. Oxygen saturation was initially 78 percent on room air. The oxygen saturation level increased to

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90% after 3 liters of oxygen had been applied.

- At 12:30 PM, an EKG was taken.
- At 12:30 PM, lab work was drawn.
- At 1:00 PM, a chest x-ray was taken with a portable X-ray machine.
- At 1:00 PM, the physician entered the room. The physician's "Emergency Room Note" documented the patient was oxygen dependent, had chronic obstructive pulmonary disease, and smoked 1-1/2 packs of cigarettes per day. The note indicated the patient did not have fever, sweats, or chills and he appeared short of breath when he was off his oxygen, but comfortable and alert when using it. The note indicated the physician listened to the patient's lungs and documented "no wheezes, rales, or rhonchi at this time. Breath sounds are distant." He also listened to the patient's heart and documented "regular rate and rhythm with a murmur heard ..." He noted no significant edema (swelling of the extremities) was present. The physician assessed the patient's symptoms to be related to congestive heart failure. The physician recommended the patient quit smoking, use his oxygen 24 hours a day (according to the instruction of the patient's primary doctor), use his BiPAP machine at night, continue with his regular medications, and follow-up with his primary doctor and his cardiologist.
- At 2:20 PM, the patient was discharged home.

The physician assessed the patient and determined medications for a respiratory infection were not warranted.

It could not be determined physician staff did not appropriately evaluate and treat patients.

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,



GARY GUILLES
Health Facility Surveyor
Non-Long Term Care



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

GG/srm