

COPY



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

June 21, 2011

Norman Stephens, Administrator
Portneuf Medical Center
777 Hospital Way
Pocatello, ID 83201

RE: Portneuf Medical Center, Provider #130028

Dear Mr. Stephens:

On June 14, 2011, a follow-up visit of your facility, Portneuf Medical Center, was conducted to verify corrections of deficiencies noted during the survey of May 24, 2011.

We were able to determine that the Condition of Participation on **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. 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

Norman Stephens, Administrator
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- 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.

After you have completed your Plan of Correction, return the original to this office by **July 5, 2011**, and keep a copy for your records.

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.

Sincerely,



TERESA HAMBLIN
Health Facility Surveyor
Non-Long Term Care



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

TH/srm
Enclosures
cc: Kate Mitchell, CMS Region X Office

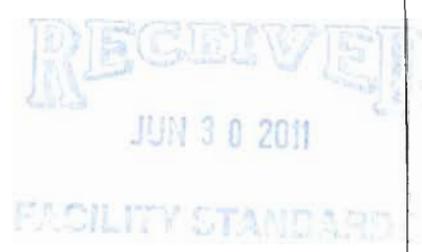
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 06/14/2011
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NAME OF PROVIDER OR SUPPLIER PORTNEUF MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 777 HOSPITAL WAY POCATELLO, ID 83201
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(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 deficiency was cited during a follow-up survey of your hospital. The following surveyors conducted the survey: Teresa Hamblin, RN, MS, HFS, Team Leader Aimee Hastriter, RN, BS, HFS	{A 000}		JUN 21 2011
{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 staff interview and record review, it was determined the hospital failed to ensure restraint orders were complete for 4 of 4 restrained patients (#1, #2, #3, and #4) whose records were reviewed. This resulted in physician orders that were not clear. Findings include: 1. Patient #1 was a 77 year old female who was admitted to the hospital on 5/27/11. "RESTRAINT ORDERS," dated 6/09/11 at 11:00 AM, included an order for soft wrist restraints. The order did not state whether soft wrist restraints were for the right wrist, left wrist, or both wrists. During an interview on 6/12/11 beginning at 2:50 PM, the Accreditation Manager reviewed Patient #1's record and confirmed the order did not	{A 168}	A168 - 482.13(e)(5) PATIENT RIGHTS: RESTRAINT OR SECLUSION Chief Quality Officer Portneuf Medical Center updated the Restraint Orders to prompt a response for location of restraint. <i>(see attached RESTRAINT ORDER sticker)</i> Portneuf Medical Center updated the Restraint Audit Tool to include the elements of the physician order requirements. 100% of all restraint use is monitored for compliance on a daily basis. <i>(see attached Restraint Audit Tool)</i> Staff and Physicians were notified of the changes on the Restraint Orders and the Restraint Audit Tool. <i>(see attached Memo and Email)</i>	6-28-11 6-28-11 6-28-11



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Diana P. Agnew</i>	TITLE Asst. / CEC	(X8) DATE 06/28/2011
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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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NAME OF PROVIDER OR SUPPLIER PORTNEUF MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 777 HOSPITAL WAY POCATELLO, ID 83201	
(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 168}	<p>Continued From page 1 identify which wrists were to be restrained.</p> <p>A physician's restraint order did not include the location of the restraint. The order was incomplete.</p> <p>2. Patient #2 was a 56 year old female who was admitted to the hospital on 6/06/11. "RESTRAINT ORDERS," dated 6/10/11 at 9:30 AM, included an order for soft wrist restraints. The order did not state whether the restraints were for the right wrist, left wrist, or both wrists.</p> <p>During an interview on 6/12/11 beginning at 2:50 PM, the Accreditation Manager reviewed Patient #2's record and confirmed the order did not identify which wrists were to be restrained.</p> <p>A physician's restraint order did not include the location of the restraint. The order was incomplete.</p> <p>3. Patient #3 was a 67 year old female who was admitted to the hospital on 6/05/11. "RESTRAINT ORDERS," dated 6/10/11 at 9:30 AM, included an order for soft wrist restraints. The order did not state whether the restraints were for the right wrist, left wrist, or both wrists.</p> <p>During an interview on 6/12/11 beginning at 2:50 PM, the Accreditation Manager reviewed Patient #3's record and confirmed the order did not identify which wrists were to be restrained.</p> <p>A physician's restraint order did not include the location of the restraint. The order was incomplete.</p>	{A 168}		

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{A 168}	<p>Continued From page 2</p> <p>4. Patient #4 was a 32 year old female who came to the Emergency Department on 6/11/11. "RESTRAINT ORDERS," dated 9/11/11 at 1:15 PM, included an order for Geodon for agitation and self-destructive behavior. The order did not state the dosage or route of the medication (chemical restraint).</p> <p>During an interview on 6/13/11 at 4:00 PM, the Accreditation Manager reviewed Patient #4's record and stated an RN took a verbal order and entered the complete order in "IBEX" (a computer software program). She stated the hospital required physicians to complete a handwritten restraint order, in addition to the computer documentation. She acknowledged the order in the computer was not identified as a restraint and the handwritten order was incomplete.</p> <p>A physician's chemical restraint order did not include the dosage or route of the restraint. The order was incomplete.</p>	{A 168}		

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June 22, 2011

Norman Stephens, Administrator
Portneuf Medical Center
777 Hospital Way
Pocatello, ID 83201

Provider #130028

Dear Mr. Stephens:

On **June 13, 2011**, a complaint survey was conducted at Portneuf Medical Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00005097

Allegation #1: Hospital staff used products for patient care even though they were aware of the patients' allergies to those products.

Finding #1: An unannounced survey of the hospital was conducted from 6/13/11 through 6/14/11. A blood draw was observed and staff and patients were interviewed. Incident reporting documentation and medical records were reviewed.

One incident report documented an event that occurred on 4/25/11. The incident report contained documentation that a laboratory technician (lab tech) used a skin preparation on a patient to obtain samples for blood cultures, even though the medical record contained documentation the patient was allergic to that skin preparation.

The Laboratory Director responded to this incident report by sending an e-mail to laboratory staff, on 5/07/11, reminding them to be sure to ask patients about allergies prior to using a skin preparation.

A second incident report documented an event that occurred on 5/16/11. The incident report contained documentation of an allergic reaction to a dressing routinely applied after blood draws. The incident occurred in the outpatient laboratory and the incident report was completed by the lab tech involved. The lab tech documented the patient confirmed she had an allergy to latex. According to the incident report, the patient confirmed the self-adhesive elastic bandage used in the dressing after a blood draw had been

Norman Stephens, Administrator
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used in the past without causing an allergic reaction. The lab tech documented the patient read the plastic wrap the elastic bandage was packaged in and noted this bandage was not latex-free. The lab tech referred to the elastic bandage as coflex.

According to documentation on the incident report, the coflex was immediately removed and replaced with paper tape. The lab tech documented the patient confirmed again that elastic bandages had been used on other occasions without any allergic reaction. However, documentation on the incident report confirmed the patient began to develop an allergic reaction and was escorted to the Emergency Department (lab tech) for evaluation and treatment.

The lab tech who completed the above incident report was interviewed. She stated the patient confirmed she had been exposed to the elastic bandages provided at that hospital without complications.

The Laboratory Director responded to the incident report by generating an e-mail which was sent to laboratory staff on 5/16/11. The Laboratory Director notified staff the coflex used in the hospital was not latex free. The Laboratory Director told staff to ask about latex allergies before applying the product and to offer paper tape (unless a patient had an allergy to adhesives).

The Laboratory Director was interviewed. He stated after the above incident there was additional investigation which led to the discovery that one specific width of the coflex contained latex, while other widths were latex-free. He stated the hospital had chosen to remove the latex-containing coflex from patient use. He confirmed the removal of coflex from circulation was in process at the time of the survey and had not been completed throughout the entire hospital as of the time of the interview.

During an observation, a lab tech was observed to draw blood on a patient for blood cultures. The lab tech was observed to verbally note the patient's allergies listed on the armband. The lab tech verified the patient was allergic to the skin preparation normally used to draw blood cultures. The lab technician explained the alternative method of cleaning the skin before drawing for blood cultures. He stated that because of the patient's latex allergy he would not use the coflex he had available on his cart. He stated the hospital was working on a solution to provide only latex-free coflex for patient use.

On 4/07/11, during a complaint investigation of the hospital, it was determined the hospital failed to provide care in a safe setting as a result of an uncoordinated allergy reconciliation process. A follow up survey to evaluate correction and compliance with this issue was completed on 5/23/11. At the conclusion of the survey it was determined the hospital had implemented processes to increase coordination regarding allergy reconciliation between departments and proper allergy documentation in the medical record and on patient arm bands.

It was determined hospital staff used products for patient care despite documentation of allergies to these products. However, corrective action had been taken. Therefore, no deficiencies were cited.

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

Allegation #2: Hospital staff were unsure of how to respond to an allergic reaction in the outpatient

laboratory.

Finding #2: An unannounced survey of the hospital was conducted from 6/13/11 through 6/14/11. A blood draw was observed and staff and patients were interviewed. Incident reporting documentation and medical records were reviewed.

One incident report contained documentation of a patient suffering an allergic reaction from a dressing applied after a blood draw in the outpatient laboratory. The individual who completed the report documented the patient alerted laboratory staff to the developing allergic reaction. The patient was then escorted to the ED.

The lab tech who completed the incident report was interviewed. She stated when the patient returned to the lab complaining of an allergic reaction both she and the one other lab tech in the outpatient laboratory were working with patients and were not available to leave the area. She stated she contacted an individual in another department to escort the patient to the ED.

Two other lab techs who routinely worked in the outpatient laboratory were also interviewed. Both stated if a patient developed an allergic reaction they would immediately have the patient escorted to the ED for evaluation. One lab tech explained if the allergic reaction was severe there was a number to call and staff would respond to the outpatient laboratory to evaluate the patient rather than taking the patient to the ED.

It could not be determined staff were unsure of how to respond to an allergic reaction that occurred in the outpatient laboratory. Therefore, no deficiencies were cited.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: Dietary staff were aware of a patient's allergies and continued to deliver meals with foods the patient was allergic to.

Finding #3: An unannounced survey of the hospital was conducted from 6/13/11 through 6/14/11. Incident reporting documentation and medical records were reviewed. Staff and patients were interviewed.

At the time of the survey five patients listed on the census had food allergies. Only two of these patients were available for interview.

One patient stated dietary staff were aware of her food allergies and had not served her any foods she was allergic to. She stated she selected her meals and while substitutions may have been provided she was not offered anything she could not eat.

The second patient stated during a past admission to the hospital, approximately three months prior to the survey, she had instances when food she was allergic to was served to her. During another admission, approximately one month later, this was not a problem. She explained that she had been admitted the day

Norman Stephens, Administrator
June 22, 2011
Page 4 of 4

prior to the interview and was still not well enough to tolerate food. She stated that nursing staff verified all of her food allergies and updated the allergy list on her arm band and in her medical record.

The Director of Dietary Services and a Registered Dietician were interviewed. They explained food allergies were entered into the electronic medical record as part of the nursing assessment. They confirmed once this information was entered into the system it was then available to the dietary department. They stated menu selections were entered into an electronic system which generated an alert to dietary staff if a food containing an allergen had been ordered. The patient was then notified and an alternative selected.

It could not be determined that patients were served foods they were allergic to. Therefore the allegation is unsubstantiated and no deficiencies were cited.

Conclusion: 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. 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/srm