



IDAHO DEPARTMENT OF
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November 9, 2012

Louis Kraml, Administrator
Bingham Memorial Hospital
98 Poplar Street
Blackfoot, ID 83221

Provider #131325

Dear Mr. Kraml:

On **August 23, 2012**, a complaint survey was conducted at Bingham Memorial Hospital. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00005629

Allegation #1: Nursing staff did not check the patient's skin during his hospitalization, allowing a six inch wound to form on the left heel.

Findings #1: An unannounced survey was conducted at the hospital. Surveyors reviewed current and closed medical records, hospital wound care records and policies related to nursing services and wound care. Surveyors also interviewed staff and patients and observed nursing staff while they provided care to patients.

The facility's documentation related to hospital-acquired skin breakdown and wound care was reviewed. There were no reported cases of hospital acquired skin breakdown in the facility at the time of the survey. The documentation showed the last reported case was in February of 2012. The follow up and documentation by the facility was found to be appropriate.

Several current patients who had surgery in the facility were interviewed about the care they had received during their hospitalization. All patients who were interviewed reported satisfactory care and voiced no complaints.

One medical record that was reviewed documented a 58 year old male who was admitted to the facility on 3/06/12 with a diagnosis of severe degenerative joint disease of the left knee. The "OPERATIVE REPORT" documented the patient underwent a left total knee replacement on the date of admission.

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Physician orders indicate the patient was discharged from the hospital on 3/12/12 and admitted to the skilled nursing facility associated with the hospital.

The "TRANSFER SUMMARY," dated 3/10/12, documented the patient developed mental confusion on the second day after surgery. At times, the patient was documented to have been agitated, uncooperative and aggressive toward staff. The record said the patient refused medication, treatments, and assistance from staff. Documentation also stated the patient would not allow staff to consistently assess him, and he was ambulating without assistance after having been instructed to call for help. On one occasion, the record stated staff contacted the police to intervene when the patient became too aggressive to manage.

The "Patient Care Plan Report," initiated on 3/06/12, identified skin integrity as an area of concern and implemented a plan of care specific to prevention of skin breakdown. According to the plan of care, a skin assessment was to be performed every shift. The medical record documented skin assessments and dressing changes to the left knee occurred on 3/06/12, 3/07/12, 3/08/12, 3/09/12, 3/10/12, 3/11/12 and 3/12/12. When cooperative, the medical record documented the patient was seen by physical therapy and assisted with ambulation as ordered by the physician.

During his stay in the facility, the record documented the patient was transferred from the surgical floor to a swing bed, and finally to the skilled nursing facility. Upon admission to the skilled nursing facility, nursing staff documented a discolored area on the inner aspect of the left heel. The nursing staff explained to the surveyors the patient refused to continue inpatient treatment and was discharged on 3/14/12 from the skilled nursing facility.

The medical record documented the patient developed mental confusion on the second day after surgery, which was attributed to the medications he was taking at the time. In response, some of the medications for the treatment of anxiety and pain were placed on hold at that time in hopes that the mental confusion would resolve. The medical record also showed elevated liver enzymes were being monitored, as well as potential symptoms of infection.

Due to a lack of sufficient evidence, the allegation that nursing staff were not performing skin assessments that resulted in hospital acquired skin breakdown could not be verified.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: When the patient requested half of the dose of pain medication that was ordered, nursing staff refused, "it was all or nothing."

Findings #2: An unannounced survey was conducted at the hospital. Surveyors reviewed current and closed medical records, hospital wound care records and policies related to nursing services and wound care. Surveyors also interviewed staff and patients and observed nursing staff while they provided care to patients.

Several patients on the surgical floor were interviewed during the survey related to pain management. All patients were satisfied with their care and felt their pain was being appropriately managed.

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One medical record that was reviewed documented a 58 year old male who was admitted to the facility on 3/06/12 with a diagnosis of severe degenerative joint disease of the left knee. The "OPERATIVE REPORT" documented the patient underwent a left total knee replacement on the date of admission. Physician orders indicate the patient was discharged from the hospital on 3/12/12 and admitted to the skilled nursing facility associated with the hospital.

The "TRANSFER SUMMARY," dated 3/10/12 and completed by a physician, indicated the patient developed mental confusion the second day after surgery. The physician attributed the confusion to "his medications." At that time, medications thought to have been causing confusion were placed on hold and other pain medication dosages were decreased. On 3/10/12, medical record documented the patient complained of pain but refused his medications. Documentation stated the medication was not given.

The physician orders and medication administration records were reviewed. Medications were administered as ordered by the physician.

No evidence was found indicating nursing staff refused to consider patients' wishes related to pain management. Therefore, the allegation could not be verified.

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 GULES
Health Facility Surveyor
Non-Long Term Care



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

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