



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

November 9, 2012

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

RE: Portneuf Medical Center, Provider #130028

Dear Mr. Stephens:

This is to advise you of the findings of the complaint investigation, which was concluded at your facility on November 5, 2012.

Enclosed is a Statement of Deficiencies/Plan of Correction form, CMS-2567, listing Medicare deficiencies. The hospital is under no obligation to provide a plan of correction for Medicare deficiencies. If you do choose to submit a plan of correction, provide it in the spaces provided on the right side of each sheet.

An acceptable plan of correction (PoC) contains the following elements:

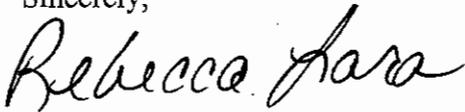
- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the PoC is effective in bringing the facility into compliance, and that the facility remains in compliance with the regulatory 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.

Norman Stephens, Administrator
November 9, 2012
Page 2 of 2

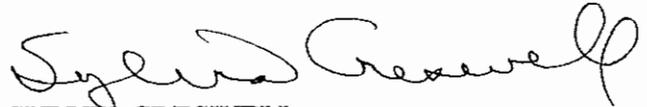
Whether you choose to provide a plan of correction or not, please sign and date the form and return it to our office by **November 22, 2012**. Keep a copy for your records. For your information, the Statement of Deficiencies is disclosable to the public under the disclosure of survey information provisions.

Thank you for the courtesies extended to us during our visit. If you have any questions, please write or call this office at (208) 334-6626.

Sincerely,



REBECCA LARA
Health Facility Surveyor
Non-Long Term Care



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

/sc
Enclosures

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

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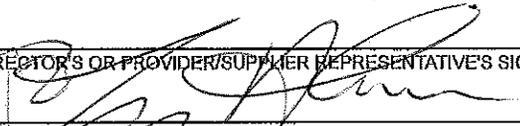
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/05/2012
NAME OF PROVIDER OR SUPPLIER PORTNEUF MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 777 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 000	INITIAL COMMENTS The following deficiencies were cited during the complaint investigation at your hospital. Surveyors conducting the review were: Rebecca Lara, RN, HFS, Team Leader Susan Costa, RN, HFS Acronyms used in this report include: CT = Computerized Tomography ED = Emergency Department mg/dl = milligrams per deciliter OOB = out of bed PA = Physician Assistant POC = Point of Care RN = Registered Nurse	A 000		
A 132	482.13(b)(3) PATIENT RIGHTS: ADVANCED DIRECTIVES The patient has the right to formulate advance directives and to have hospital staff and practitioners who provide care in the hospital comply with these directives, in accordance with §489.100 of this part (Definition), §489.102 of this part (Requirements for providers), and §489.104 of this part (Effective dates). This STANDARD is not met as evidenced by: Based on staff interview, review of policies and procedures and review of medical records, it was determined the facility failed to ensure advance directives were accurately followed for 1 of 3 patients (#6) whose medical records contained advance directives. The lack of clarity had the potential to result in patients not having their advance directives honored. Findings include:	A 132		

DEC 10 2012
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE



Acting CEO

12/5/2012

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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A 132	Continued From page 1 Patient #6 was an 84 year old female admitted to the facility on 8/15/12 for care related to a psychiatric disturbance. Her medical record contained an 11 page notarized document titled "LIVING WILL AND DURABLE POWER OF ATTORNEY FOR HEALTH CARE," dated 11/17/06. The document was marked and initialed by Patient #6 beside the statement "I direct that all medical treatment, care and procedures, including artificial life sustaining procedures, be withheld or withdrawn, except that nutrition and hydration, whether artificial or nonartificial shall not be withheld or withdrawn." Admission orders to Behavioral Health Services, dated 8/15/12 at 11:00 PM, included an order that Patient #6 was to be a "Full Code," meaning a full resuscitation would be performed, which was not in alignment with her notarized document. An "INPATIENT GERIATRIC PSYCHIATY (sic) EVALUATION," dictated on 8/16/12 at 5:04 PM, included documentation that Patient #6 was to be a Full Code. In an interview on 11/01/12 beginning at 2:50 PM, the Director of Behavioral Health reviewed Patient #6's medical record and confirmed the Advance Directive indicated she did not wish to be a Full Code, although the physician had ordered "Full Code." The Director of Behavioral Health was not able to find documentation in Patient #6's record to indicate her code status had been questioned or clarified to include her wishes. The facility failed to ensure Patient #6's record clearly and accurately reflected her code status.	A 132	The patients chart was updated when this deficiency was noted and an audit of other patients' charts throughout the facility was conducted to ensure this was an isolated incident. No other incidents of this type were noted. A stamp has been provided to each floor that states "Received" to help us identify the date Advance Directives are received, if they are not present on admission. Education has been completed in each area regarding the use of the stamp and importance of updating the Patient Profile. Each nursing unit is completing 30 documentation audits per month and comparing Advance Directives and Patient Profile has been included in that process. This is implemented and monitored by the CNO.	11/02/12 11/16/2012 11/30/2012 and ongoing
A 144	482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE	A 144		

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A 144	<p>Continued From page 2 SETTING</p> <p>The patient has the right to receive care in a safe setting.</p> <p>This STANDARD is not met as evidenced by: Based on medical record reivew, staff interview and review of hospital policies, it was determined the hospital failed to provide a safe environment for 2 of 17 patients (#5 and #10) whose records were reviewed. This failed practice had the potential to result in negative patient outcomes and interfere with the safety of all patients. Findings include:</p> <p>1. Patient #5:</p> <p>a. Patient #5 was a 62 year old male who had presented to the ED on 9/25/12 at 12:07 PM with a painful mass in his left groin area. He was in the ED approximately eight hours before transfer to the Medical Surgical patient care unit. Patient #5's medical record documented he was an insulin dependent diabetic.</p> <p>A nursing note at 12:30 PM stated the ED attending physician was notified of a POC glucose test of 326 mg/dl. The lab reported his glucose to be 325 mg/dl at 12:38 PM. An entry in the ED record documented Patient #5 was admitted to a medical-surgical unit on 9/25/12 at 7:55 PM. There was no further documentation in Patient #5's record during his eight hours in the ED of a re-assessment of his glucose level or of medication ordered to treat his hyperglycemia.</p> <p>The American Diabetes Association suggests a target range of 70-130 mg/dl for most adults with</p>	A 144		

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A 144	<p>Continued From page 3</p> <p>diabetes. Additionally, hyperglycemia (high blood sugar) can be an indicator of infection somewhere in the body.</p> <p>At 7:15 PM the ED physician initiated orders on a preprinted order sheet titled "EMERGENCY DEPARTMENT ADMISSION HOLDING ORDERS." The preprinted sheet included instructions which read: "Check off desired orders. If not checked it won't be done." The preprinted order sheet contained a box that was left unchecked for "See Diabetes Management order set." The order sheet did not contain diagnosis of diabetes, diabetic medication, or orders for monitoring Patient #5's blood sugar.</p> <p>An admission assessment for Patient #5 was completed by an RN on the medical surgical unit on 9/25/12 at 9:25 PM. Admission orders were written by a physician at 10:00 PM. Included in the admission orders was a preprinted form titled: "ADULT DIABETES MANAGEMENT," dated 9/25/12 at 10:00 PM. The form contained instructions to monitor Patient #5's glucose before meals and at bedtime.</p> <p>A POC glucose level was taken on 9/25/12 at 11:18 PM, with results of "critical high," which indicated the level was over 500 mg/dl. The POC glucose was repeated at 11:45 PM, which also read "critical high." The nurse documented the lab was contacted to draw a blood specimen to confirm the glucose. On 9/26/12 at 12:53 AM the nurse documented the lab result of Patient #5's glucose was 682 mg/dl. The nurse documented she contacted the physician and orders were received for insulin on 9/26/12 at 1:00 AM.</p>	A 144	<p>We completed an audit of 67% of patients' charts that were admitted in September and October 2012 with a diagnosis of diabetes. All records demonstrated 100% compliance with the diabetic protocol orders and evidence of physician notification and prompt follow up was found in each, when applicable.</p> <p>All current admissions for the next 90 days have concurrent documentation review for appropriate diabetic management per diabetic protocol orders and MD orders. This is monitored by the CNO. Random audits by the Quality Department for validation of audit results are completed as well. This is monitored by the CQO.</p>	11/03/2012 01/31/2013	

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A 144	<p>Continued From page 4</p> <p>During an interview on 11/02/12 at 11:20 AM, the ED Physician stated he had been aware of Patient #5's elevated glucose result of 326 mg/dl. He stated the patient had told him he had high glucose readings at home as well. The ED Physician stated he "should have rechecked the glucose, but the patient had gone to ultrasound, CT scan, and radiology for tests, and it had not been done."</p> <p>A consultation by the facility Hospitalist, dictated 9/26/12 at 9:14 PM, stated Patient #5 had complained of chills, but otherwise his review of systems was negative.</p> <p>The "Admission Assessment Record," completed by an RN on 9/25/12 at 9:39 PM, documented Patient #5 did not exhibit signs or symptoms of hyperglycemia, and stated he was steady on his feet and appropriate with conversation.</p> <p>Patient #5's blood glucose levels were not reassessed between 12:30 PM and 11:18 PM on 9/25/12.</p> <p>b. An RN entry in Patient #5's record dated 9/26/12 at 8:15 AM, indicated he was allergic to iodine. The RN documented a wrist band was placed, his profile and chart were updated as well as pharmacy and the consulting physician were notified.</p> <p>The attending physician dictated a "HISTORY AND PHYSICAL," on 9/26/12 at 2:31 PM. The H&P included Patient #5's allergy to iodine.</p> <p>The Medication Profile was printed daily, and from 9/26/12 until his discharge on 10/02/12</p>	A 144		

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A 144	<p>Continued From page 5</p> <p>documented Patient #5's allergy to iodine resulted in hives with a severity reaction as "Severe."</p> <p>On 9/27/12 Patient #5 had a surgical procedure to remove the mass in his left groin. An "OPERATIVE REPORT," dictated by the attending physician on 9/27/12 at 3:44 PM, he dictated he had placed a Telfa soaked in Betadine into the pocket of the tissue created by the removal of the mass. Betadine is the brand name of an iodine based antiseptic. The physician did not include documentation in the report that he was aware of Patient #6's allergy to iodine and his decision to use Betadine despite the documented allergy.</p> <p>During an interview on 11/01/12 beginning at 5:10 PM, the Director of the Medical Surgical unit reviewed Patient #5's record and confirmed the allergy to iodine which was documented as producing hives. The Director was unable to find documentation by the surgeon that acknowledged his use of Betadine despite the allergy to iodine.</p> <p>The record did not contain evidence of a local or systemic reaction after the use of Betadine during the surgical procedure.</p> <p>The facility administered a medication to a patient with a known allergy to that medication.</p> <p>2. Patient #10's medical record documented an 87 year old female who was admitted to the facility on 2/23/12 for nausea and vomiting related to a possible small bowel obstruction. Other diagnoses included congestive heart failure, atrial fibrillation (irregular heart rate associated with palpitations, fainting, chest pain and/or</p>	A 144	<p>Surgeon was interviewed and stated he knew of the allergy order and felt the type of reaction patient had in the past would not be an issue. There was evidence of the discussion found in the anesthesia records to PACU and in discussion with staff, allergies are addressed in the time out, but in this case not clearly documented pre operatively.</p> <p>All nursing areas complete 30 allergy audits per month and the results are monitored by the CQO. We have been doing the audits since April 2011 and the staff compares allergies in the Patient Profile with History & Physicals, ED documentation and the allergy bands on patients. This is an ongoing process and will continue. Nursing leaders in each area also complete random audits of the patients in house to ensure patient safety measures are followed. This is monitored by the CNO.</p>	<p>11/02/2012</p> <p>11/02/2012 and ongoing</p>

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A 144	<p>Continued From page 6</p> <p>congestive heart failure,) type 2 diabetes, acute kidney failure and severe osteoporosis (disease of the bones that leads to increased risk of fracture.) The "Discharge Instructions," dated 2/28/12 at 11:32 AM, indicated Patient #10 was discharged on 2/28/12, at 11:32 AM, to a skilled nursing facility.</p> <p>The nursing "Admission Assessment Report," dated 2/23/12 at 8:40 AM, documented Patient #10 required assistance to get in and out of bed and was experiencing short term memory loss at the time of the assessment. Additionally, the assessment included Patient #10 had a history of falling, and documented her mental status as "Overestimates/Forgets Limitations." Patient #10 was documented to be at high risk for falls.</p> <p>The nursing "Daily Focus Assessment Report" included documentation as follows:</p> <ul style="list-style-type: none"> - 2/23/12 at 7:51 AM - "...History of Falling, ...Overestimates/Forgets Limitations, ...Bed or Safety Alarm Placed, ...Must Be Accompanied to Tests and Procedures, ...Fall Risk Care Plan Implemented." - 2/23/12 at 9:30 AM - "...Pt. found getting up OOB fall alarm triggered. Pt. put back in bed and fall alarm reset." - 2/23/12 at 10:28 AM - "...Pt. found sitting on floor. Bed alarm went off but unable to reach pt before she [got] out of bed. Pt. doesn't have and (sic) cuts or bruises (sic). Notified [PA] of pt. a fall. To get a one to one order." <p>Patient #10 was documented to have been at exhibiting high risk behavior with a potential for falls, but 1:1 patient supervision was not</p>	A 144		



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FAX 208-364-1888

November 9, 2012

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

Provider #130028

Dear Mr. Stephens:

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

Complaint #ID00005460

Allegation #1: The facility failed to protect the confidentiality of a patient.

Findings #1: An unannounced survey was conducted at the hospital from 10/29/12 through 11/02/12. Surveyors reviewed medical records, hospital policies related to patient rights and discharge planning, incident reports, grievance logs and administrative documents. Surveyors also interviewed staff and patients and observed nursing staff providing care to patients in the emergency department and on the hospital floors.

Several current patients were interviewed in the emergency department and on the medical/surgical floor about patient rights and confidentiality. All were satisfied with the care they had received in the facility and had no concerns or complaints about matters pertaining to patient rights or confidentiality of patient's medical information.

One medical record that was reviewed documented a 44 year old female who was admitted to the hospital on 3/01/12 for care related to diverticulitis. The record documented the patient was discharged on 3/06/12.

One of the nurses on the medical/surgical floor who cared for the patient was interviewed. Additionally, a case manager assigned to the patient was interviewed. The patient's right to privacy and confidentiality were discussed. They were unable to recall a time when the patient's privacy and/or confidentiality was

violated. The nurse and case manager were familiar with proper policies and procedures related to respecting and maintaining patients' confidentiality.

Hospital policies related to a patient's right to privacy and confidentiality were reviewed and found to be appropriate. Nursing staff on the medical/surgical floor and in the emergency department were interviewed concerning a patient's right to privacy and patient confidentiality. All staff were aware of the patient rights policies and the facility's expectations. During observation, all staff were observed to exercise care in preserving patients' privacy and right to confidentiality.

Due to lack of sufficient evidence, the allegation of violation of a patient's right to privacy could not be verified.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: The facility discharged a patient before she felt she was prepared to leave the facility.

Findings #2: An unannounced survey was conducted at the hospital from 10/29/12 through 11/02/12. Surveyors reviewed medical records, hospital policies related to patient rights and discharge planning, incident reports, grievance logs and administrative documents. Surveyors also interviewed staff and patients and observed nursing staff providing care to patients in the emergency department and on the hospital floors.

Several current patients throughout the facility were interviewed during the survey about discharge planning. All patients who were interviewed stated the nursing staff and/or case managers of the facility began discussing discharge planning with them soon after admission to the facility. Patients stated aspects of discharge planning such as destination at the time of discharge, need for assistance related to obtaining medications, financial concerns, assistance in scheduling follow-up appointments and transportation at the time of discharge were discussed.

Surveyors reviewed several current and closed medical records from various floors and departments in the hospital. All records contained appropriate discharge planning documentation. Additionally, all of the close records that were reviewed contained copies of discharge instructions that were discussed with patients prior to discharge and signed by the patient or the patient's designee.

One medical record that was reviewed documented a 44 year old female who was admitted to the hospital on 3/01/12 for care related to diverticulitis. The record documented the patient was discharged on 3/06/12.

The "Daily Focus Assessment Report," dated 3/06/12 at 8:11 AM, documented the treating physician, nurse and patient discussed plans for discharge. The documentation also stated the patient was in agreement with the discharge plan. On 3/06/12 at 4:27 PM, a RN Case Manager documented she met with the patient and offered assistance in arranging transportation, but the patient stated she had already contacted her family for a ride home.

Norman Stephens, Administrator
November 9, 2012
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Hospital policies related to discharge planning were reviewed. The policies were found to be appropriate, comprehensive and met regulatory requirements.

Nursing staff and RN Case Managers assigned to the emergency department and medical/surgical floor were interviewed. All were able to accurately discuss the facility's policies and practices concerning discharge planning.

No evidence could be found supporting the allegation that the facility failed to adequately prepare the patient for discharge from the hospital. 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,



REBECCA LARA
Health Facility Surveyor
Non-Long Term Care



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

/sc



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

Provider #130028

Dear Mr. Stephens:

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

Complaint #ID00005706

Allegation: The facility left patient on a bedpan for part of the day shift and all night (approximately 16 hours). The patient suffered a pressure ulcer on her buttocks/sacrum as a result of the prolonged contact with the bedpan which resulted in a preventable complication.

Findings: An unannounced survey was conducted from 10/29/12 to 11/05/12. Patient records and policy and procedures, Quality Assessment/Performance Improvement documents, and performance indicators were reviewed. Patient and staff interviews were conducted.

A total of 17 medical records were reviewed for prolonged hospital stay and/or preventable complications.

Two records indicated patients had been left on bedpans for more than one 12 hour shift. Both patients experienced skin breakdown as a result of the prolonged contact. Both patient records indicated wound management consultations were initiated and wound care was provided.

After the initial incident of a patient on a bedpan for the prolonged period of time, a Root Cause Analysis, Action Plan and staff training on the med-surg unit was initiated. When the second

Norman Stephens, Administrator
November 9, 2012
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incident occurred, the staff training became mandatory throughout the facility, and the monitoring for compliance was modified to weekly. In addition, the staff was instructed that if they placed the patient on a bedpan, they were to be the one to take them off, not pass the task on to another staff member.

Although the complaint was substantiated, there were no deficiencies cited as the facility had responded with an action plan and performance improvement activities to prevent further incidents.

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

As the allegation 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,



REBECCA LARA
Health Facility Surveyor
Non-Long Term Care



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

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HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
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November 9, 2012

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

Provider #130028

Dear Mr. Stephens:

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

Complaint #ID00005603

Allegation: The facility left patient on a bedpan for part of the day shift and all night (approximately 16 hours). The patient suffered a pressure ulcer on his buttocks/sacrum as a result of the prolonged contact with the bedpan which resulted in a preventable complication and extended his hospitalization.

Findings: An unannounced survey was conducted from 10/29/12 to 11/05/12. Patient records and policy and procedures, Quality Assessment/Performance Improvement documents, and performance indicators were reviewed. Patient and staff interviews were conducted.

A total of 17 medical records were reviewed for prolonged hospital stay and/or preventable complications.

Two records indicated patients had been left on bedpans for more than one 12 hour shift. Both patients experienced skin breakdown as a result of the prolonged contact. Both patient records indicated wound management consultations were initiated and wound care was provided.

After the initial incident of a patient on a bedpan for the prolonged period of time, a Root Cause

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Analysis, Action Plan and staff training on the med-surg unit was initiated. When the second incident occurred, the staff training became mandatory throughout the facility, and the monitoring for compliance was modified to weekly. In addition, the staff was instructed that if they placed the patient on a bedpan, they were to be the one to take them off, not pass the task on to another staff member.

Although the complaint was substantiated, there were no deficiencies cited as the facility had responded with an action plan and performance improvement activities to prevent further incidents.

Conclusion: Substantiated. However, no deficiencies were cited as the hospital took corrective prior to the survey.

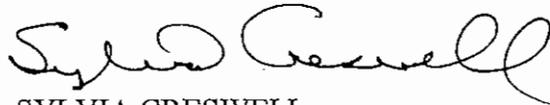
As the allegation was substantiated, but was not cited, no response is necessary.

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,



REBECCA LARA
Health Facility Surveyor
Non-Long Term Care



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

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