



IDAHO DEPARTMENT OF
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July 7, 2014

Bradley Huerta, Administrator
Lost Rivers Medical Center
P O Box 145
Arco, ID 83213

RE: Lost Rivers Medical Center, Provider #131324

Dear Mr. Huerta:

On **May 20, 2014**, a complaint survey was conducted at Lost Rivers Medical Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00005782

Allegation #1: The facility failed to ensure the staff was competent to provide nursing care for a patient with pneumonia. The staff was confused as to whether the patient needed humidified oxygen or non-humidified oxygen, his oxygen was set at 8 and 10 liters, and they did not monitor his intake and output.

Findings #1: An unannounced, on-site complaint survey was conducted from May 19, 2014 to May 20, 2014. Clinical records and facility policies were reviewed, staff were interviewed, and complaint and grievance logs were reviewed.

Medical records of 7 patients who had been transferred from the facility to a higher level of care were reviewed.

One patient record was that of a 92 year old male who was admitted for pneumonia. Additional diagnoses included acute respiratory failure, CHF, acute renal failure, and COPD. The record noted the patient was transferred to another hospital for a higher level of care after 10 days at the facility.

Initially, the patient was placed on oxygen at 2 liters/minute per nasal cannula, with nebulizer treatments every 4 hours. He was then increased to 4 liters/minute due to increased shortness of breath and wheezing. On his third day, the oxygen method of delivery was changed to mask at 6 liters due to increased respiratory distress. Later that morning, he was switched to a non-rebreather mask with the oxygen flow at 10 and 15 liters. He was gradually weaned back to a nasal cannula at 4 liters/minute. The nursing notes did not include documentation if humidification to the oxygen therapy was provided.

According to LIPPINCOTT MANUAL OF NURSING PRACTICE, eighth edition, oxygen delivery guidelines are as follows:

-Nasal Cannula is used for low flow of oxygen up to 6 liters/minute, humidity is not usually used unless the flow is greater than 4 liters/minute.

-Oxygen by face mask is used for moderate oxygen flow to the nose and mouth, is usually humidified, as the flow rate is higher and humidity may help with mobilization of secretions.

-A non-rebreather mask is used when high oxygen flow is desired. The flow rate of oxygen is at least 10 liters/minute, enough to keep the reservoir bag full during the inspiration phase. The reference also noted that humidity is usually provided, but may be discontinued if there is excessive moisture build up in the reservoir.

Additionally, the patient medical record documented accurate intake and output which included IV fluids, oral fluids, amount of meals taken, and urinary output. The intake and output was documented each day the patient was hospitalized.

During an interview on May 20, 2014, beginning at 8:30 AM, an RN who stated she was the charge nurse provided a tour of the nursing unit. She stated a patient with an IV would automatically be placed on accurate intake and output. She stated all patients who had a catheter would be placed on accurate intake and output as well. The RN described how she would initiate oxygen therapy, and stated she would routinely connect humidification.

It could not be determined that the staff was incompetent when providing nursing care, therefore the allegation was unsubstantiated and no deficient practice was identified.

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: The nursing staff was overheard to be arguing about how to provide care for the patient. Additionally, the nursing staff did not assist the patient with his meals.

Findings #2: The facility did not have any patients during the time of the survey, and therefore it was not possible to determine if there was dissention between the staff.

Each patient record included a nursing form titled "Assessment and Cares Form." The form documented patient care provided each shift.

One record, that of a 92 year old male, included documentation that the patient was in pain, had increased respiratory distress, and nausea. The record indicated the patient refused breakfast and lunch, but was able to take a nutritional supplement shake and ice cream. Later that evening, the record documented the patient refused dinner due to no appetite, but consumed a nutritional supplement shake. The record contained documentation each day of the amount of meals consumed, and when the supplemental shakes were offered.

It could not be determined the nursing staff did not assist patients with meals, therefore the allegation was unsubstantiated.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: The facility failed to ensure confidentiality, patient information was provided to callers and visitors. Additionally, lab results were reported to the patient as abnormal, then the patient was informed the results were for another patient and he was given the information by mistake.

Findings #3: Ten patient records were reviewed. Each record included a form which was signed by the patient or authorized representative to indicate if patient information could be released to callers. The form included a section where the patient could choose a "password" for designated callers to use when calling for information. The form also included a section where the patient could refuse any information be released to callers.

Ten records were reviewed. All records contained patient information with appropriate identification, including medical record number, room number, date and time the laboratory tests were obtained and reported, and who they were reported to.

One record, of a 92 year old male, included abnormal lab results. The test results were repeated the following day and the results were again abnormal. It could not be determined through the investigative process that the abnormal lab results were from a different patient.

Conclusion #3: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: The facility did not provide needed care to a patient, and staff thought it was "just his time to die." A physician informed the patient and family that if he did not transfer to a larger hospital, the care provided by this facility would kill him.

Findings #4: One patient record was that of a 92 year old male who was admitted for pneumonia. Additional diagnoses included acute respiratory failure, CHF, acute renal failure, and COPD. The record noted the patient was transferred to another hospital for a higher level of care after 10 days at the facility.

Physician progress notes on the third day of hospitalization documented the physician spoke with the patient and his wife. The progress note stated treatment options which included transfer for critical care services and possible intubation. The note stated the patient and his wife did not wish any further treatment beyond what was being provided at the current time, consistent with his POST (Physician Ordered Scope of Treatment). The physician progress note further stated the patient's pastor was called as per patient wishes. The physician noted in his plan to continue current care and provide comfort measures and divine support.

Physician progress notes on the tenth day of hospitalization documented the patient was not responding to the therapies provided, and was in acute renal failure. The physician documented the patient requested transfer to a larger hospital that could provide a higher level of care, and the patient was transferred shortly after.

The record indicated the patient and his family requested no transfer until the 10th day, and once requested, was transferred promptly. The allegation could not be substantiated.

Conclusion #4: Unsubstantiated. Lack of sufficient evidence.

Allegation #5: The facility did not provide adequate skin care to a patient, which resulted in a rash in the groin area that went untreated.

Findings #5: One patient record was that of a 92 year old male who was admitted for pneumonia. Additional diagnoses included acute respiratory failure, CHF, acute renal failure, and COPD. The record noted the patient was transferred to another hospital for a higher level of care after 10 days at the facility.

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Nursing assessment notes were reviewed, including the comprehensive admission assessment and the daily shift assessments. The skin assessments included entries of bruising, edema, and reddened areas of skin. The record did not include documentation of a genital rash or of medication to treat a rash. The documentation included daily entries of skin care, and bathing.

Inadequate skin care could not be determined, therefore the allegation could not be substantiated.

Conclusion #5: 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,



SUSAN COSTA
Health Facility Surveyor
Non-Long Term Care



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/pmt