



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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June 4, 2013

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

COPY

Provider #131325

Dear Mr. Kraml:

On May 23, 2013, a complaint survey was conducted at Bingham Memorial Hospital. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00005851

Allegation #1: Patients were not treated promptly in the Emergency Department (ED).

Finding #1: An unannounced visit was made to the hospital on 5/22/13 through 5/23/13. During the complaint investigation, surveyors reviewed 8 patient records. Quality Assessment/Performance Improvement documents and hospital policies were reviewed. Patients and nursing staff were interviewed. Observations were made in the ED and on the medical/surgical floor.

Seven of the 8 medical records showed patients were triaged within 15 minutes of presenting to the ED. One medical record documented an 80 year old female with complaints of nausea and vomiting who presented to the ED on 12/09/12 at 2:30 PM. The record documented she was not formally triaged for 27 minutes.

The Risk Manager and the Chief Nursing Officer were interviewed on 5/23/13 beginning at 9:50 AM. They stated the patient's care had been investigated and the patient's nurse was interviewed. They stated the patient was triaged 27 minutes after presenting to the ED and had to wait 71 minutes in the ED waiting room for an available bed. They stated the nurse had been in contact with the patient prior to the patient's arrival and the nurse had checked on the patient frequently

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in the ED waiting area to assure the patient was stable. A tour of the ED was conducted on the afternoon of 5/23/13. The Admissions Supervisor and the RN on duty both stated patients were immediately evaluated by an RN following presentation to the ED. In addition, the nurses made rounds when patients were in the waiting room to monitor them.

It could not be verified that patients were not assessed and monitored in the ED.

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: Preventative care was not provided to patients, resulting in the development of pressure ulcers.

Finding #2: An unannounced visit was made to the hospital on 5/22/13 through 5/23/13. During the complaint investigation, surveyors reviewed 8 patient records. Quality Assessment/Performance Improvement documents and hospital policies were reviewed. Patients and nursing staff were interviewed. Observations were made in the ED and on the medical/surgical floor.

The hospital tracked pressure sores through its Quality assessment/performance improvement program. No pressure sores were reported in 2013.

An Ostomy Nurse, who specialized in wound care and prevention, was hired in January 2013 and currently worked at the hospital as of 5/24/13. She revised policies related to pressure sores. She provided inservices related to the prevention of pressure sores for all nursing and therapy staff on 2/20/13 and 2/27/13. She provided ongoing treatment for patients with skin problems and support for staff.

Special pressure reducing mattresses were noted on all inpatient beds.

One medical record documented an 80 year old female who was admitted to the hospital on 12/09/12 and was discharged on 12/21/12. She had surgery to repair a fractured hip on 12/11/12. A nursing note, dated 12/13/12 at 1:47 AM, documented the patient was incontinent of loose stool. The same note stated "AREA OF REDNESS AND SLIGHT BREAKDOWN TO BUTTOCKS NOTED, CREAM AND TEGADERM (a transparent dressing) APPLIED." The patient continued to have loose stools. Nursing notes documented she was turned, cleaned, and barrier creams were applied. However, she did experience more skin breakdown culminating in a stage II pressure sore. She was evaluated and the wounds were formally treated by the physical therapist beginning on 12/18/13.

While one patient did experience skin breakdown, staff were currently actively working to

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prevent skin problems. No pressure sores had occurred in 2013. The hospital continued to improve measures to prevent skin breakdown. Deficiencies were not cited as the hospital implemented corrective measures prior to the survey.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: Patients were not bathed.

Finding #3: An unannounced visit was made to the hospital on 5/22/13 through 5/23/13. During the complaint investigation, surveyors reviewed 8 patient records. Quality Assessment/Performance Improvement documents and hospital policies were reviewed. Patients and nursing staff were interviewed. Observations were made in the ED and on the medical/surgical floor.

Five inpatients on the medical/surgical nursing unit were interviewed on the afternoon 5/23/13. All 5 patients stated they were satisfied with their nursing care. They all stated there appeared to be sufficient numbers of nursing staff and nurses assisted them with bathing and personal cares as needed. Four of the 5 patients were very clean and well groomed. One patient who was less well groomed stated he had refused assistance.

Seven of the 8 medical records documented patients were routinely bathed and assisted with personal cares.

One medical record documented an 80 year old female who was admitted to the hospital on 12/09/12 and was discharged on 12/21/12. She had surgery to repair a fractured left hip on 12/11/12. The medical record documented the patient refused baths on 12/10/12, 12/12/12, 12/13/12. Baths were documented on 12/14/12, 12/17/12, 12/18/12, 12/20/12, and 12/21/12. Baths were not documented on 12/11/12, 12/15/12, 12/16/12, and 12/19/12.

The Risk Manager and Chief Nursing Officer were interviewed on 5/23/13 beginning at 9:50 AM. They stated the patient's medical record had been reviewed prior to the survey. They stated the patient's baths had not all been documented but they believed the patient had at least been offered a daily bath. They stated the electronic medical record had changed in early 2013 and it was easier for staff to document bathing patients.

While baths were not consistently documented, systems were in place to assure recent and current patients received daily baths unless they refused. A current deficient practice could not be verified, therefore, no deficiencies were cited.

Conclusion #3: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: Patients did not receive pain medication.

An unannounced visit was made to the hospital on 5/22/13 through 5/23/13. During the complaint investigation, surveyors reviewed 8 patient records. Quality Assessment/Performance Improvement documents and hospital policies were reviewed. Patients and nursing staff were interviewed. Observations were made in the ED and on the medical/surgical floor.

Five inpatients on the medical/surgical nursing unit were interviewed on the afternoon 5/23/13. All 5 patients stated they were satisfied with their pain management. They all stated they had received pain medications as needed.

All of the 8 medical records documented patients' pain was monitored and medications were given in response to pain. For example, one medical record documented an 80 year old female who was admitted to the hospital on 12/09/12 and was discharged on 12/21/12. She had surgery to repair a fractured left hip on 12/11/12. Her medical record documented she received pain medication 4 times on 12/14/12, at 9:45 AM, 1:24 PM, 5:31 PM, and 9:21 PM. A nursing note on 12/14/12 at 11:00 PM stated she was sleeping and in no distress. A nursing note on 12/15/12 at 1:22 AM stated she was sleeping. A nursing note on 12/15/12 at 2:48 AM stated she was resting quietly. A nursing note on 12/15/12 at 4:53 AM stated she was sleeping and in no distress. A nursing note on 12/15/12 at 7:02 AM stated she denied pain. Her medical record documented she received pain medication 4 times on 12/15/12, at 9:07 AM, 11:09 AM, and 3:00 PM. Her highest level of pain was documented on the morning of 12/15/12. She was medicated for pain at that time.

It could not be verified that patients were not treated for pain.

Conclusion #4: Unsubstantiated. Lack of sufficient evidence.

Allegation #5: A patient with a fracture was not appropriately cared for.

Finding #5: An unannounced visit was made to the hospital on 5/22/13 through 5/23/13. During the complaint investigation, surveyors reviewed 8 patient records. Quality Assessment/Performance Improvement documents and hospital policies were reviewed. Patients and nursing staff were interviewed. Observations were made in the ED and on the medical/surgical floor.

One medical record documented an 80 year old female who was admitted to the hospital on 12/09/12 and was discharged on 12/21/12. She had surgery to repair a fractured left hip on 12/11/12. The medical record documented she presented to the ED on 12/09/12 at 5:27 PM.

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The "History and Physical," dated 12/10/12 at 8:26 AM, stated the patient complained of left hip pain. An orthopedic consultation was ordered. This was conducted on 12/10/12 at 3:00 PM. The evaluation included an x-ray of the hip. Surgery to repair the hip was conducted the following day. The record documented the patient received medical, nursing, and physical therapy services following the surgery. The record documented the hip pain was controlled and the patient was able to ambulate with assistance.

A physician progress note, dated 12/13/12 at 9:50 AM, stated the patient complained of left shoulder pain. The patient's left shoulder and elbow were x-rayed later that day. The X-rays revealed a probable non-displaced fracture of the shoulder. A physician progress note, at 8:45 AM on 12/14/12, indicated the fracture was "minor" and did not require further interventions. However, the physician did order a platform to be fitted for the patient's walker to make it more comfortable and functional for her to ambulate with the shoulder fracture. Subsequent nursing notes documented the patient's shoulder pain was controlled and the fracture was not exacerbated throughout her stay.

Four other medical records were reviewed of patients with fractures or other traumatic injuries. Medical, nursing, and therapy services in response to their changing condition were documented.

Conclusion #5: Unsubstantiated. Lack of sufficient evidence.

Allegation #6: X-rays were not completed as indicated by patient need.

Finding #6: An unannounced visit was made to the hospital on 5/22/13 through 5/23/13. During the complaint investigation, surveyors reviewed 8 patient records. Quality Assessment/Performance Improvement documents and hospital policies were reviewed. Patients and nursing staff were interviewed. Observations were made in the ED and on the medical/surgical floor.

All 8 medical records documented radiological procedures were conducted as ordered.

One medical record documented an 80 year old female who was admitted to the hospital on 12/09/12 and was discharged on 12/21/12. She had surgery to repair a fractured left hip on 12/11/12. The medical record documented she presented to the ED on 12/09/12 at 5:27 PM. The physician's examination, dated 12/09/12 but not timed, stated the patient had a history of nausea, vomiting, and diarrhea for 2 days. She also had a history of left hip surgery on 11/23/12.

The "History and Physical," dated 12/10/12 at 8:26 AM, stated the patient complained of left hip pain. An orthopedic consultation was ordered. This was conducted on 12/10/12 at 3:00 PM. The evaluation included an X-ray of the hip. Surgery to repair the hip was scheduled for the

following day.

Daily physician notes were documented. A physician progress note, dated 12/13/12 at 9:50 AM, stated the patient complained of left shoulder pain. The patient's left shoulder and elbow were X-rayed later that day. They revealed probable non-displaced fractures of the shoulder. A physician progress note, at 8:45 AM on 12/14/12, called the fracture "minor" and no treatment was ordered.

Neither complaints of shoulder pain by the patient nor requests for X-rays by the family were mentioned in nurses notes prior to 12/13/12.

It could not be verified through the investigative process that patients did not receive X-rays consistent with their needs.

Conclusion #6: Unsubstantiated. Lack of sufficient evidence.

Allegation #7: Medications were not ordered correctly when patients were discharged.

Finding #7: An unannounced visit was made to the hospital on 5/22/13 through 5/23/13. During the complaint investigation, surveyors reviewed 8 patient records. Quality Assessment/Performance Improvement documents and hospital policies were reviewed. Patients and nursing staff were interviewed. Observations were made in the ED and on the medical/surgical floor.

Eight medical records were reviewed of patients who had been discharged between November 2012 and May 2013. All of the records documented patients were provided discharge instructions which included discharge medications.

The Risk Manager and Chief Nursing Officer were interviewed on 5/23/13 beginning at 9:50 AM. They stated 1 patient's discharge instructions from 12/21/12 included medications from a previous admission. However, no cases were identified of incorrect discharge instructions from patients who were treated in 2013.

Conclusion #7: Unsubstantiated. Lack of sufficient evidence.

Allegation #8: Patients were moved within the hospital without notifying the family or the nurse.

Finding #8: An unannounced visit was made to the hospital on 5/22/13 through 5/23/13. During the complaint investigation, surveyors reviewed 8 patient records. Quality

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Assessment/Performance Improvement documents and hospital policies were reviewed. Patients and nursing staff were interviewed. Observations were made in the ED and on the medical/surgical floor.

Four nurses who were on duty were interviewed on the afternoon of 5/22/13. All of the nurses stated communication between staff was good and nurses were aware when patients were transferred within the hospital.

One medical record documented an 80 year old female who was admitted to the hospital on 12/09/12 and was discharged on 12/21/12. She had surgery to repair a fractured left hip on 12/11/12. Nurses notes at 7:56 AM on 12/14/12 documented that the patient was moved from room 229 to room 227, 2 rooms away. The nurses note stated the family was very upset about the move.

The Risk Manager and the Chief Nursing Officer were interviewed on 5/23/13 beginning at 9:50 AM. They stated the family had complained about the move and an investigation had been conducted. They stated the patient was moved because the room was needed for a patient who was infectious and no other room was available.

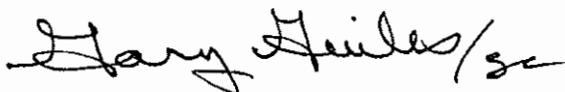
Nurses notes at 9:41 PM on 12/14/12 documented that the patient was moved from the intensive care unit to the medical/surgical floor. The note stated the patient's husband was notified of the move by telephone.

There was no evidence nursing staff were unaware of the moves and no evidence there was an interruption of care.

Conclusion #8: 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/pt

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

PRINTED: 06/03/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131325	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/23/2013
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NAME OF PROVIDER OR SUPPLIER BINGHAM MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 98 POPLAR STREET BLACKFOOT, ID 83221
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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
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C 000	<p>INITIAL COMMENTS</p> <p>A complaint investigation survey was completed at your hospital on 5/22/13 through 5/23/13. Surveyors conducting the survey were:</p> <p>Gary Guiles, RN, HFS, Team Leader Libby Doane, RN, HFS Donald Sylvester, RN, HFS</p> <p>A survey was conducted to evaluate compliance with 42 CFR Part 485.631 Condition of Participation for Staffing and Staff Responsibilities and 42 CFR Part 485.635 Condition of Participation for Provision of Services, approved by CMS on 2802. No deficiencies were identified in these areas.</p>	C 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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.