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December 11, 2014

Daniel Ordyna, Administrator  
Portneuf Medical Center  
777 Hospital Way  
Pocatello, ID 83201

Provider #130028

Dear Mr. Ordyna:

On **July 2, 2014**, a complaint survey was conducted at Portneuf Medical Center. The complaint allegations, findings, and conclusions are as follows:

**Complaint #ID00006381**

**Allegation #1:** The facility refused to perform life saving surgery as the patient was unable to pay.

**Findings #1:** An unannounced, on-site complaint investigation was conducted on 7/01/14 and 7/02/14. Ten patient records were reviewed, facility policies, and incident reports were reviewed, and staff was interviewed.

One patient record reviewed was that of a patient who presented to a physician's office with severe abdominal pain and was admitted to the hospital for pain management and hydration. The next day the patient underwent an interventional radiology procedure and an angiogram was performed which showed severe calcification and blockages of the blood vessels for the abdominal organs. The procedure involved the insertion of a thin catheter into blood vessels in the left arm and right groin, dye was introduced, x-rays were obtained, and the physician attempted to unblock blood vessels and improve circulation to the abdominal organs. The procedure was unsuccessful, and the patient was informed by the surgeon that she would need to have three separate surgical procedures to correct the blockages. Her record included documentation she was informed by the physician that a cardiac stress test to determine her ability to withstand the proposed surgeries was required, and she was encouraged to stop smoking before her planned surgeries. The patient was discharged home the following day in stable condition.

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The patient's record included documentation that six days before the first of the three proposed surgical procedures, she contacted the facility to reschedule. The documentation in her record also noted she did not have health insurance and she expressed that she wanted to wait until her insurance became effective the following month.

Policies related to patient liability for payment and charity care were reviewed. The hospital policy included the statement of "Portneuf Medical Center strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving medically necessary care." Charity was defined as healthcare services provided without charge or at a discount to qualifying patients. The hospital policy stated "Charity is not considered to be a substitute for personal responsibility. Patients are expected to cooperate with the hospital procedure for obtaining charity or other forms of payment or financial assistance, and to contribute to the cost of their care based on their individual ability to pay. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services, for their overall personal health, and for the protection of their individual assets." The policy included information related to determination of eligibility. Additionally, the policy stated that patients would be ineligible to qualify if they were non-compliant with any part of the application process. The patient would be required to complete an application that included a full disclosure of their financial status with supporting documentation.

Three of the 4 complaints reviewed included concerns related to the hospital requesting payment, either before patient discharge or scheduling surgical procedures. The hospital complaint and resolution process was reviewed, and the letters of resolution and closure were specific in the explanation of the collection process. The letters to the families also noted that they had contacted physician offices to educate the staff on the new policies of explaining patient liability before scheduling procedures. Additionally, the hospital stated they have provided further education to the staff regarding their collection tactics to ensure their scripting is non threatening.

One complaint that was reviewed included that of a patient that was asked to reschedule a procedure until she could pay 20% of the deductible amount. The written response of the hospital to the complaint included the following statement: "Due to a recent change in the health care laws regarding insurance coverage, hospitals are being paid less for many of the same services. Unfortunately, that recent decrease in reimbursement for care has resulted in the Medical Center having to implement a change to our past practice of not previously requiring some level of pre-payment for the patients portion of the charge for non-emergency procedures. We now require that patients having elective procedures pay a pre-service deposit amount calculated from what they will owe after their insurance has been processed."

The physician noted the procedures were elective, the facility scheduled the surgical procedures, and the patient chose to wait until she had insurance.

It could not be verified through the investigative process that patients were not provided surgical services for emergent medical conditions due to inability to pay.

**Conclusion #1:** Unsubstantiated. Lack of sufficient evidence.

**Allegation #2:** The hospital discharged the patient before she was ready.

**Findings #2:** An unannounced, on-site complaint investigation was conducted on 7/01/14 and 7/02/14. Ten patient records were reviewed, facility policies, and incident reports were reviewed, and staff was interviewed.

The records of each of the 10 patients reviewed included evidence of appropriate discharge.

One record reviewed was that of a patient who was to be discharged the day after a procedure was performed. On the morning of discharge, the patient's record documented she ate breakfast, was able to walk to the bathroom to void, and took a total of 120 ml of oral fluids (approximately 4 ounces). The nurse who performed the morning assessment noted the patient's abdomen was soft and flat with active bowel sounds, but she did not have a bowel movement before her discharge. The discharge nursing note on 1/15/14, stated she was discharged to home at 11:09 AM in stable condition.

As the patient met the criteria for discharge, the physician determined she was stable for discharge, and the nursing assessment did not identify abnormal findings that would prevent discharge.

It could not be verified that patients were discharged prematurely.

**Conclusion #2:** Unsubstantiated. Lack of sufficient evidence.

**Allegation #3:** The hospital discharged a patient when her pain level was intolerable.

**Findings #3:** An unannounced, on-site complaint investigation was conducted on 7/01/14 and 7/02/14. Ten patient records were reviewed, facility policies, and incident reports were reviewed, and staff was interviewed.

Each of the 10 patient records reviewed reflected patients were appropriately monitored and treated for pain.

One record reviewed was that of a female with a diagnosis of severe stenosis/occlusion (narrowing to complete closure) of celiac and superior mesenteric artery. (Celiac and mesenteric arteries provide blood flow to the intestines and abdominal organs. Altered blood flow may result in necrosis or death of the bowel and/or organs).

Additional diagnoses included severe peripheral arterial disease with bilateral leg claudication (pain and weakness in the legs with activity, which results from decreased blood flow to the muscles). (Peripheral arterial disease most often occurs as a result of atherosclerosis, a condition characterized by the gradual build up of fats, cholesterol, cellular waste, calcium, and other substances on the inner walls of large and medium-sized arteries. Plaque, the hardened, waxy substance that results from this build up, can cause narrowing of an artery and block the flow of blood and oxygen).

The patient's record indicated the patient was to have a total of 3 separately scheduled procedures to 1) remove the blockages in her legs, 2) placement of a stent in the left subclavian artery, which was occluded, and 3) placement of a stent in the celiac artery, which was causing chronic mesenteric ischemia.

The patient was admitted for the first surgical procedure that included bilateral femoral endarterectomies and bilateral iliac stent placement. The procedure involved a small incision in the groin area, a catheter was inserted into the femoral artery, and dye was introduced to determine the extent of the blockage. The plaque that was blocking the blood flow was stripped away from the inner walls of the artery to allow blood flow. The procedure was repeated on the other femoral artery, and then stents were placed in each iliac artery to maintain blood flow to the legs.

The day following the procedure, her surgeon indicated on a progress note, dated 1/15/14 at 8:10 AM, that the patient was stable for discharge, and she was to be discharged home with an office follow up appointment in 10-14 days.

The nursing assessment on 1/15/14 at 5:00 AM indicated the patient had a pain score of 6, and at 5:22 AM she was given Hydrocodone. A pain reassessment on 1/15/14 at 7:45 AM, documented her pain at a level of 1 out of a possible 10. The nursing notes on the morning of 1/15/14 at 8:15 AM, noted the patient wanted more than the clear liquid diet. Therefore, for breakfast she was ordered cream of wheat cereal. At 8:51 AM, the nurse documented the patient had nausea, and received anti-nausea medication. The nurse also noted the patient ate cereal at 9:30 AM, and was feeling better.

The nursing discharge/assessment summary report documented the patient was discharged home at 11:09 AM in stable condition. There was no indication the patient had concerns of pain at the time of her discharge.

It could not be verified that patients were discharged in severe pain or not monitored and treated for pain, as needed.

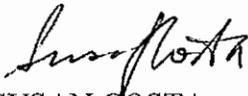
**Conclusion #3:** Unsubstantiated. Lack of sufficient evidence.

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As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

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Sincerely,



SUSAN COSTA  
Health Facility Surveyor  
Non-Long Term Care



SYLVIA CRESWELL  
Co-Supervisor  
Non-Long Term Care

SC/pmt