



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

October 15, 2013

John Olson, Administrator  
Walter Knox Memorial Hospital  
1202 East Locust Street  
Emmett, ID 83617

COPY

RE: Walter Knox Memorial Hospital, Provider #131318

Dear Mr. Olson:

This is to advise you of the findings of the Medicare/Licensure survey, which was concluded at your facility on October 8, 2013.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicare deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction.

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 Hospital into compliance, and that the hospital 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.

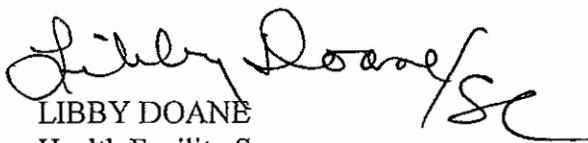
After you have completed your Plan of Correction, return the original to this office by

John Olson, Administrator  
October 15, 2013  
Page 2 of 2

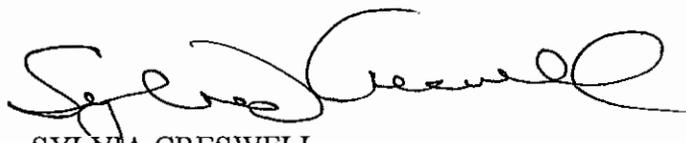
October 24, 2013, and keep a copy for your records.

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,



LIBBY DOANE  
Health Facility Surveyor  
Non-Long Term Care



SYLVIA CRESWELL  
Co-Supervisor  
Non-Long Term Care

LD/pt  
Enclosures

# RECEIVED

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

NOV 08 2013

PRINTED: 10/11/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  131318	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>FACILITY STANDARDS</b> B. WING _____	(X3) DATE SURVEY COMPLETED  C 10/08/2013
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NAME OF PROVIDER OR SUPPLIER  WALTER KNOX MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1202 EAST LOCUST STREET EMMETT, ID 83617
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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)	(X6) COMPLETION DATE
C 000	INITIAL COMMENTS  The following deficiencies were cited during the recertification survey at your hospital on 10/07/13 through 10/08/13. Surveyors conducting the investigation were:  Libby Doane, RN, BSN, HFS Team Leader Don Sylvester, RN, BSN, HFS  Acronyms used in this report include:  CFO - Chief Financial Officer CNO - Chief Nursing Officer EMS - Emergency Medical Services ER - Emergency Room QM - Quality Manager RN - Registered Nurse	C 000	<b>C304/485.638 Records System</b>  <b>Facility Plan of Correction:</b> The Emergency Department Registration Policy and Procedure was reviewed on 10/09/2013 by the Quality manager and the Business Office manager. The Procedure does state, "Register any patients who present to the desk for treatment".  An updated procedure for patient registration and triage was being developed at the time of the survey. This procedure has been implemented and the Registration Policy and Procedure is being revised to include the changes to the process. The updated procedure will include: <ul style="list-style-type: none"><li>All patients presenting to the Emergency Department will be triaged and Medically screened. The registrar will only obtain information on the presenting complaint, date of birth and primary care physician.</li></ul>	
C 304	485.638(a)(4)(i) RECORDS SYSTEMS  For each patient receiving health care services, the CAH maintains a record that includes, as applicable--  identification and social data, evidence of properly executed informed consent forms, pertinent medical history, assessment of the health status and health care needs of the patient, and a brief summary of the episode, disposition, and instructions to the patient;  This STANDARD is not met as evidenced by: Based on interview and review of policies and records, it was determined the hospital failed to ensure a medical record was maintained for 1 of 11 patients (#11) whose records were requested.	C 304		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Interim CEO* (X6) DATE *11/6/13*

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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NAME OF PROVIDER OR SUPPLIER  WALTER KNOX MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 1202 EAST LOCUST STREET EMMETT, ID 83617		
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C 304	<p>Continued From page 1</p> <p>This failure resulted in a lack of clarity as to the course of treatment during the hospital stay. Findings include:</p> <p>The policy "EMERGENCY ROOM ADMISSION," approved 3/22/11, stated "An ER record will be completed on any person presenting to the emergency room requesting treatment." The hospital did not complete a medical record in accordance with policy as follows:</p> <p>On 10/07/13 at 2:10 PM, surveyors requested the medical record of Patient #11 after finding documentation in a grievance log of an altercation between an ER physician and Patient #11's family. The CFO and QM stated Patient #11, an 18 year old male, had come to the ER just before midnight on 6/15/13, with his family for treatment of a wrist injury. The QM stated before the ER RN could register him, Patient #11's family had an altercation with the physician and left to go to another hospital. She stated ER staff did not even have Patient #11's full name at the time he left the ER. She stated because Patient #11 was not registered, there was no medical record corresponding to the ER visit. The QM and CFO also confirmed there was no medical record for Patient #11 or documentation of Patient #11 in the ER log. The QM stated she obtained written statements from staff and the physician documenting the incident.</p> <p>A statement dated 6/16/13, and signed by an RN, documented Patient #11 and his family arrived to the ER waiting room on 6/15/13 at approximately 11:45 PM. She documented Patient #11's mother stated the he had been stabbed at a park but had been treated by EMS on-site and was now presenting to the ER to have a wrist injury</p>	C 304	<ul style="list-style-type: none"> <li>If a patient presents to the Emergency Department but leaves prior to being evaluated by medical provider, the patient must be registered and a recapitulation of stay, however brief, documented in the record.</li> <li>All patients who present to the Emergency Department for care and services will be maintained in the ER log.</li> </ul> <p>Nursing staff and registration staff were educated in regards to the change in the registration process on October 9, 2013.</p> <p><b>Plan to ensure compliance:</b> At the end of each shift the ED staff, registrar and/or RN will sign a verification form stating the number of patients that presented to the ED and the number of patients</p>		

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C 304	<p>Continued From page 2</p> <p>evaluated. The RN documented she brought Patient #11 and family to an exam room and Patient #11 removed a dressing placed by EMS staff to reveal his right wrist was visibly swollen. The RN documented she placed the Patient #11's arm on a pillow, placed a blood pressure cuff and pulse oximeter, and pressed the start button to obtain vital signs. She stated Patient #11's mother was taking pictures of her son's wrist.</p> <p>The RN documented that at this time, the ER physician came into the exam room. She documented Patient #11's mother had moved to the foot of the bed and continued to point her cell phone in a manner as if to take a photo or record a video. She documented the mother pointed her phone in the direction of the physician as he was listening to Patient #11's heart and lungs with a stethoscope. The RN documented the physician told the mother that she could not take pictures or use her cell phone in the ER. The RN went on to document an argument ensued over the use of the cell phone which resulted in Patient #11 and his family leaving the ER shortly after. There was no documentation to indicate what time Patient #11 and his family left the ER.</p> <p>A statement written by the ER physician on 6/16/13 at 11:50 AM documented Patient #11 arrived to the exam room on 6/15/13 at about 11:50 PM and upon entering the patient's room, the physician examined a wound to Patient #11's chest and documented a "1/4 (inch) stab wound on the (left) breast 1/4 (inch) deep" with no active bleeding. He documented Patient #11 was breathing and conscious, in no acute distress. He documented he did a full chest and abdomen examination but before he could examine the Patient #11's wrist, he saw that he was being</p>	C 304	<p>that presented to the ED and the number of patients that were registered. The Business Office Manager or designee will audit 10% of all Emergency Department records for appropriate registration process. The audit will begin 11/15/13 and continue until 100% of charts audited show appropriated registration for no less than one month.</p>	
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C 304	<p>Continued From page 3</p> <p>filmed or photographed by Patient #11's mother on her cell phone. The physician documented an argument ensued between himself and Patient #11's parents over the use of the cell phone, during which time the physician informed the family "they could go to any ER..." The physician documented Patient #11 and family left shortly after this exchange, and Patient #11 was in no acute distress. There was no documentation to indicate what time Patient #11 and his family left the ER.</p> <p>The CNO was interviewed on 10/08/13 at 9:10 AM. He stated after midnight, there were no admission staff present in the ER so the RNs would do a "quick reg (register)," which involved entering the patient's name, date of birth, and physician name in the computer system. The RN would also make a copy of the patient's drivers license and insurance card and have the patient sign admission paperwork, including the consent for treatment. This process created a medical record and entered the patient in the ER log. The CNO confirmed nursing staff did not complete a "quick reg" on Patient #11 before he and his family left the ER. He confirmed there was no medical record for Patient #11 documenting the events detailed in the staff and physician statements described above. He confirmed that without an entry in the ER log or medical record documentation, the course of events related to Patient #11's ER visit were unclear.</p> <p>The hospital did not maintain a record documenting Patient #11's ER visit.</p>	C 304			



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October 15, 2013

John Olson, Administrator  
Walter Knox Memorial Hospital  
1202 East Locust Street  
Emmett, ID 83617

RE: Walter Knox Memorial Hospital, Provider #131318

Dear Mr. Olson:

On **October 8, 2013**, a complaint survey was conducted at Walter Knox Memorial Hospital. The complaint allegations, findings, and conclusions are as follows:

**Complaint #ID00006085**

**Allegation #1:** The hospital failed to ensure a medical record was maintained on all patients.

**Findings #1:** An unannounced visit was made to the hospital on 10/07/13 through 10/08/13. During the survey, hospital and patient records were reviewed and staff interviews were conducted.

The policy "EMERGENCY ROOM ADMISSION," approved 3/22/11, stated "An Emergency Room (ER) record will be completed on any person presenting to the emergency room requesting treatment." The hospital did not complete a medical record in accordance with policy as follows:

On 10/07/13 at 2:10 PM, surveyors requested the medical record of a patient after finding documentation in a grievance log of an altercation between an ER physician and the patient's family. The Chief Financial Officer (CFO) and Quality Manager (QM) stated the patient, an 18 year old male, had come to the ER just before midnight on 6/15/13 with his family for treatment of a wrist injury. The QM stated before the ER nurse could register him, Patient #11's family had an altercation with the physician which resulted in the patient and family going to another hospital. She stated ER staff did not even have the patient's full name at the time he left the ER. She stated because the patient was not registered, there was no medical record corresponding to the ER visit. The QM and CFO also confirmed there was no medical record for the patient or documentation of the patient in the ER log. The QM stated she obtained written statements from staff and the physician documenting the incident.

John Olson, Administrator  
October 15, 2013  
Page 2 of 4

A statement, dated 6/16/13 and signed by a Registered Nurse (RN), documented the patient and his family arrived to the ER waiting room on 6/15/13 at approximately 11:45 PM. She documented the patient's mother stated the patient had been stabbed at a park but had been treated by Emergency Medical Services (EMS) on site and was now presenting to the ER to have a wrist injury evaluated. The RN documented she placed the patient's arm on a pillow, placed a blood pressure cuff and pulse oximeter on the patient, and pressed the start button to obtain vital signs. She stated the patient's mother was taking pictures of her son's wrist.

The RN documented that at this time, the ER physician came into the exam room. She documented the patient's mother had moved to the foot of the bed and continued to point her cell phone in a manner as if to take a photo or record a video. She documented the mother pointed her phone in the direction of the physician as he was listening to the patient's heart and lungs with a stethoscope. The RN documented the physician told the patient's mother that she could not take pictures or use her cell phone in the ER. The RN went on to document an argument ensued over the use of the cell phone which resulted in the patient and his family leaving the ER shortly after. The RN documented she had taken the patient's drivers license and insurance card in order to make copies, but returned them to the family at this time. There was no documentation to indicate what time the patient and his family left the ER.

The CNO was interviewed on 10/08/13 at 9:10 AM. He stated after midnight, there were no admission staff present in the ER so the RNs would do a "quick reg (register)" which involved entering the patient's name, date of birth, and physician name in the computer system. The RN would also make a copy of the patient's drivers license and insurance card and have the patient sign admission paperwork, including the consent for treatment. This process created a medical record and entered the patient in the ER log. The CNO confirmed nursing staff did not complete a "quick reg" on the patient before he and his family left the ER. He confirmed there was no medical record for the patient documenting the events detailed in the RN statement described above. He confirmed that without an entry in the ER log or medical record documentation, the course of events related to the patient's ER visit were unclear.

The hospital failed to maintain a record of the patient's ER visit. Therefore, the allegation was substantiated and a deficient practice was cited at 42 CFR 485.638(a)(4)(i).

**Conclusion #1:** Substantiated. Federal and State deficiencies related to the allegation are cited.

**Allegation #2:** The hospital failed to perform a medical screening exam on a patient presenting to the emergency room.

**Findings #2:** An unannounced survey was made to the hospital on 10/07/13 though 10/08/13. During the survey, facility and patient records were reviewed and staff interviews were conducted.

On 10/07/13 at 2:10 PM surveyors requested the medical record of a patient after finding documentation in an incident report folder of an altercation between an emergency room (ER) physician and the patient's family. The Chief Financial Officer (CFO) and the Quality Manager (QM) stated there was no medical record for this patient. The QM stated the patient, an 18 year old male, had come to the ER just before midnight on 6/15/13 with his family for treatment of a wrist injury. She stated before the registered nurse

John Olson, Administrator

October 15, 2013

Page 3 of 4

(RN) in the ER could register him, the patient's family had an altercation with the physician and left to go to another hospital. The QM stated she obtained written statements from staff and the physician documenting the incident.

A statement dated 6/16/13 and signed by an RN documented the patient and his family arrived to the ER waiting room on 6/15/13 at approximately 11:45 PM. She documented the patient's mother stated the patient had been stabbed at a park but had been treated by Emergency Medical Services (EMS) on site and was now presenting to the ER to have a wrist injury evaluated. The RN documented she brought the patient and family to an exam room and the patient removed a dressing placed by EMS staff to reveal his right wrist was visibly swollen. The RN documented she placed the patient's arm on a pillow, placed a blood pressure cuff and pulse oximeter on the patient, and pressed the start button to obtain vital signs. She stated the patient's mother was taking pictures of her son's wrist.

The RN documented that at this time, the ER physician came into the exam room. She documented the patient's mother had moved to the foot of the bed and continued to point her cell phone in a manner as if to take a photo or record a video. She documented the mother pointed her phone in the direction of the physician as he was listening to the patient's heart and lungs with a stethoscope. The RN documented the physician told the patient's mother that she could not take pictures or use her cell phone in the ER. The RN went on to document an argument ensued over the use of the cell phone which resulted in the patient and his family leaving the ER shortly after. There was no documentation to indicate what time the patient and his family left the ER.

A statement written by the ER physician on 6/16/13 at 11:50 AM documented the patient arrived to the exam room on 6/15/13 at about 11:50 PM and upon entering the patient's room, the physician examined a stab wound to the patient's chest and documented a "1/4 (inch) stab wound on the (left) breast 1/4 (inch) deep" with no active bleeding. He documented the patient was breathing and conscious, in no acute distress. He documented he did a full chest and abdomen examination but before he could examine the patient's wrist, he saw that he was being filmed or photographed by the patient's mother on her cell phone. The physician documented an argument ensued between himself and the patient's parents over the use of the cell phone, during which time the physician informed the family "they could go to any ER...." The physician documented patient and family left shortly after this exchange, and the patient was in no acute distress. There was no documentation to indicate what time the patient and his family left the ER.

The Chief Nursing Officer was interviewed on 10/08/13 beginning at 9:10 AM. He stated that the patient and his family were in the ER such a short time a medical screening exam (MSE) could not be completed, but that the physician had attempted to examine the patient, as evidenced by his statement and the statement of other staff. He confirmed there was no medical record for the patient which would document the assessment made by the nurse or the physician.

Surveyors reviewed 10 medical records of patients that had presented to the ER. Each documented an MSE had been performed.

John Olson, Administrator  
October 15, 2013  
Page 4 of 4

It could not be determined through the investigative process that a medical screening exam had not been attempted by the hospital. Therefore, the allegation was unsubstantiated and no deficient practice was cited.

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

As only one of the allegations was substantiated, but was not cited, no response is necessary.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it was addressed in the Plan of Correction.

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,



LIBBY DOANE  
Health Facility Surveyor  
Non-Long Term Care



SYLVIA CRESWELL  
Co-Supervisor  
Non-Long Term Care

LD/pt



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John Olson, Administrator  
Walter Knox Memorial Hospital  
1202 East Locust Street  
Emmett, ID 83617

COPY

RE: Walter Knox Memorial Hospital, Provider #131318

Dear Mr. Olson:

On **October 8, 2013**, a complaint survey was conducted at Walter Knox Memorial Hospital. The complaint allegation, finding, and conclusion are as follows:

**Complaint #ID00006106**

**Allegation:** There is mold in patient rooms and nothing is being done to remove it.

**Finding:** An unannounced visit was made to the hospital on 10/07/13 through 10/08/13. During the survey, staff interviews were conducted and a tour of the hospital was completed.

On 10/07/13 beginning at 1:00 PM, surveyors toured the hospital. During the tour, it was observed that floors were being replaced in patient rooms.

An interview was conducted with the Facility's Maintenance Manager on 10/07/13 beginning at 2:00 PM. He stated a hospital project began on 9/30/13, to remove existing flooring in all patient rooms. He said it will be replaced with a solid, seamless flooring. When asked about mold in patient rooms, he stated that mold was found (under tile flooring) near two showers in patient rooms. He added that the mold was removed from the floor in the two patient rooms.

While mold may have existed on patient room floors in the past, none was observed at the time of the survey. Since mold did not exist at the time of the investigation, the allegation could not be substantiated.

John Olson, Administrator  
October 15, 2013  
Page 2 of 2

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

As the allegation was substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,



LIBBY DOANE  
Health Facility Surveyor  
Non-Long Term Care



SYLVIA CRESWELL  
Co-Supervisor  
Non-Long Term Care

LD/pt



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October 15, 2013

John Olson, Administrator  
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Emmett, ID 83617

COPY

RE: Walter Knox Memorial Hospital, Provider #131318

Dear Mr. Olson:

On **October 8, 2013**, a complaint survey was conducted at Walter Knox Memorial Hospital. The complaint allegations, findings, and conclusions are as follows:

**Complaint #ID00006117**

**Allegation #1:** There is mold in patient rooms and nothing is being done to remove it.

**Findings #1:** An unannounced visit was made to the hospital on 10/07/13 through 10/08/13. During the survey, staff interviews were conducted and a tour of the hospital was completed.

On 10/07/13 beginning at 1:00 PM, surveyors toured the hospital. During the tour, it was observed that floors were being replace in patient rooms.

An interview was conducted with the Facility's Maintenance Manager on 10/07/13 beginning at 2:00 PM. He stated a hospital project began on 9/30/13, to remove existing flooring in all patient rooms. He said it will be replaced with a solid, seamless flooring. When asked about mold in patient rooms, he stated that mold was found (under tile flooring) near two showers in patient rooms. He added that the mold was removed from the floors in the two patient rooms.

While mold may have existed on patient room floors in the past, none was observed at the time of the survey. Since mold did not exist at the time of the investigation, the allegation could not be substantiated.

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

**Allegation #2:** The hospital staff was using expired medications.

**Findings #2:** An unannounced visit was made to the facility on 10/07/13 through 10/08/13. During the survey, a hospital pharmacy tour and staff interviews were conducted.

During a tour of the pharmacy, the Pharmacist was interviewed on 10/07/13 beginning at 2:00 PM. He stated that all expired medications were discarded. The hospital had gone to a bar code expiration system. The medication coding system was overseen and audited by an outside entity. The surveyor observed the medications for expiration dates and found them to be current at the time of the tour.

It could not be determined through the investigative process that hospital pharmacy had expired medications. Therefore, the allegation was unsubstantiated and no deficient practice was identified.

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

**Allegation #3:** The hospital has LPN's working in the emergency room, instead of RN's

**Findings #3:** An unannounced visit was made to the hospital on 10/07/13 through 10/08/13. During the survey, hospital policies and patient records were reviewed, and staff interviews were conducted.

The hospital's policy titled Medical Screening Examination and Emergency Room Record, dated 3/07/12, stated "...Qualified Medical Personnel include Registered Nurses (RN) approved and appointed by the Medical Staff and Governing Board and those possessing higher licensure, can conduct and document an appropriate medical screening examination reasonably calculated to identify an emergency medical condition. The documentation of the Urgency Classification is to be completed with medical screening examination. Only a person who is a RN or possessing higher licensure can conduct this procedure.

Ten medical records of patients who presented to the emergency department were reviewed. There was no documentation in the medical records to indicate LPN's were working in the emergency room. In addition, the medical records included medical screening examinations, completed by RN's.

The Chief of Nursing Operations was interviewed on 10/08/13 at 9:10 AM. He confirmed RN's triage, conduct the medical screening examination, and assess patients' acuity.

It could not be determined through the investigative process that LPN's were working in the emergency room instead of RN's.

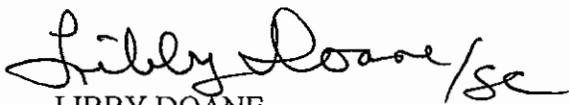
**Conclusion #3:** Unsubstantiated. Lack of sufficient evidence.

John Olson, Administrator  
October 14, 2013  
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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.

Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,



LIBBY DOANE  
Health Facility Surveyor  
Non-Long Term Care



SYLVIA CRESWELL  
Co-Supervisor  
Non-Long Term Care

LD/pt