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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

December 17, 2010

Norman Stephens, Administrator
Portneuf Medical Center
651 Memorial Drive
Pocatello, ID 83201

Provider #130028

Dear Mr. Stephens:

On **November 18, 2010**, a complaint survey was conducted at Portneuf Medical Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004152

Allegation #1: Patients did not receive appropriate medical care and services during their stay at the facility. A patient's blood glucose levels became dangerously low. A patient developed pressure sores and aquired lung and urinary infections.

Findings #1: An unannounced visit was made to the hospital on 11/15-18/2010. Surveyors reviewed 28 medical records of both inpatients and emergency patients. Meeting minutes were reviewed. Staff and patients were interviewed.

All of the medical records documented examinations and treatment in accordance with patients' needs.

One medical record documented a 50 year old female who was admitted to the hospital on 5/06/09 and passed away on 5/16/09. She became unresponsive at a local nursing home on 5/06/09. The care that was provided at the nursing home was not reviewed as part of the hospital survey. She was taken to the hospital's Emergency Department on 5/06/09. Her blood glucose level in the Emergency Department was critically low. She was given intravenous glucose. She was septic and blood and

urine cultures were obtained. Subsequent testing showed she also had blood clots in her lungs and had pneumonia. She was immediately started on antibiotics. She had multiple areas of skin breakdown on admission. She was admitted to the intensive care unit where she was intubated and placed on a ventilator. Her kidneys failed and she was placed on dialysis. She was treated aggressively with an attending physician and resident providing her primary care and 4 other consulting physicians providing care for her. Physicians documented examinations and treatment several times a day during her stay. Extensive laboratory and radiological testing was provided. The pressure sores were treated. A tube was placed to feed her. The patient responded poorly to treatment. She did not regain consciousness. Following a family meeting on 5/15/09, the decision was made to discontinue treatment. This was done and the patient died on 5/16/09.

The hospital had an active peer review process and a process to monitor the care provided by all members of the medical staff.

No deficiencies were cited in relation to care provided to patients.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: The hospital failed to provide medical records to a third party when requested.

Findings #2: The hospital maintained a log of all requests for copies of medical record and a record of all medical records that had been provided to patients and others. The hospital provided a copy of the medical record to patients and authorized family members free of charge. Policies and procedures supporting this practice had been developed and implemented.

No record was present that medical records had been requested for the patient named in the complaint.

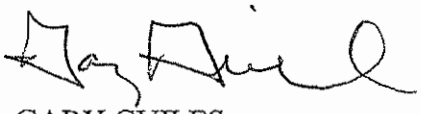
Other allegations were made in the complaint. During the investigation, however, it became clear the other allegations were related to incidents at another facility prior to a patient's transfer to the hospital. Because the allegations did not occur at the hospital, these allegations were not investigated.

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,



GARY GUILES
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

GG/srm

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December 20, 2010

Norman Stephens, Administrator
Portneuf Medical Center
651 Memorial Drive
Pocatello, ID 83201

Provider #130028

Dear Mr. Stephens:

On **November 18, 2010**, a complaint survey was conducted at Portneuf Medical Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004352

Allegation #1: A patient was discharged prematurely from the hospital following surgery.

Findings #1: An unannounced survey of the hospital was conducted 11/15/10 through 11/18/10. The medical records of nine patients who had surgery were reviewed. Four of these were current patients on the surgical floor. Five patients had been discharged from the hospital. Staff and patients were interviewed.

Four current patients were interviewed regarding their care and preparedness for discharge. Each patient confirmed they were involved in their discharge planning process and were comfortable with their plans. Two of these patients were scheduled to be discharged the day of the interviews, 11/18/10. Both patients stated they received good care and were ready for discharge.
The five medical records of discharged patients indicated thorough nursing and physician assessments had been completed prior to discharge and patients were discharged without complications.

One medical record documented a patient who was cared for on the surgical floor

from 10/08/09 through 10/11/09 following urology surgery. A discharge planner completed an initial assessment on 10/09/09 to initiate a discharge plan. A final visit was completed on 10/11/09, just prior to discharge.
The Urologist noted in the progress notes, on 10/10/09, the patient had a "new" requirement for supplemental oxygen to maintain adequate blood oxygen saturation levels. To evaluate this change in her condition he ordered a chest x-ray. The Urologist documented in the progress notes on 10/11/09, that the patient had no complaints, was afebrile (no fever), and had a blood oxygen saturation level of 90% on room air. He also documented the chest x-ray was negative and he planned to discharge the patient.

Nursing documentation on 10/11/09 at 10:13 AM indicated the Urologist visited the patient, removed the nephrostomy drain and replaced the dressing. Further nursing documentation on 10/11/09 at 11:15 AM indicated discharge instructions were given to the patient's guardian and the patient was discharged from the hospital. The guardian signed acknowledgement of the discharge instructions on 10/11/09.

It could not be verified that a patient was discharged from the hospital prematurely.

Conclusion:Unsubstantiated. Lack of sufficient evidence.

Allegation #2: A patient was readmitted to the hospital within 2 days as a result of complications from surgery.

Findings #2: An unannounced survey was conducted at the hospital 11/15/10 through 11/18/10. Nine surgical records were reviewed, including five records for discharged patients and four current patients. In addition to medical records, quality assurance documentation related to physician peer review was evaluated. Staff were interviewed.

Two of the nine surgical patients were readmitted within a couple of days of discharge after surgery. One medical record documented the readmission as a possible consequence of a complication during the first surgery.

The second medical record indicated a patient discharged from the hospital on 10/11/09 status post urology surgery, was readmitted on 10/13/09 for care of a pleural effusion. The initial set of vital signs obtained upon this readmission indicated her blood pressure was 143/57, pulse was 108 beats per minute, respirations 18 per minute, temperature was 98.1 degrees Fahrenheit, and her oxygen level was 91% on 3 liters of oxygen a minute. The initial chest x-ray, and subsequent ultrasound,

indicated the patient had a large amount of fluid which had collected in the pleural lining of her lung. She was diagnosed with pleural effusion and a drain was placed to remove the fluid and ease her breathing. Lab work ruled out an infectious process as a cause for her illness. More than six different physicians were involved in her care during the hospital stay. The medical record contained no documentation to indicate the readmission was related to her prior urology surgery.

To ensure the hospital had a process to monitor readmissions following complications of surgery, the process for peer review of medical records was discussed with the Chief Quality Officer. She described the method by which medical records were then selected for peer review. The hospital had a system in place to evaluate situations in which patients were readmitted with either the same diagnosis (the issue had not been resolved) or as a result of complications from a previous admission. She described the specific criteria for peer review of medical records. She stated since the patient, described above, was not readmitted as a result of complications from the prior surgery, but rather for a different diagnosis, the record was not identified as one of the quality indicators for peer review.

It could not be verified that a readmission to the hospital was a result of surgical complications.

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,

GARY GUILES
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
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December 20, 2010

Norman Stephens, Administrator
Portneuf Medical Center
651 Memorial Drive
Pocatello, ID 83201

Provider #130028

Dear Mr. Stephens:

On **November 18, 2010**, a complaint survey was conducted at Portneuf Medical Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004399

Allegation #1: A patient requested certain medications but hospital staff refused to prescribe these medications.

Findings #1: An unannounced visit was made to the hospital on 11/15-18/2010. A tour of the Emergency Department was conducted. Sixteen medical records of emergency patients were reviewed. Staff were interviewed.

All of the medical records reviewed documented patients received examinations by qualified medical personnel. Testing and treatment were rendered based on those examinations.

One medical record documented a 22 year old male who presented to the Emergency Department on 11/20/09 complaining of a headache. The patient was examined by a Physician Assistant. A non-narcotic medication was prescribed. The patient refused the medication and left the hospital against medical advice.

Individual treatment decisions are the responsibility of the assigned medical staff

member. Except in very limited circumstances, those decisions are not subject to federal or state regulations. Hospitals are not required to provide treatment, including specific medication, to patients if the practitioner determines it is not warranted.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: The hospital did not provide appropriate emergency services.

Findings #2: An unannounced visit was made to the hospital on 11/15-18/2010. A tour of the Emergency Department was conducted. Sixteen medical records of emergency patients were reviewed. Staff were interviewed.

The Emergency Department was adequately staffed with both medical and nursing staff. Systems and equipment were in place to care for patients.

All of the medical records reviewed documented patients received examinations by qualified medical personnel. Testing and treatment was rendered based on those examinations. All of the medical records listed patients' allergies. No medical records documented patients received medications they were allergic to.

The hospital was determined to be in compliance with federal and state requirements for emergency services.

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,

GARY GUILES
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651 Memorial Drive
Pocatello, ID 83201

Provider #130028

Dear Mr. Stephens:

On **November 18, 2010**, a complaint survey was conducted at Portneuf Medical Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004494

Allegation #1: Patients who presented to the Emergency Department (ED) were not appropriately evaluated and diagnosed.

Findings #1: An unannounced survey of the hospital was conducted 11/15/10 through 11/18/10. Sixteen Emergency Department records were reviewed. A tour of the ED was conducted and staff were interviewed.

The ED was adequately staffed with physician and nursing staff. Systems and equipment were in place to efficiently triage and care for patients.

Sixteen of the ED records reviewed documented thorough evaluations of patients based on the presenting complaints. Diagnostic testing and medications were ordered based on the results of the evaluations, and further care and treatment were provided based on the results of the diagnostic tests.

One record documented an individual involved in a high-speed motor vehicle accident who was transported to the ED via ambulance on 12/03/09. The Physician

documented, in the HPI (History of Present Illness) section of the record, the patient denied pain in his neck, back, chest, abdomen, clavicle, and to all extremities. The patient's vital signs remained stable throughout the stay and the Physician documented the patient appeared comfortable. The Physician performed a complete physical exam. The only abnormality noted was disorientation to time, a flat affect, and poor insight and concentration. Lab work was done, and based on the mechanism of injury and the above abnormalities, the patient received a CT (Computerized Tomography) scan of the head. The Physician documented the CT was negative, vital signs were stable, and the lab work was normal. The patient was discharged from the ED with discharge instructions.

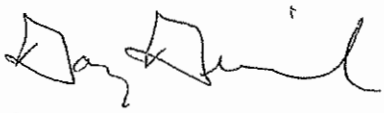
ED patients received thorough assessments and evaluations. Diagnostic testing was performed based on the results of the assessments and evaluations.

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,



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