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August 12, 2015

Jana Stowell, Administrator
St. Alphonsus Home Health And Hospice
510 S 11th Street
Boise, ID 83702

Provider #137006

Dear Ms. Stowell:

An unannounced on-site complaint investigation was conducted from July 20, 2015 to July 24, 2015 at St Alphonsus Home Health And Hospice. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00006759

Allegation #1: Criminal background checks were not completed in a timely manner.

Findings #1: Personnel documents were reviewed and staff interviews were conducted.

The Business Office Manager was interviewed on 7/21/15 at 3:00 PM. She stated, that during the agency transition miscommunication had occurred as to whose responsibility it was to ensure background checks were completed which resulted in some late background checks.

A sample of 5 current home health agency personnel files were reviewed for evidence of timely criminal history checks. All of the files selected contained criminal background checks that had been obtained in a timely manner.

Although, based on staff interview, there may have been late background checks during the transition, the agency had identified and resolved the issue prior to the survey being conducted and no current deficient practices were identified.

Conclusion #1: Substantiated. No deficiencies related to the allegation are cited.

Allegation #2: There was a significant delay in receiving patient admit orders and creating patient charts, leading to lost patient record information and agency staff being asked to re-create initial assessments. This resulted in inaccurate information being present in patients' medical records.

Findings #2: Medical records were reviewed and staff were interviewed.

The Director of Home Health and Hospice and Vice President of Operations were interviewed on 7/20/15 at 1:50 PM. They stated there had been a problem in 2014 during the agency's transition from an electronic medical record to a paper chart, which had resulted in a delay in creating charts and occasional lost paperwork. In order to correct the problem, the home health and hospice instituted a performance improvement project to improve the timeliness of chart creation and completion and to improve a filing system to minimize lost information. They stated there had been no medical records lost in 2015.

An LPN and RN who had been with the agency multiple years were interviewed separately on 7/21/15 at 10:10 PM and 7/22/15 at 8:30 AM. Both denied being asked to recreate lost assessments. Both stated they kept copies of their charting. If something was lost, they would present their copies.

The Director of Home Health and Hospice was interviewed on 7/22/15 at 10:40 AM and asked how lost paperwork, such as initial assessments, was handled. She stated, they would look to see if something had been misfiled and, if possible, retrieve it. She stated staff often kept their own copies. When asked if copies were not available, how would it be handled, she stated if the notes had been kept, the assessment, would be entered as a "late entry" and created. If notes were not available, nursing staff would have to conduct new assessments. She stated there had not been any incidents in 2015 when paperwork had to be re-created. When asked regarding the last time notes were lost and not found, she stated it had been October of 2014. She stated lost paperwork was tracked on an incident report. She stated the home health and hospice improved their filing system to reduce the risk of lost documents.

The medical records of 8 home health patients who were on services in 2015 were reviewed. All of the records included timely admit orders. Evidence of lost patient information, including initial assessment information was not identified.

The agency did experience a delay in obtaining admit orders and creating patient charts which resulted in lost patient records, therefore the allegation was substantiated. However, the agency had identified and resolved the issue prior to the survey being conducted and no current deficient practices were identified.

Conclusion #2: Substantiated. No deficiencies related to the allegation are cited.

Allegation #3: The home health and hospice did not have a system in place to ensure weekend nursing staff had access to all necessary patient information to provide quality care.

Findings #3: Medical records were reviewed and staff and patients were interviewed.

An LPN and RN who had been with the agency multiple years were interviewed separately on 7/21/15 at 10:10 PM and 7/22/15 at 8:30 AM. They both stated they covered on the weekend at times. They stated there had been a problem accessing patient information for weekend visits during the agency transition, but it was no longer a problem. They stated weekend staff had access to patient information necessary to care for patients, such as the plan of care and current medication lists. The stated the information was kept in an "on-call box" and accessible to weekend staff.

The medical records of 8 patients who were on services in 2015 were reviewed. No evidence was found that patient needs were not being met during weekends.

The agency did experience difficulty accessing information for weekend visits, therefore the allegation was substantiated. However, the agency had identified and resolved the issue prior to the survey being conducted and no current deficient practices were identified.

Conclusion #3: Substantiated. No deficiencies related to the allegation are cited.

Allegation #4: Social work visits were not provided at the frequency specified in the plan of care.

Findings #4: Medical records were reviewed and staff were interviewed.

The medical records of 8 home health patients who were on services in 2015 were reviewed. Five of the medical records reviewed included patients who had Social Work orders. All 5 records included documentation that Social Work visits were provided in accordance with plans of care.

Conclusion #4: Unsubstantiated. Lack of sufficient evidence.

Allegation #5: The home health is not reporting and tracking all falls and other incidents.

Findings #5: During the case management meeting, three patient falls were referenced. Upon request, the incident reports were promptly provided.

An LPN and RN were independently interviewed. They both stated it was the agency expectation that fall reports be completed on any observed or reported falls and that was their practice.

A stack of incident reports for 2015 was provided for review. Falls, as well as other incidents, such as urinary tract infections, were included among the incident reports.

It could not be determined that the agency failed to report and track falls and other incidents. Therefore, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion #5: Unsubstantiated. Lack of sufficient evidence.

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

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626, option 4. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

Teresa Hamblin

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TH/pmt