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February 16, 2016

Cynthia Billington, Administrator
Hospice Of Eastern Idaho
1810 Moran Street
Idaho Falls, ID 83401

Provider #131538

Dear Ms. Billington:

An unannounced on-site complaint investigation was conducted from February 2, 2016 to February 3, 2016 at Hospice Of Eastern Idaho. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00007158

Allegation: The hospice failed to coordinate care with Assisted Living Facilities (ALFs) and inappropriately transferred hospice patients into the agency's hospice home.

Findings: An unannounced survey was conducted from 2/02/16 to 2/03/16. During the survey, eight medical records were reviewed of patients who received services in the hospice home. Three of the patients whose medical records were reviewed had been transferred from an ALF into the hospice home for general inpatient care. The other patients had been transferred from home or a hospital. Nursing staff and administration from the hospice were interviewed. Additionally, an interview was conducted with a family member of a patient who had been transferred from an ALF to the hospice home where she subsequently died.

The hospice agency's brochure "The Hospice Home" stated the following information:

"Patients who may utilize this service include anyone who has elected hospice services and

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- Is in need of short term pain and symptom management not adequately addressed in the home
- Had significant physical needs which exceed the caregivers capacity in their home
- Is in need of transitional care upon hospital discharge
- Needs respite admission to provide relief for the caregiver"

The patients' medical records included documentation of coordination of care and justification for the transfers to the hospice home for short-term respite care or general inpatient care.

The Executive Director of the hospice was interviewed on 2/03/16 at 8:56 AM. She stated her agency had received a complaint on 9/08/15 from the Administrator of the ALF where one patient lived. Hospice documentation indicated the ALF Administrator "accused {a hospice Registered Nurse} of trolling for patients for Hospice Home..." The Executive Director stated attempts were made to coordinate a team meeting prior to transferring the patient to include hospice staff, the patient's family, and the ALF Administrator. However, she stated the patient's daughter, who was the patient's legal representative, refused to participate in a team meeting where the ALF Administrator would be present. Due to the patient's acuity and the daughter's insistence to have her mother removed from the ALF right away, a team meeting did not occur prior to transfer out of the ALF and into the hospice home.

The patient's medical record was reviewed. The record documented an elderly female who was receiving hospice services, related to a cancer diagnosis. She was transferred from the ALF where she was residing into the agency's hospice home on 9/09/15. The medical record documentation indicated the patient had been managing well in the ALF up until a few days prior to transfer when she developed increased anxiety, shortness of breath, falls, nausea, diarrhea, and pain, requiring a higher level of care.

The patient's medical record was reviewed and included documentation of multiple conversations between hospice staff and the ALF Administrator. For example, an RN visit note, dated 9/07/15 at 1:30 PM, included the following information:

"Received a call from {the patient's daughter}, that she {the patient} was in severe pain requesting a shot. {The patient} was sitting in the recliner when I arrived. She is anxious upset and crying. Her abdomen hurts. {Her daughter} is upset and crying because her mom is in such pain...{The daughter} wants her mom to go to the hospice house for care. I explained that the home is not ready for occupancy. I visited with {the patient} and {the daughter}.

I told them they have several options, {the daughter} can take her home with her, she can go to a skilled nursing facility where she will have a higher level of care, or wait until the hospice home is open and move her there for symptom management. they {sic} opted to stay at the assisted living for now. {The patient} is hesitant about leaving her roommate and acquiring another one. I explained that she would be in a private room, and whe {sic} would have better care for symptom management with a 24 hour RN. I did discuss respite if the symptoms could not be managed here. I notified her physiciaina {sic} and roxanol 5 mg/0.25 ml oral was started every one to two hours prn {as needed}. {The Licensed Practical Nurse} is getting the medication and will deliver to the facility. Staff will be educated. {The patient} understands that she will need to ask for the medication...I went to the kitchen area to ask for an Ativan for {the patient} and {the Administrator} started talking to me about {the patient}. She stated that {the patient} is fine until {the daughter} comes. She feels that {the daughter} and {her son} upset {the patient}. She does not think that {the patient} is in pain. I explained that {the patient} told me she was and that she has 450 mcgs of Fentanyl in the form of patches and she takes oxycodone also.. {sic} I also informed her that I started her on Roxanol for breakthrough pain. If it doesn't work . {sic} we will need to look at IV medication or some other route which would require transferring her to another facility where she can receive a higher level of care. . {sic}... I explained to {the daughter} that we will see {the patient} twice daily to try and manage her symptoms if that is not enough we will revisit her options."

A hospice RN was interviewed on 2/03/16 at 9:10 AM. She stated the patient had been declining and needed a higher level of care. She stated they tried providing continuous hospice care briefly and offered a skilled nursing facility option or to discharge the patient to the care of her daughter. She stated the patient's daughter, who was the patient's legal representative, did not want her mother to go to a skilled nursing facility but she wanted her out of the ALF. At the time of initially offering a skilled nursing facility, the hospice home had not been ready for occupancy.

The daughter of the patient, who was the patient's legal representative, was interviewed by telephone on 2/03/16 at 11:30 AM. She stated that on the day her mother was transferred to the hospice home, she had contacted the hospice and told them she wanted her mother moved that day, even though there had been no plans to move her right away. She also stated she did not want to meet with the ALF Administrator as part of a team meeting because she felt the Administrator did not care about her mother's individual needs and that her mother needed more care than the ALF could provide since her mother's decline. She stated she had been aware for months of the hospice's intention to open a hospice house and wanted this benefit for her mother.

It could not be determined the hospice failed to coordinate care or inappropriately transferred hospice patients out of ALFs to the hospice home. Therefore, the allegation was unsubstantiated and no deficient practice was identified.

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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,



TERESA HAMBLIN
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

TH/pmt