



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

TAMARA PRISOCK—ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T. – Chief
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August 31, 2016

Justin Cheney, Administrator
Solace Healthcare
197 Stockham Blvd, Suite 2
Rigby, ID 83442-1275

RE: Solace Healthcare, Provider #131566

Dear Mr. Cheney:

This is to advise you of the findings of the Medicare survey of Solace Healthcare, which was conducted on August 18, 2016.

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. It is important that your Plan of Correction address each deficiency in the following manner:

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 hospice into compliance, and that the hospice remains in compliance with the regulatory requirements;

Justin Cheney, Administrator
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- 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 **September 13, 2016**, and keep a copy for your records.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Dennis Kelly, RN or Nicole Wisenor, Co-Supervisors, Non-Long Term Care at (208) 334-6626, option 4.

Sincerely,

A handwritten signature in black ink, appearing to read "Nicole Wisenor". The signature is fluid and cursive, written over a light blue horizontal line.

NICOLE WISENOR, Supervisor
Non-Long Term Care

NW/pmt
Enclosures

SEP 13 2016

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

FACILITY STANDARDS

PRINTED: 08/30/2016
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131566 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 08/18/2016 |
|--|--|---|---|---|
| NAME OF PROVIDER OR SUPPLIER SOLACE HEALTHCARE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 197 STOCKHAM BLVD, SUITE 2 RIGBY, ID 83442 | |
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| L 000 | INITIAL COMMENTS The following deficiencies were cited during the recertification and complaint survey conducted by Healthcare Management Solutions, LLC on behalf of the Centers for Medicare and Medicaid (CMS) from 8/15/16 to 8/18/16. The surveyor conducting the survey was: Robin Tuiskula, RN, BC | L 000 | Preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the accuracy or truthfulness of any facts alleged or any conclusions set forth in this allegation of deficiencies by the State Licensing Authority. Accordingly, the facility has drafted this Plan of Correction in accordance with Federal and State Laws which mandate the submission of a Plan of Correction as a condition for participation in the Medicare and Medicaid program. This Plan of Correction shall constitute this facility's credible allegation compliance with this section. | |
| L 531 | 418.54(c)(7) CONTENT OF COMPREHENSIVE ASSESSMENT [The comprehensive assessment must take into consideration the following factors:] (7) Bereavement. An initial bereavement assessment of the needs of the patient's family and other individuals focusing on the social, spiritual, and cultural factors that may impact their ability to cope with the patient's death. Information gathered from the initial bereavement assessment must be incorporated into the plan of care and considered in the bereavement plan of care. This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to perform and document a bereavement risk assessment at the time of admission. This failure directly impacted 11 of 11 patients (Patients #1 - #11), whose records were reviewed and had the potential to impact all patients and families currently receiving hospice services. Failure to assess patients and family for a risk related to bereavement could result in services not being provided and needs not being met. Findings include: | L 531 | L 531 418.54(c)(7) CONTENT OF COMPREHENSIVE ASSESSMENT Bereavement risk assessment will be added to QAPI and Followed to ensure completeness | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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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| L 531 | <p>Continued From page 1</p> <p>Review of "Bereavement" (undated), indicated that on admission, "the Social Worker or Chaplain will complete a Bereavement Risk Assessment which is kept in the patient's clinical record."</p> <p>Review of the clinical record documented Patient #1 was admitted to hospice service on 2/22/16. There was no documented evidence of an initial bereavement risk assessment included with the admission assessments.</p> <p>Review of the clinical record documented Patient #2 was admitted to hospice service on 6/13/16. There was no documented evidence of an initial bereavement risk assessment included with the admission assessments.</p> <p>Review of the clinical record documented Patient #3 was admitted to hospice service on 6/1/16. There was no documented evidence of an initial bereavement risk assessment included with the admission assessments.</p> <p>Review of the clinical record documented Patient #4 was admitted to hospice service on 5/7/15. There was no documented evidence of an initial bereavement risk assessment included with the admission assessments.</p> <p>Review of the clinical record documented Patient #5 was admitted to hospice service on 3/9/15. There was no documented evidence of an initial bereavement risk assessment included with the admission assessments.</p> <p>Review of the clinical record documented Patient #6 was admitted to hospice service on 4/14/16. There was no documented evidence of an initial bereavement risk assessment included with the</p> | L 531 | <p>Solace team has reviewed our bereavement risk assessment we have reassessed the living/current patients Will have all the assessments on all current patients by 09/23/16. Social worker will have ongoing training at least monthly and will be tailored to include bereavement assessments.</p> <p>Patient #1 has had bereavement assessment completed and no risk noted.</p> <p>Patient #2 had bereavement assessment completed and anticipatory grief noted will continue with visits to the daughter continued since admit</p> <p>Patient #3 has had bereavement assessment completed and findings no risk family declined bereavement.</p> <p>Patient #4 has passed away Prior to survey.</p> <p>Patient #5 was discharged prior to survey</p> <p>Patient #6 passed away prior to survey.</p> | |

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| L 531 | <p>Continued From page 2 admission assessments.</p> <p>Review of the clinical record documented Patient #7 was admitted to hospice service on 2/26/16. There was no documented evidence of an initial bereavement risk assessment included with the admission assessments.</p> <p>Review of the clinical record documented Patient #8 was admitted to hospice service on 8/1/16. There was no documented evidence of an initial bereavement risk assessment included with the admission assessments.</p> <p>Review of the clinical record documented Patient #9 was admitted to hospice service on 8/4/16. There was no documented evidence of an initial bereavement risk assessment included with the admission assessments.</p> <p>Review of the clinical record documented Patient #10 was admitted to hospice service on 4/18/16. There was no documented evidence of an initial bereavement risk assessment included with the admission assessments.</p> <p>Review of the clinical record documented Patient #11 was admitted to hospice service on 6/17/16. There was no documented evidence of an initial bereavement risk assessment included with the admission assessments.</p> <p>During an interview at 2:45 p.m. on 8/17/16, the Social Worker said that she had talked with patients and families about the bereavement services that were offered by the hospice, but had not completed initial bereavement risk assessments on Patients #1 - #11.</p> | L 531 | <p>Patient #7 Family Declined assessment but wants to reassess at time of passing.</p> <p>Patient #8 Bereavement risk assessment declined will continue to follow family. Will reassess at time of passing</p> <p>Patient #9 bereavement risk assessment declined and will reassess at time of death.</p> <p>Patient #10 no family available to do assessment.</p> <p>Patient #11 has passed away</p> | |

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| L 531 | Continued From page 3 In an interview at 5:00 p.m. on 8/17/16, the Spiritual Care Coordinator said he had not completed bereavement risk assessments on Patients #1 - #11. | L 531 | | | |
| L 663 | During an interview at 2:00 p.m. on 8/18/16, the Director of Nursing confirmed the 11 bereavement risk assessments on Patients #1 - #11 had not been done. 418.100(g)(3) TRAINING (3) A hospice must assess the skills and competence of all individuals furnishing care, including volunteers furnishing services, and, as necessary, provide in-service training and education programs where required. The hospice must have written policies and procedures describing its method(s) of assessment of competency and maintain a written description of the in-service training provided during the previous 12 months. This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure annual evaluations or performance appraisals were completed for 8 of 16 employees (Director of Nursing, Spiritual Care Coordinator, 2 Social Workers, 2 Registered Nurses, and 2 Certified Nurse Aide). Failure to complete 90 day and annual evaluations or performance appraisals had the potential to result in missed opportunities for improvement in patient care for all 23 current hospice patients and all future patients. Findings include: Review of "Employee Handbook" documented "evaluations or performance appraisals are done | L 663 | L663- 418.100(g)(3) TRAINING Evaluations will be placed in a electronic calendar to remind that evaluations are due. Administrator and Director of Nurses will perform all evaluation. This task will also be followed in QAPI. | | |

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| L 663 | <p>Continued From page 4 90 days after hire and one year after hire."</p> <p>The personnel files for the 16 Hospice staff were reviewed. Evaluations or performance appraisals were not completed per the "Employee Handbook," as follows:</p> <p>The Director of Nursing's personnel file documented the date of hire was 4/27/15. There was no documented evidence of an annual evaluation or performance appraisal for 2016.</p> <p>The Spiritual Care Coordinator's personnel file documented the date of hire was 9/3/12. There was no documented evidence of an annual evaluation or performance appraisal for 2015.</p> <p>Social Worker #1's personnel file documented the date of hire was 3/11/15. The annual evaluation was done. However there was no 90 day evaluation or performance appraisal found.</p> <p>Review of Social Worker #2's personnel file revealed the date of hire was 10/22/10. There was no documented evidence of annual evaluations or performance appraisals for 2011, 2012, 2013, 2014, or 2015.</p> <p>Registered Nurse 1's personnel file documented the date of hire was 12/2/14. Annual evaluations were done. However, there was no 90 day evaluation or performance appraisal found.</p> <p>Registered Nurse 5's personnel file documented the date of hire was 2/11/13. There was no documented evidence of annual evaluations or performance appraisals for 2016.</p> <p>Certified Nurse Aide 1's personnel file</p> | L 663 | <p>Director of Nursing had evaluation done see attached.</p> <p>Spiritual Care Coordinator is no longer with us.</p> <p>Social Worker #1 Has had evaluation done see Attached.</p> <p>Social Worker #2 has had evaluation done see Attached</p> <p>Registered Nurse #1 has has evaluation done See Attachment</p> <p>Registered Nurse #5 has had evaluation done See Attachment</p> | |

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| L 663 | <p>Continued From page 5</p> <p>documented the date of hire was 8/16/13. There was no annual evaluation or performance appraisal found for 2014. Annual evaluations or performance appraisals were completed for 2015 and 2016.</p> <p>Certified Nurse Aide 2's personnel file documented the date of hire was 3/21/16. There was no documented evidence of a 90 day evaluation or performance appraisal.</p> <p>During an interview with the Administrator on 8/17/16 at 1:30 p.m. and again on 8/18/16 at 1:30 p.m., the Administrator confirmed the employee evaluations and performance appraisals were not completed.</p> | L 663 | <p>Certified Nurses Aide #1 has had evaluation done See Attachment</p> <p>Certified Nurse Aide #2 has had evaluation done See Attachment.</p> <p>Administrator will over see that assessments are done timely and QAPI will assess on a monthly basis to make sure assessments are done. See Attached form.</p> <p><i>9.14.16 AT 10:25 A.M. telephone conversation with Katheryn Horton, QA the completion date is 9.12.16</i></p> | | |



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August 31, 2016

Justin Cheney, Administrator
Solace Healthcare
197 Stockham Blvd, Suite 2
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Provider #131566

Dear Mr. Cheney:

An unannounced on-site complaint investigation was conducted from August 15, 2016 to August 18, 2016 at Solace Healthcare. The complaint allegation, findings, and conclusions are as follows:

Complaint #ID00007337

Allegation: Cognitively impaired patients, who have Power of Attorney or Durable Power of Attorney representation, are allowed to elect the hospice benefit independently.

Findings: An unannounced visit was made to the hospice agency from 8/15/16 to 8/18/16. During the investigation, medical records were reviewed and patient family members and staff were interviewed.

Eleven patient medical records were reviewed. All records included documentation of election of the hospice benefit. For example, one patient record was that of a female patient whose diagnoses included dementia. The patient resided at a local Assisted Living Facility, until her death on 7/12/16.

The "Face Sheet" from the Assisted Living Facility indicated the patient had a Payee but no Power of Attorney or Durable Power of Attorney. A relative was listed as "emergency contact" and another relative was listed as "other contact." An interview with the patient's family member was conducted at 8:50 a.m. on 8/18/16.

Justin Cheney, Administrator
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The family member stated she was concerned as to how the patient was able to sign herself onto hospice services and the family, who had a Durable Power of Attorney for Healthcare, was not notified. The family member stated the patient's Attending Physician did not sign the patient onto hospice service, but she (the family member) had not spoken to the Attending Physician about the patient being on hospice. The family member stated she thought that the Assisted Living facility gave the hospice some erroneous information about the patient relative to the Durable Power of Attorney and family involvement.

The Assisted Living facility Administrator was not available for interview due to termination from the facility. However, the hospice Director of Nursing was interviewed at 3:25 p.m. on 8/17/16. The Director of Nursing stated that the Assisted Living facility Administrator told the hospice staff there was no family involvement, no Power of Attorney, and the patient could sign for herself.

The patient's record included a "Mini-Mental Status Examination," dated 4/13/16, which indicated the patient was cognitively impaired. However, the patient's "Patient Demographic Verification Form" from the patient's Attending Physician, listed the patient as her own responsible party, with a relative being listed as "emergency contact." The patient's record also included a physician order, dated 4/13/16, from the patient's Attending Physician which documented the patient was to be evaluated and admitted to hospice service if appropriate.

The hospice Case Manager was interviewed at 10:45 a.m. on 8/18/16. The Case Manager stated she had conducted the admission evaluation for the patient when the patient was admitted to hospice service on 4/14/16. The Case Manager said there was a physician order from the patient's Attending Physician to evaluate the patient and admit her to hospice service if appropriate. The Case Manager said that she asked the Administrator of the Assisted Living Facility if there was family, Power of Attorney, or Durable Power of Attorney that needed to be contacted and the Administrator said "no." The Case Manager stated she asked the patient if there was anyone to contact and the patient said "no." The Case Manager said she reviewed the patient's clinical record at the Assisted Living Facility and saw no evidence of a Power of Attorney or Durable Power of Attorney.

A subsequent "Physician Certification of Terminal Illness" was dated 4/14/16 and signed by both the patient's Attending Physician and the hospice Medical Director. The patient's record also included an "Election of Hospice Care Informed Consent Verification" that was signed by the patient and dated 4/14/16 and an "Idaho Physician Orders for Scope of Treatment (POST)," dated 4/14/16 and signed by the patient. The documentation did not indicate the presence of a Power of Attorney or Durable Power of Attorney.

The Ombudsman was interviewed at 8:30 a.m. on 8/18/16. The Ombudsman stated the patient signed the admission papers for hospice services and she had not ever known the patient to be competent to do that. She said she did not know what would have qualified the patient for hospice, but said she was not really familiar with hospice.

Justin Cheney, Administrator
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An interview with the patient's Attending Physician was conducted at 1:30 p.m. on 8/18/16. The Attending Physician stated that he was the patient's physician in the community. The Attending Physician stated the Assisted Living Facility requested an evaluation for Hospice for the patient and he signed the order to evaluate and admit if appropriate. The Attending Physician stated it was appropriate for the patient to sign her own admission papers for hospice.

Additionally, a hospice "Social Worker Progress Note," dated 4/21/16, documented the Social Worker was going to call the Administrator of the Assisted Living Facility to discuss finding a Power of Attorney for the patient. A subsequent "Social Worker Progress Note," dated 7/11/16, documented the patient's family members arrived at the Assisted Living Facility and met with the Administrator and the Social Worker. The note documented the family presented Power of Attorney papers, but they were incomplete.

An interview with the Social Worker was conducted at 3:00 p.m. on 8/17/16. The Social Worker stated that prior to admitting the patient to hospice she had spoken with the patient's Attending Physician's office to discuss suitability for hospice. The Social Worker stated she was told by the Assisted Living Facility Administrator that there was no Power of Attorney or Durable Power of Attorney. She said it was her understanding, from information received from the Assisted Living Facility, that the patient was placed there by Adult Protective Service and there was no family involvement. The Social Worker also said she had spoken with the Administrator at the Assisted Living Facility about obtaining a guardian for the patient.

It could not be determined that cognitively impaired patients, who had Power of Attorney or Durable Power of Attorney representation, were allowed to elect the hospice benefit independently. Therefore, the allegation was unsubstantiated and no deficient practice was identified.

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,



NICOLE WISENOR, Supervisor
Non-Long Term Care

NW/pmt