February 20, 2018

Travis Leach, Administrator
Saint Alphonsus Medical Center - Nampa
4300 E Flamingo Ave
Nampa, ID 83687

Provider #130013

Dear Mr. Leach:

An unannounced on-site complaint investigation was conducted from February 12, 2018 to February 13, 2018 at Saint Alphonsus Medical Center - Nampa. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00007732

Allegation #1: The hospital failed to implement discharge plans and failed to inform families of those plans.

Findings #1: An unannounced visit was made to the hospital on 2/12/18 and 2/13/18. Eight medical records, of patients who were discharged between 11/01/17 and 2/08/18, were reviewed. Policies were reviewed. Grievances were reviewed. Patients, families, and staff were interviewed.

All medical records included discharge planning assessments and discharge plans. All records contained documentation of communication between the Case Manager (CM) and family members. All records contained documentation of efforts to implement discharge plans, such as contacting post-discharge providers and arranging for durable medical equipment.

One family member who was interviewed during the survey stated her relative was transported to the incorrect skilled nursing facility (SNF) at discharge.
This event was investigated by the surveyor. The medical record stated the CM spoke with the patient's relative on the day of discharge. The relative informed the CM which facility to transport the patient to.

The hospital contacted the receiving facility and the receiving facility arranged for transportation. Originally, the receiving facility did not have a bed available until the following day. However, a bed opened up that day. There was a miscommunication. The CM asked the RN to call the family and tell them the patient was being discharged early. Apparently, this did not happen.

It was determined the patient was transported by the company that owned the SNF and it was the corporation's driver that took the patient to the wrong place. After bringing the patient into the wrong facility, they noticed the error and took her to the correct place. This was an error on the part of the SNF, not the hospital.

Four current patients, who were scheduled for discharge, were interviewed. These patients stated they were provided with discharge planning. They stated staff had assessed their discharge planning needs and arranged for needed services, placement, and equipment. They stated they were comfortable with their discharge plans and did not have questions about the plans.

Three CMs were interviewed. They stated many factors, which were impossible to predict, could speed up or delay discharges.

The hospital had systems and staff sufficient to provide discharge planning services. The hospital was in compliance with regulatory requirements related to discharge planning. The allegation was not substantiated.

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

**Allegation #2:** The hospital did not respond adequately to patient grievances.

**Findings #2:** Four grievances were reviewed. All grievances were acknowledged and investigated in a timely manner. The investigations were thorough. All grievances included specific responses to complainants in a timely manner. All responses included contact information.

The hospital was in compliance with regulatory requirements related to grievances. The allegation was not substantiated.

**Conclusion #2:** Unsubstantiated. Lack of sufficient evidence.
As none of the allegations were substantiated, no response is necessary.

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,

DENNIS KELLY, RN, Supervisor
Non-Long Term Care

DK/pmt