An unannounced on-site complaint investigation was conducted from October 1, 2018 to October 2, 2018 at Saint Alphonsus Regional Medical Center. The complaint allegation, findings, and conclusions are as follows:

Complaint #ID00007925

Allegation: The facility inappropriately discharged patients to homeless shelters.

Findings: An unannounced visit was made to the facility from 10/01/18 - 10/02/18. Policies were reviewed, medical records were reviewed, and staff interviews were conducted as follows:

A policy titled Discharge Planning, approved 2/05/18, outlined the discharge planning process. The policy stated "The RN will provide discharge instructions, prescriptions (if appropriate and prescribed by the LIP), and directions regarding needed follow-up appointments ordered by the LIP.

Five medical records were reviewed for patients discharged during the month of August, 2018. Focus was placed on the discharge planning process for these patients.
One patient had been admitted from a Critical Access Hospital in another part of the state. Discharge planning was initiated on 8/22/18, the date of his admission, as evidenced by MSW documentation.

Upon being medically cleared for discharge, on 8/29/18, he was provided with discharge instructions that included "physical activity as tolerated, no activity restrictions, weight bearing as tolerated exercises as instructed by therapist, take several short walks a day, and you may need occasional supervision." Information related to follow up medical appointments, and written prescriptions for medication were provided. Case management resources in his home town were provided because the patient wanted to start application for SSD.

An MSW note, dated 8/29/18 at 4:33 P.M., stated "Patient wants to go home back to his apartment, but his friends can't come get him today. Patient chose to go to the (name of the local homeless shelter). The MSW called to verify the shelter had room for the patient. A taxi voucher was provided for his transportation to the shelter.

In an interview on 10/01/18 at 1:00 P.M., the Director of Case Management explained the options available to patients who did not have their own transportation available when discharged. She said the patient could be transported home, or could possibly stay an extra night at the hospital, although the patient may be held liable for the charge for an extra night. The patient could stay in a hotel, at their own expense, or at a facility listed in the Community Resource Manual available on the hospital's intranet. In any case, a taxi voucher could be provided for travel within a 25 mile radius of the hospital.

The patient returned to the hospital several hours later for pain management. He had been unable to fill his discharge prescription for pain medication because he did not have identification. It had not been transferred with him from the CAH.

The hospital had previously identified the inability to fill discharge medications as a problem, and currently had a performance improvement plan in process to resolve the issue for all patients.

It could not be established that the facility inappropriately discharged patients to homeless shelters. 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 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
October 4, 2018

Odette Bolano, Administrator
Saint Alphonsus Regional Medical Center
1055 North Curtis Road
Boise, ID 83706

Provider #130007

Dear Ms. Bolano:

An unannounced on-site complaint investigation was conducted from October 1, 2018 to October 2, 2018 at Saint Alphonsus Regional Medical Center. The complaint allegation, findings, and conclusion are as follows:

Complaint #ID00007926

Allegation: The facility inappropriately discharged patients to homeless shelters.

Findings: An unannounced visit was made to the facility from 10/01/18 - 10/02/18. Policies were reviewed, medical records were reviewed, and staff interviews were conducted as follows:

A policy titled Discharge Planning, approved 2/05/18, outlined the discharge planning process. The policy stated "The RN will provide discharge instructions, prescriptions (if appropriate and prescribed by the LIP), and directions regarding needed follow-up appointments ordered by the LIP.

Five medical records were reviewed for patients discharged during the month of August, 2018. Focus was placed on the discharge planning process for these patients.
One patient had been admitted from a Critical Access Hospital in another part of the state. Discharge planning was initiated on 8/22/18, the date of his admission, as evidenced by MSW documentation.

Upon being medically cleared for discharge, on 8/29/18, he was provided with discharge instructions that included "physical activity as tolerated, no activity restrictions, weight bearing as tolerated exercises as instructed by therapist, take several short walks a day, and you may need occasional supervision." Information related to follow up medical appointments, and written prescriptions for medication were provided. Case management resources in his home town were provided because the patient wanted to start application for SSD.

An MSW note, dated 8/29/18 at 4:33 P.M., stated "Patient wants to go home back to his apartment, but his friends can't come get him today. Patient chose to go to [the name of the local homeless shelter]. The MSW called to verify the shelter had room for the patient. A taxi voucher was provided for his transportation to the shelter.

In an interview on 10/01/18 at 1:00 P.M., the Director of Case Management explained the options available to patients who did not have their own transportation available when discharged. She said the patient could be transported home, or could possibly stay an extra night at the hospital, although the patient may be held liable for the charge for an extra night. The patient could stay in a hotel, at their own expense, or at a facility listed in the Community Resource Manual available on the hospital's intranet. In any case, a taxi voucher could be provided for travel within a 25 mile radius of the hospital.

The patient returned to the hospital several hours later for pain management. He had been unable to fill his discharge prescription for pain medication because he did not have identification. It had not been transferred with him from the CAH.

The hospital had previously identified the inability to fill discharge medications as a problem, and currently had a performance improvement plan in process to resolve the issue for all patients.

It could not be established that the facility inappropriately discharged patients to homeless shelters. 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 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,

[Signature]

DENNIS KELLY, RN, Supervisor
Non-Long Term Care

DK/pmt