May 17, 2019

Sheryl Rickard, Administrator
Bonner General Hospital
520 North Third Avenue
Sandpoint, ID 83864

Provider #131328

Dear Ms. Rickard:

An unannounced on-site complaint investigation was conducted from April 29, 2019 to April 30, 2019 at Bonner General Hospital. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00008081

Allegation #1: The critical access hospital did not coordinate care with caregivers of Emergency Department (ED) patients.

Findings #1: An unannounced visit was made to the hospital on 4/29/19 and 4/30/19. Medical records of 8 ED patients were reviewed. Staff and others were interviewed.

All medical records documented patients who presented to the ED with potential orthopedic injuries. All patients were treated and discharged to their home situations, including residents of assisted living facilities. All of the records documented discharge instructions and preliminary arrangements for follow up care with patients and/or family members.

Two patients resided in assisted living facilities. One of those patient records documented contact with the facility prior to discharge.
The other assisted living facility patient's record documented a 94 year old female who fell on 4/07/19 and fractured her left tibia. She arrived by ambulance at the ED at 10:15 PM. She was examined, and her fracture was reduced under conscious sedation. Her leg was splinted.

The patient's son came to the hospital and stayed with her. The patient was discharged to the son via wheelchair at 12:30 AM on 4/08/19. The record documented discharge instructions and follow up information were given to the son. There was no documentation the hospital spoke with the patient's assisted living facility.

The Chief Nursing Officer was interviewed on 4/30/19 beginning at 8:10 AM. She confirmed the patient was discharged to the son and he was given aftercare instructions and information. She stated the patient left the hospital in the son's vehicle. She confirmed there was no documentation of communication between the hospital and the assisted living facility. However, it was not clear if hospital personnel knew the patient was returning to the assisted living facility. The Chief Nursing Officer stated typically patients from facilities were kept overnight and arrangements were made with the facility in the morning for transportation. She stated this did not happen because the family member accepted responsibility for the patient. She did not know how eager the son was to take the patient, but she said, if the patient's family had not accepted the patient, the discharge would have taken place in the morning with participation by the assisted living facility.

**Conclusion #1:** There are no federal or state hospital regulations that require participation with the discharge by the assisted living facility. The complaint was not substantiated, and no deficiencies were cited.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

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/slj
No deficiencies were cited during the Federal Medicare complaint investigation conducted at your critical access hospital on 4/29/19 to 4/30/19. Surveyors who conducted the complaint investigation were:

Gary Guiles, RN, HFS, Team Leader
Nancy Bax, RN, BSN, HFS