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January 19, 2012

Jessica Salguero, Administrator
Journeys Hospice
223 East Amity
Nampa, ID 83686

Provider #131555

Dear Ms. Salguero:

On **January 5, 2012**, a complaint survey was conducted at Journeys Hospice. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00005028

Allegation #1: The agency failed to only supplement aide cares provided to a hospice patient residing in a Skilled Nursing Facility (SNF).

Finding #1: An unannounced complaint investigation of the agency was conducted 1/03/12 through 1/05/12. Agency contracts with SNFs and medical records were reviewed. Staff members from the three SNFs and the agency were interviewed with the following results:

Five of the six medical records reviewed were for patients who received hospice services while residing in a SNF. Contracts between the agency and the SNFs were reviewed for delineation of tasks when working collaboratively. The contracts defined the services to be provided by the SNF and those to be provided by the hospice.

All of the medical records reviewed contained documentation of coordination and communication between the agency and the facilities. Documented coordination between agency staff and facility staff included detailed progress notes, collaborative agreements (which outlined the delineation of responsibilities), care conferences, and interdisciplinary team (IDT) meetings.

One medical record contained documentation of an elderly female hospice patient who was admitted to a SNF, on 2/02/11, following hospitalization for a dislocated hip. She had an open pressure ulcer on her coccyx and multiple other areas of concern for skin breakdown. She required two people to assist with either a bed bath or a shower and a Hoyer sling for transfers to and from the bed. Prior to her hospitalization, the patient resided in an Assisted Living Facility and was receiving aide services for bathing twice a week.

The patient's medical record contained a "FACILITY COLLABORATIVE AGREEMENT," dated 2/02/11, which outlined the responsibility of care for the patient. The agreement was signed by both hospice and SNF staff members. A portion of this agreement indicated that hospice staff provided the SNF staff with a copy of the IDT documentation and the patient's plan of care (which included hospice aide services two times a week). The "HOSPICE AIDE CARE PLAN," dated 1/24/11, indicated the patient received bathing and personal hygiene care twice a week.

A nursing note, dated 2/08/11, indicated hospice nursing, social work, and aide staff joined the SNF's care conference for the patient. The hospice nurse documented a discussion with the SNF wound care nurse regarding her recommendations for a bed bath for the patient. The hospice nurse documented, "Will coordinate (nursing) visits (with aide) to assist (with) bed bath as she had difficulty finding (SNF) staff to help last Friday."

On 2/17/11, the hospice Social Worker documented a meeting between herself, the hospice nurse, and the SNF Director of Nursing (DON) and Social Worker. According to the note, the SNF DON stated, "her staff can give patient a bed bath Monday & Thursday. (Hospice) staff will give a bed bath Tuesday & Wednesday (with) a full shower on Friday. (SNF DON) states her staff will be available to assist on Fridays if around 2:30 (PM)."

An interview with hospice staff, including the DON, hospice aides, and nursing staff, was conducted on 1/04/12. Agency staff discussed the above patient's care at the SNF. They stated they were concerned the patient was not receiving the level of skin care required as the patient had open pressure ulcers and was at risk for developing more. The IDT decided the patient needed to be seen five days a week by hospice staff to ensure the patient received the care necessary.

Three SNFs were visited and administrative staff were interviewed. All three SNF staff members reported good communication and coordination between their facilities and the hospice agency. The three staff members stated the hospice agency consistently left copies of visit notes, plans of care, and IDT meeting minutes.

It could not be determined the agency provided more than supplementary aide cares. Therefore, the allegation was unsubstantiated and no deficiencies were cited.

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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,



AIMEE HASTRITER
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

AH/srm