



IDAHO DEPARTMENT OF  
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January 18, 2013

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

Provider #131555

Dear Ms. Salguero:

On **January 16, 2013**, a complaint survey was conducted at Journeys Hospice. The complaint allegations, findings, and conclusions are as follows:

**Complaint #ID00005789**

**Allegation #1:** The hospice did not coordinate care with the patients' primary physicians.

**Findings #1:** An unannounced complaint investigation survey was conducted from 1/11/13 to 1/16/13. During the investigation, record review and interviews were conducted with the following results:

Of the 6 patient records reviewed, 4 patients utilized the hospice Medical Director as their primary physician. The remaining 2 records documented the patients' attending physicians were being utilized as their primary physicians. Those 2 patient records included documentation of hospice coordination. For example, one record reviewed was that of a 91 year old woman with a diagnosis of debility. The record documented a visit to her primary care physician the month before hospice services began on 3/28/12. The progress notes stated the patient had increased confusion and weight loss after the flu.

A faxed message, dated 4/17/12 between the facility and her primary care physician stated the patient continued to decline in health with weight loss, disinterest in her environment, weakness, and inability to maintain balance. The patient's family was requesting a hospice evaluation with

Journeys Hospice. The physician responded with approval for the hospice evaluation.

The hospice case manager sent a fax message, dated 4/19/12 to the patient's primary care physician. The message stated: "Patient has elected hospice services. Would you like to continue to follow this patient as the primary physician or have our Medical Director assume care?" The physician responded with a return fax: "I will continue to follow patient."

During an interview with the patient's physician, she stated she preferred to follow hospice patients because she wanted to be updated. She expected the hospice physician to write orders and be available when she was not.

The hospice medical record documented ongoing communication with the patient's primary care physician. For example the hospice Medical Director had ordered oxygen and pain medications, over a weekend when the primary care physician was unavailable. However, the hospice had communicated with and received orders from the primary care physician for oxygen as well as adjustments to her pain medication on 4/27/12, 4/30/12, and 5/02/12.

It could not be determined the hospice failed to coordinate care with the primary physician. Therefore, the allegation is unsubstantiated.

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

**Allegation #2:** The hospice failed to inform the patients' families about the services the agency was to provide.

Findings #2: An unannounced complaint investigation survey was conducted from 1/11/13 to 1/16/13. During the investigation, patient admission information, including rights information, as well as patient medical records and consents were reviewed. Staff and patient representatives were interviewed with the following results:

The hospice's admission packets, including rights information was reviewed and included the following:

- The right to be informed of patient rights and responsibilities in advance concerning care and treatment received.
- The right to have pain management needs recognized and addressed as appropriate.
- The Right to be informed of the extent to which payment for the hospice services may be expected from Medicare, Medicaid or any other payer.

The records of 6 patients were reviewed. All 6 medical records documented the patients had

been certified by their attending physicians and the hospice's medical director as having a prognosis of six months or less life expectancy, in accordance with agency policy. All records included patient admission information and appropriately executed consents for hospice services and treatment.

For example, one record documented a 91 year old female who had been admitted to hospice with a diagnosis of debility. Her record contained a fax communication from the ALF to her primary physician that stated her family was requesting hospice services. The record indicated a family member was the designated Power of Attorney (POA), and was present during the admission process. The consent for hospice services stated the goal of hospice was to maintain quality of life through the management of pain and other symptoms when no further curative measures are planned. The consent contained verbiage that the patient/POA had been advised of their rights and responsibilities and all services had been explained to them. In addition, the document stated the patient/POA had ample opportunity to ask questions. A hospice social worker signed the consent forms as well as the family member POA.

Additionally, 2 patient representatives were interviewed. When asked, they both stated they had been informed of the services the hospice agency provided, received information, and had opportunity to ask questions. Both patient representatives stated the hospice had advocated for the patient in the ALF to improve the quality of care.

It could not be determined patient and her family were not fully informed of the purpose of hospice services. Therefore, the allegation was unsubstantiated.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

**Allegation #3:** The hospice over medicated patients and utilized treatments which were not prescribed by the patients' physicians.

Findings #3: An unannounced complaint investigation survey was conducted from 1/11/13 to 1/16/13. During the investigation, patient medical records were reviewed and staff and patient interviews were conducted with the following results:

The medical records of six hospice patients were reviewed. All records documented medications and treatments were administered in accordance with physicians' orders.

For example, one record documented a patient who resided in an ALF. The record documented the patient fell on 4/19/12 in the afternoon after starting on hospice earlier that day. Records from the ALF and the hospice documented the patient had increasing lower back pain and required the use of a wheelchair after the fall. A hospice Registered Nurse (RN) visited the

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patient on 4/22/12 and noted the patient required medication for her pain, had low oxygen levels, and difficulty with eating and swallowing. The hospice RN obtained orders from the hospice Medical Director to start oxygen, pain medications and to crush her medications.

The patient was again seen by the hospice RN on 5/02/12. The hospice records indicated the RN noted increased patient confusion and requested the pain medication dosage be decreased after her assessment and discussion with the patient's family members. A corresponding fax, dated 5/02/12, to the primary physician by the hospice RN requested a decrease in the pain medication due to the patient's confusion.

It could not be determined the hospice over medicated the patients or utilized treatments which were not prescribed. Therefore, the allegation was unsubstantiated.

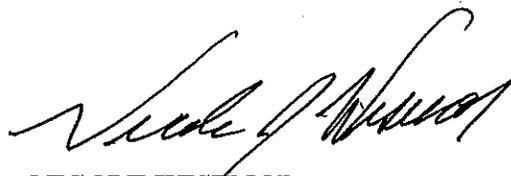
Conclusion #3: Unsubstantiated. Lack of sufficient evidence.

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,



SUSAN COSTA  
Health Facility Surveyor  
Non-Long Term Care



NICOLE WISENOR  
Co-Supervisor  
Non-Long Term Care

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