

COPY



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor  
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N., R.H.I.T., Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0009  
PHONE 208-334-6626  
FAX 208-364-1888

June 14, 2012

Paul Weil, Administrator  
Hospice Of North Idaho  
9493 Government Way  
Hayden, ID 83835

Provider #131504

Dear Mr. Weil:

On **June 12, 2012**, a complaint survey was conducted at Hospice Of North Idaho. The complaint allegations, findings, and conclusions are as follows:

**Complaint #ID00005548**

**Allegation #1:** Plans of care were not communicated to patients or their representatives.

**Findings #1:** An unannounced visit was made to the hospice agency from 6/07/12 through 6/11/12. During that time, ten patient records were reviewed and patient representatives and staff were interviewed with the following results:

All ten medical records contained plans of care specific to patients. All of the medical records contained documentation of communication regarding care and the plans for care between staff and patients and their representatives.

A registered nurse was interviewed. She stated she discussed plans of care with patients and actually read the plans of care to them. Additionally, a patient's family member was interviewed by telephone during the survey. The family member stated there had been some communication problems approximately two months after the start of the patient's care but the issues had been resolved.

It could not be determined that the facility failed to inform patients and their representatives

about patient care. Therefore, the allegation was unsubstantiated.

---

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

**Allegation #2:** The facility failed to ensure patients were not subjected to reprisal as a result of exercising patient rights.

**Findings #2:** An unannounced visit was made to the hospice agency from 6/07/12 through 6/11/12. During that time, ten patient records who had been discharged from hospice care or who had revoked their hospice benefit were reviewed. Facility policies were reviewed and patient representatives and staff were interviewed with the following results:

The facility's policy "YOUR BILL OF RIGHTS," not dated, stated patients were not to be subjected to reprisal as a result of exercising patient rights.

The medical records of 10 patients were reviewed and included patient rights information signed by appropriate representatives. None of the records contained evidence of facility reprisal as a result of patients exercising their rights.

For example, one medical record documented a 94 year old male who was admitted to hospice care on 10/19/11 and revoked hospice care on 5/02/12. His medical record stated in April 2012, staff began questioning if the patient continued to remain eligible for hospice care. A joint visit was conducted to the patient's home by a nurse practitioner, a registered nurse, and a social worker on 5/02/12. The progress note from the visit stated the team did not believe the patient was eligible for continued hospice care. The note also suggested the possibility of moving the patient to an assisted living facility. The note stated the family became upset regarding the suggestion for the patient to move and the patient elected to revoke his hospice benefit. The note stated the team determined the patient's living situation was unsanitary and notified Adult Protective Services.

The above patient's plan of care, dated 10/19/11, contained a plan to address an unsanitary environment. The plan was "Closed" on 12/31/11, indicating the problem was resolved. Progress notes by the nurse and the social worker did not mention this as a problem in after the problem was resolved.

The patient's nurse and social worker were interviewed on 6/08/12 beginning at 9:40 AM. The nurse practitioner later joined the interview. They stated the patient's condition had not deteriorated and he did not appear to be eligible for continued hospice care. They stated the patient's environment had been a continuing problem but confirmed they had not documented it. They stated they had reported the case to Adult Protective Services after the patient's revocation

Paul Weil, Administrator  
June 14, 2012  
Page 3 of 3

because they were no longer available to monitor the situation.

The patient's family member was also interviewed on 6/11/12 beginning at 2:00 PM. She confirmed the events and stated she felt the patient was pressured into revoking his hospice benefit.

While the patient's medical records did not document the facility's ongoing concerns with the patient's environment, it could not be established that the reporting to Adult Protective Services was done as an act of reprisal for the patient's refusal to change living situations. Therefore the allegation was unsubstantiated.

**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,



GARY GILES  
Health Facility Surveyor  
Non-Long Term Care



NICOLE WISENOR  
Co-Supervisor  
Non-Long Term Care

GG/srm