



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

May 21, 2013

COPY

Cindy Lee, Administrator
Heart N Home Hospice & Palliative Care
1100 Nw 12th Street
Fruitland, ID 83619

Provider #131545

Dear Ms. Lee:

On **May 7, 2013**, a complaint survey was conducted at Heart N Home Hospice & Palliative Care. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00005849

Allegation #1: The agency did not appropriately communicate with patients and family members which led misunderstandings of what services would be provided to patients.

Findings #1: An unannounced visit was made to the agency on 5/06/13 and 5/07/13. Staff were interviewed. Twelve medical records of past and current patients were reviewed and policies were reviewed with the following results:

The agency's policies were reviewed and documented the agency only provided hospice services. The agency did not provide home health services or private duty home care services.

All of the 12 medical records reviewed contained documentation that patients and/or their legal representatives were informed of hospice services, consented to hospice services and elected to receive hospice benefits. For example,

One medical record documented an 84 year old female who elected hospice services on 8/13/12. She lived in her own home with her husband. Her diagnoses included debility, Parkinson's Disease, anemia, and coronary artery disease. The patient signed her own "Election of Medicare

Cindy Lee, Administrator
May 21, 2013
Page 2 of 4

Hospice Benefit" form as well as her consent forms. A "HEAD TO TOE NURSING ASSESSMENT" form, dated 8/13/12 at 4:27 PM, stated the patient was alert and oriented to person, place, and event. The patient was her own guardian and was legally competent to sign her own consents. The patient was referred to the hospice agency by a nurse practitioner who was the patient's primary care provider.

A clinical note by the RN, dated 12/01/12 at 5:28 PM, stated the patient had fallen 3 times in the past week. The note stated the patient complained "I'm dizzy all the time. I can't see very well right now and I'm so tired of this feeling...I'm not in pain but I just feel awful and I don't like it." The note stated a walker was ordered for the patient and furniture was rearranged to make the patient safer. A clinical note by the RN, dated 12/03/12 at 4:35 PM, stated the patient was confused. A urine specimen was obtained to check for infection.

A clinical note by the social worker, dated 12/04/12 at 9:37 AM, stated she visited with the patient's daughter and son regarding alternative living situations and the safety of the patient and her spouse.

A clinical note by the RN, dated 12/05/12 at 4:40 AM, stated the patient had fallen again and had a large bruise on her right buttocks. Another clinical note by another RN, dated 12/05/12 at 9:47 AM, stated she worked with the patient's husband on fall prevention and medications. The note stated the patient was able to ambulate without assistance. The note stated the RN spoke with the patient's physician and her daughter.

A clinical note by the RN, dated 12/06/12 at 8:50 AM, stated the patient was not able to bear weight on her right leg. The nurse practitioner was notified. An order was received for respite care in a skilled nursing facility. The nearest skilled nursing facility was located in a town approximately 52 miles away. The note stated the patient's daughter wanted the patient transferred to a skilled nursing facility approximately 108 miles away.

A clinical note by the social worker, dated 12/06/12 at 4:36 PM, stated she visited with the patient's daughter and informed her she would have to pay for the ambulance to take the patient to the farther skilled nursing facility. The note stated the daughter agreed to this. The transfer was facilitated by the hospice agency.

Nursing clinical notes by the RN on 12/07/12 stated the patient was unresponsive and it was feared the patient might die. However, subsequent notes stated the patient rallied and became responsive again. After the patient recovered, she moved to an assisted living facility and revoked her hospice benefit.

The nurse and the social worker for the above patient were no longer employed by the agency

Cindy Lee, Administrator
May 21, 2013
Page 3 of 4

and were not available for interview. The administrator was interviewed on 5/07/13 beginning at 1:20 PM. She confirmed the documentation.

It could not be established that the agency failed to obtain appropriate consents for treatment or failed to communicate with patients and their family members. Therefore, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: A nurse practitioner ordered hospice services.

Findings #2: An unannounced visit was made to the agency on 5/06/13 and 5/07/13. Staff were interviewed. Twelve medical records of past and current patients were reviewed and policies were reviewed with the following results:

Medicare regulations require that a physician certify that patients meet certain requirements for hospice eligibility including an anticipated life expectancy of 6 months or less. All 12 medical records contained this documentation of this certification by a physician. Medicare regulations do not require that a physician refer patients for hospice care. This can be done by a nurse practitioner as long as a physician certifies the prognosis.

Eleven of the 12 records reviewed documented patient referrals by a physician. One medical record documented an 84 year old female who elected hospice services on 8/13/12. Her diagnoses included debility, Parkinson's Disease, anemia, and coronary artery disease. She was referred to the hospice by a nurse practitioner. The patient's eligibility for hospice was certified by a physician on 8/15/12.

Medicare regulations allow nurse practitioners to write orders and participate in the patient's care while on hospice. This was done for the above patient.

It could not be established that the agency failed to ensure hospice eligibility was certified by a physician. Therefore, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

Cindy Lee, Administrator
May 21, 2013
Page 4 of 4

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 GULES
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

GG/pt