CORE ISSUES

Facility	License #	Physical Address	Phone Number
Partners in Home Care Hospice	13230	2673 Palmer St. Ste 201	406-728-8848
Administrator	City	Zip Code	Survey Date
	Missoula	59808	09/18/2018
Survey Team Leader	Survey Type		Response Due
Egebjerg, Linda	Renewal Inspection		09/28/2018

Item #	Rule ()	Description
1	37.106.330-1 MINIMUM STANDARDS FOR ALL HEALTH CARE FACILITIES: WRITTEN POLICY AND PROCEDURES	Patient file review, Incident Report, and staff interview. Records indicate patient fell on March 13, 2018 and reported fall to hospice nurse on March 14, 2018. Incident Report filed on March 15, 2018. Dr. not notified until March 17, 2018 leaving a three day gap from the time patient reported fall until physician was notified. Patient file review, Incident Report, and staff interview.Records indicate "Hospice. Medication error. Was supposed to have .5 Risperdone at 8pm but was given .5 Lorazepam" on August 3, 2018, Incident Report filed on August 6, 2018. It was communicated by the Assisted Living Facility that the physician was notified with no response there is no documentation that the physician was notified by Hospice. Per policy #7511 Incidents reported include: Medication and treatment errors, complications and reactions, Patient/family injury, including falls; psychological injury Immediate follow up for Patient Care Incidents #4 states "The supervisor or other appropriate clinician will notify the physician immediately when the person has suffered an injury. If there is no injury, notification can be by fax. Next of kin or appropriate family member will also be notified".

		Immediate follow up for Patient Care Incidents #6 states "The medical record will contain documentation of the facts related to the incident and medical follow-up, including notification of the physician". Based on these Incident Reports Patient #1's physician was not notified immediately upon learning of a fall resulting in "Lt black eye, nose bruised, small laceration to upper and lower lips, bilateral palms of hands, Lt knee. Patient #2's physician was not notified at all for medication error. Patient #2's chart was also lacking documentation of physician notification regarding medication error.