

COPY



IDAHO DEPARTMENT OF
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February 14, 2012

Mary Langenfeld, Administrator
Lifes Doors Hospice
PO Box 5754
Boise, ID 83705

Provider #131516

Dear Ms. Langenfeld:

On **February 2, 2012**, a complaint survey was conducted at Lifes Doors Hospice. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00005239

Allegation #1: The hospice failed to ensure patient care was sufficiently coordinated with other health care providers.

Findings #1: An unannounced complaint investigation was conducted at the hospice agency from 1/31/12 to 2/02/12. During that time, observations, record reviews, and staff interviews were conducted with the following results:

When asked, during an interview on 1/31/12 at 9:30 AM, the owner stated the hospice was providing hospice care in multiple skilled nursing facilities as well as assisted living facilities. Facility records included written contracts between the hospice and the other facilities.

The medical records of 5 patients, who resided in a skilled nursing facility, were reviewed. All 5 patient records included coordinated plans of care. For example, one record documented a 79 year old female, who resided in an assisted living facility and was admitted to hospice services on 4/13/11. Her hospice admission assessment, dated 4/13/11, documented the patient's needs, including frequent dressing changes to a large wound on the patient's right buttock. A form, titled "INTERDISCIPLINARY PLAN OF CARE, Residential Care or Assisted Living

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Facilities," dated 4/18/11, was initiated by the hospice Interdisciplinary Team, and delineated which cares the hospice and assisted living facility would be responsible for. The form noted the wound on the buttocks, but did not include information regarding wound care. The form included Hospice RN visits three times a week, as well as prn or "as needed" visits.

On 5/31/11 the patient transferred from the assisted living facility to a skilled nursing facility. The patient's record included forms titled "INTERDISCIPLINARY TEAM PLAN OF CARE UPDATE," dated at two week intervals from her admission on 5/31/11 to the most recent date of 1/11/12. The updates to the patient's plan of care documented the delineation of care between the hospice and skilled nursing facility and included continued documentation of the patient's wound care and status.

Additionally, hospice staff were observed providing care for 2 patients, who resided in a skilled nursing facility on 1/31/12 at 1:00 PM, and on 1/31/12 at 2:30 PM. During the observations, hospice staff was noted to provide wound care in accordance with the patients' coordinated plan of care.

It could not be determined the hospice agency failed to sufficiently coordinate patient care with other health care providers. Therefore, due to the lack of sufficient evidence, the allegation was unsubstantiated and no deficient practice was identified.

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,



SUSAN COSTA
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

SC/srm