



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

OEBRA 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

July 13, 2011

Gayle Lovette, Administrator  
Lifes Doors Home Health  
P.O. Box 5754  
Boise, ID 83705

RE: Lifes Doors Home Health, Provider #137114

Dear Ms. Lovette:

This is to advise you of the findings of the Medicare/Licensure survey at Lifes Doors Home Health, which was concluded on June 30, 2011.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicare deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction.

An acceptable plan of correction (PoC) contains the following elements:

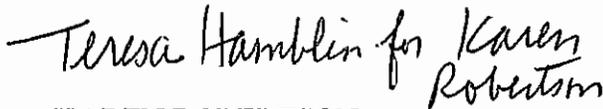
- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the PoC is effective in bringing the home health agency into compliance, and that the home health agency remains in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
- The administrator's signature and the date signed on page 1 of the Form CMS-2567 and State Form 2567.

Gayle Lovette, Administrator  
July 13, 2011  
Page 2 of 2

After you have completed your Plan of Correction, return the original to this office by **July 25, 2011**, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, please write or call this office at (208) 334-6626.

Sincerely,



KAREN ROBERTSON  
Health Facility Surveyor  
Non-Long Term Care



SYLVIA CRESWELL  
Co-Supervisor  
Non-Long Term Care

KR/srm  
Enclosures

# Life's Doors

420 S. Orchard • P.O. Box 5754 • Boise, ID 83705

Life's Doors  
Gayle Lovette RN  
420. Orchard St  
Boise, Idaho 83705

July 21 2011

Bureau of Facility Standards  
Attn: Debra Ransom  
3232 Elder Street  
PO Box 83720  
Boise, Idaho 83720-0009

Dear Debra Ransom

Your Team completed a facility survey at Life's Doors Home Health on June 30<sup>th</sup> 2011. Please find enclosed our plan of correction. If you have any questions regarding our Plan of Correction, please contact me by phone at 208-639-8880 or by email at [glovette@lifesdoors.com](mailto:glovette@lifesdoors.com).

I would like to express my appreciation for the professional and helpful way in which your surveyors, Karen Robertson and Teresa Hamblin conducted our survey.

Sincerely



Gayle Lovette RN  
Clinical Administrator

**RECEIVED**

JUL 25 2011

**FACILITY STANDARDS**

Life's Doors  
Hospice & Palliative Care  
Boise 344-6500

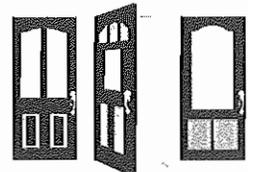
Life's Doors  
Home Health  
Boise 639-8880

Life's Doors  
Home Care Solutions  
Boise 344-9228

Life's Doors  
Lifeline  
Boise 344-9228

Life's Doors  
Door to Door  
Boise 344-9228

Camp Erin  
Boise 275-0000



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/08/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  137114	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  06/30/2011
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  LIFES DOORS HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 420 SOUTH ORCHARD BOISE, ID 83705
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

G 000	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the recertification survey of your agency. The surveyors conducting the survey were:</p> <p>Karen Robertson, RN, BS, HFS, Team Leader Teresa Hamblin RN, MS, HFS</p> <p>Acronyms used in this report include:</p> <p>CNA - Certified Nursing Assistant POC - Plan of Care PT = Physical Therapist PT/INR - Prothrombin time-international normalized ratio RN - Registered Nurse ROC - Resumption of Care SOC - Start of Care SN - Skilled Nursing</p>	G 000	<p><b>RECEIVED</b> JUL 25 2011</p> <p><b>FACILITY STANDARDS</b></p> <p><i>See attached plan of correction dated July 21-2011 prepared &amp; signed by Gayle Lovette, clinical administrator</i></p>	
G 158	<p><b>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER</b></p> <p>Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure care followed a written plan of care for 6 of 10 patients (#1, #3, #4, #5, #7, and #10) whose records were reviewed. This resulted in missed visits and a failure to monitor PT/INR at a frequency ordered by the physician. Findings include:</p> <p>1. Patient #10 was an 64 year old female who was admitted to the agency on 3/14/11 for care</p>	G 158		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Gayle Lovette* TITLE: *Clinical Administrator* DATE: *7/11/11*

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/08/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  137114	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  06/30/2011
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  LIFES DOORS HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 420 SOUTH ORCHARD BOISE, ID 83705
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

G 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the recertification survey of your agency. The surveyors conducting the survey were:</p> <p>Karen Robertson, RN, BS, HFS, Team Leader Teresa Hamblin RN, MS, HFS</p> <p>Acronyms used in this report include:</p> <p>CNA - Certified Nursing Assistant POC - Plan of Care PT = Physical Therapist PT/INR - Prothrombin time-international normalized ratio RN - Registered Nurse ROC - Resumption of Care SOC - Start of Care SN - Skilled Nursing</p>	G 000	<p><b>RECEIVED</b> JUL 25 2011</p> <p><b>FACILITY STANDARDS</b></p> <p><i>See attached plan of correction dated July 21-2011 prepared + signed by Gayle Roberts for clinical administrator</i></p>	
G 158	<p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER</p> <p>Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure care followed a written plan of care for 6 of 10 patients (#1, #3, #4, #5, #7, and #10) whose records were reviewed. This resulted in missed visits and a failure to monitor PT/INR at a frequency ordered by the physician. Findings include:</p> <p>1. Patient #10 was an 84 year old female who was admitted to the agency on 3/14/11 for care</p>	G 158		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/08/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  137114	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  06/30/2011
NAME OF PROVIDER OR SUPPLIER  LIFES DOORS HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 420 SOUTH ORCHARD BOISE, ID 83705		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G 158	<p>Continued From page 1</p> <p>primarily related to a pulmonary embolism and anticoagulant therapy. Faxed physician orders, dated 3/29/11, included orders for SN to obtain blood samples for PT/INR daily until the results were stable for 1 week with a goal of INR in the 2.0 to 3.0 range. There was no documentation the order for daily PT/INRs was followed. The first SN visit note that documented obtaining a blood sample for PT/INR was on 4/04/11 at 11:45 AM, 6 days after the order on 3/29/11 for daily PT/INRs.</p> <p>During an interview on 6/29/11 at 9:00 AM, the RN Clinical Administrator reviewed Patient #10's record and stated that based on the physician's order on 3/29/11 for daily PT/INRs, the agency should have obtained PT/INRs on 3/30/11, 3/31/11, 4/01/11, 4/02/11, 4/03/11, 4/04/11, and 4/05/11 rather than just on 4/04/11. She stated the RN who was seeing Patient #10 in April, 2011 was no longer working for the agency and therefore was not available for interview.</p> <p>Patient #10's physician discharge orders from a Rehabilitation Facility, dated 3/23/11, documented orders for home health services, including services of a bath aide. There was no documentation found in Patient #10's record that agency staff provided bath aide services to Patient #10. There was also no documentation the physician had been notified that Patient #10 had refused bath aide services.</p> <p>During an interview on 6/29/11 at 9:00 AM, the RN Clinical Administrator reviewed Patient #10's record. She stated Patient #10 refused bath aide services. She confirmed there was no documentation of patient refusal or of notification</p>	G 158			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/08/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>137114</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/30/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>LIFES DOORS HOME HEALTH</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 SOUTH ORCHARD BOISE, ID 83705</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G 158	<p>Continued From page 2 to the doctor.</p> <p>PT/INR blood draws and aide services did not follow written physician orders.</p> <p>2. Patient #1 was a 91 year old male who was admitted to the agency on 5/11/11 for care primarily related to muscle weakness. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 5/11/11 to 7/09/11, included orders for PT 2 times per week for 3 weeks. There was no documentation in Patient #1's medical record of PT visits during the first week of the certification period, beginning 5/11/11. The first PT visit note, dated 5/16/11 at 3:30 PM, was during the second week of the certification period. There was no documentation the physician had been notified of the delay in PT SOC.</p> <p>During an interview on 6/29/11 at 10:00 AM, the RN Clinical Administrator reviewed Patient #1's record and confirmed PT visits did not begin until 5/16/11, during the second week of certification. She stated it was agency preference that therapies get out to see patients within 48 hours of SOC.</p> <p>PT visit frequency did not follow the written plan of care.</p> <p>3. Patient #3 was an 85 year old male who was admitted to the agency on 3/17/11 for care primarily related to diabetes and wound care. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 3/17/11 to 5/15/11, included orders for skilled nursing services 2 times per week for 1 week followed by</p>	G 158		07/01/11	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/08/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>137114</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/30/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>LIFES DOORS HOME HEALTH</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 SOUTH ORCHARD BOISE, ID 83705</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G 158	<p>Continued From page 3</p> <p>3 times per week for 8 weeks. There were two documented visits during the third week (3/28/11 and 40/1/11), seventh week (4/25/11 and 4/29/11), and eighth week (5/09/11 and 5/11/11) instead of the three visits that were ordered for each week.</p> <p>During an interview on 6/29/11 at 8:20 AM, the RN Clinical Administrator, reviewed Patient #3's record and stated visits were missed because Patient #3 had doctor appointments. She stated there should have been a missed visit form completed and sent to the doctor to account for the missed visits but there was not.</p> <p>SN visit frequency did not follow the written plan of care.</p> <p>4. Patient #4 was an 84 year old female admitted to the agency on 6/06/11, for care primarily related to a repaired left femur fracture resulting from a fall.</p> <p>The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 6/06/11 to 8/04/11, included orders for the home health aide to visit Patient #4 one time per week the first week, then 2 times per week for the next seven weeks. During the second week, one aide visit was done 6/14/11 and one visit was missed without physician notification. During the third week, no home health aide visits were done. There was documentation of physician notification for one missed during the third week. However, there was no documentation of notification to the physician of a second missed visit during the same week.</p>	G 158			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/08/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  137114	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  06/30/2011
NAME OF PROVIDER OR SUPPLIER  LIFES DOORS HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 420 SOUTH ORCHARD BOISE, ID 83705		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G 158	<p>Continued From page 4</p> <p>In an interview on 6/28/11 at 3:45 pm, the RN Clinical Administrator reviewed Patient #4's record and confirmed a missed aide visit during the second week and a missed aide visit during the third week without evidence of physician notification.</p> <p>The aide visits were not made according to the POC.</p> <p>5. Patient #5 was a 55 year old female admitted to the agency on 1/27/11, for care primarily related to pressure ulcers on her feet, diabetes, and ovarian cancer.</p> <p>The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 3/28/11 to 5/26/11, included orders for nursing to measure Patient #5's wound weekly. In addition to the POC, the agency received updated orders for nursing visits from the wound clinic Patient #5 was going to every other week. "Wound Care Orders," dated 3/31/11, ordered skilled nursing visits 3 times a week for 2 weeks. Two nursing visits had been made that week, on 3/28/11 and 3/30/11. No third nursing visit was made that week.</p> <p>In an interview on 6/28/11 at 1:15 PM, the RN Clinical Administrator reviewed Patient #5's record and stated one nursing visit was not done the first week of the certification period 3/28/11 to 5/26/11.</p> <p>The nursing visits were not made according to the POC.</p> <p>6. Patient #7 was a 68 year old female admitted</p>	G 158			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/08/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  137114	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  06/30/2011
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  LIFES DOORS HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 420 SOUTH ORCHARD BOISE, ID 83705
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

G 158	<p>Continued From page 5 to the agency on 5/25/11, for care after surgery of the cervical spine.</p> <p>Patient #7's medical record included hospital physician discharge orders, dated 5/23/11, for home health aide services. There was no documentation in the record that the agency provided home health aide services or that Patient #7 refused services and the physician was notified.</p> <p>In an interview on 6/30/11 at 9:15 AM, the RN Clinical Administrator stated Patient #7 had refused the home health aide. She further stated no notification was sent to the physician and no documentation was in the record indicating Patient #7 had refused the aide.</p>	G 158		
G 159	<p>484.18(a) PLAN OF CARE</p> <p>The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure the POC included all pertinent information for 7 of 10</p>	G 159		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/08/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  137114	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  06/30/2011
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  LIFES DOORS HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 420 SOUTH ORCHARD BOISE, ID 83705
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

G 159	<p>Continued From page 6</p> <p>sample patients (#2, #3, #4, #7, #8, #9, and #10) whose records were reviewed. This had the potential to result in incomplete or uncoordinated patient care. Findings include:</p> <p>1. Patient #2 was an 87 year old male admitted to the agency on 3/25/11, for care primarily related to atrial fibrillation, aortic valve disorder, and diabetes.</p> <p>The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period of 5/24/11 to 7/22/11, included the diagnosis of controlled diabetes. The OASIS "RECERTIFICATION/FOLLOW-UP ASSESSMENT," completed 5/23/11 by the RN, addressed Patient #2's diabetes under the assessment "ENDOCRINE/HEMATOLOGY." The assessment documented Patient #2's spouse/caregiver would be monitoring the blood glucose on a daily basis. However, the POC did not address the agency's interventions related to blood glucose monitoring, such as assessing a blood glucose log kept by Patient #2's spouse.</p> <p>In an interview on 6/28/11 at 1:15 PM, the RN Clinical Administrator stated she agreed there was no intervention on the POC related to blood glucose monitoring and there should have been.</p> <p>The POC did not include appropriate interventions related to blood glucose monitoring.</p> <p>2. Patient #4 was an 84 year old female admitted to the agency on 6/06/11, for care primarily related to a repaired left femur fracture resulting from a fall.</p>	G 159		
-------	---	-------	--	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/08/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>137114</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2011</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>LIFES DOORS HOME HEALTH</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 SOUTH ORCHARD BOISE, ID 83705</b>
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 159	<p>Continued From page 7</p> <p>The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 6/06/11 to 8/04/11, included a diagnosis of diabetes in addition to the repaired femur fracture. There were no interventions for blood glucose monitoring related to Patient #4's diabetes or interventions to assess pain related to Patient #4's femur fracture.</p> <p>The "COMPREHENSIVE ADULT NURSING ASSESSMENT," completed 6/06/11 by the RN for Patient #4 documented assessments done related to pain and diabetes. The pain assessment documented that Patient #4 experienced chronic severe pain and used pain medications to help control the pain. The "ENDOCRINE/HEMATOLOGY" assessment documented a current blood glucose and a blood glucose range for Patient #4, but it did not include who was monitoring blood glucoses or how often. Based on these assessments and the above diagnoses, it would have been appropriate and pertinent to include interventions related to blood glucose monitoring and assessing pain.</p> <p>In an interview on 6/28/11 at 3:45 PM, the RN Clinical Administrator stated the POC was missing interventions for both blood glucose monitoring and assessing pain. She stated both interventions would have been appropriate and should have been included on the POC.</p> <p>The POC did not include appropriate interventions related to blood glucose monitoring and assessing pain.</p> <p>3. Patient #7 was a 68 year old female admitted to the agency on 5/25/11, for care primarily</p>	G 159		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/08/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>137114</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/30/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>LIFES DOORS HOME HEALTH</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 SOUTH ORCHARD BOISE, ID 83705</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G 159	<p>Continued From page 8 related to cervical spine surgery aftercare.</p> <p>The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 5/25/11 to 7/23/11, included pain control goals for Patient #7 to meet by the end of the certification period. Patient #7 was also using narcotics for pain control. The POC did not include nursing interventions to assess pain in order to evaluate progress toward meeting pain control goals.</p> <p>In an interview on 6/30/11, the RN Clinical Administrator stated there was no intervention for assessing pain on Patient #7's POC. She stated assessing pain should have been included as an intervention on the POC.</p> <p>The POC did not include appropriate interventions related to assessing pain.</p> <p>4. Patient #9 was a 69 year old female admitted to the agency on 3/04/11, for care primarily related to rheumatoid arthritis, chronic pain, diabetes, and pressure ulcers on her heels.</p> <p>The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 5/03/11 to 7/01/11, included pain control goals for Patient #9 to meet by the end of the certification period. Patient #9 was also using narcotics for pain control. The POC did not include nursing interventions to assess pain in order to evaluate progress toward meeting pain control goals.</p> <p>In an interview on 6/30/11, the RN Clinical Administrator stated there was no intervention for assessing pain on Patient #9's POC. She stated assessing pain should have been an intervention</p>	G 159			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/08/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>137114</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/30/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>LIFES DOORS HOME HEALTH</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 SOUTH ORCHARD BOISE, ID 83705</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G 159	<p>Continued From page 9 included on the POC.</p> <p>The POC did not include appropriate interventions related to assessing pain.</p> <p>5. Patient #8 was a 66 year old male who was admitted to the agency on 6/11/11 for care after a joint replacement. He also had a pertinent diagnosis of hypertension. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 6/11/11 to 8/09/11, included orders for skilled nursing assessment of cardiopulmonary status. It did not include parameters for reporting variations in vital signs. A "SKILLED NURSING VISIT NOTE," dated 6/13/11 at 12:15 PM, documented a blood pressure of 160/100, which was elevated from the previous reading on 6/11/11 of 160/84.</p> <p>During an interview on 6/30/11 at 9:30 AM, the RN Clinical Administrator reviewed Patient #8's record and confirmed the POC did not include reporting parameters for blood pressure. She also confirmed the elevated blood pressure on 6/13/11 was not reported to the physician based on nursing judgment. When asked if the agency had a general policy for reporting parameters, she stated the agency did not have standardized protocols for vital signs, that reporting was based on nursing judgment. She stated, based on a question on the OASIS assessment, she thought the agency should have reporting parameters.</p> <p>The "PHYSICAL THERAPY CARE PLAN," dated 6/11/11, documented the need for a toilet riser and referred to the "485" for physician orders. The 485, also known as the "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for</p>	G 159			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/08/2011  
FORM APPROVED:  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>137114</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/30/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>LIFES DOORS HOME HEALTH</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 SOUTH ORCHARD BOISE, ID 83705</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G 159	<p>Continued From page 10</p> <p>certification period 6/11/11 to 8/09/11, did not include a toilet riser on the physician ordered plan of care.</p> <p>During an interview on 6/30/11 at 9:30 AM, the RN Clinical Administrator reviewed Patient #8's record and confirmed the toilet riser should have been on the physician approved POC.</p> <p>The POC did contain relevant reporting parameters or DME.</p> <p>6. Patient #10 was an 84 year old female who was admitted to the agency on 3/14/11 for care related to a pulmonary embolism and anticoagulant therapy. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 3/24/11 to 5/24/11, included diagnoses of rheumatoid arthritis, osteoarthritis, myalgia (muscle pain), and myositis (an inflammation of skeletal muscles). The POC included a goal of Patient #10 being able to verbalize pain controlled at acceptable levels. The POC did not include SN intervention to assess for pain.</p> <p>During an interview on 6/29/11 at 9:00 AM, the RN Clinical Administrator reviewed Patient #10's record and stated there should have been a written intervention to assess pain but there was not.</p> <p>The POC did not include a SN intervention relevant to stated goals.</p> <p>7. Patient #3 was an 85 year old male who was admitted to the agency on 3/17/11 for care primarily related to diabetes and wound care.</p>	G 159			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/08/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>137114</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/30/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>LIFES DOORS HOME HEALTH</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 SOUTH ORCHARD BOISE, ID 83705</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G 159	Continued From page 11 The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 3/17/11 to 5/15/11, included diagnoses of diabetes and hypertension and orders for skilled nursing assessment of cardiopulmonary status and blood glucose monitoring as needed. The POC did not include parameters for reporting blood pressure readings or blood sugar results.  During an interview on 6/29/11 at 8:20 AM, the RN Clinical Administrator reviewed Patient #3's record and confirmed the POC did not include reporting parameters. She also stated the agency did not have standardized guidelines for reporting blood pressures or blood sugars.	G 159			
G 176	The POC did not contain relevant reporting parameters. <b>484.30(a) DUTIES OF THE REGISTERED NURSE</b>  The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs.  This STANDARD is not met as evidenced by: Based on record review and staff interview, the agency failed to ensure the registered nurse coordinated services related to Coumadin dosages for 1 of 3 patients (#10) on Coumadin therapy whose records were reviewed. This resulted in delayed communication with the physician and patient and had the potential to negatively impact safety of medication usage. Findings include:	G 176			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/08/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>137114</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2011</b>	
NAME OF PROVIDER OR SUPPLIER  <b>LIFES DOORS HOME HEALTH</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 SOUTH ORCHARD BOISE, ID 83705</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 176	<p>Continued From page 12</p> <p>Patient #10 was an 84 year old female who was admitted to the agency on 3/14/11 for care related to a pulmonary embolism and anticoagulant therapy. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 3/24/11 to 5/24/11, included orders for Coumadin.</p> <p>A physician's faxed order, dated 4/18/11, called for agency nursing staff to obtain Patient #10's blood for PT/INR testing on the same date (4/18/11). A fax, dated Thursday 4/21/11, 3 days after obtaining results, documented agency staff notified the physician of the PT/INR results (PT 37.2 and INR 3.5). The target range was 2.0 - 3.0 according to the "HOME HEALTH CERTIFICATION AND PLAN OF CARE" for certification period 3/24/11 to 5/24/11. PT/INR results are typically provided to the physician on the same day to get immediate Coumadin orders to guide patients on proper dosage adjustment. A "COUMADIN TRACKING LOG," dated 4/08/11, documented Patient #10 was on a Coumadin dose of 6 mg daily. New physician's orders, dated 4/21/11, called for Patient #10 to hold the Coumadin dose on Monday and Tuesday and start taking 5 mg of Coumadin daily beginning on Wednesday. This order was documented as received after the fact, since the order was received on Thursday for orders that applied to Monday, Tuesday and Wednesday of the same week. A "COUMADIN TRACKING" log documented RN staff notified Patient #10 on Tuesday 4/19/11 to hold the Coumadin dose on Monday and Tuesday and begin Coumadin 5 mg on Wednesday. The documentation indicated Patient #10 was given Coumadin dosage instructions two days prior to the physician's order</p>	G 176		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/08/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>137114</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2011</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>LIFES DOORS HOME HEALTH</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 SOUTH ORCHARD BOISE, ID 83705</b>
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

G 176	<p>Continued From page 13 and one day after Patient #10 was affected by the order (notified on Tuesday to hold the Coumadin from the day before on Monday).</p> <p>The RN Clinical Administrator was interviewed on 6/29/11 at 9:00 AM. She reviewed Patient #10's record and stated one RN obtained blood for PT/INR testing on 4/18/11 and another RN notified the physician by fax on 4/21/11 of the results. She stated neither RN worked for the agency any longer and were not available for interview. She speculated that an undocumented verbal order was received by an RN prior to 4/21/11 regarding the Coumadin dosages since an RN documented notifying Patient #10 on 4/19/11. She acknowledged the physician's order was written after the fact to hold the Coumadin dosages on Monday and Tuesday and start on 5 mg Coumadin on Wednesday. She also acknowledged that the nursing documentation on 4/19/11 was after the fact. There was no documentation to state what dosages Patient #10 actually took or held on Monday, 4/18/11.</p> <p>PT/INR results and Coumadin dosage changes were not coordinated effectively between nursing staff, patient, and physician.</p>	G 176		
G 224	<p>484.36(c)(1) ASSIGNMENT &amp; DUTIES OF HOME HEALTH AIDE</p> <p>Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section.</p> <p>This STANDARD is not met as evidenced by:</p>	G 224		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/08/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  137114	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  06/30/2011	
NAME OF PROVIDER OR SUPPLIER  LIFES DOORS HOME HEALTH		STREET ADDRESS, CITY, STATE, ZIP CODE 420 SOUTH ORCHARD BOISE, ID 83705		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 224	<p>Continued From page 14</p> <p>Based on observation, staff interview, and record review, it was determined the agency failed to ensure RN staff provided complete written patient care instructions for the home health aide in the care of 3 of 4 patients (#4, #6, and #9) whose records were reviewed who received home health aide services. This had the potential to interfere with patient safety, coordination of patient care, and the ability to meet patient needs. Findings include:</p> <p>1. Patient #6 was a 91 year old female who was admitted to the agency on 12/08/10 for care primarily related to venous insufficiency and an ulcer on her foot. The "AIDE CARE PLAN," dated 6/06/11, did not reference Patient #6's foot wound or give guidance to the aide as to whether the foot could get wet or should be kept dry, and if it should be kept dry how it should be covered. It did not indicate the need for a bath bench during bathing.</p> <p>During a home visit on 6/28/11 beginning at 9:30 AM, a surveyor observed care a home health aide provided for Patient #6 and talked with the home health aide about the care. The home health aide said she was to keep Patient #6's foot wound dry so she used a grocery bag to put around the foot and then held the bag shut with tape and a stretchy elastic wrap. When asked how she decided to use these products since instructions were not provided on the aide care plan, she stated the nurse told her to keep it dry and it was her idea to use the garbage sack, tape, and elastic wrap. A bath bench was observed in the shower. The home health aide confirmed routine use of the bath bench when assisting Patient #6 with her shower.</p>	G 224		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/08/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>137114</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/30/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>LIFES DOORS HOME HEALTH</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 SOUTH ORCHARD BOISE, ID 83705</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G 224	<p>Continued From page 15</p> <p>Written patient care instructions for the home health aide were incomplete.</p> <p>2. Patient #4 was an 84 year old female admitted to the agency on 6/06/11, for care primarily related to a repaired left femur fracture resulting from a fall.</p> <p>The "AIDE CARE PLAN," dated 6/06/11 and signed by Patient #4's RN and CNA, included direction for the aide to assist with bathing and grooming as requested by Patient #4. Assist with walker and in the shower were circled under "ACTIVITY." The CNA documented on the "AIDE VISIT RECORD," dated 6/14/11 at 1:00 PM, that she inspected/reinforced a dressing and that she cleaned the bathroom. Neither of these tasks were included on the "AIDE CARE PLAN."</p> <p>In an interview on 6/28/11 at 3:45 PM, the RN Clinical Administrator stated the aide care plan should be clarified by the RN regarding wounds and dressings when bathing. She further stated the aide is expected to clean up the bathroom after assisting a patient with bathing and not including that task on the aide care plan was an oversight by the RN. She stated it was the agency's expectation that the RN updates the aide care plan as needed.</p> <p>The aide care plan did not include all tasks the RN had instructed or expected the aide to do.</p> <p>3. Patient #9 was a 69 year old female admitted to the agency on 3/04/11, for care primarily related to rheumatoid arthritis, chronic pain,</p>	G 224			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/08/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  137114	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  06/30/2011	
NAME OF PROVIDER OR SUPPLIER  LIFES DOORS HOME HEALTH		STREET ADDRESS, CITY, STATE, ZIP CODE 420 SOUTH ORCHARD BOISE, ID 83705		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 224	<p>Continued From page 16</p> <p>diabetes, and pressure ulcers on her heels.</p> <p>The "AIDE CARE PLAN," dated 5/02/11 and signed by Patient #9's RN and CNA, included direction for the aide to assist with bathing and grooming as requested by Patient #9. The CNA documented on the "AIDE VISIT RECORD" additional tasks done beyond what was included on the aide care plan.</p> <p>The CNA documented assistance with ambulation using a walker, assistance with mobility in the shower, and cleaning the bathroom on 5/03/11, 5/06/11, 5/10/11, 5/13/11, 5/17/11, 5/20/11, 5/24/11, 5/27/11, 5/31/11, 6/03/11, 6/07/11, 6/10/11, 6/14/11, 6/17/11, and 6/21/11.</p> <p>The CNA also documented "Inspect/Reinforce Dressing" on 5/31/11, 6/03/11, 6/07/11, 6/10/11, and 6/21/11.</p> <p>In an interview on 6/28/11 at 3:45 PM, the RN Clinical Administrator stated the aide care plan should be clarified by the RN regarding wounds and dressings when bathing. She further stated the aide was expected to clean up the bathroom after assisting a patient with bathing and not including that task on the aide care plan was an oversight by the RN. She stated it was the agency's expectation that the RN updates the aide care plan as needed.</p>	G 224		
G 340	<p>484.55(d)(2) UPDATE OF THE COMPREHENSIVE ASSESSMENT</p> <p>The comprehensive assessment must be</p>	G 340		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/08/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>137114</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2011</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>LIFES DOORS HOME HEALTH</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 SOUTH ORCHARD BOISE, ID 83705</b>
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 340	<p>Continued From page 17</p> <p>updated and revised (including the administration of the OASIS) within 48 hours of the patient's return to the home from a hospital admission of 24 hours or more for any reason other than diagnostic tests.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure a comprehensive assessment was completed for 1 of 1 patient (#2) reviewed who underwent a resumption of care after a hospitalization longer than 24 hours. This resulted in a ROC assessment not being done in the required timeframe. Findings include:</p> <p>Patient #2 was an 87 year old male admitted to the agency on 3/25/11, for care primarily related to atrial fibrillation, aortic valve disorder, and diabetes.</p> <p>Patient #2 was admitted to a hospital for an aortic valve repair during the certification period 5/24/11 to 7/22/11. Physician discharge orders from the hospital, dated 6/16/11, were written for the agency to resume care. An initial visit was made by the RN on 6/17/11. The "COMPREHENSIVE ADULT NURSING ASSESSMENT," for Patient #2's resumption of care, was completed on 6/21/11, 5 days after his discharge from the hospital.</p> <p>In an interview on 6/28/11 at 1:15 PM, the RN Clinical Administrator stated her understanding of OASIS assessments for ROC was that an initial visit had to be made within 48 hours of discovering a patient's discharge, then the OASIS portion had to be done within 5 days of the initial</p>	G 340		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/08/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  137114	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  06/30/2011
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  LIFES DOORS HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 420 SOUTH ORCHARD BOISE, ID 83705
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

G 340	Continued From page 18 visit. After discussing the CMS regulations with her, she stated she agreed the comprehensive assessment for Patient #2's ROC was late as it should have been completed within 48 hours of discovering his return home.  Patient #2's comprehensive assessment for ROC was completed 5 days late.	G 340		07/10/11
-------	---	-------	--	----------

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  137114	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  06/30/2011
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  LIFES DOORS HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 420 SOUTH ORCHARD BOISE, ID 83705
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	16.03.07 INITIAL COMMENTS  The following deficiencies were cited during the state licensure survey of your agency. The surveyors conducting the survey were:  Karen Robertson, RN, BS, HFS, Team Leader Teresa Hamblin RN, MS, HFS	N 000		
N 097	03.07024. SK. NSG. SERV.  N097 01. Registered Nurse. A registered nurse assures that care is coordinated between services and that all of the patients needs identified by the assessments are addressed. A registered nurse performs the following:  e. Prepares clinical and progress notes, and summaries of care;  This Rule is not met as evidenced by: Refer to G 176.	N 097	Skilled Nursing Serv. Refer to Plan of corrections for G 176 + addendum	
N 122	03.07024.SK.NSG.SERV.  N122 05. Training, Assignment and Instruction of A Home Health Aide.  c. Written instructions for home care, including specific exercises, are prepared by a registered nurse or therapist as appropriate.  This Rule is not met as evidenced by: Refer to G 224.	N 122	Skilled Nursing Serv. Refer to Plan of corrections for G 224 + addendum	

Bureau of Facility Standards

*Laura Loveth RN*  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

*Clinical Administrator*  
TITLE

(X8) DATE

STATE FORM

6889

UD9K11

If continuation sheet 1 of 2

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  137114	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  06/30/2011
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  LIFES DOORS HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE  420 SOUTH ORCHARD BOISE, ID 83705
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 152	Continued From page 1	N 152	<p><i>Plan of Care Refer to Plan of Correction for G 158 + addendum -</i></p>	
N 152	03.07030.01.PLAN OF CARE  N152 01. Written Plan of Care. A written plan of care shall be developed and implemented for each patient by all disciplines providing services for that patient. Care follows the written plan of care and includes:  This Rule is not met as evidenced by: Refer to G 158.	N 152		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  137114	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  06/30/2011
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  LIFES DOORS HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 420 SOUTH ORCHARD BOISE, ID 83705
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	16.03.07 INITIAL COMMENTS  The following deficiencies were cited during the state licensure survey of your agency. The surveyors conducting the survey were:  Karen Robertson, RN, BS, HFS, Team Leader Teresa Hamblin RN, MS, HFS	N 000		
N 097	03.07024. SK. NSG. SERV.  N097 01. Registered Nurse. A registered nurse assures that care is coordinated between services and that all of the patients needs identified by the assessments are addressed. A registered nurse performs the following:  e. Prepares clinical and progress notes, and summaries of care;  This Rule is not met as evidenced by: Refer to G 176.	N 097	 JUL 25 2011  <b>FACILITY STANDARDS</b>	
N 122	03.07024.SK.NSG.SERV.  N122 05. Training, Assignment and Instruction of A Home Health Aide.  c. Written instructions for home care, including specific exercises, are prepared by a registered nurse or therapist as appropriate.  This Rule is not met as evidenced by: Refer to G 224.	N 122		

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>137114</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2011</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>LIFES DOORS HOME HEALTH</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 SOUTH ORCHARD BOISE, ID 83705</b>
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 152 N 152	Continued From page 1 03.07030.01.PLAN OF CARE  N152 01. Written Plan of Care. A written plan of care shall be developed and implemented for each patient by all disciplines providing services for that patient. Care follows the written plan of care and includes:  This Rule is not met as evidenced by: Refer to G 158.	N 152 N 152		

**RECEIVED**

JUL 25 2011

**FACILITY STANDARDS**

**Life's Doors Home Health  
Recertification Survey  
Plan of correction  
June 30<sup>th</sup> 2011**

**Prepared BY: Gayle Lovette RN, Clinical Administrator**

**G158, 484.18 Acceptance of Patients, POC, Medical Supervision**

**DEFICIENCY:** Agency failed to follow POC for obtaining PT/INR and documenting change in orders:

- Plan of correction: Nurses were educated on expectation to follow the physician order and all verbal orders received will be transcribed into a written order and is to be faxed to physician for signature the next business day. Faxed order along with fax confirmation will be retained as a permanent record of patient's chart and reviewed quarterly by Clinical Administrator or designee.

**Compliance:**

- This will ensure POC will be followed and that appropriate physician orders are maintain in chart.

**Person Responsible for Implementing/ Monitoring/Ensuring Compliance**

- Clinical Administrator
- RN case Manager

**Date Deficiency Corrected:** July 20<sup>th</sup> 2011

**DEFICIENCY:** Agency failed to document the physician had been notified that patient had refused bath aide service.

- Plan of correction: Nurses and Therapist educated and required to fax written notification when and why patient refuses services of Bath Aide to Physician. This notification along with fax confirmation will be a permanent record in patients chart and will be reviewed quarterly by Clinical Administrator or designee.

**Compliance:**

- This will ensure that Physician is informed when and why patient refuses physician ordered care.

**Person responsible for Implementing/ Monitoring /Ensuring Compliance**

- Clinical Administrator
- Intake Coordinator
- RN Case Manager/Therapists

**Date Deficiency Corrected: July 20<sup>th</sup> 2011**

**DEFICIENCY:** Physical Therapy visit not initiated within 48 hours, therefore PT frequency did not follow plan of care.

- Plan of correction: All Therapist, Nurses, and Intake Coordinator, educated on expectation that all services to be initiated within 48 hours. If unforeseen circumstances arise, Physician will be promptly notified via fax of Delay of Service form then along with fax confirmation will become permanent record of patient's chart and reviewed at time of processing by Clinical Administrator or designee.

**Compliance:**

- This will ensure POC for therapy visits will be followed and visits initiated within a 48 hour time frame.

**Person Responsible for Implementing/monitoring/ensuring compliance**

- Clinical Administrator
- RN Case Manager/Therapist
- Intake Coordinator

**Date Deficiency Corrected: July 20<sup>th</sup> 2011**

**DEFICIENCY:** Skilled Nurse frequency did not follow plan of care. Patient had Physician visit and therefore missed visit note was not forwarded to Physician.

- Plan of correction: Clinical Administrator educated nurses on need to follow frequency as stated on POC. If Nurse unable to make visit for any reason a missed visit note will be completed and faxed to Physician within 24 hours and along with fax confirmation will become permanent record of patient's chart and reviewed quarterly by Clinical Administrator or designee.

**Compliance:**

- This will ensure Physician will be kept informed of all changes in Skilled Nurse frequency.

**Person Responsible for implementing/monitoring/ensuring compliance**

- Clinical Administrator
- RN Case Manager

**Date Deficiency corrected: July 20<sup>th</sup> 2011**

**DEFICIENCY: Home Health Aide visits were not made according to POC.**

- Plan of correction: Home health aides educated on need to follow frequency as noted on POC. Home Health Aide will complete missed visit note for all missed visits and physician will be notified via fax. Missed visit note along with fax confirmation will be placed in patients chart as a permanent record and reviewed quarterly by Clinical Administrator or designee.

**Compliance:**

- This will ensure that Physician will be informed of all Home Health Aide frequency changes when there is a missed visit and permanent record be maintained.

**Person Responsible for Implementing/Monitoring/Ensuring Compliance**

- Clinical Administrator
- RN Case Manager
- Home Health Aides

**Date Deficiency Corrected: July 20<sup>th</sup> 2011**

**G 159 484.18 Plan of care.**

**DEFICIENCY: Agency failed to address interventions in POC related to perimeters for blood glucose monitoring, vital signs, and assessment of pain.**

- Plan of correction: Nurses and Therapist educated on appropriate interventions to monitor blood glucose, vital signs and assessment of pain. Appropriate interventions with parameters will be stated on nursing POC. If MD chooses not to establish parameters, case manager will establish perimeters based on agency policy and procedure as to when to notify Physician when Blood Glucose, Temperature, Pulse, Blood pressure, Respirations and complaints of pain is outside patient's stated

perimeters. A form to record all vital signs, weights and blood glucose will be placed in patient's home at time of start of care so accurate records may be kept and reviewed by each discipline at every home visit.

- Nurses and Therapists educated on appropriate interventions to assess complaints of pain in order to evaluate progress or lack of progress toward meeting pain control goals. Nurses and therapist will use standardized pain scale, Faces or 0/10 scale. And establish interventions in POC to include at what level of pain that physician will be contacted.
- POC will include relevant intervention to each stated goal.
- This will be reviewed quarterly by Clinical Administrator or designee.

**Compliance:**

- This will ensure that perimeters for all Vital signs, Blood Glucose will be addressed on the Nursing POC to include Interventions for each goal with perimeters designated by physician or RN Case Manager per agency policy and procedure.
- This will ensure that a record of all patient vital signs will be available to each discipline in the home.
- This will ensure that interventions will be addressed on POC for assessing Patient progress or lack of progress toward pain goals.
- This will ensure Physician will be notified promptly when patient vital signs, blood glucose or complaints of pain are assessed to be outside of stated perimeters.

**Person Responsible for Implementing/Monitoring/Ensuring Compliance**

- Clinical Manager
- RN Case Manager/Therapist

**Date Deficiency Corrected:** July 20<sup>th</sup> 2011

**DEFICIENCY:** The POC did not contain listing of DME, toilet riser.

- Plan of correction: Nurses/Therapist instructed to list all DME on physician ordered plan of care.

**Compliance:**

- This will ensure that all DME will be listed on POC. This will be reviewed quarterly by Clinical Administrator or designee.

**Person Responsible for Implementing/Monitoring/Ensuring Compliance**

- Clinical Administrator
- RN Case Managers/Therapist

- **Date deficiency corrected:** July 20<sup>th</sup> 2011

### **G 176 484.30 Duties of the Registered Nurse**

**DEFICIENCY:** PT/INR results and Coumadin dosage changes were not coordinated effectively between nursing staff, patient, and physician.

- **Plan of correction:** Although the nurses responsible for this deficiency are no longer employed by this agency, Clinical Administrator educated current nurses on need to be punctual with immediate coordination with Patient and Physician regarding PT/INR with Coumadin dose changes. A PT/INR log is maintained and updated with each PT/INR results and reflects any Coumadin dose change.
- SN will make every effort to obtain PT/INR early in the day either by Hemosense or Venipuncture and fax Coumadin Fax Form with results immediately to physician so that Physician will have time to respond to lab results before 4PM. If Agency has not received intervention from Physician by 4PM, RN case manager or designee will attempt to resolve lack of Physician communication by refaxing PT/INR results and follow immediately with phone call to Physician office. If resolution still not received by 5PM, and PT/INR results are not Supratherapeutic, patient will be contacted to continue previous dose until contacted by Physician or designee. If PT/INR is Supratherapeutic patient will be contacted to hold Coumadin until further orders/direction are given by physician. Documentation to reflect all actions will be completed and become a permanent record in patient's chart. If after hours and on call nurse receives orders for Coumadin dose change, Nurse will contact patient with new dose and write telephone order the following day and fax to physician for Signature.
- Clinical Administrator will be informed when Physician fails to respond to a PT/INR result in a timely manner, and will elect to obtain resolution of the ineffective communication with Physician next business day.
- PT/INR log, order and fax confirmation will be retained as a permanent record in patients chart.
- This will be reviewed quarterly by Clinical Administrator or designee.
- **Compliance:**
  - This will ensure patient will receive prompt direction of change in Coumadin dose.
  - This will ensure clarity as to the course of patient care.
  - This will show agency efforts to notify Physician of results of PT/INR to obtain orders.

#### **Person Responsible for Implementing/Monitoring/Ensuring Compliance**

- Clinical Administrator
- RN Case Manager

- Intake Coordinator/Office Nurse/LPN

**Date Deficiency Corrected:** July 20<sup>th</sup> 2011

### **G 224 484.36 Assignment and Duties of Home Health Aide**

**DEFICIENCY:** Written patient care instructions for the Home Health Aide were incomplete. The Aide care plan did not include all task the RN had instructed or expected the Aide to do.

- **Plan of correction:** The Aide care plans for all patients were rewritten with plain and clear instructions for all task Home Health Aides are expected to perform.
- This will be reviewed quarterly by Clinical Administrator or Designee.

#### **Compliance:**

- This will ensure Home Health Aides have received instruction on all aspects of Personal cares for patient.

#### **Person Responsible for Implementing/Monitoring/Ensuring Compliance**

- Clinical Administrator
- RN Case Manager

**Date Deficiency Corrected:** July 20<sup>th</sup> 2011

### **G 340 484.55 Update of the Comprehensive Assessment**

**DEFICIENCY:** ROC Assessment was not done within the required time frame. Initial visit was made day one however the comprehensive assessment was completed day 5.

- **Plan of correction:** Educated staff to ensure ROC comprehensive assessment to be completed within 48 hours of known discharge from inpatient stay.
- This will be reviewed at time of processing by Clinical Administrator or designee.

#### **Compliance:**

- This will ensure compliance of completing ROC comprehensive assessment within the required time frame.

#### **Person Responsible for Implementing/Monitoring/Ensuring Compliance**

- Clinical Administrator
- RN Case Manager

**Date Deficiency Corrected:** July 20<sup>th</sup> 2011

Prepared and Submitted by

A handwritten signature in black ink, reading "Gayle Lovette RN". The signature is written in a cursive style with a large initial 'G' and 'L'.

Gayle Lovette RN Clinical Administrator