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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

July 18, 2012

Mary Langenfeld, Administrator
Life's Doors Hospice
PO Box 5754
Boise, ID 83705

RE: Life's Doors Hospice, Provider #131516

Dear Ms. Langenfeld:

This is to advise you of the findings of the Medicare survey of Life's Doors Hospice, which was conducted on July 13, 2012.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicare deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. It is important that your Plan of Correction address each deficiency in the following manner:

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 Hospice into compliance, and that the Hospice 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.

Mary Langenfeld, Administrator
July 18, 2012
Page 2 of 2

After you have completed your Plan of Correction, return the original to this office by **July 31, 2012**, and keep a copy for your records.

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

Sincerely,



AIMEE HASTRITER
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

AH/srm
Enclosures

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Life's Doors Hospice 2012 Survey

L573 Attached document includes:

1. Original Committee Meeting regarding the 2012 Performance Improvement Plan.
2. Performance Improvement Plan.
3. Updated forms, to include one new form.

Responsible Person: Scott Bostrom, RN, BSN Life's Doors Hospice Administrator.

L633 Life's Doors Hospice will hold an in-service/education for all Registered Nurse Case Managers (RN CM) and Hospice Aides (HA). This training will include:

1. Supervision components.
2. Documentation requirements.

The Aide Supervisory Visit section of the Hospice Nursing Visit notes has been updated to assist in complying with this regulatory requirement. See attached Hospice Nursing Visit document.

These actions will be completed in August 2012.

Eight charts will be audited in September and again in November to ensure PoC (Plan of Correction) is effective and brings Life's Doors Hospice in compliance with regulatory requirements.

Scott Bostrom, RN, BSN Life's Doors Hospice Administrator will be responsible for implementing this PoC.

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



L671 A policy has been developed to address admission documentation and Physician orders.

An in-service/education for RN CMs will be held in July 2012.

See attached Policy.

This PoC has been implemented and is currently in effect.

Life's Doors Hospice Administrator will review all new patient charts for the 3rd and 4th quarters of 2012 to ensure the PoC keeps Life's Doors Hospice in compliance with the regulatory requirements.

Scott Bostrom, RN, BSN Life's Doors Hospice Administrator will be responsible for implementing this PoC.

Life's Doors

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

August 2, 2012

The following in-service trainings have or will take place on the dates specified in order to keep or place Life's Doors Hospice in compliance with the noted regulations.

L671 In-service was held on July 31, 2012.

L633 An in-service will be held on August 7, 2012.

Respectfully submitted by



Scott Bostrom, RN, BSN

Life's Doors Hospice Administrator

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Boise 344-9228

Camp Erin
Boise 275-0000



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131516	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/13/2012
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NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 420 S ORCHARD STREET BOISE, ID 83705
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L 000	INITIAL COMMENTS The following deficiencies were cited during the Medicare recertification survey of your hospice agency. Surveyors conducting the recertification were: Aimee Hastriter RN, BSN, HFS, Team Leader Rebecca Lara RN, BA, HFS Acronyms used in this report include: CEO - Chief Executive Officer COPD - Chronic Obstructive Pulmonary Disease DPOA - Durable Power of Attorney PIP - Performance Improvement Project POC - Plan of Care RN - Registered Nurse QAPI - Quality Assessment Performance Improvement	L 000		
L 573	418.58(d)(2) PERFORMANCE IMPROVEMENT PROJECTS (2)The hospice must document what performance improvement projects are being conducted, the reasons for conducting these projects, and the measurable progress achieved on these projects. This STANDARD is not met as evidenced by: Based on interview and review of quality assurance documentation and policies, it was determined the agency failed to document the 2012 performance improvement project, the reason the project was chosen, the plan for the project, and the measurable progress achieved. Lack of documentation impeded the ability of the hospice agency to track progress throughout the process of data collection, implementation of	L 573	SEE ATTACHED	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Scott Bartlow RN TITLE: Administrator (X6) DATE: 7-26-2012

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.

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L 573	<p>Continued From page 1 actions, and continued monitoring. Findings include:</p> <p>According to the "QAPI - PERFORMANCE IMPROVEMENT ACTIVITIES AND PROJECTS" policy, last reviewed on 11/2011, "All performance improvement projects conducted, the reasons for selecting specific projects and the measurable progress achieved of all activities and projects are documented in QAPI Committee meeting minutes and communicated throughout the hospice and to the organization's governing body."</p> <p>QAPI Committee meeting minutes for 2011 through 2/15/12 and the QAPI plans for 2011 and 2012 were reviewed. QAPI data for 2011 through the 1st quarter of 2012 was reviewed. At the meeting on 2/15/12, the 2011 Annual Report and the 2011 PIP were discussed. There was no mention of the PIP to be conducted during 2012.</p> <p>The Administrator was interviewed on 7/16/12 at 11:15 AM. He stated he was responsible for the quality assurance program for the agency. He stated on 1/24/12 the committee met and developed the plan for the 2012 PIP. He stated based on the data collected from the 3rd and 4th quarters of 2011, staff felt responses related to specific issues in the bereavement process were not adequate. At that time they decided to increase phone contact with family/guardians to ensure individuals felt they received appropriate support. He stated the agency has continued to collect data on survey responses and will evaluate later in the year. He confirmed that this plan and the process were not documented.</p>	L 573			

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L 573	Continued From page 2 The agency failed to document the 2012 performance improvement project, the reason the project was chosen, the plan for the project, and the measurable progress achieved.	L 573		
L 633	418.76(h)(3) SUPERVISION OF HOSPICE AIDES (3) The supervising nurse must assess an aide's ability to demonstrate initial and continued satisfactory performance in meeting outcome criteria that include, but is not limited to-- (i) Following the patient's plan of care for completion of tasks assigned to the hospice aide by the registered nurse. (ii) Creating successful interpersonal relationships with the patient and family. (iii) Demonstrating competency with assigned tasks. (iv) Complying with infection control policies and procedures. (v) Reporting changes in the patient's condition. This STANDARD is not met as evidenced by: Based on observation, medical record and policy review, and staff interview, it was determined the agency failed to ensure supervising nurses adequately evaluated the care delivered to 8 of 10 sample patients (#1, #2, #3, #4, #7, #8, #9 and #10) who received hospice aide services. Failure to thoroughly assess the performance of hospice aides had the potential to negatively impact patient care when care was not provided in accordance with the POC. Findings include: 1. According to the "HOSPICE AIDE/HOMEMAKER SERVICES" policy, last reviewed 11/2011, the RN Case Manager was	L 633	SEE ATTACHED	

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L 633	<p>Continued From page 3</p> <p>responsible for developing a written plan of care that provided instructions to the hospice aide of the care to be provided. In turn, according to the "HOSPICE AIDE JOB DESCRIPTION," last reviewed 11/2011, the aide was responsible to the RN Case Manager for carrying out the duties assigned and those in accordance with the plan of treatment. A policy titled, "RN CASE MANAGER," last revised 11/2011, indicated the RN Case Manager was responsible to teach, supervise, and evaluate care provided by the hospice aides. In addition, the RN Case Manager was responsible for re-evaluation of the needs of the patient/family and modifying the plan of care in accordance with the changing needs.</p> <p>Hospice aide supervisory visits were documented by RNs on the "HOSPICE NURSING VISIT" form. The form contained a section entitled "AIDE SUPERVISORY VISIT" and allowed the RN to check boxes that indicated whether the patient accepted or declined the visit, if the aide care plan was updated and whether the aide was following the POC.</p> <p>Hospice aide care was not adequately evaluated by supervising RNs as follows:</p> <p>a. Patient #3 was an 82 year old male who was admitted to the agency on 2/22/12 with a diagnosis of end stage COPD. The "WEEKLY HOSPICE AIDE ASSIGNMENT SHEET" was completed by the RN Case Manager on 2/23/12. The aide was directed to perform the following cares twice a week: tub/shower, perineal care, assistance with dressing, hair care/shampoo, shaving, skin care, foot care, nail care, and assistance with mobility. Patient #3's record</p>	L 633		

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L 633	<p>Continued From page 4</p> <p>contained documentation for 13 aide visits from 5/22/12 to 7/06/12. The aide documented Patient #3 declined the offer of cares every Tuesday, or 5 of the 13 visits. In addition, according to the aide documentation the established plan of care was not consistently followed. For example, for 7 out of 8 visits provided the aide did not document providing assistance with shaving. On 7/06/12 the aide documented Patient #3 was independent with shaving. The aide did not document assistance with foot care or mobility/positioning for 8 of the 8 visits provided. The aide documented regarding nail care on 2 of the 8 visits provided. On 6/08/12 the aide documented Patient #3 declined nail care and on 6/29/12 the aide documented Patient #3 was dependent with nail care.</p> <p>Patient #3's record contained documentation from RN visits at least twice a week. At one visit each week the RN documented completion of an aide supervisory visit. "HOSPICE NURSING VISIT" notes were reviewed for aide supervisory visits between 5/21/12 and 7/02/12. The RN Case Manager documented that hospice aide services were accepted twice a week, the aide was following the POC and it did not need to be altered, and the patient/family were satisfied with the care.</p> <p>On 7/10/12 from 11:50 AM to 12:30 PM the hospice aide visit with Patient #3 was observed. The aide assisted Patient #3 to put on his nasal cannula so that he would have a supply of oxygen during the showering activity. The aide was then observed to assist Patient #3 during his shower. The Aide was interviewed following the shower and explained that Patient #3 was able to wash</p>	L 633			

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L 633	<p>Continued From page 5</p> <p>his own perineal area and hair but she washed his feet. She stated Patient #3 shaved himself and refused any skin care such as lotion. She stated that she cleaned and trimmed his fingernails and the RN took care of his toenails.</p> <p>Patient #3's RN Case Manager was interviewed on 7/10/12 at 3:45 PM regarding her role in creating the aide POC and supervising the aides. She stated she created the POC and typically identified tasks to be completed twice a week by the hospice aide. She stated it was expected that the aide document what cares were provided at each visit but that she, as well as other nursing staff, does not necessarily review each visit note and would not necessarily know if the established POC was followed.</p> <p>The CEO reviewed Patient #3's record on 7/13/12 at 11:30 AM. She confirmed the cares documented by the aide did not coincide with the cares outlined in the established POC. She also confirmed the RN's documentation that the aide was following the POC was inconsistent with the aide documentation.</p> <p>Aide services were not adequately evaluated to determine if care was provided in accordance with the established POC or if the POC needed to be altered for Patient #3.</p> <p>b. Patient #1 was an 86 year old male admitted to the agency on 3/17/12 for care related to end stage cardiopulmonary disease. The "WEEKLY HOSPICE AIDE ASSIGNMENT SHEET" was completed by the RN Case Manager on 3/19/12. The aide was directed to perform the following cares twice a week: tub/shower/bed bath,</p>	L 633			

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L 633	<p>Continued From page 6</p> <p>perineal care, assistance with dressing, hair care/shampoo, shaving, skin care, foot care, nail care, oral care, and assistance with mobility. Patient #1's record contained documentation for 32 aide visits from 3/20/12 to 7/03/12. The aide documented one visit, on 4/10/12, when Patient #1 was too short of breath for any activity. According to the aide documentation the established plan of care was not consistently followed. For example, for 31 of 31 visits completed there was no documentation related to foot care or oral care. Only one visit note, on 5/18/12, contained documentation the aide provided nail care.</p> <p>The "HOSPICE NURSING VISIT" notes from 3/19/12 through 7/03/12 were reviewed. The RN Case Manager documented completing an aide supervisory visit every week. The RN consistently documented that Patient #1 accepted aide services twice a week, the aide was following the POC and it did not need to be altered, and that Patient #1 was satisfied with the care provided by the aide.</p> <p>The CEO reviewed Patient #1's record on 7/13/12 at 11:30 AM. She confirmed the cares documented by the aide did not coincide with the cares outlined in the established POC. She also confirmed the RN's documentation that the aide was following the POC was inconsistent with the aide documentation.</p> <p>The care provided to Patient #1 was not adequately evaluated by the supervising RN.</p> <p>c. Patient #9 was a 93 year old male admitted to the agency on 6/07/12 with Parkinson's. The</p>	L 633			

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L 633	<p>Continued From page 7</p> <p>"WEEKLY HOSPICE AIDE ASSIGNMENT SHEET" was completed by the RN Case Manager on 6/08/12. The aide was directed to perform the following cares twice a week: tub/shower/bed bath, perineal care, assistance with dressing, hair care/shampoo, shaving, skin care, foot care, oral care/denture care, and assistance with mobility and positioning. Documentation from 6 aide visits, from 6/11/12 through 6/28/12, was reviewed. According to the aide documentation the established plan of care was not consistently followed. For example, for 6 out of the 6 visits there was no documentation related to oral/denture care or positioning. There was no documentation related to shaving Patient #9 during 3 of the 6 visits, and there was no documentation of skin or foot care for 2 of the visits.</p> <p>The "HOSPICE NURSING VISIT" notes from 6/18/12, 6/25/12, and 7/02/12 were reviewed. The RN Case Manager documented completing an aide supervisory visit each week. The RN documented that Patient #9 accepted aide services twice a week, the aide was following the POC and it did not need to be altered, and that the patient/family was satisfied with the care provided by the aide.</p> <p>The CEO reviewed Patient #9's record on 7/13/12 at 11:30 AM. She confirmed the cares documented by the aide did not coincide with the cares outlined in the established POC. She also confirmed the RN's documentation that the aide was following the POC was inconsistent with the aide documentation.</p> <p>The care provided to Patient #9 was not</p>	L 633			

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L 633	<p>Continued From page 8</p> <p>adequately evaluated by the supervising RN.</p> <p>d. Patient #2 was a 65 year old male who was admitted to the agency on 6/05/12 for care related to failure to thrive, unspecified schizophrenia, anxiety and type 2 diabetes. The aide plan of care was completed on 6/06/12 by an RN Case Manager on a form entitled, "WEEKLY HOSPICE AIDE ASSIGNMENT SHEET." The aide was directed to perform the following cares once a week: tub/shower/bed bath, perineal care, assistance with dressing, hair care/shampooing, shave, skin care, foot care, oral care, assistance with ambulation using a wheel chair, and assistance with mobility and positioning. However, the "HOSPICE AIDE VISIT RECORD" documented Patient #2 refused aide services on 5 of 5 occasions, between 6/07/12 and 7/02/12.</p> <p>The "HOSPICE NURSING VISIT" notes were reviewed for aide supervisory visits between 6/12/12 and 7/03/12. Though the aide documented Patient #2 was refusing aide services, the RN Case Manager documented that the aide visit was accepted by Patient #2 and that the aide was following the POC.</p> <p>The RN Case Manager for Patient #2 was interviewed on 7/12/12, beginning at 9:45 AM. The RN reviewed Patient #2's medical record and confirmed documentation that Patient #2 was consistently refusing aide services. The RN also confirmed the nursing visit notes consistently documented the aide was following the POC and Patient #2 was accepting aide visits. When questioned about the process of supervising hospice aides, the RN stated communication related to supervision between the hospice aide</p>	L 633		
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L 633	<p>Continued From page 9</p> <p>and RN occurred primarily by phone and on a weekly basis. She also stated calls/conversations were not consistently documented. The RN said it was not her practice to provide joint supervisory visits or consistently review aide visit notes.</p> <p>e. Patient #4 was a 98 year old female who was admitted to the agency on 10/26/09 for care related to failure to thrive and dementia. The aide plan of care was completed on 10/26/09 by an RN, on a form entitled, "WEEKLY HOSPICE AIDE ASSIGNMENT SHEET." The aide was directed to perform the following cares twice a week: tub/shower/bed bath, perineal care, assistance with dressing, hair care/shampooing, skin care, foot care, nail care, denture care, and assistance with mobility and positioning. According to the aide documentation the established plan of care was not consistently followed. For example, denture care and positioning were not documented for 19 of 19 visits between 5/01/12 and 7/03/12. Additionally and during the same period of time, assistance with mobility was not documented for 17 of 19 visits and hair care was not documented on 11 occasions. Documentation related to skin care and foot care was missing for 13 of 19 visits, and there was no documentation related nail care for 18 of 19 visits.</p> <p>The "HOSPICE NURSING VISIT" notes were reviewed for aide supervisory visits between 5/02/12 and 7/03/12. Though the aide was not adhering to Patient #4's POC consistently, the RN Case Manager documented that the POC was being followed by the aide.</p>	L 633			

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L 633	<p>Continued From page 10</p> <p>RN supervision of hospice aides was discussed with the CEO on 7/13/12 beginning at 12:00 noon. The CEO reviewed Patient #4's medical record and confirmed the RN continued to document the aide was following the POC even though the aide documentation was not consistent with this assessment. She agreed supervision of the hospice aide did not reflect the care that was actually provided to Patient #4.</p> <p>f. Patient #7 was a 93 year old male who was admitted to the agency on 6/23/11 for care related to Alzheimer's and type 2 diabetes. The aide plan of care was completed on 6/24/11, by an RN, on a form entitled, "WEEKLY HOSPICE AIDE ASSIGNMENT SHEET." The aide was directed to perform the following cares twice a week: tub/shower/bed bath, perineal care, assistance with dressing, hair care/shampoo, skin care, denture care and assistance with mobility. According to the aide documentation the established plan of care was not consistently followed. For example, denture care and assistance with mobility were not documented for 11 of 11 visits occurring between 6/01/12 through 7/06/12. Hair care was not documented for 2 visits during the same period of time.</p> <p>The "HOSPICE NURSING VISIT" notes were reviewed for aide supervisory visits between 6/05/12 and 7/05/12. Though the aide was not adhering to Patient #7's POC consistently, the RN Case Manager documented that the POC was being followed by the aide.</p> <p>RN supervision of hospice aides was discussed with the CEO on 7/13/12 beginning at 11:50 AM. The CEO reviewed Patient #7's medical record</p>	L 633		
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L 633	<p>Continued From page 11</p> <p>and confirmed the RN continued to document the aide was following the POC even though the aide documentation was not consistent with this assessment. She agreed supervision of the hospice aide did not reflect the care that was actually provided to Patient #7.</p> <p>g. Patient #8 was a 92 year old female admitted to the agency on 4/12/12 for care related to failure to thrive. The aide plan of care was completed by an RN on 4/13/12, on a form entitled, "WEEKLY HOSPICE AIDE ASSIGNMENT SHEET." The aide was directed to perform the following cares twice a week: shower, perineal care, assistance with dressing, nail care, oral care and bed linen change. According to the aide documentation, from 4/16/12 through 7/09/12, the established plan of care was not consistently followed. For example, assistance with showering was not documented for 17 of 24 visits and documentation of perineal care was missing for 2 of 24 visits. Additionally, nail care was not documented on 17 occasions, oral care was missing for 14 visits, and linens were not documented as having been changed for 16 of 24 visits. Numerous visit notes included care that was provided that was not included on the aide plan of care. Examples were shampoo/hair care, skin care, bed bath, positioning, mobility assistance, feeding assistance and cleaning an air mattress.</p> <p>RN supervision of hospice aides was discussed with the CEO on 7/13/12 beginning at 11:25 AM. The CEO reviewed Patient #8's medical record and confirmed the RN continued to document the aide was following the POC even though the aide documentation was not consistent with this</p>	L 633		

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L 633	<p>Continued From page 12</p> <p>assessment. She agreed supervision of the hospice aide did not reflect the care that was actually provided to Patient #8.</p> <p>h. Patient #10 was a 107 year old female who was admitted to the agency on 8/29/11 for care related to failure to thrive. The aide plan of care was completed by an RN on 8/30/11, on a form entitled, "WEEKLY HOSPICE AIDE ASSIGNMENT SHEET." The aide was directed to perform the following cares twice a week: tub/shower/bed bath, perineal care, assistance with dressing, hair care/shampoo, skin care, foot care, nail care, denture care and assistance with mobility. According to the aide documentation the established plan of care was not consistently followed. For example, denture care was not documented for 18 of 21 visits between 5/01/12 and 7/06/12. Similarly and during the same period of time, foot and nail care were not documented for 20 of 21 visits, and skin care was not documented on 10 occasions.</p> <p>The "HOSPICE NURSING VISIT" notes were reviewed for aide supervisory visits between 6/18/12 and 7/09/12. Though the aide was not adhering to Patient #10's POC consistently, the RN Case Manager documented that the POC was being followed by the aide.</p> <p>RN supervision of hospice aides was discussed with the CEO on 7/13/12 beginning at 11:40 AM. The CEO reviewed Patient #10's medical record and confirmed the RN continued to document the aide was following the POC even though the aide documentation was not consistent with this assessment. She agreed supervision of the hospice aide did not reflect the care that was</p>	L 633		
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L 633	Continued From page 13 actually provided to Patient #10.	L 633			
L 671	<p>The agency failed to ensure supervising nurses adequately evaluated the care provided to patients by the hospice aide.</p> <p>418.104 CLINICAL RECORDS</p> <p>A clinical record containing past and current findings is maintained for each hospice patient. The clinical record must contain correct clinical information that is available to the patient's attending physician and hospice staff. The clinical record may be maintained electronically.</p> <p>This STANDARD is not met as evidenced by: Based on review of patient rights information, job descriptions and medical records, and interview it was determined the agency failed to ensure each medical record contained clear documentation identifying the physician who was responsible for providing hospice care for 6 of 11 patients (#1, #2, #4, #6, #7 and #11) who chose to have their primary provider to oversee hospice care. The lack of clarity in the medical record related to admission documentation and physician orders led to the potential of the patient's right to choose their attending physician not being upheld. Findings include:</p> <p>1. Each medical record contained admission paperwork to document the receipt of patient rights information. On one of these forms the patient and/or caregiver had the opportunity to document which physician (either their primary provider or the hospice medical director) they wanted to be involved in making decisions regarding their hospice plan of care and ordering</p>	L 671	SEE ATTACHED		

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L 671	<p>Continued From page 14</p> <p>medications, treatments, etc. The line read, "I designate Dr. [space to fill in name] as my hospice physician."</p> <p>The agency's admission paperwork contained a document titled, "Patient Notification Regarding Rights and Responsibilities," dated 10/2008. This document indicated patients had the right to choose their attending physician. The "MEDICAL DIRECTOR" job description, last reviewed 11/2011, documented the medical director's responsibilities included, "Consulting with the patient's attending physician as needed and appropriate" and that this individual, "May be contacted for emergency orders when the patient's physician cannot be reached."</p> <p>Seven of the sample patients designated their primary provider as the hospice physician and subsequent orders were obtained from the hospice medical director. The medical records did not contain documentation the primary provider deferred care to the hospice medical director or that the orders were obtained in an emergency situation when the primary provider was not available. There was no documentation the patient/caregiver was notified of the change in attending physicians as follows:</p> <p>a. Patient #1 was an 86 year old male who elected hospice benefits on 3/17/12 with a diagnosis of end stage cardiopulmonary disease. His medical record contained admission paperwork signed and dated by Patient #1 on 3/15/12. Patient #1 indicated he chose his cardiologist as his hospice physician. A "PHYSICIAN'S CERTIFICATION FOR HOSPICE BENEFIT" form contained a list of basic hospice</p>	L 671			

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L 671	<p>Continued From page 15</p> <p>orders and a section for a brief narrative to be completed by a physician to provide clinical justification for admission to hospice. The cardiologist referred to a recent hospital discharge summary for the justification for Patient #1's admission to hospice and signed the form on 3/16/12. The hospice medical director also signed the form on 3/21/12.</p> <p>The medical record contained "PRE-PRINTED PHYSICIAN DIRECTIONS FOR HOSPICE," last reviewed 5/2011, initiated on 3/15/12, and signed by the hospice medical director. A "Physician's Fax Sheet" was sent to the cardiologist on 3/16/12, requesting a prescription for Morphine Sulfate for Patient #1. The next order in the medical record was a copy of a prescription for Morphine Sulfate, completed on 3/20/12 and signed by the hospice medical director. An additional prescription for Morphine Sulfate was ordered on 6/26/12 by the hospice medical director. The record did not contain documentation indicating that either the cardiologist was unavailable and the hospice medical director filled the prescription on an emergency basis, or the cardiologist had deferred care to the hospice medical director. The record did not contain documentation that Patient #1 was notified the chosen physician was not providing his hospice care.</p> <p>The CEO reviewed Patient #1's medical record on 7/12/12 at 10:55 AM. She confirmed that Patient #1's cardiologist was designated as the hospice provider. She stated the order to transfer care to the hospice medical director was probably a verbal order but confirmed there was no documentation of this in the medical record. She</p>	L 671			

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L 671	<p>Continued From page 16</p> <p>stated it was staff practice to communicate a transfer in physician care to the patient and/or their representative but was unsure there was a specific way this was documented. She confirmed this information was not found in Patient #1's record.</p> <p>The medical record did not clearly indicate who was providing hospice care for Patient #1.</p> <p>b. Patient #2 was a 65 year old male who elected hospice benefits on 6/05/12 with a diagnosis of failure to thrive. His medical record contained admission paperwork signed and dated by Patient #2's DPOA 6/05/12. The DPOA indicated choosing Patient #2's primary physician as his hospice physician. A "PHYSICIAN'S CERTIFICATION FOR HOSPICE BENEFIT" form contained a list of basic hospice orders and a section for a brief narrative to be completed by a physician to provide clinical justification for admission to hospice. This form was not completed by the primary provider and was not signed by the hospice medical director.</p> <p>All of the orders for medications and treatments were completed and signed for by the hospice medical director. The record did not contain documentation indicating that either the primary provider was unavailable and the hospice medical director completed the orders on an emergency basis, or the primary provider had deferred care to the hospice medical director. The record did not contain documentation that Patient #2 or his DPOA were notified that the chosen physician was not providing hospice care.</p> <p>The CEO reviewed Patient #2's medical record</p>	L 671		
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L 671	<p>Continued From page 17</p> <p>on 7/12/12 at 10:45 AM. She explained that the provider designated by the DPOA was actually the medical director for a different hospice facility. She stated the physician refused to oversee hospice care for patient's who were admitted to a competing facility. She stated an order to transfer care from one physician to another should be on the medical record. She confirmed the record did not contain documentation that Patient #2 or his DPOA were notified of this transfer of care or that they were informed of who would be providing hospice care.</p> <p>The medical record did not clearly indicate who was providing hospice care for Patient #2.</p> <p>c. Patient #6 was an 88 year old female who elected hospice benefits on 4/12/12 with a diagnosis of failure to thrive. Her medical record contained admission paperwork signed and dated by Patient #6's DPOA on 4/12//12. The DPOA indicated choosing Patient #6's primary provider as the hospice physician. A "PHYSICIAN'S CERTIFICATION FOR HOSPICE BENEFIT" form contained a list of basic hospice orders and a section for a brief narrative to be completed by a physician to provide clinical justification for admission to hospice. The primary provider completed the narrative for clinical justification of admission and signed and dated the form on 4/13/12. The hospice medical director also signed the form on 4/18/12.</p> <p>The medical record contained "PRE-PRINTED PHYSICIAN DIRECTIONS FOR HOSPICE," last reviewed 5/2011, initiated on 4/12/12, and signed by the hospice medical director. The record contained subsequent physician orders for</p>	L 671			

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L 671	<p>Continued From page 18</p> <p>medications and treatments signed by the hospice medical director. The record did not contain documentation indicating that either the primary provider was unavailable and the hospice medical director completed orders on an emergency basis, or the primary provider had deferred care to the hospice medical director. The record did not contain documentation that Patient #6 and/or her DPOA were notified that the original choice for her hospice physician was not providing her hospice care.</p> <p>The medical record did not clearly indicate who was providing hospice care for Patient #6.</p> <p>d. Patient #4 was a 99 year old female who elected hospice benefits on 10/26/09 with a diagnosis of failure to thrive. Her medical record contained admission paperwork signed and dated by Patient #4's DPOA on 10/16/09. The DPOA indicated choosing Patient #4's primary provider as the hospice physician. A "PHYSICIAN'S CERTIFICATION FOR HOSPICE BENEFIT" form contained a list of basic hospice orders and a section for a brief narrative to be completed by a physician to provide clinical justification for admission to hospice. The primary provider documented Patient #4 was evaluated on 10/22/09 and qualified for hospice evaluation. The form was signed and dated by the primary provider on 10/22/09. The hospice medical director also signed the form on 10/28/09.</p> <p>The medical record contained "PRE-PRINTED PHYSICIAN DIRECTIONS FOR HOSPICE," last reviewed 5/2011, initiated on 10/16/09, and signed by the hospice medical director. The record contained subsequent physician orders for</p>	L 671			

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L 671	<p>Continued From page 19</p> <p>medications and treatments signed by the hospice medical director. The record did not contain documentation indicating that either the primary provider was unavailable and the hospice medical director completed orders on an emergency basis, or the primary provider had deferred care to the hospice medical director. The record did not contain documentation that Patient #4 and/or her DPOA were notified that the original choice for her hospice physician was not providing her hospice care.</p> <p>The medical record did not clearly indicate who was providing hospice care for Patient #4.</p> <p>e. Patient #11 was an 82 year old female who elected hospice benefits on 11/18/11 with a diagnosis of end stage COPD. Her medical record contained admission paperwork signed and dated by Patient #11 on 11/18/11. Patient #11 indicated she chose her primary provider as her hospice physician. A "PHYSICIAN'S CERTIFICATION FOR HOSPICE BENEFIT" form contained a list of basic hospice orders and a section for a brief narrative to be completed by a physician to provide clinical justification for admission to hospice. The primary provider documented justification for admission and noted that Patient #11 desired hospice care. The form was signed by the primary provider on 11/18/11 and by the hospice medical director on 11/28/11.</p> <p>The medical record contained "PRE-PRINTED PHYSICIAN DIRECTIONS FOR HOSPICE," last reviewed 5/2011, initiated on 11/18/11, and signed by the hospice medical director. On 1/23/12, the RN Case Manager for Patient #11 faxed a note to the primary provider. The RN</p>	L 671		

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L 671	<p>Continued From page 20</p> <p>Case Manager informed the primary provider that the hospice medical director wrote two prescriptions for pain medications and then indicated that a list of medications would be faxed to the primary provider for an order to discontinue oral medications. The record did not contain documentation indicating that either the primary provider was unavailable and the hospice medical director filled the pain medication prescription on an emergency basis, or the primary provider had deferred care to the hospice medical director. It was unclear who managed Patient #11's hospice care. The record did not contain documentation that Patient #11 was notified the chosen physician was not providing her hospice care.</p> <p>The medical record did not clearly indicate who was providing hospice care for Patient #11.</p> <p>f. Patient #7 was a 94 year old female who elected hospice services on 6/23/11 with a diagnosis of Alzheimer's. Her medical record contained admission paperwork signed and dated by Patient #7's guardian on 6/23/11. The guardian indicated choosing Patient #7's primary provider as the hospice physician. A "PHYSICIAN'S CERTIFICATION FOR HOSPICE BENEFIT" form contained a list of basic hospice orders and a section for a brief narrative to be completed by a physician to provide clinical justification for admission to hospice. An associate of the primary provider completed the narrative for clinical justification of admission and signed and dated the form on 6/24/11. The hospice medical director also signed, but did not date, the form.</p> <p>The medical record contained "PRE-PRINTED</p>	L 671			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131516	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/13/2012	
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 420 S ORCHARD STREET 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
L 671	<p>Continued From page 21</p> <p>PHYSICIAN DIRECTIONS FOR HOSPICE," last reviewed 5/2011, initiated on 6/23/11, and signed by the hospice medical director. The record contained subsequent physician orders for medications and treatments signed by the hospice medical director. The record did not contain documentation indicating that either the primary provider was unavailable and the hospice medical director completed orders on an emergency basis, or the primary provider had deferred care to the hospice medical director. The record did not contain documentation that Patient #7 and/or her guardian were notified that the original choice for her hospice physician was not providing her hospice care.</p> <p>The medical record did not clearly indicate who was providing hospice care for Patient #7.</p> <p>The CEO was interviewed on 7/13/12 beginning at 11:25 AM. Identification and documentation of the medical provider who was responsible for overseeing care of hospice patients was discussed. She stated it was the practice of the agency for the attending physician to document, when applicable, transfer of care to the hospice medical director on the "PHYSICIAN'S CERTIFICATION FOR MEDICARE HOSPICE BENEFIT form." She stated it was also possible that the RN Case Manager may receive a verbal order to transfer care to the hospice medical director. She stated if a verbal order was given she expected the order to be documented appropriately in the medical record. The CEO reviewed the medical records for Patients #4, #6, #7 and #11. She confirmed that orders to transfer care from the attending physician to the hospice medical director could not be found in the</p>	L 671		

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

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L 671	Continued From page 22 records. The agency failed to ensure the medical record clearly documented which physician was providing hospice care and that the patient/representative was notified if the designated physician transferred care to the hospice medical director.	L 671		
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