



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

DEBRA RANSOM, R.N., R.H.I.T., Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0009  
PHONE 208-334-6626  
FAX 208-364-1888

May 21, 2013

COPY

Lois Boomer, Administrator  
Lifes Doors Home Health  
P.O. Box 5754  
Boise, ID 83705

Provider #137114

Dear Ms. Boomer:

On **May 9, 2013**, a complaint survey was conducted at Lifes Doors Home Health. The complaint allegations, findings, and conclusions are as follows:

**Complaint #ID00005811**

**Allegation:** A patient did not have bowel movement for 2 weeks. The nurse did not intervene which resulted in medical complications.

**Findings:** An unannounced visit was made to the home health agency on 5/08/13 and 5/09/13. Staff were interviewed. Agency policies and 10 medical records of current and past patients were reviewed.

All 10 medical records contained comprehensive nursing assessments. All 10 medical records contained plans of care which were updated as patient needs changed. Nursing visits were conducted in accordance with the plans of care for all 10 patients. Documentation was present that physicians were notified in response to patients' changing condition.

Monitoring patients' bowel status:

All 10 medical records documented the status of patients' bowel movements.

One patient's medical record documented a 69 year old female. Following back surgery, she

Lois Boomer, Administrator  
May 21, 2013  
Page 2 of 4

received home health services from 11/01/12 to 11/16/12. A "COMPREHENSIVE ADULT NURSING ASSESSMENT" was dated 11/01/12 at 11:15 AM. It stated the patient had a bowel movement the previous day and said the patient had bowel movements daily. The plan of care called for a nurse to visit the patient on a weekly basis. It also called for the patient to receive physical therapy.

The patient's first "SKILLED NURSING NOTE" was dated 11/05/12 at 10:30 AM. It stated the patient had a good appetite but currently complained of some nausea. It did not state when the patient last had a bowel movement. The next "SKILLED NURSING NOTE" was dated 11/13/12 at 11:00 AM. Again, it stated the patient reported her appetite was good. The note stated the patient's water intake was decreased. The note stated the patient complained of constipation and claimed she had not had a bowel movement for 7 days. The note stated the patient had taken Miralax, a laxative medication, that day. The note stated the patient complained of back pain. The note stated the patient was instructed to increase her water intake which helps prevent constipation. The note stated the patient was to obtain a "Fleets enema" and take it as directed. An order for the enema was obtained by the nurse.

A "PATIENT COORDINATION COMMUNICATION RECORD," dated 11/13/12 at 4:00 PM, stated the registered nurse (RN) called the patient's house and spoke with her husband. The note stated the husband told the nurse the patient had a bowel movement. The note stated the RN told the husband not to let the patient go more than 2-3 days without having a bowel movement. The note stated the RN gave the husband her cellular telephone number. The note stated the husband relayed the information to the patient and then told the nurse "everything is good."

A "PATIENT COORDINATION COMMUNICATION RECORD," dated 11/16/12 at 11:30 AM, stated the RN called the patient's house but there was no answer. The note stated the RN left a message. The next "PATIENT COORDINATION COMMUNICATION RECORD," was dated 11/16/12 at 2:06 PM. It stated the RN called the patient's house and spoke with her husband. The note stated the husband reported the patient had "belly pain" and fever with chills. The husband was instructed to take the patient to the hospital "ASAP." The "PATIENT COORDINATION COMMUNICATION RECORD," dated 11/16/13 at 4:00 PM, stated the RN again called the patient's home but received no answer.

A hospital "History and Physical," dated 11/16/12 at 7:49 PM, stated the patient had a "...perforated colon and severe diverticulitis." The report stated the patient was being taken for abdominal surgery.

Physical therapy notes were documented for the patient on 11/02/12, 11/05/12, 11/07/12, 11/09/12, and 11/13/12. The 11/13/12 note at 12:00 noon, stated the patient reported being constipated and was going to try enemas. The note stated the patient completed her exercises.

None of the other therapy notes documented problems with constipation or abdominal pain.

The RN Case Manager for the patient was interviewed on 5/09/13 beginning at 9:50 AM. She reviewed the medical record and confirmed the documentation. She confirmed the status of bowel movements was not documented on the 11/05/12 "SKILLED NURSING NOTE." However, she stated she always asked if there were any problems with patients' bowel and bladder elimination. She stated if there had been a problem it would have been documented. She stated the patient said her last bowel movement was 7 days ago but the patient was not in any distress. She stated she instructed the patient's husband to obtain a fleets enema. She stated she called the physician's office but was not immediately able to reach him. She stated she called back to the patient's house that afternoon. She said the husband told her the patient had had a bowel movement. She stated the husband said the patient was fine. She stated she did not know if the patient actually took the enema or not. The patient had an order for prn nursing visits. The RN stated if the patient had indicated she was having problems the RN would have made another visit to the home that day.

Monitoring patients blood pressure status:

All medical records documented blood pressures with nursing and therapy visits.

The above patient's "COMPREHENSIVE ADULT NURSING ASSESSMENT," dated 11/01/12 at 11:15 AM, stated her blood pressure (BP) was 98/62. "SKILLED NURSING NOTE{s}, dated 11/05/12 at 10:30 AM and 11/13/12 at 11:00 AM, stated the patient's blood pressures were 107/67 and 110/80, respectively. Physical therapy notes dated 11/02/12, 11/05/12, 11/07/12, 11/09/12, and 11/13/12 documented blood pressures of 98/48, 95/55, 95/49, 91/47, and 107/64, respectively. None of the nursing or therapy notes documented the patient complained of dizziness or light headedness. The patient's plan of care stated to call the physician if the patient's systolic blood pressure (the top number) was below 80.

The "PHYSICAL THERAPY REVISIT NOTE," dated 11/07/13 at 11:00 AM, stated "{low} BP, very easily fatigued. Advised she check {with primary care provider regarding hypertension} meds when she asked if she should be taking them."

The physical therapist was interviewed on 5/09/13 beginning at 2:20 PM. She stated she did not remember if she told the RN about the patient's blood pressure. She stated the patient did not complain of dizziness or light headedness. She stated the patient's blood pressure was not so low that she was concerned about the patient's health.

The RN Case Manager for the patient was interviewed on 5/09/13 beginning at 9:50 AM. She stated the patient did not complain of blood pressure problems to her. She stated the patient's

Lois Boomer, Administrator  
May 21, 2013  
Page 4 of 4

blood pressure was not abnormally low and she was not aware of any problems.

All sampled patients' care was monitored and supervised by the RN. No deficiencies were cited that pertained to patient care. A related deficiency was cited at 42 CFR part 484.10(b,5) because the agency had not followed its grievance procedure.

Conclusions: Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the complaint investigation, a deficiency was cited and included on the survey report. No response is necessary to this complaint report, as it was addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,



GARY GUILLES  
Health Facility Surveyor  
Non-Long Term Care



SYLVIA CRESWELL  
Co-Supervisor  
Non-Long Term Care

GG/pt

# Life's Doors

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

May 28, 2013

Sylvia Creswell, Co-Supervisor  
Idaho Dept. of Health & Welfare  
Bureau of Facility Standards  
PO Box 83720  
Boise, ID 83720-0009

**RECEIVED**

**MAY 29 2013**

**FACILITY STANDARDS**

Dear Ms. Creswell:

Enclosed is our Plan of Correction to the Statement of Deficiencies resulting from the complaint survey which was conducted on May 9, 2013.

In the event you need additional information, please do not hesitate to contact me at the above telephone number or by email at [hadmin@lifesdoors.com](mailto:hadmin@lifesdoors.com).

Please express our appreciation to Gary Guiles for the professional and helpful way in which he conducted the survey.

Sincerely,



Lois J. Boomer  
Administrator

Enclosures

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

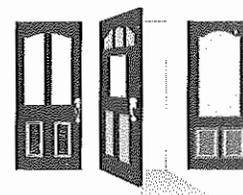
Life's Doors  
Home Health  
Boise 639-8880

Life's Doors  
Home Care Solutions  
Boise 344-9228

Life's Doors  
Door to Door  
Boise 344-9228

Life's Doors  
Lifeline  
Boise 344-9228

Healing Hearts  
Boise 275-0000



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

PRINTED: 05/15/2013  
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  C 05/09/2013
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NAME OF PROVIDER OR SUPPLIER  LIFES DOORS HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 420 SOUTH ORCHARD BOISE, ID 83705
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(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
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G 000	INITIAL COMMENTS	G 000		
	<p>The following deficiency was cited during the complaint investigation survey of your agency. The surveyor conducting the investigation was Gary Guiles, RN, HFS.</p> <p>Acronyms used in this report include:</p> <p>RN = registered nurse</p>			
G 107	484.10(b)(5) EXERCISE OF RIGHTS AND RESPECT FOR PROP	G 107	<p>Please see attached Plan of Correction dated May 28, 2013. Prepared and signed by Lois Boomer, Administrator.</p>	
	<p>The HHA must investigate complaints made by a patient or the patient's family or guardian regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for the patient's property by anyone furnishing services on behalf of the HHA, and must document both the existence of the complaint and the resolution of the complaint.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of medical records, it was determined the agency failed to ensure complaints regarding patient care were identified, investigated, and documented for 1 of 1 patient (#4) who complained to the agency and whose record was reviewed. This prevented the agency from evaluating the care of patients who perceived problems with care. Findings include:</p> <p>Patient #4's medical record documented a 69 year old female who received home health services from 11/01/12 to 11/16/12. A "PATIENT COORDINATION RECORD," dated 11/26/12 but not timed, stated Patient #4 called and complained about her care related to constipation</p>			
			<p>RECEIVED MAY 29 2013 FACILITY STANDARDS</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Lois Boomer* TITLE *Administrator* (X6) DATE *5/28/2013*

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: 05/15/2013  
FORM APPROVED  
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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  C 05/09/2013
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 107	<p>Continued From page 1</p> <p>and blood pressure medication. The note stated Patient #4 felt her concerns were overlooked by the RN.</p> <p>The Administrator was interviewed on 5/09/13 beginning at 8:50 AM. She stated she was aware of Patient #4's complaint but she stated it was not treated as a grievance. She stated the matter had not been investigated but said the Clinical Director had spoken to the RN about it. She stated a grievance log was not kept by the agency and she could not identify any grievances that had been filed in the past year.</p> <p>The Clinical Director was interviewed on 5/09/13 beginning at 9:05 AM. She stated she had spoken with the RN. She said she thought the RN's actions sounded reasonable. She stated that, except for the interview with the nurse, an investigation had not been conducted into the care of Patient #4 and agency procedures had not been evaluated. She also stated Patient #4 had not received a response to her complaints.</p> <p>The agency did not acknowledge Patient #4's grievance and did not respond to her concerns.</p>	G 107		

**Life's Doors Home Health  
Complaint Survey – May 9, 2013  
Plan of correction - May 28, 2013  
Prepared by: Lois Boomer, Administrator**

**G107 484.10(b)(5) Exercise of Rights and Respect for Property**

**Deficiency:** Agency failed to properly investigate a patient complaint and document the existence of the complaint and the resolution of the complaint.

**Action:** A Grievance Log was established on May 10, 2013, which is being maintained in the Performance Improvement Binder. The Administrator will be responsible for documenting any grievance within 5 days of the alleged grievance. The Administrator will investigate the grievance within 5 days of receipt of such grievance and will make every effort to resolve the grievance to the patient's satisfaction. All complaints will be documented on a complaint form, along with investigative findings and resolution information will be communicated in writing to the patient or his/or representative within 10 days. If the patient feels their complaint has not been resolved, the Administrator will remind them of their right to register a complaint with the State via the toll-free hotline number.

All home health agency staff will be re-educated regarding agency policy and procedure concerning patient complaints/grievances, and the immediate reporting of same to the Administrator.

**Compliance:** This will ensure that the agency protects patient and family rights by properly investigating, documenting and responding to patient complaints.

**Monitoring and tracking:** At the agency's weekly Case Conference, staff will be queried as to the existence of any patient dissatisfaction or possible grievance. All such cases will be properly logged and investigated per agency policy.

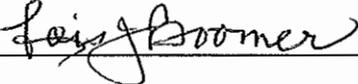
All patient grievances will be tracked and trended and reported to the Professional Advisory Committee on a quarterly basis.

**Person(s) Responsible for Implementing/ Monitoring/Ensuring Compliance:**

- Administrator
- Clinical Director/CEO

**Date Deficiency Corrected:** June 15, 2013

Respectfully submitted,

 5/28/2013

Lois J. Boomer, Administrator – Life's Doors Home Health



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

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

DEBRA RANSOM, R.N., R.H.I.T., Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0009  
PHONE 208-334-6626  
FAX 208-364-1888

May 21, 2013

Lois Boomer, Administrator  
Lifes Doors Home Health  
P.O. Box 5754  
Boise, ID 83705

COPY

RE: Lifes Doors Home Health, Provider #137114

Dear Ms. Boomer:

This is to advise you of the findings of the complaint survey at Lifes Doors Home Health, which was concluded on May 9, 2013.

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.

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.

After you have completed your Plan of Correction, return the original to this office by

Lois Boomer, Administrator  
May 21, 2013  
Page 2 of 2

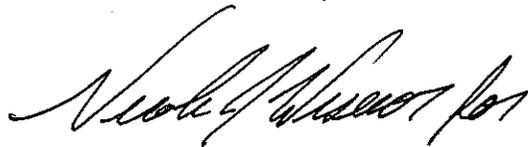
June 3, 2013, and keep a copy for your records.

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,



GARY GULES  
Health Facility Surveyor  
Non-Long Term Care



SYLVIA CRESWELL  
Co-Supervisor  
Non-Long Term Care

GG/pt  
Enclosures