



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

CERTIFIED MAIL: 7000 1670 0011 3315 1842

July 28, 2014

Daniel Walker, Administrator
Life's Doors Home Health & Hospice
P.O. Box 5754
Boise, ID 83705

RE: Life's Doors Home Health & Hospice, Provider #137114

Dear Mr. Walker:

Based on the survey completed at Life's Doors Home Health & Hospice, on July 11, 2014, by our staff, we have determined Life's Doors Home Health & Hospice is out of compliance with the Medicare Home Health Agency (HHA) **Conditions of Participation of Acceptance of Patients, POC, Med Super (42 CFR 484.18), Skilled Nursing Services (42 CFR 484.30) and Comprehensive Assessment of Patients (42 CFR 484.55)**. To participate as a provider of services in the Medicare Program, a HHA must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

The deficiencies, which caused these conditions to be unmet, substantially limit the capacity of Life's Doors Home Health & Hospice, to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). Enclosed, also, is a similar form describing State licensure deficiencies.

You have an opportunity to make corrections of those deficiencies, which led to the finding of non-compliance with the Condition of Participation referenced above by submitting a written Credible Allegation of Compliance/Plan of Correction.

An acceptable Plan of Correction 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;

Daniel Walker, Administrator
July 28, 2014
Page 2 of 2

- 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 each form.

Such corrections must be achieved and compliance verified by this office, before August 25, 2014. To allow time for a revisit to verify corrections prior to that date, it is important that the completion dates on your Credible Allegation/Plan of Correction show compliance no later than August 17, 2014.

Please complete your Allegation of Compliance/Plans of Correction and submit to this office by August 10, 2014.

Failure to correct the deficiencies and achieve compliance will result in our recommending that CMS terminate your approval to participate in the Medicare Program. If you fail to notify us, we will assume you have not corrected.

In accordance with 42 CFR 488.745, you have one opportunity to question the deficiencies which resulted in the Condition(s) of Participation being found out of compliance through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in the attached document.

This request must be received by **August 10, 2014**. If your request for informal dispute resolution is received after **August 10, 2014**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

We urge you to begin correction immediately.

If you have any questions regarding this letter or the enclosed reports, please contact me at (208) 334-6626.

Sincerely,



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/pmt
Enclosures

cc: Debra Ransom, R.N., R.H.I.T., Bureau Chief
Kate Mitchell, CMS Region X Office

Life's Doors

Life's Doors Home Health & Hospice
Daniel Walker, Administrator
63 W. Willowbrook Dr.
Meridian, ID 83646
208-334-6500

July 31, 2014

Bureau of Facility Standards
Attn: Sylvia Creswell
3232 Elder Street
PO Box 83720
Boise, ID 83720-0009

Re: CREDIBLE ALLEGATION OF COMPLIANCE/PLAN OF CORRECTION

Dear Ms. Creswell,

Pursuant to the survey completed at Life's Doors Home Health on July 11, 2014, please find attached the completed Statement of Deficiencies/Plan of Correction (CMS2567) along with attachments that give further evidence that Life's Doors Home Health complies with the Conditions of Participation.

As evidenced in the Plan of Correction and the enclosures, we have and will continue to conduct full staff education in each of the deficiencies cited and will continue to maintain evidence of compliance through chart audits and supervisory visits. The enclosures will speak to our compliance with the Conditions of Participation and include:

- Organizational Chart
- Roster of Qualifying Staff
- Staff Training Outlines
 - Medication Reconciliation
 - Education on Vital Sign, Oxygen, and Blood Glucose Parameters
 - Comprehensive Assessment
 - Policy 2-007.1 Initial and Comprehensive Assessment
 - Skin Care – Pressure Ulcer Prevention, Skin Integrity Preservation
 - Policy 2-025.1 Care Coordination
 - Policy 2-049.1 Patient Education
 - Policy 1-010.1 Complaint/Grievance Process

RECEIVED

AUG - 5 2014

FACILITY STANDARDS

Life's Doors Home Health
63 W Willowbrook Dr
Meridian, ID 83646
Phone: (208) 639-8880
Fax: (208) 344-6590

Life's Doors Hospice
63 W Willowbrook Dr
Meridian, ID 83646
Phone: (208) 344-6500
Fax: (208) 344-6590

- Duties of the Registered Nurse Case Manager
- Policy 1-002.1, Informed Consent/Refusal of Treatment
- Policy 2-049.1 Safe/Effective Use of Equipment and Supplies
- Policy 10-003.1 Home PT/INR Testing
- Policy 2-018.1 Care Planning Process
- Policy 2-011.1 Nutritional Assessment
- Policy 2-0.29.1 Monitoring Patient's Response/Reporting to Physician
- Policy 1-003.1 Financial Responsibility and Medicare Written Notices

In the event that you need additional information, please do not hesitate to contact me at 334-6500 or by email at dwalker@ensigngroup.net.

Please express our appreciation for the professionalism and helpfulness demonstrated by Susan Costa RN, Nancy Bax RN, and Laura Thompson RN during the conduction of our survey.

Sincerely,

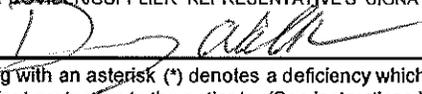


Daniel Walker
Administrator
Life's Doors Home Health & Hospice

Enclosures
cc: files

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

PRINTED: 07/28/2014
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 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646	
(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)
G 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the Medicare recertification survey of your home health agency completed 7/07/14 - 7/11/14.</p> <p>The surveyors conducting the recertification were:</p> <p>Susan Costa RN, HFS, Team Lead Nancy Bax RN, BSN, HFS Laura Thompson, RN, BSN, HFS</p> <p>Acronyms used in this report include:</p> <p>ALF - Assisted Living Facility BG - Blood Glucose CHF - Congestive Heart Failure CHOW - Change of Ownership CKD - Chronic Kidney Disease CM - Case Manager CMS - Centers for Medicare and Medicaid Services CNA - Certified Nurse Aide COPD - Chronic Obstructive Pulmonary Disease OM - Diabetes Mellitus OM II - Type 2 Diabetes Mellitus DME - Durable Medical Equipment DON - Director of Nursing HHA - Home Health Aide HTN - Hypertension LPN - Licensed Practical Nurse MSW - Masters of Social Work OASIS - Outcome and Assessment Information Set OT - Occupational Therapy POC - Plan of Care PT - Physical Therapy RN - Registered Nurse SN - Skilled Nursing</p>	G 000	<p style="text-align: center;">RECEIVED AUG - 7 2014 FACILITY STANDARDS</p>
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	
		Administrator	

(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: 07/28/2014
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 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646	
(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	Continued From page 1 SOC - Start of Care	G 000		
G 107	484.10(b)(5) EXERCISE OF RIGHTS AND RESPECT FOR PROP 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. 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 (#10) who complained she was dissatisfied with care provided by a Home Health Aide, and whose record was reviewed. This prevented the agency from evaluating the care of patients who perceived problems with care. Findings include: An agency policy titled "COMPLAINTS AND GRIEVANCES," revised April 2014, stated: "Any difference of opinion, dispute, or controversy between a patient or family/caregiver or patient representative and Life's Doors Home Health and Hospice concerning any aspect of services or the application of policies or procedures will be considered a grievance." The agency did not investigate a complaint as follows:	G 107	G107 PLAN: Director of Nursing will conduct in-service program on complaint/occurrence reporting and investigating by 8-6-14. Instructing the SN/PT/OT/ST and home health aide on supervision documentation within the electronic documentation system and use of paper forms when required. Instruction will also include the definition of a complaint, occurrence, dispute, difference of opinion, and controversy as well as requirements to report complaint to their immediate supervisor and Director of Nursing. Director of Nursing or designee will review 100% Home Health Aide Supervisory notes through the Performance Improvement Program until the agency achieves 100% compliance. Ongoing the Agency will review quarterly through the clinical auditing process, auditing 10% of the clinical records based on the average daily census, 50% active and 50% inactive. Responsible: Director of Nursing has overall responsibility for the corrective action and ongoing completion of this standard. Completion: 8/06/14	

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

PRINTED: 07/28/2014
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 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646	
(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' Continued From page 2

Patient #10's medical record documented a 72 year old female who received home health services from 3/14/14 to 5/12/14. HHA supervision by the RN was documented on 03/19/14. The following two examples indicate the RN identified concerns related to the patient's dissatisfaction with care provided by her HHA:

a. A "SKILLED NURSING VISIT NOTE" dated 4/22/14 at 4:00 PM, included a HHA supervisory visit by the RN. The form documented the HHA was not present at the time of the nursing visit, and Patient #10 answered "No" when questioned if she was satisfied with her care. No further details were provided in the nursing note.

b. A "SKILLED NURSING VISIT NOTE" dated 4/29/14 at 2:05 PM, included a HHA supervisory visit by the RN. The form documented the HHA was not present at the time of the nursing visit, and Patient #10 answered "No" when questioned if she was satisfied with her care. No further details were provided in the nursing note.

The record did not indicate investigation of the complaint verbalized by Patient #10 had occurred.

During an interview on 7/11/14 at 9:30 AM, the DON reviewed Patient #10's record and confirmed the RN documented Patient #10 was unsatisfied with care by the HHA. She confirmed the RN and the agency did not follow up the concerns expressed by Patient #10. The DON further stated the RN did not communicate Patient #10's concerns to her, and the RN no longer worked with the agency.

The agency did not acknowledge Patient #10's

G 107

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

PRINTED: 07/28/2014
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 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646		
(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 CORRECTJON (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 107 G 109	<p>Continued From page 3 dissatisfaction with care provided by the HHA, and did not respond to her concerns.</p> <p>484.10(c)(2) RIGHT TO BE INFORMED AND PARTICIPATE</p> <p>The patient has the right to participate in the planning of the care.</p> <p>The HHA must advise the patient in advance of the right to participate in planning the care or treatment and in planning changes in the care or treatment.</p> <p>This STANDARD is not met as evidenced by: Based on review of patient medical records and staff interview, it was determined the agency failed to ensure patients were fully informed of their rights to appeal a discharge from home health services for 1 of 3 patients (#7) who were Medicare beneficiaries and whose closed records were reviewed. This had the potential for services to be terminated before the patients' ability to appeal the discharge. Findings include:</p> <p>The Medicare Claims Processing Manual, Chapter 30, includes direction to the provider related to the delivery of the "Notice of Medicare Non-Coverage" (NOMNC) form. Section. 260.2.1 includes "The provider must ensure that the beneficiary or representative signs and dates the NOMNC to demonstrate that the beneficiary or representative received the notice and understands that the termination decision can be disputed." Section 260.3.4, Required Delivery Timeframes, states "The NOMNC should be delivered to the beneficiary at least two calendar days before Medicare covered services end or</p>	G 107 G 109	<p>G109 PLAN: by 8-8-14 Director of Nursing will conduct in-service program on provision of the Notice of Medicare Provider Non-Coverage (NOMNC) form. Instruction for all discharging disciplines on Policy 1-003 "Financial Responsibility and Medicare Written Notice." Instruction to include the parameters of delivering the "Notice of Medicare Provider Non-Coverage" form to the patient, at least 2 days prior to discharge, instructing the patient how they may contact the QIO. Instruction also to be given on other payor types that require an Expedited Determination Notice, such as the Blue Cross/Blue Shield Payors. A " Buddy Code" has been added to the Electronic Documentation System to be attached to the next to the last visit (at least 2 days prior to discharge) to queue the clinician to deliver the NOMNC form at that visit.</p> <p>Director of Nursing or designee will review 100% of all patient discharges for the completion of the Notice of Medicare Provider Non-Coverage and that it has been provided to patients at least 2 days prior to discharge from home health services through the Performance Improvement Program until the agency achieves 100% compliance,. Agency will then review quarterly through the clinical auditing process, auditing 10% of the clinical records based on the average daily census, 50% active and 50% inactive.</p>	

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

PRINTED: 07/28/2014
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 _____ 8. WING _____	(X3) DATE SURVEY COMPLETED 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646	
(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)	(X5) COMPLETION DATE
G 109	Continued From page 4 the second to last day of services if care is not being provided daily." Patient #7 was a 70 year old male admitted to the agency on 4/24/14, for PT services related to cerebral vascular accident. Additional diagnoses included hemiplegia, occlusion and stenosis vertebral artery, DM Type II, hypertension, hyperlipidemia, history of fall, long-term use of insulin. He was discharged from the agency on 5/29/14. Prior to his discharge he was receiving PT services 2 times per week. Patient #'s record for the certification period 4/24/14 to 6/22/14 was reviewed and the following was noted: -The form "NOTICE OF MEDICARE NON-COVERAGE," noted Patient #'s home health services would end on 5/29/14. It was signed and dated by Patient #7 on 5/29/14. During an interview on 7/11/14 at 9:15 AM, the Therapy Coordinator reviewed Patient #'s record and confirmed he was not informed the second to last day of services of his right to dispute termination of services.	G109	Responsible: Director of Nursing Completion: 8/8/14	
G 114	484.10(e)(1)(i-iii) PATIENT LIABILITY FOR PAYMENT Before the care is initiated, the HHA must inform the patient, orally and in writing, of: (i) The extent to which payment may be expected from Medicare, Medicaid, or any other Federally	G114	G114 PLAN: Upon intake, all private insurance will be verified, initial authorization obtained, and patient notification will occur per regulations. Patient/caregiver will be notified prior to admission, of insurance coverage, patient's	

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

PRINTED: 07/28/2014
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 07/11/2014	
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646		
(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 114	<p>Continued From page 5</p> <p>funded or aided program known to the HHA; (ii) The charges for services that will not be covered by Medicare; and (iii) The charges that the individual may have to pay.</p> <p>This STANDARD is not met as evidenced by: Based on review of medical records and interviews with staff and patients, it was determined the agency failed to ensure patients were informed in writing of home health charges they might have to pay for 7 of 10 patients (#3 - #9) whose records were reviewed. This resulted in patients not being fully informed of financial liability that could have impacted decision-making regarding accepting or refusing home health services. Findings include:</p> <p>An agency policy titled "FINANCIAL RESPONSIBILITY AND MEDICARE WRITTEN NOTICES," revised April 2014, stated "To outline the process by which patients, families and caregivers will understand their financial responsibility for home health services. Upon admission, the admitting clinician will inform the patient and/or his/her representative of his/her payment responsibilities for home health services. The patient will be informed of any subsequent changes in his/her financial responsibility." The agency did not inform patients of their financial liability as follows:</p> <p>1. Patient #6 was a 65 year old female with a SOC of 6/13/14. The "ADMISSION CONSENT," signed and dated 6/13/14, had a section which read "ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITY," that authorized payments directly to the agency, but did not include</p>	G 114	<p>responsibility for copayment, charges and financial responsibility for home health services. Financially responsibility form to be completed and presented to the patient at the time of admission with the actual copays if known, if not known the total organizational charges will be provided until more accurate information can be obtained from the payer. Patients who incur further financial liability during an episode of care will be notified in writing within 30 calendar days from the date Life's Doors Home Health is notified of any changes from payers.</p> <p>Director of Nursing/Administrator will review the internal office process and instruct the intake department and admitting disciplines on the authorization process, patient notification of financial responsibility, documentation of provision of financial responsibility, and Policy 1-002.1, Informed Consent/Refusal of Treatment – Policy 2-005.1 Admission Criteria and Process by 8-15-14.</p> <p>Electronic Consents will be added to the electronic documentation system that allows the clinicians to populate the financial responsibility directly into the consents that are then automatically saved in the electronic medical record. The admitting clinician will explain this information verbally and in writing. The patient will be given a hard copy of this form with the specific financial responsibility documented for their records. Completion date: 8/15/14</p> <p>Director of Nursing or Designee will review 100% of all admissions for the completion of the financial responsibility notification for home health services</p>	

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

PRINTED: 07/28/2014
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 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646	
(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 114	<p>Continued From page 6 information of patient financial liability.</p> <p>During an interview on 7/11/14 at 9:15 AM, the Physical Therapist who completed the SOC assessment and witnessed the consents signed by Patient #6 reviewed her record and confirmed the consent form did not include patient financial liability. He stated he did not routinely talk with patients about their financial responsibility and assumed that Medicare would pay the entire amount.</p> <p>Patient #6 was not informed in writing of potential financial liability before services were provided.</p> <p>2. Patient #5 was a 75 year old female with a SOC of 5/27/14. The "PATIENT CONSENT, ACKNOWLEDGEMENT & SERVICE AGREEMENT," signed and dated 5/27/14, had a section which read "FINANCIAL RESPONSIBILITY," that authorized payments directly to the agency, but did not include information of patient financial liability,</p> <p>During an interview on 7/10/14 at 2:45 PM, the RN Case Manager reviewed Patient #5's record and confirmed the consent form did not include patient financial liability. She stated she did not receive direction from the business office regarding patient liability.</p> <p>Patient #5 was not informed in writing of potential financial liability before services were provided.</p> <p>3, Patient #3 was a 54 year old male with a SOC of 5/29/14, The "PATIENT CONSENT, ACKNOWLEDGEMENT & SERVICE AGREEMENT," signed and dated 5/29/14, had a section which read "FINANCIAL</p>	G 114	<p>through the Performance Improvement Program until the agency achieves 100% compliance. Ongoing the Agency will review quarterly through the clinical auditing process, auditing 10% of the clinical records based on the average daily census, 50% active and 50% inactive.</p> <p>Responsible: Director of Nursing/Administrator</p> <p>Completion: 8/15/14</p>

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

PRINTED: 07/28/2014
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 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646	
(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)
G 114	<p>Continued From page 7</p> <p>RESPONSIBILITY" that authorized payments directly to the agency, but did not include information of patient financial liability.</p> <p>During an interview on 7/11/14 at 9:15 AM, the DON reviewed Patient #3's record and confirmed he was not informed of charges he may have had to pay.</p> <p>Patient #3 was not informed in writing of potential financial liability before services were provided.</p> <p>4. Patient #7 was a 70 year old male with a SOC of 4/24/14. The "PATIENT CONSENT, ACKNOWLEDGEMENT & SERVICE AGREEMENT," signed and dated 4/24/14, had a section which read "FINANCIAL RESPONSIBILITY" that authorized payments directly to the agency however, the form did not include information of patient financial liability.</p> <p>During an interview on 7/11/14 at 9:15 AM, the DON reviewed Patient #Ts record and confirmed he was not informed of charges he may have had to pay.</p> <p>Patient #7 was not informed in writing of potential financial liability before services were provided.</p> <p>5. Patient #9 was a 74 year old female with a SOC of 1/13/14. The "ADMISSION CONSENT," had a section which read, "ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITY," that authorized payments directly to the agency, but did not include information of patient financial liability. The "BILLING SOURCE AND PATIENT RESPONSIBILITY," signed and dated 1/13/14, had a section which authorized payments directly to the agency and had a section which read</p>	G 114	

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

PRINTED: 07/28/2014
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 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646	
(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 1141	<p>Continued From page 8</p> <p>"HEALTH INSURANCE", that informed Patient #9 of the percentage to be paid by her insurance, and the percentage of her responsibility. The amounts were left blank with no information regarding Patient #9's financial liability.</p> <p>During an interview on 7/11/14 at 9:15 AM, the DON reviewed Patient #9's record and confirmed she was not informed of charges she may have had to pay.</p> <p>Patient #9 was not informed in writing of potential financial liability before services were provided.</p> <p>6. Patient #8 was a 96 year old female with a SOC of 6/07/14. The "ADMISSION CONSENT," signed and dated 6/07/14, had a section which read "ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITY," that authorized payments directly to the agency, but did not include information of patient financial liability.</p> <p>During an interview on 7/10/14 beginning at 2:15 PM, the RN who completed the SOC assessment and witnessed the consents signed for Patient #8 reviewed her record and confirmed the consent form did not include patient financial liability. She stated she did not routinely talk with patients about their financial responsibility and assumed that Medicare would pay the entire amount.</p> <p>Patient #8 was not informed in writing of potential financial liability before services were provided.</p> <p>7. Patient #4 was a 78 year old female with a SOC of 7/01/14. The "ADMISSION CONSENT," signed and dated 7/01/14, had a section which read "ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITY," that authorized payments</p>	G 114	

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

PRINTED: 07/28/2014
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 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID83646		
(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 114	Continued From page 9 directly to the agency, but did not include information of patient financial liability. During an interview on 7/10/14 beginning at 2:15 PM, the RN who completed the SOC assessment and witnessed the consents signed for Patient #8 reviewed her record and confirmed the consent form did not include patient financial liability. She stated she did not routinely talk with patients about their financial responsibility and assumed that Medicare would pay the entire amount. Patient #4 was not informed in writing of potential financial liability before services were provided. The agency did not ensure patients were fully informed of financial liability.	G 114			
G 127	484.14(a) SERVICES FURNISHED Part-time or intermittent skilled nursing services and at least one other therapeutic service (physical, speech or occupational therapy; medical social services; or home health aide services) are made available on a visiting basis, in a place of residence used as a patient's home. An HHA must provide at least one of the qualifying services directly through agency employees, but may provide the second qualifying service and additional services under arrangements with another agency or organization. This STANDARD is not met as evidenced by: Based on staff interview and review of personnel files, it was determined the agency failed to ensure at least one of its qualifying services was	G 127	G127 PLAN: Agency Administration has identified; Skilled Nursing, Home Health Aide and Master of Social Work as the qualifying services of Life's Door Home Health. Employees are directly employed by Life's Door Home Health. Responsible: Administrator and Director of Nursing have overall responsibility for the corrective action and ongoing completion of this standard. Completed 7/14/14.		

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

PRINTED: 07/28/2014
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 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 63 WILLOWBROOK DR MERIDIAN, ID 83646	
(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 127	<p>Continued From page 10</p> <p>provided directly through agency employees for 7 of 10 patients (#3-#8, and #10) whose records were reviewed. This resulted in the lack of direct employees providing services. Findings include:</p> <p>A policy titled "SERVICES PROVIDED," revised April 2014, stated "At least one (1) home health qualifying service (nursing, physical therapy, occupational therapy, speech therapy, medical social services, or home health aide services) will be provided directly by organization staff."</p> <p>A list of agency clinical staff was requested during the entrance conference with the agency Administrator on 7/07/14 at 9:00 AM. The Administrator provided a list of 31 individuals that provided direct patient care. The list identified 3 employees of the agency as a CNA, an RN, and a MSW. Additionally, the Administrator and the DON were on the list. The remaining individuals were identified as employees of another home health agency under common ownership or a therapy group which provided contracted services to the agency.</p> <p>The medical records of patients who were provided services after a CHOW which occurred on April 1, 2014, were reviewed. The records reviewed were those of Patients #3-#8 and #10. Each patient's record documented patient care was provided by employees from the agency, as well as, the contracted agencies. Nursing services were provided by both the Life's Doors RNs and contracted RN's and LPN's. The SOC assessments were performed by the contracted RN's and physical therapists. The CNA identified as being on staff at Life's Doors had not provided services to Life's Doors patients. CNAs providing services to Life's Doors patients were on contract</p>	G 127		

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

PRINTED: 07/28/2014
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 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646	
(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 127	Continued From page 11 from the other agency. The MSW identified as being on staff at Life's Doors, was also a contracted employee from the other agency. During an interview on 7/10/14, beginning at 1:30 PM, the Administrator confirmed the agency did not provide one service in its entirety by Life's Doors agency staff. The agency failed to ensure at least one service was provided directly by agency staff.	G 127		
G 143	484.14(g) COORDINATION OF PATIENT SERVICES All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. 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 care coordination between disciplines for 3 of 10 patients (#3, #5, and #10) who received services from more than one discipline. This interfered with quality and continuity of patient care and resulted in a repeat deficiency. Findings include: 1. Patient #3 was a 54 year old male admitted to the agency on 5/29/14, for services related to non-healing surgical wounds. Additional diagnoses included complication of cystostomy, OM Type II, polyneuropathy, bipolar disorder, anxiety, Hepatitis C, HTN, colostomy, urinary device, lower limb amputation, cerebral infarct and transient ischemic attack. He received SN,	G 143	G143 PLAN (Part A): Director of Nursing or designees to provide in-service to all staff; office and field staff by 8/6/2014, regarding documentation of patient coordination, including review of Policy 2-025 "Care Coordination", correct use of hard copy forms when needed, scanning of forms into the patient's electronic record, documentation within the electronic documentation system utilizing the patient care coordination note to relay pertinent patient information to other clinicians or to document information relayed to the specific clinician/office personnel documenting. Case Conference notes will be entered on the date held and will include progression to goals, disciplines required and interventions provided as well as the skilled need of the patient. The electronic documentation system has been updated on 7-13-14 to include prompts in the "Care Coordination" section to include: 1. Discipline coordinated with 2. Date coordination occurred 3. What was discussed	

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

PRINTED: 07/28/2014
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 07/11/2014	
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646		
(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 143	<p>Continued From page 12 HHA and PT services.</p> <p>a. Patient #3's record included a "Visit Note Report" dated 6/11/14, and signed by an LPN. The visit note included a fasting blood sugar result of 246 mg/di. The note stated the patient checked his blood sugar levels three times a day and results ranged from 90-350 mg/di.</p> <p>The American Diabetes Association suggests the following targets for adults with diabetes:</p> <ul style="list-style-type: none"> - Before a meal: 70-130 mg/di - 1-2 hours after a meal: Less than 180 mg/di <p>Patient #3's record did not include documentation the RN Case Manager was notified of his elevated blood sugar result levels.</p> <p>During an interview on 7/09/14 at 1:40 PM, the RN Case Manager reviewed Patient #3's record and confirmed she was not notified of the elevated blood sugar results.</p> <p>The LPN did not communicate abnormal blood sugar readings to Patient #3's RN Case Manager.</p> <p>b. The RN Case Manager did not coordinate Patient #3's care with his physician to ensure his needs were met, as follows:</p> <ul style="list-style-type: none"> - Upon referral for home health services the agency on 5/29/14, the agency received a list of Patient #3's medications from his physician's office. The list included Xarelto, an anticoagulant medication used to prevent blood clots. <p>Upon referral for home health services on</p>	G 143	<p>A note type titled "Coordination of Care" has been added to the electronic documentation system for clearer documentation of coordination. Director of Nursing or designee will review quarterly through the clinical auditing process, auditing 10% of the clinical records based on the average daily census, 50% active and 50% inactive.</p> <p>Responsible: Director of Nursing has overall responsibility for the corrective action and ongoing completion of this standard.</p> <p>Completion: 8/6/14</p>	

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

PRINTED: 07/28/2014
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 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646	

(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 143

Continued From page 13

5/29/14, the agency received a list of Patient #3's medications from his physician's office. The list included Xarelto, an anticoagulant medication used to prevent blood clots.

Patient #3's POC for the certification period 5/29/14 - 7/27/14, did not include Xarelto. An untitled document in his record which listed Patient 3's medication, signed by the RN at SOC on 5/29/14, included documentation that Patient #3 refused to take the medication. However, there was no documentation indicating his physician was notified of his refusal.

During an interview on 7/10/14 at 2:35 PM, the RN who completed Patient #3's SOC assessment confirmed she did not notify his physician of his refusal to take Xarelto.

- Patient #3's POC included orders for sliding scale insulin (dose of insulin based on blood glucose levels) to be administered three times a day.

The 5/29/14 SOC assessment did not include documentation of Patient #3's ability to manage his insulin dosing.

During an interview on 7/09/14 at 2:35 PM, the RN who completed Patient #3's SOC assessment on 5/29/14, stated Patient #3 did not have his insulin at the time of her visit. She confirmed she did not inform Patient #3's physician that he did not have insulin available to comply with the sliding scale orders.

- Life's Doors Home Health and Hospice procedure, Section 6-9, titled "Endocrine: Hyperglycemia" states, "The MD should be

G 143

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

PRINTED: 07/28/2014
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 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646	
(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)
G 143	<p>Continued From page 14 notified for blood glucose levels greater than 200 mg/di unless the MD has previously ordered parameters".</p> <p>Patient #3's record included a "Visit Note Report" dated 6/05/14, and signed by the RN Case Manager. The visit note included a fasting blood sugar result of 209 mg/di. The note stated the patient checked his blood sugar levels daily and results ranged from 130-270 mg/di. There was no documentation to indicate the physician was notified of Patient #3's elevated blood sugar levels.</p> <p>Patient #3's record included a "Visit Note Report" dated 6/30/14, and signed by the RN Case Manager. The note stated the patient checked his blood sugar levels daily and results ranged from 77-272 mg/di. There was no documentation to indicate the physician was notified of Patient #3's elevated blood sugar levels.</p> <p>Patient #3's record included a "Visit Note Report" dated 7/08/14, and signed by the RN Case Manager. The note stated the patient checked his blood sugar levels daily and results ranged from 222-300 mg/di. There was no documentation to indicate the physician was notified of Patient #3's elevated blood sugar levels.</p> <p>During an interview on 7/09/14 at 1:40 PM, the RN Case Manager reviewed Patient #3's record and confirmed his physician had not been informed of his elevated blood sugars.</p> <p>- Patient #3's sliding scale insulin order required him to use a glucometer to check his blood sugar</p>	G 143	

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

PRINTED: 07/28/2014
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER: 137114	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646	
(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 143	<p>Continued From page 15</p> <p>level three times a day to determine the dose of insulin to be injected.</p> <p>Patient #3's record included a "Visit Note Report" dated 7/08/14, and signed by the RN Case Manager. The narrative section of the note included, "Pt stated that his glucometer recently broke. Pt stated that he has ordered a new one." There was no documentation to indicate the physician was notified of Patient #3's inability to check his blood sugar level and take his insulin as ordered.</p> <p>During an interview on 7/09/14 at 1:40 PM, the RN Case Manager reviewed Patient #3's record and confirmed his physician had not been informed he was unable to check his blood sugar level and take his insulin accordingly.</p> <p>The RN Case Manager did not effectively coordinate Patient #3's care with his physician to ensure his needs were met</p> <p>2. Patient #10 was a 72 year old female admitted on 3/14/14 for SN, PT, HHA, and OT services related to surgical complications. Additional diagnoses included acute myocardial infarction , non-healing surgical wound, OM Type II uncontrolled, chronic skin ulcer, obstructive chronic bronchitis with acute exacerbation.</p> <p>a. Patient #10's POC, for the certification period 3/14/14 to 5/12/14, was reviewed. It did not include orders for oxygen therapy.</p> <p>In a SN visit note, dated 4/7/14, the RN documented Patient #10's oxygen saturations were 87% at 1.5 liters per minute. There was no documentation of communication with the</p>	G 143		

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

PRINTED: 07/28/2014
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 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646	
(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 143	<p>Continued From page 16</p> <p>physician to obtain an order for the oxygen or to obtain parameters. Visit notes dated 4/10/14, 4/14/14, 4/15/14, and 4/25/14 indicated Patient #10 was receiving oxygen therapy, however, twelve other visit notes did not indicate if Patient #12 was on oxygen.</p> <p>During an interview, on 7/11/14 at 9:30 AM, the DON reviewed Patient #10's record and confirmed there was no documented communication with the physician. She stated Patient #10's oxygen saturation levels were outside of the agency's accepted parameters.</p> <p>The agency did not clarify oxygen orders with the physician and notify the physician of decreased oxygen saturation levels.</p> <p>b. Patient #10's POC, for the certification period 3/14/14 to 5/12/14, was reviewed and the following was noted:</p> <ul style="list-style-type: none"> - In a PT note, dated 4/14/14 at 8:45 AM, the therapist documented he spoke with the RN Case Manager to inform her that Patient #10 was vomiting her medications. He documented the RN Case Manager was going to call the physician. However, the nurse visit note, documented by the RN Case Manager on 4/14/14 at 12:35 PM, did not indicate the RN Case Manager spoke with the therapist, evaluated Patient #10's vomiting, or contacted her physician. - In a PT note, dated 4/23/14 at 10:10 AM, the therapist documented he spoke with the RN Case Manager regarding Patient #10's low blood pressure measurement during his visit, and her 	G 143	<p>G143 PLAN (Part B):</p> <p>Director of Nursing or designee will instruct all staff by 8/15/2014 on the completion of the 485 plan of care to include all diagnosis pertinent to the care of the patient's current plan of care, DME equipment; i.e. wheelchairs, walkers, hospital beds. Oxygen to be included on all relevant plans of care, including the medication profile with the liter per minute and if the use is intermittent or continuous. For patients being followed by more than one physician, staff will be instructed that all secondary ordering physicians must be listed on the patients' plan of care in locator 21. Office staff will be instructed to send a copy of the 485 to the secondary physicians identified.</p> <p>Director of Nursing will review 100% of all 485 plans of care; diagnosis, equipment, patient use of oxygen and secondary physician(s) until 100% compliance is achieved. Ongoing Director of Nursing or designee will review quarterly through the clinical auditing process, auditing 10% of the clinical records based on the average daily census, 50% active and 50% inactive.</p> <p>Responsible: Director of Nursing has overall responsibility for the corrective action and ongoing completion of this standard.</p> <p>Completion: 8/15/14</p>	

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

PRINTED: 07/28/2014
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 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646		
(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 143	<p>Continued From page 17</p> <p>complaint of nausea. Patient #10's medical record was reviewed for documentation the RN Case Manager was aware of Patient #10's low blood pressure or nausea. None was found. There was no documentation Patient #10's physician was notified.</p> <p>- In a PT note, dated 4/28/14 at 8:40 AM, the therapist documented he informed the RN Case Manager that Patient #10 had diarrhea over the weekend. However, a nursing visit note documented by the RN Case Manager on 4/29/14 at 2:05 PM, did not indicate Patient #10 was assessed for her complaint of diarrhea over the weekend or her bowel status during the visit.</p> <p>- In a PT note, dated 5/5/14 at 8:40 AM, the therapist documented he informed the RN Case Manager of Patient #10's blood sugar of 70. He documented the RN Case Manager was to call Patient #10's son. Patient #10's record did not indicate the RN Case Manager contacted Patient #10's son regarding the low blood sugar result.</p> <p>During an interview on 7/09/14 beginning at 4:00 PM, the DON reviewed Patient #10's medical record and confirmed the documentation by the physical therapist. She confirmed the notes indicated communication occurred from the therapist to the RN Case Manager, but not from the Case Manager to Patient #10's physician. The DON stated the RN Case Manager was no longer employed by the agency.</p> <p>The RN did not coordinate Patient #10's care with his physician.</p> <p>3. Patient #5 was a 75 year old female admitted</p>	G 143		

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

PRINTED: 07/28/2014
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 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 63 WWILLOWBROOK DR MERIDIAN, ID 83646		
(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 143	Continued From page 18 to the agency on 5/27/14 for SN services related to COPD, weakness, CKD, and HTN. The POC for the certification period 5/27/14 to 7/25/14, included nursing services once weekly for 6 weeks. Patient #5's record included 3 nursing visits of the 6 ordered. There were no visits for weeks 3, 4, and 6. The record did not indicate why the nursing visits did not occur, and there was no documentation the physician was notified Patient #5's POC was not implemented as ordered and why. During an interview on 7/09/14 at 3:40 PM, the DON reviewed Patient #5's record and confirmed the missed visits. She stated there was a delay in obtaining insurance authorization, so the agency approved the first 2 visits. The DON stated Patient #5 requested no further nursing visits until authorization from her insurance as she did not want to be financially responsible if the insurance was denied. The DON stated the agency approved the nurse to see Patient #5 for an additional visit on 6/26/14, although the insurance company had still not authorized care. The DON stated the agency approved the nursing visit because they did not want Patient #5 to go an additional week without being seen. The DON confirmed there were no case conference notes, documentation of physician notification, or other documentation of the missed visits or the reason for the missed visits. Patient #5's care was not coordinated with her physician.	G 143			
G 156	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER	G 156	G156 PLAN: Upon intake the agency will verify with the patient's primary care physician, his/her agreement to follow the		

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

PRINTED: 07/28/2014
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 _____ 8. WING _____	(X3) DATE SURVEY COMPLETED 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646	
(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 156	Continued From page 19 This CONDITION is not met as evidenced by: Based on observation, patient interview, medical record review, policy review, and staff interview, it was determined the agency failed to ensure care was provided in accordance with patients' POCs, that the POCs included all pertinent information, and the physician was notified if the POCs were altered or patients' conditions changed. This resulted in unmet patient needs, negative patient outcomes, and care provided without physician authorization. Findings include: 1. Refer to G158 as it relates to the failure of the agency to notify physicians when the POC for patients was altered by missed visits or not otherwise followed. 2. Refer to G159 as it relates to the failure of the agency to ensure all pertinent information was included in patients' POCs. 3. Refer to G160 as it relates to the failure of the agency to consult the physician to approve the POC. 4. Refer to G164 as it relates to the failure of the agency to notify the physician with changes in patients' conditions. The cumulative effect of these negative systemic practices impeded the ability of the agency to provide care of sufficient scope and quality.	G 156	patient on service, sign the 485 (plan of care), all supplemental orders, accept communication from clinicians in reference to the patient. If the patient does not have a primary care physician or the identified physician is not willing to accept the responsibility of signing the plan of care or supplemental orders, the agency cannot admit the patient to service. If the agency receives notification from a physician refusing to follow a patient, the patient will be immediately notified. The patient must have obtained another primary care physician within 1 week who gives approval for continued home health services. If the patient is unable to obtain a primary care physician, discharge planning must be implemented. Director of Nursing or Designee will review 100% of all intake referrals for clinical appropriateness, review for an identified and accepting physician, and then sign off on all potential admissions. Responsible: Administrator and Director of Nursing have overall responsibility for the corrective action and ongoing completion of this standard. Completed: 7/11/14	
G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER	G 158	G 158 Plan: Director of Nursing or Designee will instruct all disciplines	

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

PRINTED: 07/28/2014
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 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83846	
(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 20</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, observation, and patient and staff interview, it was determined the agency failed to ensure care followed a physician's written plan of care for 4 of 10 patients (#3, #5, #9, and #10) whose records were reviewed. This resulted in unauthorized treatments, as well as, omissions of care. Findings include:</p> <p>1. Patient #3 was a 54 year old male admitted to the agency on 5/29/14, for services related to non-healing surgical wounds. Additional diagnoses included complication of cystostomy, OM Type II, polyneuropathy, bipolar disorder, anxiety, Hepatitis C, HTN, colostomy, urinary device, lower limb amputation, cerebral infarct and transient ischemic attack. He received SN, HHA and PT services.</p> <p>Patient #3's POC for the certification period 5/29/14 - 7/27/14, was reviewed. Patient #3's POC established by his physician was not followed. Examples include:</p> <p>a. Patient #3's POC included an order for monthly SP (supra-pubic) catheter changes, with the first catheter change due on 6/19/14.</p> <p>Patient #3's record included an SN visit report dated 6/13/14, and signed by an RN. The note documented she removed Patient #3's SP catheter and inserted a new SP catheter.</p>	G 158	<p>providing skilled care on the establishment of the patient's plan of care, following the plan of care, notifying the physician when changes to the plan of care are required, obtaining supplemental/verbal orders – timeliness of transmission of orders, patient care coordination among team members. Staff to receive instruction on how to write complete orders with the date the order was received – the effective date, the purpose of the order, frequency and duration if related to visits, wound care orders to include the type of wound, location of the wound, the procedure of treating the wound and dressings. Staff to be instructed if they have not done a procedure in the field – they are to notify the office immediately for assistance. Staff to be instructed that with each visit all teaching addressed on the patient's plan of care must be addressed at each visit. Staff to be instructed that all parameters written within the plan of care must be followed each visit, and orders/interventions must indicate who is to perform the task, i.e. is the SN to perform the blood sugar each visit or is the patient, if the SN has an order to instruct the patient to record his blood sugar and the nurse is to send the readings to the MD – this should be noted in the clinical notes as completed with notation of readings, etc. Instruction to be provided to staff to adhere to the frequencies and duration of visits established in the plan of care and or supplemental orders, all visits require a physician's order and cannot be performed without, visits performed without orders require the clinician to</p>

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

PRINTED: 07/28/2014
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER: 137114	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/11/2014	
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646		
(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)	
G 158	<p>Continued From page 21</p> <p>During an interview on 7/09/14, the RN who completed the visit stated she changed the catheter on 6/13/14, because Patient #3 requested a new catheter.</p> <p>b. Patient #3's POC included orders to educate him regarding wound care to his SP catheter site and his abdominal incision wounds. There was no documentation in the SOC visit note dated 5/29/14, and signed by the RN, to indicate the patient was educated regarding wound care, which was to be completed daily. The next SN visit was documented on 6/02/14.</p> <p>Patient #3's POC, dated 5/29/14, included the following order, "Skilled nurse to perform/teach wound care to incision/suture site located RUQ ABD (right upper quadrant of abdomen). Cleanse with wound cleanser, pack with 1/2" packing gauze. Cover with ABD (dressing). Secure web tape. Using clean/aseptic technique."</p> <p>A visit was made to Patient #3's home, on 7/09/14 at approximately 3:30 PM, to observe a PT visit. Upon arrival it was noted there was no dressing in place to his abdominal wound. When the physical therapist assisted Patient #3 to a sitting position, his abdominal wound began to drain. Patient #3 used a 4x4 gauze dressing to wipe the drainage off his abdomen, then inserted the same dressing into the open area of his abdominal wound. He did not cleanse the wound with wound cleanser or pack it with 1/2 inch gauze as directed in the POC. Patient #3 stated he was not taught to pack his abdominal wound and he was only covering it when it drained.</p> <p>During an interview on 7/09/14 at 2:35 PM, the RN who completed the SOC assessment and</p>	G 158	<p>complete an occurrence report with explanation of why the visits were completed without orders, visits not made to the patient require an explanation of why the visit was missed and documentation of the missed visit, the physician is notified via phone and documented in the coordination notes or the missed visit note is faxed to the physician with fax confirmation attached to the clinical record.</p> <p>Director of Nursing or Designee will review 100% of the clinical records until the clinical audits demonstrate 90% compliance. Ongoing the agency will review, based on the average daily census 50 % of active clinical record and 50 discharge records on a quarterly basis. All variances of indicators of less than 85% will require an action plan of continued auditing until compliance is obtained.</p> <p>Responsible: Director of Nursing</p> <p>Completion: 8/15/14.</p>	(X5) COMPLETION DATE

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

PRINTED: 07/28/2014
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 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646	
(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 22</p> <p>drafted the POC, reviewed Patient #3's record and confirmed there was no documentation of wound care education. She was unable to remember whether she instructed the patient, and unable to explain how the wound care would be completed daily if the patient was not able to do it.</p> <p>c. Patient #3's POC included orders to apply antibiotic ointment to his SP catheter insertion site. The type of antibiotic ointment was not specified in the order and antibiotic ointment was not included in the list of medications on the POC.</p> <p>During an interview, on 7/09/14 at 2:35 PM, the RN who completed the SOC assessment and drafted the POC, reviewed Patient #3's record and confirmed she did not document the specific antibiotic ointment in the wound care order and did not include it in the list of medications.</p> <p>d. Patient #3's record included a SN visit note dated 6/13/14 and signed by an RN. The note documented wound care to the SP catheter insertion site and stated hydrogel (a water based gel) was applied to the area. There was no order for hydrogel.</p> <p>During an interview on 7/09/14, the RN who completed the visit reviewed Patient #3's record and confirmed there was no order for hydrogel to be applied to his SP catheter site.</p> <p>e. Patient #3's POC included orders for HHA visits 2 times a week for 7 weeks, effective 6/08/14. His record documented 1 HHA visit the week of 6/22/14 and 1 HHA visit the week of 6/29/14. No other HHA visits were documented.</p>	G 158		

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

PRINTED: 07/28/2014
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 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646	
(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 23</p> <p>During an interview on 7/11/14 at 8:10 AM, the DON reviewed Patient #3's record and confirmed the HHA visits were not completed as ordered on the POC.</p> <p>Patient #3's care did not follow the written POC.</p> <p>2. Patient #10 was a 72 year old female admitted to the agency on 3/14/14 for SN, PT, HHA, and OT services related to surgical complications. Additional diagnoses included acute myocardial infarction, non-healing surgical wound, OM Type II uncontrolled, chronic skin ulcer, obstructive chronic bronchitis with acute exacerbation.</p> <p>Patient #10's medical record and POC for the certification period 3/14/14 to 5/12/14, was reviewed. Her POC was not followed. Examples include:</p> <ul style="list-style-type: none"> - Patient #10's POC included orders for OT once weekly for 6 weeks. Her record documented one visit on 3/19/14. No further visits were documented. - The POC noted. Patient #10 was to monitor daily BG readings. There was no documentation to indicate Patient #10 had been instructed to maintain a daily record of her BG readings. A total of 17 SN visits were documented. Two of the visit notes, dated 4/04/14 and 4/07/14, included documentation of BG levels; the other 15 did not. Both notes documented Patient #10's BG as 132. No further information related to Patient #10's BG levels or her monitoring of them, was documented. 	G 158	

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

PRINTED: 07/28/2014
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 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZJP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646	
(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 24</p> <p>- Weekly wound measurements were ordered on the POC. Wound measurements were not documented in nursing visit notes for weeks 2, 4, 5, and 7.</p> <p>During an interview on 7/11/14 at 9:30 AM the DON reviewed the record and confirmed that one visit was documented by OT and she verified there was no documentation to discontinue therapy. Additionally she confirmed there were only 2 BG readings documented and that on 4 of the 9 weeks of the certification period there were no wound measurements.</p> <p>Patient #10's POC was not followed by agency staff.</p> <p>3. Patient #5 was a 75 year old female admitted to the agency on 5/27/14 for SN services related to COPD, weakness, CKD, and HTN. The POC for the certification period 5/27/14 to 7/25/14, included nursing services once weekly for 6 weeks.</p> <p>Patient #5's record included 3 nursing visits of the 6 ordered. There were no visits for weeks 3, 4, and 6. The record did not indicate why the nursing visits did not occur, and there was no documentation the physician was notified Patient #5's POC was not implemented as ordered and why.</p> <p>During an interview on 7/09/14 at 3:40 PM, the DON reviewed Patient #5's record and confirmed the missed visits. She stated there was a delay in obtaining insurance authorization, so the agency approved the first 2 visits. The DON stated Patient #5 requested no further nursing visits until authorization from her insurance as she did not</p>	G 158		

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

PRINTED: 07/28/2014
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 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646		
(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	Continued From page 25 want to be financially responsible if the insurance was denied. The DON stated the agency approved the nurse to see Patient #5 for an additional visit on 6/26/14, although the insurance company had still not authorized care. The DON stated the agency approved the nursing visit because they did not want Patient #5 to go an additional week without being seen. The DON confirmed there were no case conference notes, documentation of physician notification, or other documentation of the missed visits or the reason for the missed visits. Patient #5's care was not provided as ordered on her POC and her physician was not notified of that her POC was not being followed. 4. Patient #9 was a 73 year old woman admitted to the agency on 1/13/14, for PT services related to kidney transplant. Additional diagnoses included non-insulin dependent OM, end stage renal disease, anemia, malaise and fatigue. Patient #9's record included an order for PT visits 3 times a week for 2 weeks, effective 1/27/14. However, 2 visits, instead of 3, were documented the week of 2/02/14. During an interview on 7/09/14 at 4:15 PM, the Therapy Coordinator reviewed Patient #9's record and confirmed the PT visit frequency did not follow the POC. : Patient #9 did not receive PT services at the frequency ordered in his POC.	G 158			
G 159	484.18(a) PLAN OF CARE	G 159	G159 PLAN: Director of Nursing or designee will instruct all staff by 8/15/2014 on the completion of the 485 plan of care		

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

PRINTED: 07/28/2014
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 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646		
(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 26</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 review of patient records and policies, and staff interview, it was determined the agency failed to ensure the plan of care included all pertinent information for 4 of 10 patients (#3, #5, #7, and #8) whose records were reviewed. This had the potential to interfere with continuity and completeness of patient care. Findings include:</p> <p>An agency policy titled "CARE PLANNING PROCESS," revised April 2014, included "The plan of care will be based upon the physician's orders and will encompass the equipment, supplies, and services required to meet the patient's needs."</p> <p>1. Patient #5 was a 75 year old female admitted to the agency on 5/27/14, for SN services related to COPD, weakness, CKD, and HTN. Her POC for the certification period 5/27/14 to 7/25/14, did not include DME and information or interventions related to her diagnoses as follows:</p> <p>a. Patient #5 was receiving dialysis treatments three times weekly and had a fistula (a modification of her blood vessels through which she received dialysis) in her arm. The fistula was</p>	G 159	<p>to include all diagnosis pertinent to the care of the patient's current plan of care, DME equipment; i.e. wheelchairs, walkers, hospital beds. Oxygen to be included on all relevant plans of care, including the medication profile with the liter per minute and if the use is intermittent or continuous. For patients being followed by more than one physician, staff will be instructed that all secondary ordering physicians must be listed on the patients' plan of care in locator 21. Office staff will be instructed to send a copy of the 485 to the secondary physicians identified.</p> <p>Director of Nursing will review 100% of all 485 plans of care; diagnosis, equipment, patient use of oxygen and secondary physician(s) until 100% compliance is achieved. Ongoing Director of Nursing or designee will review quarterly through the clinical auditing process, auditing 10% of the clinical records based on the average daily census, 50% active and 50% inactive.</p> <p>Responsible: Director of Nursing has overall responsibility for the corrective action and ongoing completion of this standard.</p> <p>Completion: 8/15/14</p>	

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

PRINTED: 07/28/2014
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 _____ 8. WING _____	(X3) DATE SURVEY COMPLETED 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646	
(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)
G 159	<p>Continued From page 27</p> <p>not noted on Patient #S's SOC comprehensive assessment, completed on 5/27/14, and was not included on her POC. The presence of the fistula was not documented in nursing notes until 6/27/14, when it was noted in a Client Coordination Note Report. The note did not specify which arm the fistula was in.</p> <p>b. Patient #S had COPD and was on dialysis, however, her POC did not include pertinent information and/or interventions such as monitoring daily weights, or whether she had fluid restrictions.</p> <p>c. The POC did not include pertinent information related to Patient #S's diagnosis of DM Type II, such as whether she was monitoring her blood sugar levels, if it was diet controlled, or if further patient education was required.</p> <p>d. The POC in locator 14, "DME and Supplies," listed "NONE," meaning Patient #S had no durable medical equipment. Nursing notes, dated 6/03/14, documented Patient #S had a walker, wheelchair, a cane, and was on oxygen.</p> <p>During an interview on 7/09/14 at 3:40 PM, both the DON and RN who performed the comprehensive assessment reviewed Patient #S's record. The RN confirmed she did not identify Patient #S as having a dialysis fistula. The DON confirmed the POC did not include interventions specific to Patient #S's diagnoses.</p> <p>Patient #S's POC did not include information pertinent to her diagnoses and did not include her DME.</p> <p>2. Patient #8 was a 96 year old female admitted</p>	G 159	

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

PRINTED: 07/28/2014
FORM APPROVED
OMB NO 093S-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 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646	
(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 2S</p> <p>to the agency on 6/07/14 for SN and PT services related to CHF, dementia, and irregular heartbeat. Her POC for the certification period 6/07/14 through 8/05/14 did not include DME, information, and interventions related to her care as follows:</p> <p>a. The POC in locator 14, "DME and Supplies," listed "NONE," meaning Patient #S had no durable medical equipment. The comprehensive assessment, dated 6/07/14, documented Patient #S had a walker and a wheelchair.</p> <p>b. The comprehensive assessment, dated 6/07/14, documented Patient #S suffered a fall on 6/06/14, which resulted in a laceration on her scalp requiring staples. The POC did not include information or interventions related to the scalp wound.</p> <p>During an interview, on 7/09/14 beginning at 2:30 PM, the RN who performed the comprehensive assessment and developed the POC reviewed Patient #S's record. She stated Patient #S resided in an ALF, and the facility provided her DME, so she did not include it in the assessment or POC. The RN stated the ALF was to monitor the scalp wound. This pertinent information was not noted on Patient #S's POC.</p> <p>Patient #S's POC was not complete and specific to her needs.</p> <p>3. Patient #3 was a 54 year old male admitted to the agency on 5/29/14, for services related to non-healing surgical wounds. Additional diagnoses included complication of cystostomy, OM Type II, polyneuropathy, bipolar disorder, anxiety, Hepatitis C, HTN, colostomy, urinary</p>	G 159	

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

PRINTED: 07/28/2014
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 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646		
(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 29</p> <p>device, lower limb amputation, cerebral infarct and transient ischemic attack. He received SN, HHA and PT services.</p> <p>Patient #3's POC for the certification period of 5/29/14 - 7/27/14, was reviewed. Patient #3's POC did not include all pertinent information as follows:</p> <p>a. Patient #3's POC included orders for wound care to the incision on his abdomen, however the order did not specify how often the wound care was to be completed.</p> <p>b. Patient #3's POC also included orders for wound care to his SP catheter site. which included application of an antibiotic ointment, however the specific name of the antibiotic ointment was not included in the wound care order or in the medication list on the POC.</p> <p>c. Patient #3's POC did not include parameters to specify when his physician should be notified of out of range vital signs or blood sugar levels.</p> <p>Patient #3's POC was incomplete and did not include all orders and information pertinent to his care.</p> <p>4. Patient #7 was a 70 year old male admitted to the agency on 4/24/14, for PT services related to ; Cerebral Vascular Accident. Additional diagnoses include hemiplegia unspecified side, occlusion and stenosis vertebral artery, DM Type II, unspecified essential hypertension, unspecified hyperlipidemia, history of fall, long-term use of insulin.</p> <p>Patient #Ts POC for the certification period</p>	G 159		

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

PRINTED: 07/28/2014
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 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646		
(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 30 4/24/14 - 6/22/14, included diagnoses of DM and long term use of insulin. However, his diet was noted as regular, indicating no restriction of sugars or carbohydrates. During an interview on 7/09/14 at 4:50 PM, the Therapy Coordinator reviewed Patient #'s record and stated the POC was developed by a Physical Therapist. He stated the therapist would only document dietary restrictions that were mechanical, such as a pureed diet. He said if there was no mechanical restriction the diet would be documented as regular.	G 159			
G 160	Patient #'s POC did not include complete information related to his dietary restrictions. 484.18(a) PLAN OF CARE If a physician refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician is consulted to approve additions or modification to the original plan. This STANDARD is not met as evidenced by: Based on review of patient records, and staff interview, it was determined the agency failed to ensure a physician was consulted to approve the plan of care for 3 of 10 patients (#3, #4, and #8) whose records were reviewed. This resulted in plans of care that were developed and initiated without appropriate physician approval. Findings include: 1. Patient #4 was a 78 year old female admitted to the agency on 7/01/14, for SN and PT services related to back pain and degenerative joint disease. His POC for the certification period of	G 160	G160 PLAN: Director of Nursing has instructed all admitting disciplines and staff performing subsequent evaluations of the requirement to call the attending physician, inform the physician of their findings and seek approval of their plan of care for the patient. The electronic documentation section of the Verbal order has been updated to reflect the name of the physician called, date and time and any pertinent comments. Director of Nursing or designee will review 100% of all admission assessments to ensure that the physician has been notified of the admission/subsequent evaluation; verbal order section has been completed with the date, time and physician spoken to until 100% compliance is achieved. Ongoing Director of Nursing or designee will review quarterly through the clinical		

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

PRINTED: 07/28/2014
FORM APPROVED
OMS 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 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646	
(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 160	<p>Continued From page 31 7/01/14 - 8/29/14, was reviewed.</p> <p>During the SOC assessment visit, completed 7/01/14 beginning at 12:50 PM, the RN indicated under the Order Verification section, that she "REPORTED ASSESSMENT AND PATIENT'S STATUS TO PHYSICIAN, PLAN OF CARE AND MEDICATIONS REVIEWED WITH AND APPROVED BY PHYSICIAN." As of 7/11/14, the POC was not signed by Patient #4's physician.</p> <p>On 7/02/14 a Physical Therapist performed an evaluation. The therapist did not document communication with Patient #4's physician after the evaluation. A subsequent therapy visit was made on 7/07/14. The visits were conducted before the physician approved the POC.</p> <p>During an interview, on 7/09/14 beginning at 3:10 PM, the RN who performed the SOC assessment reviewed Patient #4's record and confirmed she had not contacted the physician. She stated the summary of the visit was printed onto a "Client Coordination Note," and sent to the physician. She stated if a problem was noted during the SOC assessment, then the patient's physician would be notified. The RN confirmed she did not receive verbal orders approving the POC.</p> <p>After the SOC assessment, Patient #4's physician was not contacted to approve her POC.</p> <p>2. Patient #8 was a 96 year old female admitted to the agency 6/07/14 for SN and PT services related to CHF, dementia, and irregular heartbeat. Patient #8's POC for the certification period 6/07/14 to 8/05/14 was reviewed.</p> <p>During the SOC assessment visit, completed</p>	G 160	<p>auditing process, auditing 10% of the clinical records based on the average daily census, 50% active and 50% inactive.</p> <p>Responsible: Director of Nursing has overall responsibility for the corrective action and ongoing completion of this standard.</p> <p>Completed on 7/9/2014.</p>

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

PRINTED: 07/28/2014
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 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646	
(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 160	<p>Continued From page 32</p> <p>6/07/14 beginning at 9:37 AM, the RN indicated under the Order Verification section, that she "REPORTED ASSESSMENT AND PATIENT'S STATUS TO PHYSICIAN, PLAN OF CARE AND MEDICATIONS REVIEWED WITH AND APPROVED BY PHYSICIAN." Patient #S's POC was not signed by her physician until 7/03/14. Subsequent nursing visits were made on 6/08/14 and 6/12/14. PT visits were made on 6/09/14 and 6/11/14. The visits were made before the physician approved the POC.</p> <p>During an interview, on 7/09/14 beginning at 2:30 PM, the RN who performed the SOC assessment reviewed Patient #S's record and confirmed she had not contacted the physician. She stated it was a Saturday, and would not have been able to reach the physician. She stated the summary of the visit would be printed onto a "Client Coordination Note," and sent to the physician. She stated if a problem was noted during the SOC assessment, then the patient's physician would be notified. The RN confirmed she did not receive verbal orders authorizing the POC.</p> <p>Following completion of her SOC assessment, Patient #S's POC was not authorized by her physician prior to initiation.</p> <p>3. Patient #3 was a 54 year old male admitted to the agency on 5/29/14, for services related to non-healing surgical wounds. Additional diagnoses included complication of cystostomy, OM Type II, polyneuropathy, bipolar disorder, anxiety, Hepatitis C, HTN, colostomy, urinary device, lower limb amputation, cerebral infarct and transient ischemic attack. He received SN, HHA and PT services.</p>	G 160		

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

PRINTED: 07/28/2014
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 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646	
(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 160	Continued From page 33 Patient #3's POC for the certification period of 5/29/14 - 7/27/14, included medications and orders for wound care, colostomy care and SP catheter care. The SOC "Visit Note Report" dated 5/29/14, and signed by the RN, included the statement "Plan of care and medications reviewed with and approved by physician". Subsequent nursing visits were made on 6/02/14, 6/05/14, 6/11/14, 6/13/14, 6/17/14, 6/24/14, 6/30/14, and 7/08/14. HHA visits were made on 6/09/14, 6/12/14, 6/16/14, 6/19/14, 6/26/14, and 7/01/14. The visits were made before the physician approved the POC. During an interview on 7/09/14 at 2:35 PM, the RN who completed the SOC assessment stated she did not communicate verbally with Patient #3's physician after the SOC assessment. She stated she created the POC based on information given to her by Patient #3 and sent a fax to his physician to verify frequency of visits, medications, wound care, and care of his colostomy and SP catheter. The fax and the written POC remained unsigned as of 7/11/14. Patient #3's physician was not consulted to approve his POC following the SOC assessment.	G 160		
G 164	484.18(b) PERIODIC REVIEW OF PLAN OF CARE Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care. This STANDARD is not met as evidenced by: Based on staff interview and review of agency policies and clinical records, it was determined	G 164	G164 PLAN: Director of Nursing or Designee will instruct all direct care personnel regarding the requirements to promptly notify the physician of any decline in the patient's condition and the requirement to document such notification completely within the patient's clinical record. Director of Nursing will review each discipline's job descriptions and required job functions with the discipline and educate them of the requirement to communicate and coordinate care, follow	

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

PRINTED: 07/28/2014
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 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 63WWILLOWBROOK DR MERIDIAN, ID 83646		
(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 164	<p>Continued From page 34</p> <p>the agency failed to ensure the physician was notified of changes in patient health status, or delays in patient care for 3 of 10 patients (#3, #7, and #10) whose records were reviewed. This failure resulted in a lack of physician involvement with patient care and modification of patients' POC. Findings include:</p> <p>An agency policy titled "CARE PLANNING PROCESS," revised April 2014, stated "Clinicians will inform the patient's physician of any changes that suggest a need to alter the plan of care, which will be documented in the clinical record." Physicians were not notified in the following examples:</p> <ol style="list-style-type: none"> 1. Patient #3 was a 54 year old male admitted to the agency on 5/29/14, for services related to non-healing surgical wounds. Additional diagnoses included complication of cystostomy, OM Type 11, polyneuropathy, bipolar disorder, anxiety, Hepatitis C, HTN, colostomy, urinary device, lower limb amputation, cerebral infarct and transient ischemic attack. He received SN, HHA and PT services. <p>Patient #3's medical record and POC, for the certification period of 5/29/14 - 7/27/14, were reviewed. Patient #3's physician was not informed of changes in his condition as follows:</p> <ol style="list-style-type: none"> a. Upon referral for home health services on 5/29/14, the agency received a list of Patient #3's medications from his physician's office. The list included Xarelto, an anticoagulant medication used to prevent blood clots. <p>Patient #3's POC did not include Xarelto. An untitled document in his record which listed</p>	G 164	<p>physician's plan of care as written and notify physician with any updates and requests for changes made to the physician will have orders written on the day received.</p> <p>Director of Nursing will review the policy and procedure "Care Planning Process" and "Anticoagulant Management" with all disciplines and provide instruction on following the Plan of care orders, reporting on the specific parameters established within the plan of care to the MD and documenting the communication to the patient's MD. Communication to the MD also includes when the patient has not been taking their medications due to non-compliance, lack of understanding or the inability to obtain the medication. Staff will be instructed on the requirement to have a specific order to perform a oxygen saturation and at what parameter the discipline is to report to the MD. Nursing is to write their own Oxygen saturation orders and therapy theirs as the use is different for the disciplines. Oxygen is to be included within the orders of the plan of care and Medication profile when used by the patient. Education to be provided will also include instruction on visit frequency and duration – including when disciplines are no longer required, procedure for disciplines to notify the MD and when to obtain an order for discharge. Disciplines will be educated on providing this notification and completing the discipline discharge summary in the electronic documentation system.</p> <p>Director of Nursing or Designee will review 100% of the clinical records until</p>	

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

PRINTED: 07/28/2014
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 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646	
(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 164	<p>Continued From page 35</p> <p>Patient 3's medication, signed by the RN at SOC on 5/29/14, included documentation that Patient #3 refused to take the medication. However, there was no documentation indicating his physician was notified of his refusal.</p> <p>During an interview on 7/09/14 at 2:35 PM, the RN who completed Patient #3's SOC assessment confirmed she did not notify his physician of his refusal to take Xarelto.</p> <p>b. Patient #3's POC included orders for sliding scale insulin (dose of insulin based on blood glucose levels) to be administered three times a day.</p> <p>The 5/29/14 SOC visit note did not include documentation of Patient #3's ability to manage his insulin dosing.</p> <p>During an interview, on 7/09/14 at 2:35 PM, the RN who completed Patient #3's SOC assessment stated the patient did not have his insulin at the time of her visit. She confirmed she did not inform Patient #3's physician that he did not have insulin available to comply with the sliding scale orders.</p> <p>c. Life's Doors Home Health and Hospice procedure, Section 6-9, titled "Endocrine: Hyperglycemia" states, "The MD should be notified for blood glucose levels greater than 200 mg/dl unless the MD has previously ordered parameters".</p> <p>Patient #3's record included a "Visit Note Report" dated 6/05/14, and signed by the RN Case Manager. The visit note included a fasting blood sugar result of 209 mg/dl. The note stated the</p>	G 164	<p>the clinical audits demonstrate 90% compliance, then ongoing the agency will review, based on the average daily census 50 % of active clinical record and 50 discharge records on a quarterly basis. All variances of indicators of less than 85% will require an action plan with continued auditing and education until compliance is obtained.</p> <p>Responsible: Director of Nursing</p> <p>Completion date: 8/13/14</p>	

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

PRINTED: 07/28/2014
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER: 137114	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646	
(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 164	<p>Continued From page 36</p> <p>patient checked his blood sugar levels daily and results ranged from 130-270 mg/di. There was no documentation to indicate the physician was notified of Patient #3's elevated blood sugar levels.</p> <p>Patient #3's record included a "Visit Note Report" dated 6/11/14, and signed by an LPN. The visit note included a fasting blood sugar result of 246 mg/di. The note stated the patient checked his blood sugar three times a day and results ranged from 90-350 mg/di. There was no documentation to indicate the RN Case Manager or the physician was notified of Patient #3's elevated blood sugar levels.</p> <p>Patient #3's record included a "Visit Note Report" dated 6/30/14, and signed by the RN Case Manager. The note stated the patient checked his blood sugar levels daily and results ranged from 77-272 mg/di. There was no documentation to indicate the physician was notified of Patient #3's elevated blood sugars.</p> <p>Patient #3's record included a "Visit Note Report" dated 7/08/14, and signed by the RN Case Manager. The note stated the patient checked his blood sugar daily and results ranged from 222-300 mg/di. There was no documentation to indicate the physician was notified of Patient #3's elevated blood sugar levels.</p> <p>During an interview on 7/09/14 at 1:40 PM, the RN Case Manager reviewed Patient #3's record and confirmed his physician had not been informed of his elevated blood sugar levels.</p> <p>d. Patient #3's sliding scale insulin order required him to use a glucometer to check his blood sugar</p>	G 164		

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

PRINTED: 07/28/2014
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 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646		
(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 164	<p>Continued From page 37</p> <p>level three times a day to determine the dose of insulin to be injected.</p> <p>Patient #3's record included a "Visit Note Report" dated 7/08/14, and signed by the RN Case Manager. The narrative section of the note included, "Pt stated that his glucometer recently broke. Pt stated that he has ordered a new one." There was no documentation to indicate the physician was notified of Patient #3's inability to check his blood sugar level and take his insulin as ordered.</p> <p>During an interview on 7/09/14 at 1:40 PM, the RN Case Manager reviewed Patient #3's record and confirmed his physician had not been informed he was unable to check his blood sugar levels and take his insulin accordingly.</p> <p>Patient #3's physician was not notified of changes in his condition.</p> <p>2. Patient #10 was a 72 year old female admitted on 3/14/14 for SN, PT, HHA, and OT services related to surgical complications. Additional diagnoses included acute myocardial infarction , non-healing surgical wound, DM Type II uncontrolled, chronic skin ulcer, obstructive chronic bronchitis with acute exacerbation.</p> <p>Patient #10's POC, for the certification period 3/14/14 to 5/12/14, was reviewed. It did not include orders for oxygen therapy.</p> <p>In a SN visit note, dated 4/7/14, the RN documented Patient #10's oxygen saturations were 87% at 1.5 liters per minute. There was no documentation of communication with the physician to obtain an order for the oxygen or to</p>	G 164		

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

PRINTED: 07/28/2014
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 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646		
(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 164	<p>Continued From page 38</p> <p>obtain parameters. Visit notes dated 4/10/14, 4/14/14, 4/15/14, and 4/25/14 indicated Patient #10 was receiving oxygen therapy, however, twelve other visit notes did not indicate if Patient #12 was on oxygen.</p> <p>During an interview, on 7/11/14 at 9:30 AM, the DON reviewed Patient #10's record and confirmed there was no documented communication with the physician. She stated Patient #10's oxygen saturation levels were outside of the agency's accepted parameters.</p> <p>The agency did not clarify oxygen orders with the physician and notify the physician of decreased oxygen saturation levels.</p> <p>3. Patient #7 was a 70 year old male admitted to the agency on 4/24/14, for PT services related to cerebral vascular accident. Additional diagnoses included hemiplegia, occlusion and stenosis vertebral artery, DM Type II, HTN, history of fall, long-term use of insulin.</p> <p>Patient #'s POC for the certification period 4/24/14 to 6/22/14 was reviewed .</p> <p>In a PT visit note, dated 4/24/14, the therapist documented two blood pressure measurements. The initial measurement at 2:30 PM of 91/49, and a second measurement of 75/43 at 2:59 PM. The visit note documented the therapist notified the physician, however, the visit note documented in another section the physician was not notified. This contradiction of actions led to a lack of clarity for the reader of the record.</p> <p>During an interview, on 7/11/14 at 9:15 AM, the PT reviewed Patient #'s record and confirmed</p>	G164		

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

PRINTED: 07/28/2014
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____

(X3) DATE SURVEY
COMPLETED

NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE		137114	B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646		07/11/2014
(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 164	Continued From page 39		G 164		
G 168	<p>that the EMR software program used by the agency triggered an alert to the clinician which reads "VITAL SIGNAL ALERT" with specified parameters for "LOWER LIMIT: 90/50," "UPPER LIMIT: 180/100." The therapist also confirmed that he did not verbally communicate the measurements with the physician.</p> <p>The physical therapist did not notify the physician of the low blood pressure measurements.</p> <p>484.30 SKILLED NURSING SERVICES</p> <p>This CONDITION is not met as evidenced by: Based on record review, policy review, observation, and patient and staff interview, it was determined the agency failed to ensure skilled nursing services were furnished in accordance with the plan of care and consistent with patients' needs. This negatively impacted quality, coordination, and safety of patient care. Findings include:</p> <ol style="list-style-type: none"> 1. Refer to G170 as it relates to a failure of the agency to ensure skilled nursing services were furnished in accordance with the plan of care. 2. Refer to G173 as it relates to the agency's failure to ensure that nursing staff had initiated POC updates with changes in patient conditions, as well as, to include a uniform approach of staff to monitor and assist with medication non-compliance. 3. Refer to G175 as it relates to the failure of the agency to ensure a registered nurse initiated appropriate preventive and rehabilitative nursing 		G 168	<p>G168 PLAN: The Director of Nursing and/or Designee will instruct the agency staff the specific standards G170, 173, 175, 176 and 177 to ensure that nursing nurses are provided in accordance with the plan of care established for the patient, consistent/safe level of care is provided for each patient serviced, which is demonstrated through clinical documentation of care coordination with the physician, other disciplines involved in the patients care and the patient demonstrates a positive outcome and safety.</p> <p>Responsible: Director of Nursing is responsible for the overall correction of this condition.</p> <p>Completion: 8/6/14</p>	

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

PRINTED: 07/28/2014
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 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646		
(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 168	Continued From page 40 procedures. 4. Refer to G176 as it relates to the agency's failure to ensure that staff informed the physician and other members of the health care team of changes in patients' conditions. 5. Refer to G177 as it relates to the failure of the agency to ensure a registered nurse counseled the patient and family in meeting nursing and related needs.	G 168			
G 170	The cumulative effects of these negative practices seriously impeded the ability of the agency to provide services of adequate quality. 484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care. This STANDARD is not met as evidenced by: Based on staff and patient interview, observation, and review of medical records, it was determined the facility failed to ensure SN services were provided in accordance with POCs for 3 of 10 patients (#3, #5, and #10), who received SN care and whose records were reviewed. Failure to provide care in accordance with established POCs resulted in inadequate patient care and had the potential for negative patient outcomes. Findings include: 1. Patient #3 was a 54 year old male admitted to the agency on 5/29/14 for care related to non-healing surgical wounds. Additional diagnoses included complication of cystostomy, OM Type II, polyneuropathy, bipolar disorder,	G 170	G170 PLAN: Director of Nursing or Designee will instruct all disciplines providing skilled care on the establishment of the patient's plan of care, following the plan of care, notifying the physician when changes to the plan of care are required, obtaining supplemental/verbal orders, timeliness of transmission of orders, and patient care coordination among team members. Staff to receive instruction on how to write complete orders with the date the order was received, the effective date, the purpose of the order, frequency and duration if related to visits, wound care orders to include the type of wound, location of the wound, the procedure of treating the wound and dressings. Staff to be instructed if they have not done a procedure in the field – they are to notify the office immediately for assistance. Staff to be instructed that with each visit all teaching addressed on the patient's plan of care must be address at each visit.		

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13711	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/11/2014
--	---	--	--

NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646
--	--

(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 170	<p>Continued From page 41_</p> <p>anxiety, Hepatitis C, HTN, colostomy, urinary device, lower limb amputation, cerebral infarct, transient ischemic attack. He received SN, PT and HHA services.</p> <p>Patient #3's care did not follow a written POC established by his physician. Examples include:</p> <p>a. Patient #3's POC included an order for monthly SP (supra-pubic) catheter changes, with the first catheter change due on 6/19/14.</p> <p>Patient #3's record included an SN visit report dated 6/13/14, and signed by an RN. The note documented she removed Patient #3's SP catheter and inserted a new SP catheter.</p> <p>During an interview on 7/09/14, the RN who completed the visit stated she changed the catheter on 6/13/14, because Patient #3 requested a new catheter.</p> <p>b. Patient #3's POC included orders to educate the patient regarding wound care to his SP catheter site and his abdominal incision wounds. There was no documentation in the SOC visit note dated 5/29/14, and signed by the RN, to indicate the patient was educated regarding wound care, which was to be completed daily. The next SN visit was documented on 6/02/14.</p> <p>Patient #3's POC, dated 5/29/14, included the following order, "Skilled nurse to perform/teach wound care to incision/suture site located RUQ ABD (right upper quadrant of abdomen). Cleanse with wound cleanser, pack with 1/2" packing gauze. Cover with ABD (dressing). Secure web tape. Using clean/aseptic technique."</p>	G 170	<p>Staff to be instructed that all parameters written within the plan of care must be followed each visit, and must indicate who is to perform the task, i.e. is the SN to perform the blood sugar each visit or is the patient, if the SN has an order to instruct the patient to record his blood sugar and the nurse is to send the readings to the MD – this should be completed with notation of readings, etc. Instruction to be provided to staff to adhere to the frequencies and duration of visits established in the plan of care and or supplemental orders, that all visits require a physician's order and cannot be performed without. Visits performed without orders require the clinician to complete an occurrence report with explanation of why the visits were completed without orders, visits not made to the patient require an explanation of why the visit was missed – documentation of the missed visit and the physician will be notified via phone or the missed visit note is faxed to the physician with fax confirmation attached to the clinical record.</p> <p>Director of Nursing or Designee will review 100% of the clinical records until the clinical audits demonstrate 90% compliance, then ongoing the agency will review, based on the average daily census 50% of active clinical record and 50% discharge records on a quarterly basis. All variances of indicators of less than 85% will require that an action plan with auditing is continued until compliance is obtained.</p> <p>Responsible: Director of Nursing is responsible for the overall correction of this condition.</p>	
-------	--	-------	--	--

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

PRINTED: 07/28/2014
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 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646		
(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 170	Continued From page 42 A visit was made to Patient #3's home on 7/09/14 at approximately 3:30 PM, to observe a PT visit. Upon arrival it was noted there was no dressing in place to his abdominal wound. When the physical therapist assisted him to a sitting position, his abdominal wound began to drain. Patient #3 used a 4x4 gauze dressing to wipe the drainage off his abdomen, then inserted the same dressing into the open area of his abdominal wound. He did not cleanse the wound with wound cleanser or pack it with 1/2 inch gauze as directed in the POC. Patient #3 stated he was not taught to pack his abdominal wound and he was only covering it when it drained. During an interview on 7/09/14 at 2:35 PM, the RN who completed the SOC assessment reviewed Patient #3's record and confirmed there was no documentation of wound care education. She was unable to remember whether she instructed the patient, and unable to explain how the wound care would be completed daily if the patient was not able to do it. c. Patient #3's POC included orders to apply antibiotic ointment to his SP catheter insertion site. The type of antibiotic ointment was not specified in the order and antibiotic ointment was not included in the list of medications on the POC. During an interview on 7/09/14 at 2:35 PM, the RN who completed the SOC assessment reviewed Patient #3's record and confirmed she did not document the specific antibiotic ointment in the wound care order and did not include it in the list of medications. d. Patient #3's record included a SN visit note	G 170	Completion: 8/15/14		

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

PRINTED: 07/28/2014
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 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646	
(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 170	<p>Continued From page 43</p> <p>dated 6/13/14 and signed by an RN. The note documented wound care to the SP catheter insertion site and stated hydrogel (a water based gel) was applied to the area. There was no order for hydrogel.</p> <p>During an interview on 7/09/14, the RN who completed the visit reviewed Patient #3's record and confirmed there was no order for hydrogel to be applied to his SP cath site.</p> <p>e. Patient #3's POC included orders for HHA visits 2 times a week for 7 weeks, effective 6/08/14. His record documented 1 HHA visit the week of 6/22/14 and 1 HHA visit the week of 6/29/14.</p> <p>During an interview on 7/11/14 at 8:10 AM, the DON reviewed Patient #3's record and confirmed the HHA visits were not completed as ordered on the POC.</p> <p>Patient #3's care did not follow the written POC.</p> <p>2. Patient #10 was a 72 year old female admitted to the agency on 3/14/14 for SN, PT, HHA, and OT services related to surgical complications. Additional diagnoses included acute myocardial infarction, non-healing surgical wound, OM Type II uncontrolled, chronic skin ulcer, obstructive chronic bronchitis with acute exacerbation.</p> <p>Patient #10's medical record and POC for the certification period 3/14/14 to 5/12/14, was reviewed. Her POC related to skilled nursing services was not followed. Examples include:</p> <p>- The POC noted Patient #10 was to monitor daily, BG readings. There was no documentation to</p>	G 170	

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

PRINTED: 07/28/2014
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13711	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646	
(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 170	<p>Continued From page 44</p> <p>indicate Patient #10 had been instructed to maintain a daily record of her BG readings. A total of 17 SN visits were documented. Two of the visit notes, dated 4/04/14 and 4/07/14, included documentation of BG levels; the other 15 did not. Both notes documented Patient #10's BG as 132. No further information related to Patient #10's BG levels or her monitoring of them, was documented.</p> <p>- Weekly wound measurements were ordered on the POC. Wound measurements were not documented in nursing visit notes for weeks 2, 4, 5, and 7.</p> <p>. During an interview on 7/11/14 at 9:30 AM the : DON reviewed the record and confirmed there were only 2 BG readings documented and that on 4 of the 9 weeks of the certification period there were no wound measurements.</p> <p>Patient #10's POC was not followed by nursing staff.</p> <p>3. Patient #5 was a 75 year old female admitted to the agency on 5/27/14 for SN services related to COPD, weakness, CKD, and HTN. The POC for the certification period 5/27/14 to 7/25/14, included nursing services once weekly for 6 weeks.</p> <p>Patient #5's record included 3 nursing visits of the 6 ordered. There were no visits for weeks 3, 4, and 6. The record did not indicate why the nursing visits did not occur, and there was no documentation the physician was notified Patient #5's POC was not implemented as ordered and why.</p>	G 170	

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

PRINTED: 07/28/2014
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 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 83 W WILLOWBROOK OR MERIDIAN, ID 83646		
(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 CROSSREFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G 170	Continued From page 45 During an interview on 7/09/14 at 3:40 PM, the DON reviewed Patient #5's record and confirmed the missed visits. She stated there was a delay in obtaining insurance authorization, so the agency approved the first 2 visits. The DON stated Patient #5 requested no further nursing visits until authorization from her insurance as she did not want to be financially responsible if the insurance was denied. The DON stated the agency approved the nurse to see Patient #5 for an additional visit on 6/26/14, although the insurance company had still not authorized care. The DON stated the agency approved the nursing visit because they did not want Patient #5 to go an additional week without being seen. The DON confirmed there were no case conference notes, documentation of physician notification, or other documentation of the missed visits or the reason for the missed visits. Patient #5's care was not provided as ordered on her POC and her physician was not notified her POC was not being followed.	G 170			
G 173	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates the plan of care and necessary revisions. This STANDARD is not met as evidenced by: Based on record review, observation, and patient and staff interview, it was determined the agency failed to ensure RNs developed and updated the POCs of 2 of 5 sample patients (#3 and #5) who received SN services for wound care, to ensure their medical and nursing needs were met. This resulted in inadequate patient care and negative	G 173	G173 PLAN (Part A): Director of Nursing or designee to instruct Staff by 8-15-14 on diabetic care and wound management, verifying and assessing the knowledge level of the patient, ensuring that they have adequate medications and supplies including functioning blood glucose monitor and if the patient does not, the clinician will obtain an MD order and make a referral to the MSW to assist in obtaining resources for the patient if indicated. Education will also include the need to provide dietary instruction, assessing the need for a dietician if indicated, obtaining MD order for referral to a dietician, or a referral for a		

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

PRINTED: 07/28/2014
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 _____ 8. WING _____	(X3) DATE SURVEY COMPLETED 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646	
(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 173	<p>Continued From page 46</p> <p>patient outcomes. Findings include:</p> <p>1. Patient #3 was a 54 year old male admitted to the agency on 5/29/14, for care related to non-healing surgical wounds. Additional diagnoses included complication of cystostomy, OM Type II, polyneuropathy, bipolar disorder, anxiety, Hepatitis C, HTN, colostomy, urinary device, lower limb amputation, cerebral infarct, transient ischemic attack. He received SN, PT, and HHA services.</p> <p>a. During an interview, on 7/08/14 at approximately 8:30 AM, the RN Case Manager stated she had been unable to reach Patient #3 by phone and thought he may have been admitted to the hospital. She stated on 7/04/14, he told her he was going to call 911 because he felt as though he may have skin breakdown in his , sacral area. When asked if she assessed him for skin breakdown, she stated he was very large and she was unable to turn him so she had never assessed the skin on his back side.</p> <p>During a home visit on 7/08/14 at 2:30 PM, Patient #3 stated he had not been out of bed since returning home from the hospital approximately 2 months prior. He was paralyzed from the waist down and his right leg was observed to be contracted and rotated outward. His outer ankle was pressed against his mattress, which resulted in pressure on the bony prominence of his outer ankle. He stated he was , unable to move his legs, but could turn to his side if someone pulled his right leg over for him.</p> <p>SN visit notes dated 6/05/14, 6/13/14, 6/17/14, and 6/30/14, signed by the RN Case Manager, were reviewed. The 4 notes document Patient</p>	G 173	<p>community diabetic educator to come to visit the patient if available in their community. Staff will be instructed on providing patient education and clinical record documentation regarding management of insulin injections, rotations of sites, blood glucose readings and dose of sliding scale insulin, keeping a blood glucose log, teaching the caregiver to monitor the blood glucose, signs/symptoms of hyper/hypoglycemia, emergency management for diabetics, and the relation between diabetes and wound management/healing and overall health.</p> <p>Director of Nursing or designee to instruct staff by 8/15/2014 that all patients at the time of admission noted having a blood glucose machine, that the admission nurse is to assess the working order of the machine, in addition, patient should be able to demonstrate proper use of the machine, taking of blood sample and obtaining a random blood glucose reading. Staff to be instructed to obtain MSW referral if the patient's machine is not functioning and has a lack of resources. Nurses will be instructed to obtain MD order to monitor patient's blood glucose until blood machine is obtained if indicated for the patient.</p> <p>Director of Nursing or Designee will review 100% of the clinical records until the clinical audits demonstrate 90% compliance, then ongoing the agency will review, based on the average daily census 50% of active clinical record and 50% discharge records on a quarterly basis. All variances of indicators of less than 85% will require that an action plan with auditing is continued until compliance is obtained.</p> <p>Responsible: Director of Nursing is</p>	

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

PRINTED: 07/28/2014
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 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646		
(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 173	<p>Continued From page 47</p> <p>#3's skin was assessed. There was no documentation to indicate the RN was unable to assess the patient's entire body.</p> <p>A SN visit note, dated 7/08/14 at 10:10 AM, and signed by the RN Case Manager, was reviewed. It documented a stage 2 pressure ulcer on Patient #3's right outer ankle that had not been identified prior to that visit.</p> <p>A visit was made to Patient #3's home on 7/09/14 at approximately 3:30 PM, to observe a PT visit. A dressing was noted on his right ankle, however, it had become loose and was not covering the open area. The open area was white, surrounded by reddened tissue. Brown drainage was noted on the pillow under his ankle.</p> <p>A home visit was made on 7/11/14 at 9:00 AM, to observe an RN visit. The visit was completed by the RN identified as the agency's wound specialist. The RN assessed the wound on Patient #3's right outer ankle and identified it as a stage 3 pressure ulcer.</p> <p>Patient #3's POC, for the certification period 5/29/14 - 7/27/14, did not include orders appropriate for a patient who was bedbound and at risk for skin breakdown, such as turning the patient at least every 2 hours and interventions to relieve pressure and prevent pressure ulcers. Additionally, it did not include patient/caregiver education related to the risk of skin breakdown.</p> <p>During an interview on 7/09/14 at 1:40 PM, the RN Case Manager confirmed the POC did not include measures to prevent skin breakdown.</p> <p>Patient #3's POC did not include nursing</p>	G 173	<p>responsible for the overall correction of this condition.</p> <p>Completion: 8/15/14</p>	

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

PRINTED: 07/28/2014
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 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646		
(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	
<p>G 173 Continued From page 48</p> <p>interventions to prevent the development of pressure sores.</p> <p>b. Patient #3's diagnoses included OM and non-healing surgical wounds. However, his POC for the certification period of 5/29/14 - 7/27/14, did not include patient/caregiver education related to his 1800 calorie ADA diet, or nutritional needs for wound healing.</p> <p>Patient #3's POC included sliding scale insulin (insulin dosing based on blood sugar levels). However, it did not include patient/caregiver education related to the use of a glucometer to check blood sugar levels or the administration of sliding scale insulin. Additionally, the POC did not include education regarding the importance of therapeutic blood sugar levels for wound healing.</p> <p>According to the American Diabetic Association, "Comprehensive diet and nutrition management have been shown to promote optimal glycemic control and facilitate wound prevention and healing. All healthcare professionals should know how to adequately manage blood glucose levels to support wound healing in patients living with diabetes."</p> <p>During an interview, on 7/09/14 at 2:35 PM, the RN who completed the SOC assessment and created the POC reviewed Patient #3's record and confirmed the POC was not complete to address all of Patient #3's needs.</p> <p>c. Patient #3's POC included orders for sliding scale insulin (dose of insulin based on blood glucose levels) to be administered three times a day.</p>	G 173			

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

PRINTED: 07/28/2014
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 07/11/2014	
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, D 83646		
(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 173	<p>Continued From page 49</p> <ul style="list-style-type: none"> - The 5/29/14 SOC visit note did not include documentation of Patient #3's ability to manage his insulin dosing. During an interview, on 7/09/14 at 2:35 PM, the RN who completed Patient #3's SOC assessment stated the patient did not have his insulin at the time of her visit. She confirmed she did not inform Patient #3's physician that he did not have insulin available to comply with the sliding scale orders. The RN included the sliding scale insulin on Patient #3's POC without notifying the physician he did not have insulin available. - Patient #3's sliding scale insulin order required him to use a glucometer to check his blood sugar level three times a day to determine the dose of insulin to be injected. Patient #3's record included a "Visit Note Report" dated 7/08/14, and signed by the RN Case Manager. The narrative section of the note included, "Pt stated that his glucometer recently broke. Pt stated that he has ordered a new one." There was no documentation to indicate the the RN Case Manager contacted Patient #3's physician for possible updates to his POC, given Patient #3's inability to check his blood sugar levels and take his insulin as ordered. <p>During an interview on 7/09/14 at 1:40 PM, the RN Case Manager reviewed Patient #3's record and confirmed his physician had not been informed he was unable to check his blood sugar levels and take his insulin accordingly.</p> <p>Patient #3's POC was not initially developed, nor subsequently updated, by the RN to address his medical and nursing needs.</p> <p>2. Patient #10 was a 72 year old female admitted</p>	G 173		

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

PRINTED: 07/28/2014
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 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646		
(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 173	<p>Continued From page 50</p> <p>on 3/14/14 for SN, PT, HHA, and OT services related to surgical complications. Additional diagnoses included acute myocardial infarction, non-healing surgical wound, DM Type II uncontrolled, chronic skin ulcer, obstructive chronic bronchitis with acute exacerbation.</p> <p>Patient #10's POC, for the certification period 3/14/14 to 5/12/14, was reviewed. It did not include orders for oxygen therapy.</p> <p>In a SN visit note, dated 4/7/14, the RN documented Patient #10's oxygen saturations were 87% at 1.5 liters per minute. There was no documentation of communication with the physician to obtain an order for the oxygen or to obtain parameters. Visit notes dated 4/10/14, 4/14/14, 4/15/14, and 4/25/14 indicated Patient #10 was receiving oxygen therapy, however, twelve other visit notes did not indicate if Patient #12 was on oxygen.</p> <p>During an interview, on 7/11/14 at 9:30 AM, the DON reviewed Patient #10's record and confirmed there was no documented communication with the physician. She stated Patient #10's oxygen saturation levels were outside of the agency's accepted parameters.</p> <p>The RN did not ensure Patient #10's POC was not initiated or updated to included orders for oxygen.</p>	G 173	<p>G173 PLAN (Part B): Director of Nursing or designee will instruct all staff by 8/15/2014 on the completion of the 485 plan of care to include all diagnosis pertinent to the care of the patient's current plan of care, DME equipment; i.e. wheelchairs, walkers, hospital beds. Oxygen to be included on all relevant plans of care, including the medication profile with the liter per minute and if the use is intermittent or continuous. For patients being followed by more than one physician, staff will be instructed that all secondary ordering physicians must be listed on the patients' plan of care in locator 21. Office staff will be instructed to send a copy of the 485 to the secondary physicians identified.</p> <p>Director of Nursing will review 100% of all 485 plans of care; diagnosis, equipment, patient use of oxygen and secondary physician(s) until 100% compliance is achieved. Ongoing Director of Nursing or designee will review quarterly through the clinical auditing process, auditing 10% of the clinical records based on the average daily census, 50% active and 50% inactive.</p> <p>Responsible: Director of Nursing has overall responsibility for the corrective action and ongoing completion of this standard.</p> <p>Completion: 8/15/14</p>	
G 175	<p>484.30(a) DUTIES OF THE REGISTERED NURSE</p> <p>The registered nurse initiates appropriate preventative and rehabilitative nursing procedures.</p>	G 175	<p>G175 PLAN (Part A): Director of Nursing or Designee will instruct staff by 8/13/2014 on preventive skin care measures; integumentary</p>	

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

PRINTED: 07/28/2014
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER: 137114	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646		
(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 175	Continued From page 51 This STANDARD is not met as evidenced by: Based on medical record review, observation, and staff and patient interview it was determined , the agency failed to ensure the registered nurse adequately evaluated patients to determine needed preventative or rehabilitative nursing measures for 1 of 5 sample patients (#3) who received SN services for wound care. This resulted in a patient developing a pressure sore. Findings include: Patient #3 was a 54 year old male, admitted to the agency on 5/29/14, for care related to non-healing surgical wounds. Additional diagnoses included complication of cystostomy, DM Type 11, polyneuropathy, bipolar disorder, anxiety, Hepatitis C, HTN, colostomy, urinary device, lower limb amputation, cerebral infarct, transient ischemic attack. He received SN, PT, and HHA services. During an interview, on 7/08/14 at approximately 8:30 AM, the RN Case Manager stated she had been unable to reach Patient #3 by phone and thought he may have been admitted to the hospital. She stated on 7/04/14, while at Patient #3's home, he told her he was going to call 911 because he felt as though he may have skin breakdown in his sacral area. When asked if she assessed him for skin breakdown, she stated he was very large and she was unable to turn him so she had never assessed the skin on his back side. During a home visit on 7/08/14 at 2:30 PM, Patient #3 stated he had not been out of bed since returning home from the hospital	G 175	assessment, nutrition, positioning, patient hygiene, signs/symptom of pressure areas/skin breakdown, levels of care appropriate for home care/ALF Director of Nursing or designee to instruct staff 8/13/2014 all patient at the time of admission noted having a blood glucose machine, the admission nurse is to assess the working order of the machine, patient should be able to demonstrate proper use of the machine, taking of blood sample and obtaining a random blood glucose reading. Staff to be instructed to setting, caregiver training, community resources, specialized surface mattress; resources and requirements to obtain surface support, and referral for therapy evaluation to assess patient mobility and caregiver training and proper documentation in the clinical record of teaching and measures implemented. Director of Nursing or Designee will review 100% of clinical records until clinicians demonstrate 100% accurate documentation. Director of Nursing or designee will review quarterly through the clinical auditing process, auditing 10% of the clinical records based on the average daily census, 50% active and 50% inactive. Responsible: Director of Nursing has overall responsibility for the corrective action and ongoing completion of this standard. Completion: 8/13/14		

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

PRINTED: 07/28/2014
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 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646		
(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 175]	<p>Continued From page 52</p> <p>approximately 2 months prior. He was paralyzed from the waist down and his right leg was observed to be contracted and rotated outward. He stated he was unable to move his legs, but could turn to his side if someone pulled his right leg over for him.</p> <p>SN visit notes dated 6/05/14, 6/13/14, 6/17/14, and 6/30/14, signed by the RN Case Manager, were reviewed. The 4 notes documented Patient #3's skin was assessed. There was no documentation to indicate the RN was unable to assess the patient's entire body.</p> <p>A SN visit note, dated 7/08/14 at 10:10 AM, and signed by the RN Case Manager, was reviewed. It documented a stage 2 pressure ulcer on Patient #3's right outer ankle that had not been identified prior to that visit.</p> <p>A home visit was made on 7/11/14 at 9:00 AM, to observe an RN visit. The visit was completed by the RN identified as the agency's wound specialist. The RN assessed the wound on Patient #3's right outer ankle and identified it as a stage 3 pressure ulcer.</p> <p>Patient #3's POC, for the certification period 5/29/14 - 7/27/14, did not include orders appropriate for a patient who was bedbound and at risk for skin breakdown, such as turning the patient at least every 2 hours and interventions to relieve pressure and prevent pressure ulcers. Additionally, it did not include patient/caregiver education related to the risk of skin breakdown.</p> <p>During an interview on 7/09/14 at 1:40 PM, the RN Case Manager confirmed her visit notes documented she assessed Patient #3's skin and</p>	G 175	<p>G175 PLAN (Part B):</p> <p>Director of nursing will instruct staff by 8-6-14 if they are in a situation where they cannot fully assess a patient without assistance due to the size of the patient, inability of the patient to reposition themselves and/or lack of caregiver assistance, then staff are to make arrangements for a second staff person to assist them. In-services will also include skin pressure relief measures, s/s breakdown, when to notify the nurse or MD, repositioning, use of surface support, appropriate levels of home care, caregiver instruction., request from MD PT referral – to train the patient/caregiver on repositioning techniques.</p> <p>Director of Nursing or Designee will review 100% of the clinical records until the clinical audits demonstrate 100% compliance, then ongoing the agency will review, based on the average daily census 50% of active clinical record and 50% discharge records on a quarterly basis. All variances of indicators of less than 85% will require that an action plan with auditing is continued until compliance is obtained.</p> <p>Responsible: Director of Nursing has overall responsibility for the corrective action and ongoing completion of this standard.</p> <p>Completion: 8/6/14</p>	

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

PRINTED: 07/28/2014
FORM APPROVED
OMS NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTJON	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER: 137114	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646	
(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 54</p> <p>HHA and PT services.</p> <p>The RN Case Manager did not ensure Patient #3's physician was informed of changes in his condition as follows:</p> <p>a. Upon referral for home health services on 5/29/14, the agency received a list of Patient #3's medications from his physician's office. The list included Xarelto, an anticoagulant medication used to prevent blood clots.</p> <p>Patient #3's POC for the certification period 5/29/14 - 7/27/14, did not include Xarelto. An untitled document in his record which listed Patient 3's medication, signed by the RN at SOC on 5/29/14, included documentation that Patient #3 refused to take the medication. However, there was no documentation indicating his physician was notified of his refusal.</p> <p>During an interview, on 7/09/14 at 2:35 PM, the RN who completed Patient #3's SOC assessment confirmed she did not notify Patient #3's physician of his refusal to take Xarelto.</p> <p>b. Patient #3's POC included orders for sliding scale insulin (dose of insulin based on blood glucose levels) to be administered three times a day.</p> <p>The SOC assessment did not include documentation of Patient #3's ability to manage his insulin dosing.</p> <p>During an interview on 7/09/14 at 2:35 PM, the RN who completed Patient #3's SOC assessment on 5/29/14, stated Patient #3 did not have his insulin at the time of her visit. She confirmed she</p>	G 176	<p>process, auditing 10% of the clinical records based on the average daily census, 50% active and 50% inactive.</p> <p>Responsible: Director of Nursing has overall responsibility for the corrective action and ongoing completion of this standard.</p> <p>Completion: 8/6/14</p>

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

PRINTED: 07/28/2014
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 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646		
(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 55</p> <p>did not inform Patient #3's physician that he did not have insulin available to comply with the sliding scale orders.</p> <p>c. Life's Doors Home Health and Hospice procedure, Section 6-9, titled "Endocrine: Hyperglycemia" stated, "The MD should be notified for blood glucose levels greater than 200 mg/dl unless the MD has previously ordered parameters"</p> <p>Patient #3's record included a "Visit Note Report" dated 6/05/14, and signed by the RN Case Manager. The visit note included a fasting blood sugar result of 209 mg/dl. The note stated the patient checked his blood sugar level daily and results ranged from 130-270 mg/dl. There was no documentation to indicate the physician was notified of Patient #3's elevated blood sugar levels.</p> <p>Patient #3's record included a "Visit Note Report" dated 6/11/14, and signed by an LPN. The visit note included a fasting blood sugar result of 246 mg/dl. The note stated the patient checked his blood sugar level three times a day and results ranged from 90-350 mg/dl. There was no documentation to indicate the RN Case Manager or the physician was notified of Patient #3's elevated blood sugar levels.</p> <p>Patient #3's record included a "Visit Note Report" dated 6/30/14, and signed by the RN Case Manager. The note stated the patient checked his blood sugar level daily and results ranged from 77-272 mg/dl. There was no documentation to indicate the physician was notified of Patient #3's elevated blood sugar levels.</p>	G 176		

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

PRINTED: 07/28/2014
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 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646		
(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	Continued From page 56 Patient #3's record included a "Visit Note Report" dated 7/08/14, and signed by the RN Case Manager. The note stated the patient checked his blood sugar level daily and results ranged from 222-300 mg/dl. There was no documentation to indicate the physician was notified of Patient #3's elevated blood sugar levels. During an interview on 7/09/14 at 1:40 PM, the RN Case Manager reviewed Patient #3's record and confirmed his physician had not been informed of his elevated blood sugar levels. d. Patient #3's sliding scale insulin order required him to use a glucometer to check his blood sugar three times a day to determine the dose of insulin to be injected. Patient #3's record included a "Visit Note Report" dated 7/08/14, and signed by the RN Case Manager. The narrative section of the note included, "Pt stated that his glucometer recently broke. Pt stated that he has ordered a new one." There was no documentation to indicate the physician was notified of Patient #3's inability to check his blood sugar levels and take his insulin as ordered. During an interview on 7/09/14 at 1:40 PM, the RN Case Manager reviewed Patient #3's record and confirmed his physician had not been informed he was unable to check his blood sugar levels and take his insulin accordingly. Patient #3's physician was not notified of changes in his condition.	G 176			

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

PRINTED: 07/28/2014
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 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE.			STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646		
(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	Continued From page 57 2. Patient #10 was a 72 year old female admitted on 3/14/14 for SN, PT, HHA, and OT services related to surgical complications. Additional diagnoses included acute myocardial infarction , non-healing surgical wound, DM Type II uncontrolled, chronic skin ulcer, obstructive chronic bronchitis with acute exacerbation. a. Patient #10's POC, for the certification period 3/14/14 to 5/12/14, was reviewed. It did not include orders for oxygen therapy. In a SN visit note, dated 4/7/14, the RN documented Patient #10's oxygen saturations were 87% at 1.5 liters per minute. There was no documentation of communication with the physician to obtain an order for the oxygen or to obtain parameters. Visit notes dated 4/10/14, 4/14/14, 4/15/14, and 4/25/14 indicated Patient #10 was receiving oxygen therapy, however, twelve other visit notes did not indicate if Patient #12 was on oxygen. During an interview, on 7/11/14 at 9:30 AM, the DON reviewed Patient #10's record and confirmed there was no documented communication with the physician. She stated Patient #10's oxygen saturation levels were outside of the agency's accepted parameters. The RN Case Manager did not clarify oxygen orders with the physician and notify the physician of decreased oxygen saturation levels. b. Patient #10's POC, for the certification period 3/14/14 to 5/12/14, was reviewed and the following was noted: - In a PT note, dated 4/14/14 at 8:45 AM, the	G 176			

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

PRINTED: 07/28/2014
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 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646		
(X4) IO 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 58</p> <p>therapist documented he spoke with the RN Case Manager to inform her that Patient #10 was vomiting her medications. He documented the RN Case Manager was going to call the physician. However, the nurse visit note, documented by the RN Case Manager on 4/14/14 at 12:35 PM, did not indicate the RN Case Manager spoke with the therapist, evaluated Patient #10's vomiting, or contacted her physician.</p> <p>- In a PT note, dated 4/23/14 at 10:10 AM, the therapist documented he spoke with the RN Case Manager regarding Patient #10's low blood pressure measurement during his visit, and her complaint of nausea. Patient #10's medical record was reviewed for documentation the RN Case Manager was aware of Patient #10's low blood pressure or nausea. None was found. There was no documentation Patient #10's physician was notified.</p> <p>- In a PT note, dated 4/28/14 at 8:40 AM, the therapist documented he informed the RN Case Manager that Patient #10 had diarrhea over the weekend. However, a nursing visit note documented by the RN Case Manager on 4/29/14 at 2:05 PM, did not indicate Patient #10 was assessed for her complaint of diarrhea over the weekend or her bowel status during the visit.</p> <p>- In a PT note, dated 5/5/14 at 8:40 AM, the therapist documented he informed the RN Case Manager of Patient #10's blood sugar of 70. He documented the RN Case Manager was to call Patient #10's son. Patient #10's record did not indicate the RN Case Manager contacted Patient #10's son regarding the low blood sugar result.</p>	G 176			

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

PRINTED: 07/28/2014
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 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646	
(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 59</p> <p>During an interview on 7/09/14 beginning at 4:00 PM, the DON reviewed Patient #10's medical record and confirmed the documentation by the physical therapist. She confirmed the notes indicated communication occurred from the therapist to the RN Case Manager, but not from the Case Manager to Patient #10's physician. The DON stated the RN Case Manager was no longer employed by the agency.</p> <p>The RN did not coordinate Patient #10's care with his physician.</p> <p>G 177 484.30(a) DUTIES OF THE REGISTERED NURSE</p> <p>The registered nurse counsels the patient and family in meeting nursing and related needs.</p> <p>This STANDARD is not met as evidenced by: Based on record review, observation during a home visit, and patient and staff interview, it was determined the agency failed to ensure the registered nurse provided necessary instruction to patients or caregivers for 1 of 5 sample patients (#3) who received SN services for wound care and whose records were reviewed. The lack of patient education may have contributed to negative patient outcomes. Findings include:</p> <p>Patient #3 was a 54 year old male admitted to the agency on 5/29/14 for care related to non-healing surgical wounds. Additional diagnoses included complication of cystostomy, DM Type 11, polyneuropathy, bipolar disorder, anxiety, Hepatitis C, HTN, colostomy, urinary device, lower limb amputation, cerebral infarct, transient ischemic attack. He received SN, PT and HHA</p>	G 176	<p>G 177 PLAN (Part A):</p> <p>Director of Nursing or Designee will instruct staff by 8/13/14 on how to instruct patient's on the teaching needs identified during their admission assessment, i.e. blood glucose monitoring, including parameters for reporting to the MD, ordered diet, infection control, hand hygiene, wound care, disposal of soiled wound dressings, skin care, i.e. pressure relief transfer training pain management, community resources, etc. Instruction to include documentation of what was taught to the patient or caregiver, if the patient/caregiver verbalized understanding, and if additional teaching is required. Coordination notes in the electronic documentation system have been updated to include a template to prompt the clinicians to document the training, interventions, and follow up needed.</p> <p>Director of Nursing or Designee will review 100% of clinical records until clinicians demonstrate 100% accurate documentation. Director of Nursing or designee will review quarterly through the</p>

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

PRINTED: 07/28/2014
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 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646		
(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 177	<p>Continued From page 60</p> <p>services. Patient #3's diagnoses included OM and non-healing surgical wounds. Patient #3 was also paralyzed from the waist down.</p> <p>-Patient #3's diagnoses included OM and non-healing surgical wounds. However, his POC for the certification period 5/29/14 - 7/27/14, did not include patient/caregiver education related to his 1800 calorie ADA diet, or nutritional needs for wound healing.</p> <p>-Patient #3's POC included sliding scale insulin (insulin dosing based on blood sugar levels). However, it did not include patient/caregiver education related to the use of a glucometer to check blood sugar levels or the administration of sliding scale insulin. Additionally, the POC did not include education regarding the importance of therapeutic blood sugar levels for wound healing.</p> <p>During a home visit on 7/08/14 at 2:30 PM, Patient #3 was questioned about his diabetes and management of his blood sugar levels, including sliding scale. He stated he was unable to measure his blood sugar levels for the last several days because his glucometer was not working. He stated he was taking his routine insulin and felt that was adequate because he did not want his blood sugar level to be too low. He stated that when he was checking his blood sugar levels, he sometimes had a fasting blood sugar level as low as 150mg/dl and he felt that was too low. Per the American Diabetes Association, a normal fasting blood sugar level is 70-130 mg/dl. A fasting blood sugar level of 150 is above the desired level.</p> <p>- During the home visit on 7/08/14 at 2:30 PM, Patient #3 also stated he had not been out of bed</p>	G 177	<p>clinical auditing process, auditing 10% of the clinical records based on the average daily census, 50% active and 50% inactive.</p> <p>Responsible: Director of Nursing has overall responsibility for the corrective action and ongoing completion of this standard.</p> <p>Completion: 8/13/14</p>	

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

PRINTED: 07/28/2014
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 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646		
(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 177	<p>Continued From page 61</p> <p>since returning home from the hospital approximately 2 months prior. He was paralyzed from the waist down and his right leg was observed to be contracted and rotated outward. He stated he was unable to move his legs, but could turn to his side if someone pulled his right leg over for him. Patient #3's POC for the certification period 5/29/14 - 7/27/14, did not include patient/caregiver education related to the risk of skin breakdown and the importance of frequent position changes, maintaining clean, dry skin and checking skin frequently for signs of impending breakdown.</p> <p>A SN visit note, dated 7/08/14 at 10:10 AM, and signed by the RN Case Manager, was reviewed. It documented a stage 2 pressure ulcer on Patient #3's right outer ankle that had not been identified prior to that visit.</p> <p>A home visit was made on 7/11/14 at 9:00 AM, to observe an RN visit. The visit was completed by the RN identified as the agency's wound specialist. The RN assessed the wound on Patient #3's right outer ankle and identified it as a stage 3 pressure ulcer.</p> <p>During an interview on 7/09/14 at 2:35 PM, the RN who completed the SOC assessment and created the POC reviewed Patient #3's record and confirmed the POC was not complete to address all of Patient #3's educational needs.</p> <p>Patient #3's POC was not comprehensive to meet all his needs.</p>	G 177	<p>G177 PLAN (Part B): Director of Nursing or Designee will instruct staff by 8/15/14 on performing accurate wound assessments, including identification of wounds, accurate measurements, interventions, accurate wound care orders, and documentation of wound assessments. An updated Wound Assessment Module will be implemented by 8-15-14, as part of the electronic medical record which will allow the clinicians to accurately designate wound locations and assessments. This will allow the clinicians to perform follow up documentation on the correctly identified wound at each visit.</p> <p>Director of Nursing or Designee will review 100% of clinical records until clinicians demonstrate 100% accurate documentation of wound assessments. Director of Nursing or designee will review quarterly through the clinical auditing process, auditing 10% of the clinical records based on the average daily census, 50% active and 50% inactive.</p> <p>Responsible: Director of Nursing has overall responsibility for the corrective action and ongoing completion of this standard.</p> <p>Completion: 8/15/14</p>	
G 224	484.36(c)(1) ASSIGNMENT & DUTIES OF HOME HEALTHAIDE	G 224	G224 PLAN: Director of Nursing will instruct admitting and supervising clinicians on the completion of the Home	

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

PRINTED: 07/28/2014
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 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646		
(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 CROSSREFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 224	<p>Continued From page 62</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: Based on record review and patient and staff interview, it was determined the agency failed to ensure RNs prepared accurate and current written patient care instructions for the home health aides of 1 of 2 patients (#3) who were receiving aide services and whose records were reviewed. This resulted in aides providing services not included on the plan of care, and in inaccurate documentation. Findings include:</p> <p>Patient #3 was a 54 year old male admitted to the agency on 5/29/14 for care related to non-healing surgical wounds. Additional diagnoses included complication of cystostomy, OM Type II, polyneuropathy, bipolar disorder, anxiety, Hepatitis C, HTN, colostomy, urinary device, lower limb amputation, cerebral infarct, transient ischemic attack. He received SN, PT and HHA services.</p> <p>Patient #3's record included an "Aide Care Plan Report" with an effective date of 5/29/14. The services to be provided by the HHA included the following: -Transfer client from bed/chair prn Slider board to WC, uses Trapeze -Transfer client from chair/bed prn Slider board and trapeze -Bathing (tub bath/shower) 2X week Uses tub chair with back</p>	G 224	<p>Health Aide Plan of Care and level of care that can be performed within the scope of duties of the home health aide by 8/06/2014. Home Health Aides will receive instruction including; following the Home Health Aide Plan of Care, when to report patient changes that necessitate a change in the plan of care, documentation of communication with team members, and identification of tasks that can be assigned to the aide within their scope of practice.</p> <p>Director of Nursing or designee will review 100% of Home Health Aide Plans of Care and Home Health Aide Documentation until 100% compliance is achieved</p> <p>Director of Nursing or designee will review quarterly through the clinical auditing process, auditing 10% of the clinical records based on the average daily census, 50% active and 50% inactive.</p> <p>Responsible: Director of Nursing has overall responsibility for the corrective action and ongoing completion of this standard.</p> <p>Completion: 8/06/14</p>	

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

PRINTED: 07/28/2014
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 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646		
(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 63</p> <p>During an interview, on 7/08/14 at approximately 8:30 AM, the RN Case Manager stated Patient #3 was very large and she was unable to turn him. When asked how the HHA was able to bathe him she stated she did not know as she had not observed a HHA visit</p> <p>During a home visit on 7/08/14 at 2:30 PM, Patient #3 stated he had not been out of bed since returning home from the hospital approximately 2 months prior. He was paralyzed from the waist down and stated he was unable to move his legs, but could turn to his side with assistance. Patient #3 stated the HHA had given him a bed bath on each HHA visit</p> <p>During an interview on 7/09/14 at 2:35 PM, the RN who completed the SOC assessment and created the HHA care plan, stated she instructed the HHA to perform a tub bath or shower because Patient #3 told her he could transfer to the shower. She stated he was in bed during her visit and she did not attempt to transfer him to a chair.</p> <p>Patient #3's record contained HHA Visit Note Reports dated 6/09/14, 6/12/14, 6/26/14, and 7/01/14. The visit notes documented a tub bath/shower was performed during the visit</p> <p>During an interview on 7/10/14 at 12:15 PM, the DON stated the HHA had performed a bed bath on each visit, however, the electronic medical record would not allow the HHA to document a bed bath if it was not included on the HHA care Plan.</p> <p>Patient #3's written HHA care plan instructions were not appropriate for his care.</p>	G 224		

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

PRINTED: 07/28/2014
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 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646		
(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 236 G 236	Continued From page 64 484.48 CLINICAL RECORDS A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary. This STANDARD is not met as evidenced by: Based on review of medical records and agency policy and staff interview it was determined the agency failed to ensure medical records contained timely, complete, and accurate documentation for 6 of 10 sample patients (#3 - #8) whose records were reviewed. This failure had the potential to interfere with clarity of the record and impede coordination and safety of patient care. Findings include: An agency policy titled "ENTRIES INTO THE CLINICAL RECORD," revised April 2014, stated "Entries into the clinical record will be made on the day care is provided to the patient. All documentation will be compiled within the electronic medical record within the approved timelines. Entries into the clinical record will be clear, concise, and specific statements of fact." 1. Patient #3 was a 54 year old male admitted to the agency on 5/29/14, for services related to non-healing surgical wounds. Additional diagnoses included complication of cystostomy,	G 236 G 236	G236 PLAN (Part A): Director of Nursing or designee will instruct all staff by 8/15/14 regarding: documentation is to be completed within the clinical record on the day the care is provided using the correct terminology, how to use forms within the electronic medical record, which includes the use of the wound care documentation forms, proper supervision of dependent disciplines including all aspects of adequate supervision including reviewing home health aide plan of care for accuracy, required timelines of the supervision of home health aides, and other dependent disciplines such as PTA's, instruction on who is responsible to supervise, documentation of physician notification and communications, and which form to use in the electronic documentation system if the discipline is requesting orders when unable to speak directly to the MD. All agency forms utilized for patient care will be clearly identified with the agency name, specifically as Life's Doors Home Health including the location address, telephone number, and fax number. Completion: 7-8-14. Director of Nursing or designee will review 100% of Home Health Aide Plans of Care and Home Health Aide Documentation until 100% compliance is achieved Director of Nursing or designee will review quarterly through the clinical auditing process, auditing 10% of the clinical records based on the average daily census, 50% active and 50% inactive. Responsible: Director of Nursing has overall responsibility for the corrective action and ongoing completion of this		

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

PRINTED: 07/28/2014
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 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646	
(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)
G 236	<p>Continued From page 65</p> <p>OM Type II, polyneuropathy, bipolar disorder, anxiety, Hepatitis C, HTN, colostomy, urinary device, lower limb amputation, cerebral infarct and transient ischemic attack. He received SN, HHA and PT services. Patient #3's medical record lacked clarity and accuracy as follows:</p> <p>a. Patient #3's record included a "Wound Assessment Tool Report" initiated on 5/29/14. The report identified 3 wounds as follows: -Wound Body Part: Other, Wound Location: Right, Wound Type: Surgical Incision -Wound Body Part: Other, Wound Location: Right, Wound Type: Surgical Incision -Wound Body Part: Other, Wound Location: Medial, Wound Type: excoriation</p> <p>The wound report contained information about each wound, including measurements, drainage and appearance. Similar entries were dated 6/02/14 and 6/24/14. The measurements of the 2 surgical incisions were inconsistent. As result of the lack of individual wound identifiers, it could not be determined which wound was being assessed. This impeded the ability of nursing staff to track the progress of wound healing.</p> <p>During an interview on 7/09/14 at 2:35 PM, the nurse who completed the wound assessments on 5/29/14 and 6/02/14, stated she found the wound assessment tool difficult to use. She reviewed Patient #3's record and confirmed the 2 surgical incisions were not identified adequately to differentiate between them on subsequent visits. She stated the entries on 6/02/14 were inaccurate as she had entered the measurements on the wrong surgical incision.</p> <p>Patient #3's wound documentation did not identify</p>	G 236	<p>standard.</p> <p>Completion: 8/15/14</p>

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

PRINTED: 07/28/2014
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 07/11/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646
--	--

(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 236	<p>Continued From page 66 the location of his wounds, and contained inaccurate assessment information.</p> <p>b. A "Visit Note Report" dated 6/05/14, and signed by the RN, included documentation of supervision of a HHA and therapist. However, the first HHA visit did not occur until 6/08/14, and the initial PT evaluation visit was dated 7/08/14. Additionally, the section of the note titled "Care Coordination" stated the RN communicated with a physical therapist, occupational therapist and HHA Patient #3's record did not include orders for OT services.</p> <p>During an interview on 7/09/14 at 1:40 PM, the RN who completed the 6/05/14 visit stated she thought HHA services had been initiated and confirmed she did not communicate with the HHA regarding Patient #3. Additionally she confirmed she did not communicate with a physical therapist or occupational therapist. She stated the entry regarding communication with the physical therapist, occupational therapist and HHA was just a mistake.</p> <p>Patient #3's medical record contained inaccurate information related to care coordination.</p> <p>2. Patient #7 was a 70 year old male admitted to the agency on 4/24/14, for PT services related to cerebral vascular accident. Additional diagnoses included hemiplegia, occlusion and stenosis vertebral artery, OM Type II, hypertension, hyperlipidemia, history of fall, long-term and use of insulin.</p> <p>Patient #7's record was reviewed for the certification period 4/24/14 to 6/22/14 and the following was noted:</p>	G 236		

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

PRINTED: 07/28/2014
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER: 137114	(X2) _MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646		
(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 236	<p>Continued From page 67</p> <p>-In a PT visit note, dated 4/24/14, the therapist documented two blood pressure measurements. The initial measurement at 2:30 PM of 91/49, and 75/43 at 2:59 PM. The visit note documented the therapist notified the physician, however, the visit note documented in another section the physician was not notified.</p> <p>During an interview, on 7/11/14 at 9:15 AM, the therapist who provided care to Patient #7 reviewed the record and confirmed that the physician was not notified of blood pressure measurements.</p> <p>3. Patient #8 was a 96 year old female, admitted to the agency on 6/07/14, for SN and PT services related to CHF, dementia, and irregular heartbeat.</p> <p>a. Included in Patient #B's record was a form titled "Interagency/Interfacility Physician Orders," dated 6/06/14. The form was a referral to a home health agency owned by the same organization as Life's Doors. The form indicated Patient #8 was hospitalized on 6/04/14 and was to be discharged 6/06/14. No documentation was found in Patient #S's record to indicate why she was admitted to Life's Doors Home Health, when she was referred to a different agency.</p> <p>During an interview 7/09/14 beginning at 3:30 PM, the DON reviewed Patient #B's record and confirmed the referral was to a different agency.</p> <p>b. Patient #8's medical record included 2 forms, identified as "HOME HEALTH NURSING PROGRESS NOTE," each dated 6/08/14. One form had "copy" written in the upper right corner.</p>	G 236		

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

PRINTED: 07/28/2014
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 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646		
(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 236	<p>Continued From page 6S</p> <p>Both forms indicated the time of the nursing visit was 8:30 to 9:30 AM. Discrepancies noted on the two documents are as follows:</p> <ul style="list-style-type: none"> - The first form noted Patient #S's temperature as 99.0 - The copy noted Patient #S's temperature as 96.7 - The first form noted Patient #S's blood pressure as 112/63 - The copy noted Patient #S's blood pressure as 136/6S - The first form noted Patient #S's pulse as 94 - The copy noted Patient #S's pulse as 88 - The first form noted Patient #S as being on a special cardiac diet, and appetite was noted to be poor - The copy noted Patient #8 was on a regular diet, and appetite was noted to be good <p>During an interview on 7/09/14 at 2:30 PM, the RN who provided care to Patient #8 on 6/08/14 reviewed her record and confirmed the discrepancies. She stated the form with "copy" written in the upper right corner was a copy for the ALF where Patient #S resided. She was unable to explain why the vital signs and other details as noted above were different.</p> <p>Patient #S's medical record did not include accurate information.</p> <p>4. Patient #6 was a 65 year old female, admitted to the agency on 6/13/14, for PT services only. Her diagnoses included pneumonia, CHF, Type II DM, CKD, COPD, and difficulty in walking.</p>	G 236		

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

PRINTED: 07/28/2014
FORM APPROVED
OMB NO 0938-0394

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 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646	

(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 CROSSREFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 236	<p>Continued From page 69</p> <p>- One form, dated 6/13/14, was documented by an occupational therapist. The title of the form was "PHYSICIAN VERBAL ORDER." The form had Life's Doors Home Health and Hospice at the top and listed the address of the agency's previous physical address. Additionally, the form contained the query "Order Read Back to Physician?" followed by a "Y", indicating yes. The form stated "PT DECLINED OT SERVICES." The form was not signed by a physician, and it was not noted by an RN.</p> <p>- One form, dated 6/17/14, was documented by the physical therapist who performed the SOC comprehensive assessment. The form was approved by an RN. The section where the physician was to sign had an entry blank. The title of the form was "PHYSICIAN VERBAL ORDER." The form had Life's Doors Home Health and Hospice at the top and listed the address of the agency's previous physical location. Additionally, the form contained the query "Order Read Back to Physician?" followed by a "Y", indicating yes. The form stated "PLEASE CONSIDER APPROVAL FOR MEDICAL SOCIAL WORKER TO ASSIST WITH COMMUNITY RESOURCES."</p> <p>During an interview on 7/11/14 beginning at 9:15 AM, the Physical Therapist who performed the SOC comprehensive assessment reviewed Patient #6's record and confirmed the two forms were not actually verbal orders. He stated the forms are initiated at the office and sent to the physician for signature. The therapist stated he did not speak to the physician on 6/17/14 and</p>	G 236	<p>G236 PLAN (Part B): Director of Nursing or designee will instruct all clinicians by 8/15/14, on use of the electronic documentation system and "Physician Verbal Orders" and that the "Order Read Back to Physician" defaults to a "Yes" answer. Clinicians will be instructed to remove the default "Y" mark when they have not spoken to the physician to read back the order. In addition, a "Physician Communication/SBAR" note type has been implemented to allow the clinicians to request orders and to provide communication from/to the physician.</p> <p>All agency forms, hard copy and electronic that are utilized for patient care will be clearly identified with the agency name, specifically as Life's Doors Home Health including the location address, telephone number, and fax number. Completion: 7-8-14</p> <p>Director of Nursing or designee will review 100% of Physician Verbal Orders to demonstrate 100% compliance. Director of Nursing or designee will review quarterly through the clinical auditing process, auditing 10% of the clinical records based on the average daily census, 50% active and 50% inactive.</p> <p>Responsible: Director of Nursing has overall responsibility for the corrective action and ongoing completion of this standard.</p> <p>Completion: 8/15/14</p>	

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

PRINTED: 07/28/2014
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 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646		
(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 236	<p>Continued From; page 70 : receive a verbal order.</p> <p>Patient #6's medical record did not include accurate information.</p> <p>5. Patient #4 was a 78 year old female, admitted to the agency on 7/01/14, for SN and PT services related to back pain and degenerative joint disease.</p> <p>Patient #4's record included a form titled "Home Health Order/Face-to-Face Encounter/Certification of Services", signed by the physician on 6/30/14. The form was a referral for home health services, and the agency's name was crossed through and the name of another agency under common ownership was written in. There was no further documentation in Patient #4's record to indicate why she was admitted to Life's Doors Home Health, and not the agency her physician referred her to.</p> <p>During an interview 7/09/14 beginning at 3:30 PM, the DON reviewed Patient #4's record and confirmed the referral was to a different home health agency.</p> <p>6. Patient #5 was a 75 year old female admitted to the agency on 5/27/14 for SN services related to COPD, weakness, CKD, and HTN.</p> <p>Patient #5's record included forms titled "PHYSICIAN VERBAL ORDER," that were determined to not be verbal orders as follows:</p> <p>- One form, dated 5/22/14, was noted by an LPN. The section the physician was to sign had an entry "DO NOT SEND." The title of the form was "PHYSICIAN VERBAL ORDER." The form had</p>	G 236	<p>G236 PLAN (Part C): All agency forms, hard copy and electronic that are utilized for patient care will be clearly identified with the agency name, specifically as Life's Doors Home Health including the location address, telephone number, and fax number. Completion: 7-8-14</p> <p>If Life's Doors Home Health and Hospice is unable to accept a referral, the physician and patient/DPOA will be contacted and offered referral to another agency and documentation of this will occur in the patient's medical record. Completion by 7/11/14.</p> <p>Director of Nursing or designee will review 100% of Non-admits to ensure compliance. Director of Nursing or designee will review quarterly through the clinical auditing process, auditing 10% of the clinical records based on the average daily census, 50% active and 50% inactive.</p> <p>Responsible: Director of Nursing has overall responsibility for the corrective action and ongoing completion of this standard.</p>	

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

PRINTED: 07/28/2014
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 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646		
(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 236	Continued From page 71 Life's Doors Home Health and Hospice near the top and listed the address of the agency's prior physical location. Additionally, the form included "Order Read Back to Physician?" followed by a "Y", for yes. The form stated "[name of home health agency under common ownership] LICENSED PROFESSIONAL TO EVALUATE PATIENT R/T WEAKNESS, COPD, RENAL FAILURE, HTN, AND ADMIT 5/22/14 FOR HOME HEALTH SN SERVICES; 1-2 VISITS W/POC TO FOLLOW. THANK YOU." It was unclear which home health agency was to provide services. The form was not signed by a physician, and it was not noted by an RN. During an interview, on 7/09/14 beginning at 3:40 PM, the DON reviewed the "PHYSICIAN VERBAL ORDER" form, and stated it was not a physician order. She stated the LPN who takes referrals initiated the form as part of the referral process. She stated the electronic medical record software system defaults to a physician verbal order, because there is no other option. The DON confirmed that it was misleading and led to confusion. - Patient #5's record included a consent form with a sticker at the top which read "Life's Doors." The form was signed by Patient #5, dated 5/27/14, and witnessed by the RN who performed the SOC comprehensive assessment on that date. The section of the form the RN signed noted she was a representative of another home health agency, not Life's Doors. The name of the other agency was referenced throughout the form as the agency providing the services. At the bottom of the form, 8 branch office locations and phone numbers were listed. Life's Doors did not have branch locations, however, the other agency	G 236	Completion: 7/11/14		

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

PRINTED: 07/28/2014
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 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646		
(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 236	Continued From page 72 did. The form lacked clarity as to which agency was providing home health services. During an interview on 7/09/14 beginning at 3:40 PM, the RN who performed the comprehensive assessment reviewed Patient #S's record and confirmed the consent form had the Life's Doors heading but other information referred to the a different agency. The RN stated the form was in the admission packet that she took out to Patient #S's home on S/27/14.	G 236			
G 330	Patient #5's medical record did not include accurate information. 484.S5 COMPREHENSIVE ASSESSMENT OF PATIENTS Each patient must receive, and an HHA must provide, a patient-specific, comprehensive assessment that accurately reflects the patient's current health status and includes information that may be used to demonstrate the patient's progress toward achievement of desired outcomes. The comprehensive assessment must identify the patient's continuing need for home care and meet the patient's medical, nursing, rehabilitative, social, and discharge planning needs. For Medicare beneficiaries, the HHA must verify the patient's eligibility for the Medicare home health benefit including homebound status, both at the time of the initial assessment visit and at the time of the comprehensive assessment. The comprehensive assessment must also incorporate the use of the current version of the Outcome and Assessment Information Set (OASIS) items, using the language and groupings of the OASIS items, as specified by the Secretary	G 330	G330 PLAN (Part A): Director of Nursing or Designee will instruct all admitting staff on the completion of the comprehensive patient assessment and documentation within the electronic documentation system. Instruction will include completing all additional special assessment forms; wounds, DME, Medications, accurate medication reconciliation, review of medical history and current condition, identification of the patients continuing need for home care, and measures to meet the patient's medical, nursing, rehabilitative, social, and discharge planning needs including gathering and completion of OASIS data, by 8/15/14 Director of Nursing or designee will review 100% of Comprehensive Assessment Documentation until 100% compliance is achieved. Ongoing Director of Nursing or designee will review quarterly through the clinical auditing process, auditing 10% of the clinical records based on the average daily census, 50% active & 50% inactive.		

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

PRINTED: 07/28/2014
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 _____ 8. WING _____	(X3) DATE SURVEY COMPLETED 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646	
(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 330	Continued From page 73 This CONDITION is not met as evidenced by: Based on medical record review and staff interview and review of agency policies, it was determined the agency failed to ensure comprehensive assessments accurately reflected patients' current health status and included a medication review. Failure to conduct a thorough comprehensive assessment had the potential to interfere with the delivery of safe and effective patient care. Findings include: 1. Refer to G331 as it relates to the failure of the agency to ensure the completion a comprehensive assessment at the SOC. 2. Refer to G332 as it relates to the failure of the agency to ensure the initial assessment was performed within 48 hours of referral. 3. Refer to G337 as it relates to the failure of the agency to ensure the comprehensive assessment included a medication review to obtain a current list of patient medications, evaluate for drug interactions, and identify possible significant side effects. The cumulative effect of these negative systemic practices significantly impeded the ability of the agency to provide complete and adequate care to patients.	G 330	Responsible: Director of Nursing has overall responsibility for the corrective action and ongoing completion of this standard. Completion: 8/15/14 G330 PLAN (Part B): Director of Nursing or designee, will instruct administrative staff member by 8/06/14 in reviewing and processing the "Lag Time Report" in the electronic documentation system on a daily basis during the work week to determine that all start of care evaluations are being performed with 48 hours of receipt of referral. Director of Nursing or designee will review 100% of referrals until 100% compliance is achieved. Ongoing, the Director of Nursing or designee will review quarterly through the clinical auditing process, auditing 10% of the clinical records based on the average daily census, 50% active and 50% inactive. Responsible: Director of Nursing has overall responsibility for the corrective action and ongoing completion of this standard. Completion: 8/06/14
G 331	484.55(a)(1) INITIAL ASSESSMENT VISIT A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including	G 331	G331 PLAN: Director of Nursing or designee to instruct all admitting disciplines by 8/15/14 on completion of an initial assessment and comprehensive assessment, including home health eligibility criteria for meeting homebound status. proper use of the Braden scale.

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

PRINTED: 07/28/2014
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 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646		
(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 331	<p>Continued From page 74 homebound status.</p> <p>This STANDARD is not met as evidenced by: Based on record review, patient interview, and staff interview, it was determined the agency failed to ensure the initial SOC comprehensive assessment included a thorough examination of identified items of concern for 2 of 10 patients (#3 and #5) whose records were reviewed. This resulted in incomplete plans of care. Findings include:</p> <p>1. Patient #3 was a 54 year old male admitted to the agency on 5/29/14, for services related to non-healing surgical wounds. Additional diagnoses included complication of cystostomy, OM Type II, polyneuropathy, bipolar disorder, anxiety, Hepatitis C, HTN, colostomy, urinary device, lower limb amputation, cerebral infarct and transient ischemic attack. He received SN, HHA and PT services.</p> <p>Patient #3's record included a SOC OASIS assessment, signed and dated by the RN on 5/29/14. The initial assessment was not complete and consistent. Examples include:</p> <p>a. The assessment did not contain an actual or estimated patient weight.</p> <p>b. The Braden Risk Assessment Scale (used to determine pressure sore risk) identified Patient #3 as "chairfast", however, the reason the "Timed Up and Go" screening was not performed stated "bedfast".</p> <p>c. OASIS M1830 stated, "Unable to use shower or tub...", however, the HHA Care Plan dated 5/29/14 and signed by the RN instructed the HHA to perform a shower or tub bath.</p> <p>d. OASIS M1850 stated, "Bedfast", however</p>	G 331	<p>obtaining relevant data for care planning, such as patients weights or patient stated weights, fall risk assessments and accurate OASIS coding as well as identifying and addressing any immediate care and support needs of the patient.</p> <p>Director of Nursing or designee will review 100% of Initial Assessment Documentation until 100% compliance is achieved. Ongoing Director of Nursing or designee will review quarterly through the clinical auditing process, auditing 10% of the clinical records based on the average daily census, 50% active and 50% inactive.</p> <p>Responsible: Director of Nursing has overall responsibility for the corrective action and ongoing completion of this standard.</p> <p>Completion: 8/15/14</p>	

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

PRINTED: 07/28/2014
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 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646		
(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 331	<p>Continued From page 75</p> <p>OASIS M1860 stated, "Chairfast".</p> <p>e. OASIS M2000 stated no problems were found during drug regimen review, however, a fax addressed to Patient #3's physician, dated 5/29/14 and signed by the RN, identified 7 drug interactions and notes he had refused the anticoagulant medication prescribed for him.</p> <p>During an interview on 7/09/14 at 2:35 PM, the RN who completed the SOC assessment reviewed the SOC OASIS and confirmed the information was inconsistent. The RN stated she was unable to weigh the patient and did not ask him for an estimated weight. Additionally, she stated Patient #3 was in bed during her visit and she did not assess his ability to transfer.</p> <p>Patient #3's initial assessment was not complete and accurate to determine all his needs.</p> <p>2. Patient #5 was a 75 year old female admitted to the agency on 5/27/14, for SN services related to COPD, weakness, CKD, and HTN. Patient #5 was receiving dialysis treatments three times weekly and had a fistula (a modification of her blood vessels through which she received dialysis) in her arm. The fistula was not noted on Patient #5's SOC comprehensive assessment, completed on 5/27/14. The presence of the fistula was not documented in nursing notes until 6/27/14, when it was noted in a Client Coordination Note Report. The note did not specify which arm the fistula was in.</p> <p>During an interview on 7/09/14 at 3:40 PM, both the DON and RN who performed the comprehensive assessment reviewed Patient #5's record. The RN confirmed she did not</p>	G 331			

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

PRINTED: 07/28/2014
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER: 137114	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646		
(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 331	Continued From page 76 Identify Patient #5 as having a dialysis fistula.	G 331			
G 332	484.55(a)(1) INITIAL ASSESSMENT VISIT The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician-ordered start of care date. This STANDARD is not met as evidenced by: Based on review of agency policies, patient medical records, and staff interview, it was determined the agency failed to ensure the initial patient assessment was performed within 48 hours from physician referral for 2 of 10 patients (#5 and #9) whose records were reviewed. This had the potential to result in unmet patient needs. Findings include: An agency policy titled "ADMISSION CRITERIA AND PROCESS," revised April 2014, stated "The initial visit must be performed either within 48 hours of the referral, within 48 hours of the patient's return home, or on the start of the care date ordered by the physician. In the event that the time frame for assessment cannot be met, the patient's physician and the referral source, as well as the patient, will be notified for approval of the delay. Such notification and approval will be documented." 1. Patient #5 was a 75 year old female admitted to the agency on 5/27/14, for SN services related to COPD, weakness, CKD, and HTN. A referral from Patient #5's physician was sent to the agency on 5/22/14 at 1:02 PM. The referral	G 332	G332 PLAN: Director of Nursing or designee to instruct all staff by 8-6-14 that admissions or ordered evaluations that cannot be completed within the 48 hours of referral or within 48 hours of the patients return to home from a facility admission or the MD ordered start of care, then the clinician must notify the physician and obtain a new order and commit the order to writing. By 8-6-14 administrative staff member will run the "Lag Time Report" in the electronic documentation system on a daily basis during the work week to determine that all start of care evaluations are being performed with 48 hours of receipt of referral. Director of Nursing or designee will review 100% of all admission and evaluations to ensure compliance with admission or evaluation within 48 hours, and that those outside of the 48 hour window will have new orders until the agency demonstrates 100% compliance. Ongoing Director of Nursing or designee will review quarterly through the clinical auditing process, auditing 10% of the clinical records based on the average daily census, 50% active and 50% inactive. Responsible: Director of Nursing has overall responsibility for the corrective action and ongoing completion of this		

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

PRINTED: 07/28/2014
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 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646		
(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 332	Continued From page 77 indicated the RN was notified the same day. Patient #5's SOC comprehensive assessment was completed 5/27/14. The record did not include documentation why the initial assessment was delayed 5 days. Additionally, the record did not include documentation the patient or physician was notified for approval of the delay. During an interview on 7/09/14 at 3:10 PM, the RN who performed the SOC assessment reviewed Patient #4's record and confirmed the assessment was 5 days after the referral was received. She was unable to provide a reason for the delay. Patient #5's assessment was not completed until 5 days after the physician referral. 2. Patient #9 was a 73 year old female admitted to the agency on 1/13/14 for PT services only related to unstable gait, imbalance, and therapeutic exercises. Patient #9 was referred by her physician to the agency on 1/10/14. Her SOC comprehensive assessment was performed by the therapist on 1/13/14, more than 48 hours from the receipt of referral. Her record did not include documentation why the assessment was not completed until 3 days after the referral. Additionally, her record did not include documentation she and her physician were notified for approval of the delay. During an interview, on 7/09/14 beginning at 4:15 PM, the Director of Rehabilitation reviewed Patient #9's record and confirmed the SOC assessment was completed greater than 48 hours from SOC. He stated the referral was a	G 332	standard. Completion 8/06/14		

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

PRINTED: 07/28/2014
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 07/14/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646	
(X4) ID PREFIX TAG G 337	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 79	ID PREFIX TAG G 337	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE
	<p>to Ace Inhibitors, (medications that are used primarily for the treatment of high blood pressure).</p> <p>The POC did not include Patient #4's allergy to Ace Inhibitors.</p> <p>A home visit was conducted, on 7/07/14 at 2:45 PM, to observe the Physical Therapist. After the therapy session, the therapist reviewed medications Patient #4 was taking. Patient #4's medication vials were on a counter in the dining area. The therapist noted an empty vial labeled "Flexeril, 10 mg take 1 tablet three times daily." Flexeril was not on Patient #4's POC. The therapist asked her about the medication, and Patient #4 stated she had a 10 day supply and ran out of the medication 2 days prior to the visit. She stated she called the pharmacy to request a refill of the Flexeril that morning.</p> <p>After the therapist left the home, Patient #4 was interviewed further. She stated she had disclosed all her medications to the nurse who performed the SOC assessment on 7/01/14. Patient #4 also clarified that she was taking Fosamax (medication to prevent or treat osteoporosis) once a week and not daily as the POC noted. Additionally, Patient #4 confirmed her allergies and verified she was allergic to Ace Inhibitors.</p> <p>During an interview on 7/09/14 beginning at 3:10 PM, the RN who performed Patient #4's SOC assessment confirmed the allergy to Ace Inhibitors was not included on the POC or assessment. She reviewed the POC and confirmed the Fosamax was entered incorrectly as once daily, and should have been documented</p>	<p>medication list to identify possible duplicate drug therapy, omissions, potential drug – drug interactions and contact the MD if applicable.</p> <p>Staff to be instructed on high risk medications such as anticoagulants and also diabetic medication management. Instruction to be provided on the completion of the medication profile within the electronic documentation system: which includes the names of the medication, dose, specific instructions, and frequency. All PRN medications must state the reason for the PRN. If new medications are found in the home, then the medication profile must be updated, including a review of the medication, and notification to the physician of any possible interactions/adverse side effects, same as upon admission. For medications with a dosage change – the medication profile requires updating with the new dosage. Once the Medication profiles have been reviewed and generated – the office will print out the medication profile and place a copy in the clinician's in-box. A copy of the profile is to be taken to the patient's home at the next visit following the SOC and any medication changes, along with a copy of the patient teaching handouts printed from the electronic documentation system. Staff instruction to also include: For patient's not taking their medications as directed or patients who have not obtained their medications or have run out of refills, then the physician is to be notified. For patients without resources to obtain medications, staff to contact MD and obtain an MSW referral and assist the patient with locating additional resources.</p> <p>Staff instruction to include utilization of resources that are readily available in the field including but not limited to: the electronic documentation system to identify Drug to drug and drug to food interaction, on-line WebMD.com, on-line</p>	

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

PRINTED: 07/28/2014
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 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646		
(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 337	<p>Continued From page 80</p> <p>as once weekly. The RN described the process of medication reconciliation with patients during the SOC assessment. She stated she reviewed patient medications with a list the physician or facility provided, and if discrepancies were found, she included that information in an order to the physician. The RN stated she documented "No problems found during review," on the assessment for OASIS M2000. She stated that after the patient visit, she had the medications entered into the computer to screen for interactions, duplicative therapy, or other problems. She stated the software program would not allow her to proceed until she answered the prompt, so she answered the question before knowing if there were problems. The RN stated after the visit with Patient #4 she screened for interactions, discrepancies were noted, and a list of the interactions was generated. She stated she assumed the list of interactions was sent to the physician by agency office staff. The RN confirmed she did not go back and change the OASIS M2000 entry to correct it.</p> <p>The RN did not ensure a full medication reconciliation was performed during the SOC assessment.</p> <p>2. Patient #5 was a 75 year old female admitted to the agency on 5/27/14, for SN services related to COPD, weakness, CKD, and HTN.</p> <p>Patient #5's record included a medical assessment from a visit to her physician's office 5/22/14, the same day she was referred to home health services. The medical assessment included a list of her current medications. The POC, for the certification period 5/27/14 through</p>	G 337	<p>Epocrates.com, An up-to date copy of a drug handbook in the office, and may utilize the office RN to assist.</p> <p>Staff education to include review of the OASIS MO2000-2030 questions and answers.</p> <p>Director of Nursing or designee will review 100% of all Medications profiles on admission and OASIS SOC admission assessments for accuracy of the MO2000-MO2030 responses until the agency demonstrates 100% compliance</p> <p>Ongoing Director of Nursing or designee will review quarterly through the clinical auditing process, auditing 10% of the clinical records based on the average daily census, 50% active and 50% inactive.</p> <p>Responsible: Director of Nursing has overall responsibility for the corrective action and ongoing completion of this standard.</p> <p>Completion: 8/13/14</p>	

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

PRINTED: 07/28/2014
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 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646		
(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 337	<p>Continued From page 81 7/25/14, differed from the medical assessment list as follows:</p> <p>a. The medical assessment list of medications included the following medications that were not on the POC:</p> <ul style="list-style-type: none"> - Benadryl Allergy 25 mg, 2 tablets every 4-6 hours as needed - Potassium Chloride 10 mEq, 2 tablets every day with food <p>b. The medical assessment list of medications noted Ferrous Gluconate 324 mg, 1 tablet 2 times daily. The POC included Ferrous Gluconate 324 mg, 1 tablet once a day.</p> <p>c. The POC noted Patient #5 was taking Mucinex D 60-600, 1 daily, however the medical assessment list did not include Mucinex.</p> <p>d. The POC included Triamcinolone Acetonide topical, apply 2 times daily, but did not include where the medication was to be applied. The medical assessment list did not include the topical medication.</p> <p>In Patient #5's SOC comprehensive assessment, at section OASIS M2000, the RN documented "No problems found during review."</p> <p>During an interview, on 7/09/14 beginning at 3:00 PM, the RN who performed the medication reconciliation during the SOC comprehensive assessment on 5/27/14, reviewed Patient #5's record and confirmed the above noted discrepancies. She confirmed she noted there were no problems found during the review, and stated she did not communicate with Patient #5's</p>	G 337		

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

PRINTED: 07/28/2014
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTJON	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER: 137114	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULA.TORY 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 337	<p>Continued From page 82</p> <p>physician following the medication reconciliation.</p> <p>The SOC medication review for Patient #5 was incomplete.</p> <p>3. Patient #10 was a 72 year old female admitted on 3/14/14 for SN, PT, HHA, and OT services related to surgical complications. Additional diagnoses included acute myocardial infarction, non-healing surgical wound, OM Type II uncontrolled, chronic skin ulcer, obstructive chronic bronchitis with acute exacerbation. Patient#10's SOC comprehensive assessment was completed on 3/14/14.</p> <p>-Patient #10's recbrd included a printed document titled "INTERACTING MEDICATIONS," dated 3/21/14. The form indicated there were 4 "severe" interactions and 7 "moderate" interactions between Patient #10's medications. There was no documentation Patient #10's physician was notified of the interactions.</p> <p>During an interview on 7/11/14 at 9:30 AM, the DON reviewed Patient #10's record and confirmed there was no documentation the physician was notified of the medication interactions.</p> <p>The RN did not ensure Patient #10's medications were reconciled during the SOC assessment.</p> <p>4. Patient #3 was a 54 year old male admitted to the agency on 5/29/14, for services related to non-healing surgical wounds. Additional diagnoses included complication of cystostomy, OM Type II, polyneuropathy, bipolar disorder, anxiety, Hepatitis C, HTN, colostomy, urinary</p>	G 337		

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

PRINTED: 07/28/2014
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 _____ 8. WING _____	(X3) DATE SURVEY COMPLETED 07/11/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646
--	--

(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 337	<p>Continued From page 83</p> <p>device, lower limb amputation, cerebral infarct and transient ischemic attack. He received SN, HHA and PT services.</p> <p>a. Upon referral for home health services the agency received a list of Patient #3's medications from his physician's office. The medications on Patient #3's POC for the certification period 5/29/14 - 7/27/14, did not match the medication list from his physician's office. Examples include:</p> <ul style="list-style-type: none"> -Physician's list stated Aspirin 81 mg daily, the POC stated Aspirin 500 mg daily -Physician's list stated Bupropion 150 mg daily, the POC stated Bupropion states 300 mg daily -Physician's list included Metformin 1000 mg daily, the POC did not include Metformin -Physician's list included Strattera 60 mg daily, the POC did not include Strattera <p>During an interview on 7/09/14 at 2:35 PM, the RN who completed the SOC assessment stated she asked Patient #3 what he was taking and included those medications on the POC. She confirmed she did not reconcile the list from the physician's office with Patient #3's stated medications.</p> <p>b. The physician's list included Xarelto, an anticoagulant medication used to prevent blood clots. Patient #3's POC did not include Xarelto. His record included documentation he refused to take the medication. However, there was no documentation indicating his physician was notified of his refusal.</p> <p>During an interview on 7/09/14 at 2:35 PM, the RN who completed Patient #3's SOC assessment confirmed she did not notify his physician of his</p>	G 337		
-------	--	-------	--	--

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

PRINTED: 07/28/2014
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 _____ 8. WING	(X3) DATE SURVEY COMPLETED 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646	
(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 337 1	Continued From page 84 refusal to take Xarelto. c. Patient #3's physician's medication list and POC included orders for sliding scale insulin (dose of insulin based on blood glucose levels) to be administered three times a day. The SOC visit note did not include documentation of Patient #3's ability to manage his insulin dosing. During an interview on 7/09/14 at 2:35 PM, the RN who completed Patient #3's SOC assessment stated the patient did not have his insulin at the time of her visit. She confirmed she did not inform Patient #3's physician that he did not have insulin available to comply with the sliding scale orders. The SOC comprehensive assessment, related to Patient #3's medications and his ability to manage their use, was incomplete.	G 337	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OAS001315	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING	(X3) DATE SURVEY COMPLETED 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646	

(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 0001	16.03 07 INITIAL COMMENTS The following deficiencies were cited during the state licensure survey of your home health agency on 7/07/14 - 7/11/14. The surveyors conducting the recertification were: Susan Costa RN, HFS, Team Lead Nancy Bax RN, BSN, HFS Laura Thompson, RN, BSN, HFS	N 000	<p>RECEIVED</p> <p>AUG - 7 2014</p> <p>FACILITY STANDARDS</p>	
N 013	03 07020.ADMIN.GOV.BODY. N013 03. Responsibilities. The governing body shall assume responsibility for: j. Assuring that services will be provided directly or under arrangement with another person, agency or organization. Overall administrative and supervisory responsibility for services provided under arrangement rests with HHA. The HHA assures that legal physician's orders are carried out regardless of whether the service is provided directly or under arrangement. The home health agency and it's staff, including staff services under arrangement, must operate and furnish services in accordance with all applicable federal, state, and local laws. This Rule is not met as evidenced by: Refer to G127	N 013		Please refer to G127 for N 013 Plan of Correction

Bureau of Facility Standards

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

TITLE

(X6) DATE



Administrator

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OAS001315	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING	(X3) DATE SURVEY COMPLETED 07/11/2014
--	---	---	--

NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646
--	--

(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
N026	<p>03.07020. ADMIN. GOV. BODY</p> <p>N026 04. Patients' Rights. Insure that patients' rights are recognized and include as a minimum the following:</p> <p>d.viii. 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 Rule is not met as evidenced by: Refer to G107</p>	N026	Please refer to G107 for N 026 Plan of Correction	
N036	<p>03.07020. ADMIN. GOV. BODY</p> <p>N036 04. Patients' Rights. Insure that patients' rights are recognized and include as a minimum the following:</p> <p>d.xviii. A patient has the right to participate in the development of the plan of care, treatment, and discharge planning. The HHA must advise the patient in advance of the right to participate in planning the care or treatment.</p> <p>This Rule is not met as evidenced by: Refer to G109</p>	N036	Please refer to G109 for N 036 Plan of Correction	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OAS001315	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING	(X3) DATE SURVEY COMPLETED 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646		
(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 041	Continued From page 2	N041	Please refer to G114 for N 041 Plan of Correction	
N 041	03.07020. ADMIN. GOV BODY N041 04. Patients' Rights. Insure that patients' rights are recognized and include as a minimum the following: d.xxi. Before the care is initiated, the HHA must inform a patient orally and in writing of the following: c) The charges that the patient may have to pay; and This Rule is not met as evidenced by: Refer to G114	N041		
N 062	03.07021. ADMINISTRATOR N062 03. Responsibilities. The administrator, or his designee, shall assume responsibility for: i. Insuring that the clinical record and minutes of case conferences establish that effective interchange, reporting, and coordination of patient care between all agency personnel caring for that patient does occur. This Rule is not met as evidenced by: Refer to G143.	N062		Please refer to G143 for N 062 Plan of Correction
N 093	03.07024. SK. NSG. SERV. N093 01. Registered Nurse. A registered nurse assures that care is	N093	Please refer to G331 for N 093 Plan of Correction	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OAS001315	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646	

(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 093	Continued From page 3 coordinated between services and that all of the patients needs identified by the assessments are addressed. A registered nurse performs the following: a. Makes the initial evaluation visit and regularly reevaluates the patient's nursing needs; This Rule is not met as evidenced by: Refer to G331.	N 093		
N 094	03.07024. SK. NSG. SERV. N094 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: b. Initiates the plan of care and makes necessary revisions; This Rule is not met as evidenced by: Refer to G173.	N 094	Please refer to G173 for N 094 Plan of Correction	
N 096	03.07024. SK. NSG. SERV. N096 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:	N 096	Please refer to G175 for N 096 Plan of Correction	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OAS001315	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING		(X3) DATE SURVEY COMPLETED 07/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 63 WILLOWBROOK DR MERIDIAN, ID 83646		
(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 096	Continued From page 4 d. Initiates appropriate preventive and rehabilitative nursing procedures; This Rule is not met as evidenced by: Refer to G175.	N096		
N 098	03.07024. SK. NSG. SERV N098 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: f. Informs the physician and other personnel of changes in the patient's condition and needs; This Rule is not met as evidenced by: Refer to G176.	N098	Please refer to G176 for N 098 Plan of Correction	
N 099	03.07024.SK. NSG. SERV. N099 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: g. Counsels the patient and family in meeting nursing and related needs; This Rule is not met as evidenced by:	N099	Please refer to G177 for N 099 Plan of Correction	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OAS001315	(X2). MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING	(X3) DATE SURVEY COMPLETED 07/11/2014	
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646		
(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 099	Continued From page 5 Refer to G177.	N 099		
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 G224.	N 122	Please refer to G224 for N 122 Plan of Correction	
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 G158.	N 152	Please refer to G158 for N 152 Plan of Correction	
N 153	03.07030.PLAN OF CARE N153 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:	N 153	Please refer to G159 for N 153 Plan of Correction	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OAS001315	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING	(X3) DATE SURVEY COMPLETED 07/11/2014
--	---	---	--

NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646
--	--

(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 153	Continued From page 6 a. All pertinent diagnoses; This Rule is not met as evidenced by: Refer to G159.	N 153		
N 155	03.07030. PLAN OF CARE N155 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: c. Types of services and equipment required; This Rule is not met as evidenced by: Refer to G159.	N 155	Please refer to G159 for N 155 Plan of Correction	
N 170	03.07030.04.PLAN OF CARE N170 04. Initial Plan of Care. The initial plan of care and subsequent changes to the plan of care are approved by a doctor of medicine, osteopathy, or pediatric medicine. This Rule is not met as evidenced by: Refer to G160.	N 170	Please refer to G160 for N 170 Plan of Correction	
N 172	03.07030.06.PLAN OF CARE N172 06. Changes to Plan. Agency professional staff promptly alert the physician to any changes that suggest	N 172	Please refer to G164 for N 172 Plan of Correction	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OAS001315	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING	(X3) DATE SURVEY COMPLETED 07/11/2014	
NAME OF PROVIDER OR SUPPLIER LIFE'S DOORS HOME HEALTH & HOSPICE		STREET ADDRESS, CITY, STATE, ZIP CODE 63 W WILLOWBROOK DR MERIDIAN, ID 83646		
(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 172	Continued From page 7 a need to alter the plan of care. This Rule is not met as evidenced by: Refer to G164.	N 172		
N 173	03 07030.07 PLAN OF CARE N173 07. Drugs and Treatments. Drugs and treatments are administered by agency staff only as ordered by the physician. The nurse or therapist immediately records and signs oral orders and obtains the physician's countersignature. Agency staff check all medications a patient may be taking to identify possible ineffective side effects, the need for laboratory monitoring of drug levels, drug allergies, and contraindicated medication and promptly report any problems to the physician. This Rule is not met as evidenced by: Refer to G337.	N 173	Please refer to G337 for N 173 Plan of Correction	
N 175	03.07031.02.CLINICAL REC. N175 02. Contents. Clinical records must include: a. Appropriate identifying information; This Rule is not met as evidenced by: Refer to G236.	N 175	Please refer to G236 for N 175 Plan of Correction	
N 177	03.07031.CLINICAL REC.	N 177	Please refer to G236 for N 177 Plan of Correction	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OAS001315	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING	(X3) DATE SURVEY COMPLETED 07/11/2014
--	---	---	--

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE'S DOORS HOME HEALTH & HOSPICE	63 W WILLOWBROOK DR MERIDIAN, ID 83646

(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 177	Continued From page 8 N177 02. Contents. Clinical records must include: c. The plan(s) of care; This Rule is not met as evidenced by: Refer to G236.	N 177		
N 182	03.07031.CLINICAL REC. N182 02. Contents. Clinical records must include: h. Signed patient release or consent forms where indicated; This Rule is not met as evidenced by: Refer to G236.	N 182	Please refer to G236 for N 182 Plan of Correction	