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

September 3, 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:

On August 25, 2014, a follow-up visit of your facility, Life's Doors Home Health & Hospice, was conducted to verify corrections of deficiencies noted during the survey of July 11, 2014.

We were able to determine that the 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)** are now met.

Your copy of a Post-Certification Revisit Report, Form CMS-2567B, listing deficiencies that have been corrected is enclosed.

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

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

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;

- Monitoring and tracking procedures to ensure the PoC is effective in bringing the Home Health Agency into compliance, and that the Home Health Agency remains in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
- The administrator's signature and the date signed on page 1 of the Form CMS-2567 and State Form 2567.

After you have completed your Plan of Correction, return the original to this office by **September 15, 2014**, and keep a copy for your records.

Thank you for the courtesies extended to the surveyors during their visit. If we can be of any help to you, please call us at (208) 334-6626.

Sincerely,

NANCY BAX
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

NB/pmt
Enclosures
ec: 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

September 12, 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 follow-up survey completed at Life's Doors Home Health on August 25, 2014, please find the completed Statement of Deficiencies/Plan of Correction (CMS2567) attached.

As evidenced in the Plan of Correction, 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.

In the event that you need additional information, please do not hesitate to contact me at 334-6500 or by email at amcorn@horizonhh.com. You may also reach Daniel Walker at DaWalker@ensigngroup.net.

Please express our appreciation for the courtesy demonstrated by Nancy Bax, RN and Laura Thompson, RN during the conduction of our follow-up survey. We appreciate the opportunity to continue to refine our processes.

Sincerely,

Amanda Corn RN, CHPN
Director of Nursing
Horizon Home Health and Hospice

cc: files

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137114	A. BUILDING _____ B. WING _____	R 08/25/2014

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) COMPLETION DATE
{G 000}	INITIAL COMMENTS The following deficiencies were cited during the follow up survey of your home health agency on 8/25/14. Surveyors conducting the follow up were: Nancy Bax, RN, BSN, HFS - Team Leader Laura Thompson, RN, BSN, HFS Acronyms used in this report include: DM - Diabetes Mellitus DON - Director of Nursing HHA - Home Health Aide HTN - Hypertension POC - Plan of Care PT - Physical Therapy RN - Registered Nurse SN - Skilled Nursing SOC - Start of Care	{G 000}	RECEIVED SEP 15 2014 FACILITY STANDARDS	
{G 159}	484.18(a) PLAN OF CARE 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. This STANDARD is not met as evidenced by: Based on review of patient records and staff interview, it was determined the agency failed to	{G 159}	G159 484.18 (a) PLAN OF CARE Director of Nursing will instruct all staff by 9/16/14 on the accurate completion of the 485 upon admission and re-certification to include all	

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

Amanda Cornell | Director of Nursing | 9-15-14

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

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{G 159}	Continued From page 1 ensure patients' POCs included pertinent information related to functional limitations and activities permitted for 1 of 2 patients (Patient #1) whose records were reviewed. This resulted in incomplete clinical information and lack of direction to staff caring for the patient, and had the potential to result in an unsafe environment. Findings include: Patient #1 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, DM 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 #1's record, including the POC, for the certification period 7/28/14 to 9/25/14, was reviewed. During the previous recertification survey conducted 7/11/14, a home visit was made on 7/08/14 at 2:30 PM. At the home visit Patient #1 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. He stated he was unable to move his legs, but could turn to his side if someone pulled his right leg over for him. Additionally, Patient #1's left leg had been amputated below his knee, and the toes on his right foot had been amputated. Patient #1's record included a PT visit note,	{G 159}	diagnoses pertinent to the care of the patient; to also include DME equipment and supplies including but not limited to: wheelchairs, walkers, and hospital beds, and gloves; to include accurate functional limitations and activities permitted. Instruction will also include updating the Plan of Care when the patient experiences a change in condition or needs, or if the Plan of Care is found to not contain all current patient care elements. Director of Nursing will review 100% of all 485 plans of care, and will monitor diagnosis, equipment, functional limitations, and activities permitted until 100% compliance is achieved. Ongoing, the Director of Nursing or designee will review this standard on a quarterly basis through the clinical auditing process; auditing 10% of the clinical records based on the average daily census with 50% active and 50% inactive. Responsible: Director of Nursing has overall responsibility for the corrective action and ongoing completion of this standard.	

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{G 159}	Continued From page 2 completed on 8/18/14, and signed by the physical therapist. The note stated Patient #1 required a wheelchair, and included the statement "Still needs max assist X 2 (maximum assistance of 2 people) for slide transfer. Family caregivers are not able to assist transfer without help from therapist. Needs more upper body strength and trunk control to improve slide transfer." Patient #1's POC for the certification period 7/28/14 to 9/25/14, included an area to document "Functional Limitations". Patient #1's ability to function was limited by amputation, paralysis, weakness, and decreased endurance, however, no functional limitations were noted on the POC. Patient #1's POC for the certification period 7/28/14 to 9/25/14, included an area to document "Activities Permitted". It stated, "Up as tolerated", however, it did not include information related to the maximum assistance he required to transfer from his bed. Additionally, it did not indicate Patient #1's need for a wheelchair. During an interview on 8/25/14 at 4:15 PM, the DON reviewed Patient #1's record and POC. She confirmed his POC did not include his functional limitations. Additionally, she confirmed his POC was incomplete related to activities permitted. Patient #1's POC for the certification period 7/28/14 to 9/25/14, did not include his functional limitations and activities completed.	{G 159}	Completion: 9/16/14	
{G 236}	484.48 CLINICAL RECORDS A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every	{G 236}	G236 484.48 CLINICAL RECORDS Director of Nursing will instruct the RNCM by 9/16/14 on completing accurate descriptions of the current wound assessment tool, specifically identifying the anatomical region, landmark, or any other wound/location identifiers within the wound assessment input of the EMR for any new wounds that are entered on Patient #1 up to the recertification date of 9-25-14 for Patient #1, at which time his wound records will be	

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{G 236}	Continued From page 3 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 staff interview it was determined the agency failed to ensure medical records contained complete and accurate documentation for 1 of 2 patients (#1) 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: Patient #1 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, DM Type II, polyneuropathy, bipolar disorder, anxiety, Hepatitis C, HTN, colostomy, urinary device, lower limb amputation, cerebral infarct, and transient ischemic attack. Patient #1's record was reviewed for the certification period 7/28/14 to 9/25/14, including the POC. The record included a "Wound Assessment Tool Report" which identified 3 wounds as follows: -Wound Body Part: Other, Wound Location: Left, Wound Type: Burn -Wound Body Part: Other, Wound Location: Right, Wound Type: Surgical Incision	{G 236}	transferred to the new ICC Wound Assessment Module within the EMR. The updated wound assessment tool includes anatomical markings to identify each wound with clarity. All new patient admissions to the agency will have access to the ICC Wound Assessment Module in the EMR. Patient #1's clinical record was updated on 8/25/14 with more descriptive wound locations and descriptions to ensure proper identification of each wound and wound location. Director of Nursing will review 100% of all wound assessment logs, and will monitor data input to ensure that accurate and identifiable wound locations are documented until retirement of the current wound assessment tool on 9/25/14. On going, after implementation of the ICC Wound Assessment Tool, Director of Nursing or designee will monitor 10% of current charts to ensure that	

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{G 236}	Continued From page 4 -Wound Body Part: Ankle, Wound Location: Lateral, Wound Type: Pressure Ulcer, Wound Stage: Stage 2 The documentation for the first two wounds indicate the body part as " Other. " The documentation for the third wound states the body part is an ankle, however, does not specify whether the wound is on the right or left ankle. The wound report contained information about each wound, including measurements, drainage, and appearance. The report lacked clarity as to which body part and which ankle was affected. As a result of the lack of individual wound identifiers, it could not be determined where each wound was on the body in order to be properly assessed. During an interview on 8/25/14 at 4:05 PM, the Director of Nursing reviewed the medical record and confirmed the 3 wounds were not identified adequately using the current documentation tool. She stated due to lack of clarity as to which body parts had wounds, it would be difficult to locate or differentiate them on subsequent visits. The Director of Nursing stated after the recertification survey on 7/11/14, the agency determined that a new documentation tool would be developed and used for wound assessment. She stated it was implemented in the electronic charting system on 8/15/14, but could not be used for existing patients until their current POC ended, and a new POC for the next 60 days was started. She further stated, the agency was not aware of this until after the new tool was implemented in the electronic charting system. Patient #1's wound documentation did not clearly	{G 236}	accurate wound locations and descriptions are documented. Responsible: Director of Nursing has overall responsibility for the corrective action and ongoing completion of this standard. Completion: 9/16/14	

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{G 236}	Continued From page 5 identify the location of his wounds.	{G 236}		

Bureau of Facility Standards

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	OAS001315	A. BUILDING: _____ B. WING _____	R 08/25/2014

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{N 000}	16.03.07 INITIAL COMMENTS The following deficiencies were cited during the follow up licensure survey of your home health agency on 8/25/14. Surveyors conducting the follow up were: Nancy Bax, RN, BSN, HFS - Team Leader Laura Thompson, RN, BSN, HFS Acronyms used in this report include: DM - Diabetes Mellitus DON - Director of Nursing HHA - Home Health Aide HTN - Hypertension POC - Plan of Care PT - Physical Therapy RN - Registered Nurse SN - Skilled Nursing SOC - Start of Care	{N 000}	RECEIVED SEP 15 2014 FACILITY STANDARDS	
N 157	03.07030.PLAN OF CARE N157 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: e. Functional limitations; This Rule is not met as evidenced by: Refer to G159	N 157	**N157 PLAN OF CARE** Please see response for G159 – 484.18 (a) PLAN OF CARE **N159 PLAN OF CARE** Please see response for G159 – 484.18 (a) PLAN OF CARE	
N 159	03.07030.PLAN OF CARE	N 159		

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amanda Cook	Director of Nursing	9-15-14

Bureau of Facility Standards

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N 159	Continued From page 1 N159 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: g. Activities permitted; This Rule is not met as evidenced by: Refer to G159	N 159		
N 176	03.07031.CLINICAL REC. N176 02. Contents. Clinical records must include: b. Assessments by appropriate personnel. This Rule is not met as evidenced by: Refer to G236	N 176	N176 CLINICAL RECORD Please see response for G236 – 484.48 CLINICAL RECORDS	