



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

C.L. "BUTCH" OTTER -- GOVERNOR  
RICHARD M. ARMSTRONG -- DIRECTOR

TAMARA PRISOCK -- ADMINISTRATOR  
DIVISION OF LICENSING & CERTIFICATION  
JAMIE SIMPSON -- PROGRAM SUPERVISOR  
RESIDENTIAL ASSISTED LIVING FACILITY PROGRAM  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: 208-364-1962  
FAX: 208-364-1888

Cable Amsden, Administrator  
Copper Springs Senior Living  
3570 East Amity Road  
Meridian Idaho 83642

Provider ID: RC-1087

Mr. Amsden:

An initial state licensure survey was conducted at Copper Springs Senior Living between May 26, 2015 and June 1, 2015. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level(s):

- Core issues, which are described on the Statement of Deficiencies, and for which you have submitted a Plan of Correction.
- Non-core issues, which are described on the Punch List, and for which you have submitted evidence of resolution.

Your submitted evidence of resolution and plan of correction are being accepted by this office. Please ensure the corrections you identified are implemented for all residents and situations, and implement a monitoring system to make certain the deficient practices do not recur.

Thank you for your work to correct these deficiencies. Should you have questions, please contact, Rae Jean McPhillips, RN, BSN, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 364-1962.

Sincerely,

RAE JEAN MCPHILLIPS, RN, BSN  
Team Leader  
Health Facility Surveyor

RM/sc

cc: Jamie Simpson, MBA, QMRP Supervisor, Residential Assisted Living Facility Program



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Boise, Idaho 83720-0009  
PHONE: 208-364-1982  
FAX: 208-364-1888

June 11, 2015

**CERTIFIED MAIL #: 7007 3020 0001 4050 8920**

Shannon Skidmore  
Copper Springs Senior Living  
3570 East Amity Road  
Meridian, Idaho 83642

Provider ID: RC-1087

Ms. Skidmore:

Based on the initial state licensure survey and complaint investigation conducted by Department staff at Copper Springs Senior Living between May 26, 2015 and June 1, 2015, it has been determined that the facility failed to protect residents' rights, failed to provide adequate supervision and retained residents who were a danger to themselves or others.

These core issue deficiencies substantially limit the capacity of Copper Springs Senior Living to furnish services of an adequate level or quality to ensure that residents' health and safety are protected. The deficiency is described on the enclosed Statement of Deficiencies.

You have an opportunity to make corrections and thus avoid a potential enforcement action. Correction of this deficiency must be achieved by **July 16, 2015**. **We urge you to begin correction immediately.**

After you have studied the enclosed Statement of Deficiencies, please write a Plan of Correction by answering **each** of the following questions for **each** deficient practice:

- ◆ What corrective action(s) will be accomplished for those specific residents/personnel/areas found to have been affected by the deficient practice?
- ◆ How will you identify other residents/personnel/areas that may be affected by the same deficient practice and what corrective action(s) will be taken?
- ◆ What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?
- ◆ How will the corrective action(s) be monitored and how often will monitoring occur to ensure that the deficient practice will not recur (i.e., what quality assurance program will be put into place)?
- ◆ By what date will the corrective action(s) be completed?

Return the **signed** and **dated** Plan of Correction to us by **June 24, 2015**, and keep a copy for your records. Your license depends upon the corrections made and the evaluation of the Plan of Correction you develop.

Shannon Skidmore

June 11, 2015

Page 2 of 2

Pursuant to IDAPA 16.03.22.003.02, you have available the opportunity to question the core issue deficiency through an informal dispute resolution process. If you disagree with the survey report findings, you may make a written request to the Supervisor of the Residential Assisted Living Facility Program for an IDR meeting. The request for the meeting must be in writing and must be made within ten (10) business days of receipt of the Statement of Deficiencies. The facility's request must include sufficient information for Licensing and Certification to determine the basis for the provider's appeal, including reference to the specific deficiency to be reconsidered and the basis for the reconsideration request. If your request for informal dispute resolution is received more than ten (10) days after you receive the Statement of Deficiencies, your request will not be granted. Your IDR request must be made in accordance with the Informal Dispute Resolution Process. The IDR request form and the process for submitting a complete request can be found at [www.assistedliving.dhw.idaho.gov](http://www.assistedliving.dhw.idaho.gov) under the heading of Forms and Information.

Please bear in mind that non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference. Your evidence of resolution (e.g., receipts, pictures, policy updates, etc.) for each of the non-core issue deficiencies is to be submitted to this office by **July 1, 2015**.

Also, be aware that any variance allowing the administrator to serve over other facilities is revoked as of the date of the exit conference. The facility must now employ a single, licensed administrator who is not serving as administrator over any other facilities. Failure to do so within thirty (30) days of the date of the exit conference will result in a core issue deficiency.

If, at the follow-up survey, the core deficiencies still exists or a new core deficiency is identified, or if any of the non-core punches are identified as still out of compliance, the Department will have no alternative but to initiate an enforcement action against the license held by Copper Springs Senior Living.

Enforcement actions may include:

- imposition of civil monetary penalties;
- issuance of a provisional license;
- limitation on admission to the facility;
- requirement that the facility hire a consultant who submits periodic reports to Licensing and Certification.

Our staff is available to answer questions and to assist you in identifying appropriate corrections to avoid further enforcement actions. Should you have any questions, or if we may be of assistance, please contact us at (208) 364-1962 and ask for the Residential Assisted Living Facility program. Thank you for your continued participation in the Idaho Residential Care Assisted Living Facility program.

Sincerely,



JAMIE SIMPSON, MBA, QMRP  
Program Supervisor  
Residential Assisted Living Facility Program

JS/sc

Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13R1087</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/01/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>COPPER SPRINGS SENIOR LIVING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3570 EAST AMITY ROAD MERIDIAN, ID 83642</b>
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R 000	<p>Initial Comments</p> <p>The following deficiencies were cited during the initial and complaint investigation survey conducted between May 26, 2015 and June 1, 2015 at your residential care/assisted living facility. The surveyors conducting the survey were:</p> <p>Rae Jean McPhillips, RN, BSN Team Coordinator Health Facility Surveyor</p> <p>Donna Henscheid, LSW Health Facility Surveyor</p> <p>Matt Hauser, QMRP Health Facility Surveyor</p> <p>Gloria Keathley, LSW Health Facility Surveyor</p> <p>Polly Watt-Geier, MSW Health Facility Surveyor</p> <p>Survey Abbreviations and Definitions:</p> <p>@ = At 1st = First Bld/Bldg = Building BMP = Behavior Management Plan c/o = Complaint Of d/t = Due to dysphagia = Difficulty Swallowing ER = Emergency Room f/u = Follow-up ISP = Individual Service Plan MAR = Medication Assistance Record meds = Medications NSA = Negotiated Service Agreement</p>	R 000		

Bureau of Facility Standards  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

Residential Care/Assisted Living

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R 000	Continued From page 1  Pick's disease = A Form of Dementia PRN = As Needed pt = Patient RCC = Resident Care Coordinator res = Resident ROM = Range of Motion tech = Technical TSP = Temporay Service Plan UAI = Uniform Assessment Instrument variance = Permission by Licensing and Certification to do something contrary to rule, usually only on a temporary basis. x = Times	R 000		
R 008	16.03.22.520 Protect Residents from Inadequate Care.  The administrator must assure that policies and procedures are implemented to assure that all residents are free from inadequate care.  This Rule is not met as evidenced by: Based on observation, interview and record review, it was determined the facility retained 2 of 10 sampled residents (Residents #4 and #8), who were a danger to themselves or others. The facility also failed to provide appropriate supervision to 4 of 10 sampled residents (Residents #3, #4, #6 and #7). Additionally, the facility failed to protect residents' rights for 1 of 5 sampled residents (Resident #8) to be free from chemical restraints. The facility also failed to protect residents' right to choose their own pharmacy which had the potential to affect 100% of the residents. The findings include:  I. RETENTION	R 008		

Residential Care/Assisted Living

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R 008	<p>Continued From page 2</p> <p>According to IDAPA 16.03.22.152.05.e, a resident will not be admitted or retained who is violent or a danger to himself or others.</p> <p>1. According to her record, Resident #8 was a 64 year-old female admitted to the facility on 9/1/14, with diagnoses of Pick's disease and dysphagia.</p> <p>A nursing assessment, dated 3/30/15, documented Resident #8 urinated outside and on the floor instead of using the toilet. It further documented, Resident #8's behaviors included agitation and anxiety and the non-drug intervention was to "walk" the resident outside.</p> <p>Chart notes documented the following:</p> <p>*4/16/15 at 10:41 PM - Resident #8 refused cares and urinated on the floor in her bedroom.</p> <p>*4/24/15 at 4:40 AM - Resident #8 was wandering around and going into other residents' rooms. The resident was "combative" digging her fingernails into the palm of one of the caregivers. The resident also grabbed a dirty toilet brush and "flicked it" at staff. A staff member from Bld. #4 came to assist with the resident.</p> <p>*4/24/15 at 4:20 PM - Resident #8 was going into other residents' rooms and taking their things. When staff tried to redirect the resident, the resident "dug her nails" into the staff member's hand. The resident took a picture off another resident's door. When staff tried to redirect her, she pushed them away.</p> <p>*4/25/15 at 6:46 PM - Resident #8 was exit seeking. Staff attempted to redirect the resident and the resident grabbed the staff member's arm, pulled and would not let go. Another staff member</p>	R 008	<p>1. Retention.</p> <p>All resident re-assessed by RN behavioral intervention form implemented to ensure intervention are effective. They have a behavioral log in place with 4 interventions that need to be implemented, that are specific to resident behaviors. Training on behavioral log with staff and how and when to report to RN resident behaviors. Current ISP updated and training provided to staff on how to follow ISP and implement interventions and or medication per behavioral log. Physician has evaluated and changed medications due to behaviors that may help resolve some of resident behaviors, also physician ordered outside agency for added support and attention. Additional RN will be hired to oversee and manage the memory care residents. All residents on psychotropic medication used on a as needed basis will have a phototropic RN assessment along with a evaluation of the psychotropic medication, behavioral log, and interventions reviewed by the physician every 6 months. Care conferences will be scheduled every 90 days to ensure residents needs are taken care off and medication and</p>	
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Residential Care/Assisted Living

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R 008	<p>Continued From page 3</p> <p>tried to intervene and the resident started pushing and pulling both staff members.</p> <p>*4/26/15 at 1:55 PM - Resident #8 was "trying" to get out the front door. When staff tried to approach her, the resident hit and went for their "thoughts" [sic]</p> <p>*4/26/15 at 5:31 PM - Resident #8 was exit seeking and going into other residents' rooms and taking items. When staff tried to "redirect" the resident became "very combative and aggressive." Resident #8 was "upsetting other residents." Staff approached her three times and the resident "just became very combative and aggressive." The resident was "getting very upset with other residents as well and would start getting combative towards" them.</p> <p>*4/27/15 at 4:54 AM - The resident woke up at 2:30 AM and wandered around the inside of the building. When redirected back to her room, the resident began throwing clothes around. The resident's room was "a disaster."</p> <p>*4/27/15 at 10:04 AM - Resident #8 "continues to go in and out back door."</p> <p>*4/27/15 at 12:27 PM - Resident #8 "continues" to go in and out of the building. The medication technician from Bld #2 reported Resident #8 "tried" to go out the front door in Bld #2 and when they attempted to "redirect" her, she became "aggressive and began swinging" at the staff.</p> <p>*4/29/15 at 10:22 PM - Resident #8 was "trying" to hit another resident. The resident "grabbed" the other resident's clothes and "grabbed" the other resident, "hurting" the other resident. The caregiver tried to redirect, but nothing was</p>	R 008	<p>behaviors addressed. This would include outside agency to be present as well, and notes from outside agency will be placed in RN box or report given to RN after every visit. Caregivers will be receiving addition training on proper documentation, what to report to RN, following ISP, documenting in 24 hour log book, and implementing interventions. New care givers hired per acuity of residents needs. Ensured by the administrator that they are completed.</p> <p>All service plans will be review and if applicable updated for accuracy and specific to each resident needs.</p> <p>All new assessments in regards to restraints/merry walker will be completed, letter wrote to The state for approval of specific variance to be signed off by a State representative. Systemic changes will include training for staff members on implementing 24 hour log book and its contents which is the link for communication for all cares and needs of residents. RN and ED will begin process immediately with completion date of July 16, 2015. Additional RN hired by July 6, 2015.</p>	

Residential Care/Assisted Living

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R 008	<p>Continued From page 4</p> <p>"resolved."</p> <p>*4/29/15 at 11:02 AM - Late entry for 4/28/15 - The RN, administrator and RCC met with the family regarding the family concerns with Resident #8's behaviors and the community not being "appropriate for resident care." The note documented Resident #8 had been sent to the emergency room three months prior for "combative/aggressive behaviors that were "harmful to resident and others."</p> <p>*4/30/15 at 11:2 AM - Resident #8 "came out in the living room with no pants on." The resident went into another resident's room and started going through their belongings. When staff attempted to redirect Resident #8, the resident became "combative and was scratching and pushing" them.</p> <p>*5/1/15 at 6:59 PM - Resident #8 was going into Bld #2 and into other residents' rooms and taking items. When staff tried to "redirect" Resident #8, she became "very combative and aggressive towards staff." The staff redirected the resident out of Bld. #2.</p> <p>*5/2/15 at 12:29 PM - Resident came out of her room without pants on. The resident became "combative" towards staff as they attempted to assist her with dressing.</p> <p>*5/6/15 at 2:13 PM - When trying to redirect Resident #8 out of another resident's room, Resident #8 tried to bite staff and was "very aggressive and combative."</p> <p>*5/6/15 at 7:50 PM - After attempting to take clothes away from another resident, Resident #8 got "very aggressive and combative" with staff</p>	R 008	<p>Resident specifics:</p> <p>Resident #4: Updated ISP, training for staff on following and reporting from ISP, training behavioral log, 24 hour log book documentation, medication review by MD and changed, outside agency for extra care and support.</p> <p>Resident #8: Updated ISP, resident specific behavioral log implemented, conference with outside agency and family on medication and resident natural decline, RN require psychotropic evaluation by physician even when on hospice. RN ensure outside agency reports to RN after every visit, and note left before leaving the community. Training on reporting and documenting with staff. Resident passed shortly after survey.</p>	
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R 008	<p>Continued From page 5</p> <p>who were trying to "redirect" her. The resident was "running after staff trying to hit and grab at them."</p> <p>An incident and accident report, dated 5/9/15 at 5:00 PM, documented Resident #8 "got angry," flipped her chair backwards, walked around the table, and "grabbed" another resident on the "right side of neck" and tried to push the resident to the ground from the chair.</p> <p>Charting notes documented the following:</p> <p>*5/9/15 at 9:33 AM - Resident #8 "got physical with resident" in another room and grabbed the resident's right wrist and "wouldn't let go."</p> <p>*5/9/15 at 3:42 PM - Resident #8 had "several" behaviors, was "combative" and "grabbed" another resident.</p> <p>*5/10/15 at 9:22 AM - Resident #8 was fighting, biting and scratching staff during oral cares.</p> <p>*5/10/15 at 11:05 AM - Resident #8 attempted to bite, hit and dig her nails into caregiver's skin "multiple" times and shoved the caregiver into a door.</p> <p>*5/12/15 at 1:15 PM - Resident #8 was standing over another resident getting ready to kick her. It further documented, "staff directed to constantly monitor resident and maintain line of sight at all times to ensure resident safety."</p> <p>*5/12/15 at 4:00 PM - Resident #8 pulled another resident off the sofa and onto the ground. It further documented, the staff were "directed not to leave resident alone, must be one on one care." This was signed by the facility RN and</p>	R 008		

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R 008	<p>Continued From page 6</p> <p>administrator.</p> <p>*5/13/15 at 9:40 PM - Resident #8 was trying to sit on other residents, grabbing things from them. When staff tried to "redirect," the resident was "very aggressive and combative," trying to bite and hit staff.</p> <p>*5/17/15 at 11:33 AM - Resident #8 tried to take another resident's walker away. Resident #8 grabbed the wrist of the other resident and tried to pull her out of her chair. Staff separated the two residents and gave Resident #8 a PRN lorazepam per the RN's instructions.</p> <p>A chart note, dated 5/22/15 at 1:29 PM, documented Resident #8 had behaviors three times. It documented the resident cornered a caregiver and tried to keep her from moving.</p> <p>A hospice note, dated 5/25/15, documented Resident #8 had "increasing agitation and behaviors" and was scratching staff. The hospice RN gave permission to give PRN Risperdal.</p> <p>A chart note, dated 6/2/15 at 9:55 AM, documented Resident #8 "swung" out at the caregiver when attempting oral care.</p> <p>On 5/28/15 at 11:55 PM, the facility RN stated Resident #8's behaviors increased a few months ago, so she was sent to the ER for evaluation. The RN stated the resident was doing "really well." The facility RN stated Resident #8 began having behaviors again, Risperdal was tried and they attempted to find her placement. The RN confirmed the facility never issued a discharge notice to Resident #8's family.</p> <p>On 5/28/15 at 3:50 PM, the administrator stated</p>	R 008		
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R 008	<p>Continued From page 7</p> <p>they had "tried" to place Resident #8 at a skilled behavioral facility, but they were full.</p> <p>On 5/29/15 at 3:56 PM, a caregiver stated Resident #8 was "combative and became agitated at the "drop of a dime."</p> <p>For over two months, the facility retained Resident #8 who had been socially inappropriate and physically aggressive towards staff and other residents.</p> <p>2. According to her record, Resident #4 was an 89 year-old female who was admitted to the facility on 9/1/14, with diagnoses which included dementia and depression.</p> <p>Chart notes documented the following:</p> <p>*4/23/15 at 9:16 PM - The resident was "very emotional" and called staff into her room at 6:30 PM. Staff assured her everything was fine. However, the resident continued to cry and asked staff to leave her alone.</p> <p>*5/8/15 at 8:03 PM - Staff reported the resident fell in her room. When the RN assessed her, the resident stated, "I wish I could push a button and God would take me."</p> <p>*5/10/15 at 11:08 AM - Resident complaining of "wishing she could die." The resident repeated the statement later in the same morning.</p> <p>*5/12/15 at 5:57 AM - The resident was very upset about another resident going into her room. Stated she was afraid of that resident and that she "wants out of here and to die."</p> <p>*5/23/15 at 2:47 PM - The staff heard Resident #4</p>	R 008		
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R 008	<p>Continued From page 8</p> <p>state she wished she were dead and that she "may as well crack her head open on the table and get it over with."</p> <p>*5/31/15 at 1:45 PM - Resident #4 was "making very depressing comments to staff saying 'Just give me a gun so I can end it all'."</p> <p>On 5/28/15 at 11:55 AM, the facility RN stated there was no documentation nor a plan put into place regarding Resident #4's suicidal comments.</p> <p>Resident #4 made suicidal comments over the course of a month and the facility failed to have the resident evaluated for her safety.</p> <p>The facility retained Resident #4 and Resident #8 when they were a danger to themselves or others.</p> <p><b>II. SUPERVISION</b></p> <p>According to IDAPA 16.03.22.012.25, supervision is defined as "a critical watching and directing activity which provides protection, guidance, knowledge of the residents general whereabouts, and assistance with activities of daily living. The administrator is responsible for providing appropriate supervision based on each resident's Negotiated Service Agreement or other legal requirements."</p> <p><b>A. Supervising Residents with Behaviors</b></p> <p>Resident #3 and #13 resided in one of the facility's secured memory units. The residents' rooms were close to the secured entrance and were two doors apart. If caregivers were in the kitchen, they would not be able to observe Resident #13's room and potentially Resident</p>	R 008	<p>2. Supervision: In addition to what was stated above for retention. RN will assess and implement interventions and behavioral management and add to plan of care to ensure safety of all residents. Proper training on redirection for staff. Additional training on dementia/ behaviors, will be provided to staff by outside community support. Provided staff training on what, when and how to report for assisted living facilities. Included in updated ISP staff will notify RN of each statement at time of statement. To ensure resident safety resident being moved to different building, during interim resident moved to different table for dinning and redirect and separation and reporting trained to staff. All new assessment will be completed for all resident with assistive devices, letter written to The State for approval, proper ISP in place and proper equipment/training to effectively follow ISP and variance. Additional staff member being hired. Weight binders placed in each building to be reviewed by RN by the 10th of every month, and implement care needs</p>	
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Residential Care/Assisted Living

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R 008	<p>Continued From page 9</p> <p>#3's room. Additionally, the building housed 13 residents and was staffed with 2 caregivers on the day shift, 2 caregivers on the afternoon shift and 1 caregiver on the night shift. Between 5/26 and 5/29/15, the caregivers on the day and afternoon shifts were often in and out of residents' rooms, in the kitchen prepping and cleaning up dishes, showering residents, doing laundry and were not always in the common area or in the vicinity of Resident #3 or Resident #13's room to provide appropriate supervision.</p> <p>1. According to Resident #13's record, she was a 79 year-old female, who was admitted to the facility on 2/4/11, with diagnoses including dementia.</p> <p>Resident #13's UAI, dated 1/16/15, documented she was unable to remember when family visited and needed occasional reminders and cueing. The UAI also documented the resident was unable to make appropriate health decisions.</p> <p>According to Resident #3's record, he was an 89 year-old male, who was admitted to the facility on 12/03/14, with diagnoses including dementia.</p> <p>An undated, unsigned NSA, did not document Resident #3 had behaviors. The NSA documented the resident had poor judgement in decision making and required staff assistance with safety issues.</p> <p>On 5/27/15 at 2:31 PM, a RCC, who wrote the TSP on 4/16/15, stated she was not aware of Resident #3 having behaviors that "we need to manage."</p> <p>On 5/27/15 at 3:55 PM, the facility RN was asked if Resident #3 had behaviors. The nurse asked if</p>	R 008	<p>at that time. RN and ED will begin process immediately with completion date of July 16, 2015.</p> <p>Resident #3: Updated behavioral log implemented to direct more specific issues resident is displaying. Staff training on reporting behavioral implemented. Training on staff for reporting using 24 hour log books which is key to successful care of residents. Systemic changes will include, additional RN hired to manage memory care, additional training on reporting and documenting by staff and using the 24 hour log effectively, and additional training on dementia/behaviors. Possible remodel of kitchen in memory care to provide better visual of residents. Additional staff hired.</p>	
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R 008	<p>Continued From page 10</p> <p>"sexual comments" would be behaviors? The nurse stated, Resident #3 made inappropriate sexual statements to staff and all of the residents, but never acted on it. The facility RN stated she was not aware Resident #3 had grabbed Resident #13's butt on 5/26/15.</p> <p>5/27/15 at 2:41 PM, a caregiver stated they had observed Resident #3 a few times being inappropriate. The caregiver stated Resident #3 told Resident #13, she could "come over and play with it," in the middle of the night. The caregiver stated when the incident happened, they reported it to the RCC and were verbally instructed to document what happened and not to let it happen again. They were also instructed if Resident #3 said inappropriate things, to tell him it was inappropriate and to change the subject. The caregiver stated most of Resident #3's comments were directed towards Resident #13.</p> <p>5/28/15 at 9:35 AM, a caregiver stated they were not aware of Resident #3 making any inappropriate sexual remarks to anyone.</p> <p>5/28/15 10:38 AM, a caregiver stated Resident #3 did not have any behaviors. The caregiver said Resident #3 made inappropriate comments, but it had "been awhile." The caregiver stated if Resident #3 said anything inappropriate, they would remind him it was not okay. The caregiver further stated, she did not remember any plan being put in place, but was "sure something was put in place."</p> <p>On 5/28/15 at 10:45 AM, a caregiver stated Resident #3 had behaviors and would say "inappropriate things." The caregiver stated, Resident #3 said things like wanting another resident to join him in his room. The caregiver</p>	R 008	<p>Resident #13: Training on reporting and using 24 hour log, to follow current ISP for safety. RN complete assessment of resident and update ISP. Move resident to different table for dining, and different sides of building from other resident while getting room ready for transfer to new building.</p> <p>Resident #6: RN will provide new assessment and letter for approval of variance for specific resident. Proper variance in place with updated ISP, and care plan updated. Resident currently has a timer set for staff to ensure resident current variance is being followed. Additional staff and activities implemented to provide resident with proper needs. Additional training for care staff for specific variance completed. Staff training to properly follow ISP and using 24 hour log for reporting, and training on proper documentation. Staff training on signs that indicate resident may want to exit the walker. Systemic changes will include RN new</p>	
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R 008	<p>Continued From page 11</p> <p>stated, the inappropriate comments were directed specifically towards Resident #13. The caregiver stated, when Resident #13 was standing facing the window that looked into the kitchen, the resident told her, Resident #3 had "grabbed" her butt.</p> <p>On 5/28/15 at 11:50 AM, the facility nurse confirmed a protection plan had not been put into place after Resident #3 displayed inappropriate behaviors.</p> <p>On 5/28/15 at 2:58 PM, a caregiver confirmed Resident #3 made inappropriate comments to Resident #13. The caregiver stated the comments usually occurred when Resident #13 was walking by Resident #3's room. The caregiver stated the only instruction they had received was to "just watch to make sure nothing inappropriate happens."</p> <p>On 5/28/15 at 4:00 PM, the administrator stated she was not aware Resident #3 had any behaviors, as none had been reported to her.</p> <p>On 5/29/15 at 2:54 PM, a caregiver stated Resident #3 did not "have too many behaviors," but had been "attaching" himself to Resident #13.</p> <p>A 24 hour report log, dated 4/15/15 PM, documented Resident #3 was "making sexual remarks towards [Resident #13's name]. Make sure they are separated or supervised."</p> <p>Chart notes, dated 4/15/15 at 8:57 PM, documented around 7:00 PM, Resident #3 had Resident #13 go into his room and he tried to close the door. The staff "made sure it stayed open and over heard" Resident #3 "making sexual remarks and comments to" Resident #13.</p>	R 008	<p>assessment on all resident with need of variance for equipment needs. Variance signed of by The State representative with follow up assessments for resident safety, condition of equipment and staff compliance with variance every 90 days. Possible remodel of kitchen to ensure residents are always in the line of sight, additional staff hired.</p> <p>Resident #4: In addition to what was stated in retention portion, a additional RN will be hired to manage memory care residents. Training on proper documentation will be provided. RN assessments will be documented in QMAR. Skin checks on all residents will be obtain on Monday's every week. Proper training for staff on when to notify RN and to proper use 24 hour log which is key for communication and proper resident care. RN assessments will include past history of specific issues demonstrated by residents. This will provide a verified clear story of resident in addition to better care.</p>	
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R 008	<p>Continued From page 12</p> <p>The staff separated the residents and told Resident #3, "that it was not appropriate to say things like that." The note further documented, the staff asked Resident #3 "repeatedly" to stay out of Resident #13's room and reminded him that "sexual remarks" were inappropriate 5 times.</p> <p>A 24 hour report log, dated 4/16/15, documented Resident #3 told Resident #13 it was "okay to go into his room anytime she wants."</p> <p>Chart notes, dated 4/16/15 at 2:04 PM, documented Resident #3 "went to another resident and said that he would like to rub it, and he would like for her to come over this afternoon or tonight and he said that he'll use vasaline [sic]. I redirected him back to his room and told him that it wasn't appropriate and had him sit down in his room."</p> <p>A "Temporary Service Plan," dated 4/16/15, documented Resident #3 asked an aide if he could "touch her" and encouraged his "neighbor to visit him @ night." The service plan instructed the caregiver to "monitor client going in &amp; out of other peoples' room" and others going into his room. "Monitor inappropriate suggestions he makes to anyone else."</p> <p>There were no other instructions on how staff would provide appropriate supervision in order to protect Resident #13 or other female residents, from Resident #3's verbal and physical sexual advances.</p> <p>Chart notes, dated 4/16/15 at 3:59 PM, written by the RCC, documented, "increased inappropriate sexual behaviors with staff and other female resident." The note also documented a "Temporary Service Plan" was implemented,</p>	R 008	<p>Resident #8: In addition to what was written for retention portion of this review for diet plan. Training for staff will occur In regards to special diets. Dietary updated on proper mechanical and soft mechanical diets per The State requirements. RN review orders and correct at time of order including outside agency reporting new changes immediately to RN per policy of documentation left or report given with note after each visit. Training for staff on appropriate reporting for assisted living facilities. Weight logs binders have been implemented and training completed in each building to simplify weight management RN will review this within the first 10 days of the month, provide assessment and implement needs at the time for specific residents and up date service care plans. Service care plan meeting will include outside agencies. Psychotropic evaluations will be implemented with behavior log to physicians every 6 months. Provide proper and timely documentation.</p>	
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R 008	<p>Continued From page 13</p> <p>which instructed staff to monitor if Resident #3 wandered into other residents' rooms and to redirect other wandering residents away from Resident #3's room.</p> <p>Chart notes, dated 4/16/15 at 10:06 AM, documented Resident #3 made four "different visits" to Resident #13's room "trying to get her to his room willingly." The note further documented, Resident #3 walked into the common area "with pants undone" looking for Resident #13 and told her "you can touch it."</p> <p>Chart notes, dated 4/17/15 at 9:59 AM, documented, Resident #3 "was trying to get another female resident to go into his room." The note further documented, the caregiver told Resident #3 he could not have other residents in his room. As he walked away from the caregiver, he turned back to the female resident and said, "I cant [sic] wait to love you later." The note documented the caregiver told Resident #3 that it was not appropriate.</p> <p>A 24 hour report log, dated 4/17/15, documented Resident #3 made "sexual remarks" towards Resident #13 six times.</p> <p>Chart notes, dated 4/17/15 at 8:52 PM, documented Resident #3 "went to same female he has been approaching" and tried to get her into his room six times with "sexual advances."</p> <p>Chart notes, dated 4/18/15 at 1:52 PM, documented, Resident #3 attempted "to kiss another female resident."</p> <p>Chart notes, dated 4/20/15 at 1:24 PM, documented, Resident #3 asked another resident to come into his room so he could "take off her</p>	R 008	<p>Resident #7: Training for staff on following ISP and implementing what is on ISP and then documentation on what they completed. Training for staff on properly following the 24 hour log books and documentation RN review ISP as needed for specific ISP written.</p>	

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R 008	<p>Continued From page 14</p> <p>clothes and run his hands down her butt." The note documented the caregiver told him that it was not appropriate.</p> <p>Chart notes, dated 4/20/15 at 8:47 PM, documented Resident #3 was redirected out of Resident #13's room once. The note documented Resident #3 told Resident #13, "if the weather gets bad you can come sleep in my room, you know where it is."</p> <p>Chart notes, dated 4/27/15 at 9:18 PM, written by the facility RN, documented she was following up on Resident #3's "past issues with behaviors with sexual verbiage and gestures." The note further documented, Resident #3 "had no issues for the past 3 days" and the facility would "continue to monitor resident behaviors and follow interventions set in place."</p> <p>There were no notes from 4/20 to 4/27/15, to indicate what other behaviors occurred before this note was written or what supervision was being provided to ensure Resident #13 or other female residents were protected from Resident #3's verbal and physical sexual advances.</p> <p>A 24 hour report log, dated 5/1/15, documented Resident #3 had a "behavior." There were no further notes about what behavior the resident displayed.</p> <p>Chart notes, dated 5/6/15 at 9:52 AM, documented, Resident #3 was talking to a family member in his room and the caregiver overheard him saying, "the girls here wont [sic] play with my peter" and he took Resident #13 "into her room and poked her butt." The staff shut the door and "let him talk" to his family member.</p>	R 008		
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R 008	<p>Continued From page 15</p> <p>There was no investigation by facility staff whether or not something had occurred to Resident #13. Nor were any further plans developed to increase supervision in order to protect Resident #13 or other female residents from Resident #3's verbal or physical sexual advances.</p> <p>Chart notes, dated 5/26/15 at 11:00 AM, documented a female resident complained to a caregiver that Resident #3 had grabbed "her butt." The caregiver documented Resident #3 was "asked to stop."</p> <p>Resident #13's "Charting Notes," dated 5/26/15 at 10:39 AM, documented Resident #13 had informed a caregiver that "a male res keeps grabbing her butt."</p> <p>Chart notes, dated 5/26/15 at 1:32 PM, documented Resident #3 "recited an inappropriate poem" and a female resident "informed him that she didn't like it."</p> <p>The facility implemented a TSP, written by the RRC on 4/16/15; however, Resident #3 continued to make verbal and physical sexual advances toward Resident #13 and potentially other female residents. The facility failed to investigate the incidents and did not increase the level of supervision to ensure Resident #13 and other female residents were protected against any unwanted verbal or physical sexual advances by Resident #3.</p> <p>For at least 42 days, Resident #3 made verbal and physical sexual advances towards Resident #13 and possibly other female residents. During that time, the facility did not investigate if any abuse had occurred nor did they increase</p>	R 008		
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R 008	<p>Continued From page 16</p> <p>supervision or instruct staff on how to protect Resident #13 from Resident #3's sexual advances.</p> <p>B. Compliance with the variance for the use of a Merry Walker</p> <p>According to Resident #6's record, he was an 82 year-old male, who was admitted to the facility on 4/18/11, with diagnoses including Alzheimer's dementia.</p> <p>A history and physical, dated 7/29/13, documented the resident "...continues to do well with the use of the 'Merry Walker,' although occasionally gets scuffed on the extremities from running into things...has had multiple falls d/t gait instability when using standard walker with assist..."</p> <p>The Merry Walker was observed to be a metal walker with a seat. Fabric covered the back of the walker and there was a strap from the front of the walker that dropped between Resident #6's legs to the back to the walker. The strap had a large buckle that had to be unclipped and then the front gate of the walker could be opened.</p> <p>An NSA, dated 3/25/15, documented Resident #6 ambulated safely with a "supportive device with Restraining Quality." The NSA did not contain any conditions or limitation of the "supportive device."</p> <p>A variance, granted by Licensing &amp; Certification, dated 12/27/12, documented the resident was approved for a "Temporary Continuing with Conditions" variance for using a Merry Walker.</p> <p>After the variance had been granted, the facility went through two changes of licensure, one on</p>	R 008		

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R 008	<p>Continued From page 17</p> <p>9/30/14 and the other on 4/1/15, making the variance null and void. Variances are not transferable between licenses and the facility failed to request a new variance for Resident #6's use of a Merry Walker.</p> <p>The following five conditions specified in the 12/27/12 variance, were not observed to be met during 5/26/15 through 5/29/15:</p> <p>1) "The facility nurse shall conduct and document quarterly (every 90 days) assessments, to include how well and how safely [Resident's name] is using the Merry Walker, the physical condition of the device and the consistency and compliance of the staff in following the conditions of this variance."</p> <p>A quarterly nursing assessment, dated 1/20/15, documented Resident #6 used a Merry Walker. The nursing assessment did not include how well, or if, the resident was safely using the Merry Walker. Additionally, the nursing assessment did not indicate the physical condition of the device or how the staff were meeting the conditions of the variance.</p> <p>A note on the bottom of the nursing assessment, dated 4/12/15, documented "no changes for quarterly assessment." The assessment completed on 4/12/15, did not document how well, or if, the resident was safely using the Merry Walker. Additionally, the nursing assessment did not indicate the physical condition of the device or how the staff were meeting the conditions of the variance.</p> <p>2) "[Resident's name] shall be within the line of sight of a staff member at all times while in his Merry Walker."</p>	R 008		
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R 008	<p>Continued From page 18</p> <p>3) "The Merry Walker shall at no time be used for the convenience of staff, or as a substitute for staff supervision."</p> <p>4) "[Resident's name] shall not spend more than one consecutive hour in the Merry Walker, and shall be out of the Merry Walker for at least fifteen minutes before getting back in it."</p> <p>5) "All staff members shall be trained to observe for signs or indications that [Resident's name] may want to exit his walker, and shall immediately respond by assisting him out of it."</p> <p>See below observations and interviews which show the conditions were not being met for conditions 2 through 5:</p> <p>Building #2 was observed, on 5/26/15, to consist of a long common area, which included the dining room and living room. In between the dining room and living room was a small railing dividing the two rooms. The kitchen was next to the dining room with an open rectangular-shaped window with a solid door that lead into the kitchen that was shut and locked. At the end of the dining room and living room, there were two half-doors leading to exit areas. The residents' rooms and bath/shower room were located along the sides of the common area.</p> <p>Observations of Resident #6 on 5/26/15:</p> <p>* Between 2:22 PM and 2:30 PM, Resident #6 was observed standing and walking throughout the dining and living rooms in his Merry Walker. As the resident was walking in his Merry Walker, caregivers were observed carrying laundry to the laundry room and assisting other residents. There</p>	R 008		

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R 008	<p>Continued From page 19</p> <p>were times when Resident #6 was not in the direct sight of caregivers.</p> <p>* Between 2:33 PM and 2:35 PM, Resident #6 was observed approaching a half-door to the secure door and bumped his Merry Walker into door and the door did not move. The resident was then observed to back up and bump the Merry Walker into the door again. No caregivers were observed to intervene when Resident #6's was bumped into the door or checked on him.</p> <p>*Resident #6 was walking throughout the facility and bumping his Merry Walker into the half-door without being in the caregivers line of sight or being supervised at all times.</p> <p>The following observations were made of Resident #6 while in the Merry Walker on the on the morning of 5/27/15 Between 9:48 AM and 10:15 AM:</p> <p>*Resident #6 was standing in his Merry Walker in his room. A caregiver checked on the resident twice, but left the resident unattended in his room.</p> <p>*A caregiver directed Resident #6 out of his room into the living room and walked away. The caregivers were observed going into other residents' rooms leaving Resident #6 unattended.</p> <p>The following observations were made of Resident #6 while in the Merry Walker on the afternoon of 5/27/15, between 2:36 PM to 3:41 PM:</p> <p>*Resident #6 was walking throughout the dining room, bumping his Merry Walker into chairs, walking through the living room and going in and out of a resident's room. Caregivers were in and</p>	R 008		

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R 008	<p>Continued From page 20</p> <p>out of the common area assisting residents with cares and did not keep Resident #6 in their line of sight.</p> <p>*Resident #6 was standing in his Merry Walker behind two residents ,who were sitting at a table. Resident #6 went to the front half-door and tried to pull the door open, but was unable to do so. There were no staff in in the common area, one staff was in the kitchen and the other was showering a resident. Resident #6 squeezed the fabric and yanked the strap from in between his legs really hard. When the strap did not budge, he shook his head from side to side and let go of the strap.</p> <p>*A caregiver spent most of this time putting away dishes in the kitchen, but did approach Resident #6 to see if he wanted to lay down. When the resident's responses could not be interpreted by the caregiver, she walked away. The other caregiver was in the shower room at this time.</p> <p>*Resident #6 stood at the half-door shaking the handle, but was not able to open it. One caregiver was busy with an activity and the other caregiver was observed in the laundry room. Resident #6 continued to stand at the door and then sat down in his Merry Walker.</p> <p>For over one hour, Resident #6 was observed standing or sitting in his Merry Walker. He attempted to release the strap on his Merry Walker and no staff responded to assist him out of the walker as indicated in the variance. Further, staff did not supervise or maintain Resident #6 in their line of sight.</p> <p>The following observations were made of Resident #6 while in the Merry Walker on the</p>	R 008		
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R 008	<p>Continued From page 21</p> <p>afternoon of 5/28/15, between 9:06 AM and 10:28 AM:</p> <p>*Resident #6 was walking in the living room, wandering into a room at the far end of the living room, walking in the dining room and bumping his Merry Walker into the closed kitchen door. Staff were not visible in the common areas. One caregiver was in the kitchen office, another caregiver was in a resident's room and a housekeeper was cleaning a resident's room.</p> <p>*Resident #6 was walking in the living room and dining room in his Merry Walker. No caregivers were observed in the common area. One caregiver was in the kitchen and the other caregiver was not visible. He attempted to walk into the kitchen and staff redirected Resident #6 away from the door. Resident #6 then went and stood in front of the window to the kitchen. A caregiver was observed to walk by the resident without acknowledging him. As the caregive walked by, Resident #6 looked up and when not acknowledged, looked back to the ground.</p> <p>*Resident #6 continued to walk around the dining room in his Merry Walker and stood at a table. A few minutes later, he sat down in his Merry Walker and rubbed both of his eyes. His head drooped and his chin rested on his chest. One caregiver was observed working in the kitchen and occasionally peeking out of the kitchen area checking on the residents. The other caregiver was not visible.</p> <p>*At 10:28 AM, a caregiver awakened Resident #6 and told him, "let's take a nap." The caregiver assisted the resident into a recliner in the living room.</p>	R 008		

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R 008	<p>Continued From page 22</p> <p>For approximately 1 hour and 22 minutes Resident #6 was constrained in his Merry Walker and was not always within the caregivers' line of sight.</p> <p>On 5/27/15 at 2:39 PM, a caregiver stated Resident #6 used his Merry Walker because "he liked to be in it."</p> <p>On 5/27/15 at 2:41 PM, a caregiver stated Resident #6 used the Merry Walker "quite regularly." When asked if there were limitations, the caregiver stated the resident should not sleep in the Merry Walker. The caregiver stated if they did not use the Merry Walker, it was very hard to care for the resident. The caregiver denied they had ever seen Resident #6 trying to get out of the Merry Walker. They stated, he "liked to be in it."</p> <p>On 5/28/15 at 9:23 AM, a caregiver stated Resident #6 was placed in the Merry Walker when he became "restless." The caregiver stated when the resident became restless, it was very clear as he is "up and out of chairs constantly." The caregiver stated, when he becomes tired, they moved him into a recliner and elevated his legs. The caregiver denied ever seeing Resident #6 attempt to exit his Merry Walker.</p> <p>On 5/28/15 at 9:35 AM, a caregiver stated, they were not aware of any restrictions regarding Resident #6's Merry Walker. They stated if he sat in the Merry Walker for 5 minutes, they would get him up and transfer him to a recliner.</p> <p>On 5/28/15 10:38 AM, a caregiver stated Resident #6 was usually in the Merry Walker for a few hours each day. The caregiver stated Resident #6 was in the Merry Walker if he was "up and about...typically 2-3 hours a day." The</p>	R 008		

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R 008	<p>Continued From page 23</p> <p>caregiver stated, she had never seen Resident #6 try to get out of the Merry Walker. However, she had seen the resident play with the fabric on the Merry Walker. The caregiver further stated, "if we catch him snoozing [in the Merry Walker], we put him in the recliner."</p> <p>On 5/28/15 at 10:45 AM, a caregiver stated, Resident #6 "likes to walk the whole building." The caregiver stated, when he became tired, staff would put him in his chair to rest. The caregiver stated they had not observed the resident trying to get out of the Merry Walker and or be "upset" while he was in it.</p> <p>On 5/28/15 at 11:50 AM, the facility RN confirmed Resident #6 used a Merry Walker. She stated Resident #6 had a variance prior to her starting her position. The facility RN stated she was not aware the variance was not transferable with the changes of licensure. When asked about the limitations/conditions placed on the Merry Walker use, she said she could not remember them off the "top of her head." She stated she thought that he could only be in it for 15 minutes and had to be out of it for 15 minutes. In addition, she confirmed that Resident #6 should be within the caregivers' line of sight at all times.</p> <p>On 5/28/15 at 2:55 PM, a caregiver stated Resident #6 was in his Merry Walker when he was "up and restless." The caregiver stated there was a strap that prevented the resident from getting out of the Merry Walker. The caregiver confirmed Resident #6 had tried to get out of the Merry Walker, but he usually would just walk in it.</p> <p>On 5/28/15 at 4:00 PM, the administrator stated she was under the assumption the variance for Resident #6 went with the community, she was</p>	R 008		
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R 008	<p>Continued From page 24</p> <p>not aware it was not transferable.</p> <p>On 5/29/15 at 2:54 PM, a caregiver stated the resident was usually up late, walking in his Merry Walker. The caregiver stated when the resident fell asleep in the Merry Walker, he was placed in a recliner, but only when the caregivers had time to move him.</p> <p>Resident #6's variance became null and void after the facility went through two changes of licensure. Even if the current licensee had requested and been granted a variance, the variance would have become null and void as they failed to meet 5 out of the 6 required conditions as follows:</p> <ol style="list-style-type: none"> <li>1. The facility nurse failed to conduct quarterly nursing assessments which contained how well and safely Resident #6 was using his Merry Walker, what the physical condition of the device was and how consistent and compliant the caregivers were in ensuring the other conditions of the variance were met.</li> <li>2. Resident #6 was not within the line of caregivers' sight at all times.</li> <li>3. Resident #6 was left unsupervised while caregivers were focused on other residents and tasks.</li> <li>4. Resident #6 spent more than one consecutive hour in his Merry Walker.</li> <li>5. Staff did not assist Resident #6 when he attempted to release the strap on the Merry Walker.</li> </ol> <p>C. Lack Of Nursing Involvement</p>	R 008		
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R 008	<p>Continued From page 25</p> <p>1. According to her record, Resident #4 was an 89 year-old female who was admitted to the facility on 9/1/14 with diagnoses which included dementia and depression.</p> <p>An NSA, dated 2/11/15, documented Resident #4 had no diagnosis of dementia or memory loss, her depression would be monitored by staff, and staff were to check on her every two hours due to her trying to get up on her own, was on home health and was at high risk for skin tears.</p> <p>A nursing assessment, dated 3/1/15, documented the resident fractured her right hip and required 1-2 person assistance with "slider board" transfers.</p> <p>Chart notes documented the following:</p> <p>*4/4/15 at 3:45 PM - Observed new skin tear to the right upper arm. Reported by care staff this morning. It is closed and she denies pain in the area at time of assessment. ROM normal. This was signed by a caregiver.</p> <p>*4/6/15 at 7:01 AM - The nurse made a "visit" with the resident and the resident was "doing well" and her right hip was improving. There was no documentation the resident's skin tear to her right upper arm had been assessed.</p> <p>*4/16/15 at 4:07 PM - The resident had a skin tear on her right arm just below the elbow about 3 to 4 centimeters. The skin was still in place, cleaned, applied Neosporin and bandaged with a non-stick pad and Coban. This was documented by a caregiver.</p> <p>An incident report, dated 4/16/15, documented</p>	R 008		

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R 008	<p>Continued From page 26</p> <p>Resident #4 called staff into her room because her arm was bleeding. The resident stated she bumped her arm on the shelf.</p> <p>Chart notes documented the following:</p> <p>*4/18/15 at 4:07 PM - The resident was assessed after a non-injury fall "this morning about 0500." The resident denied any "major pain or discomfort. No new skin issues identified." This was documented by a caregiver.</p> <p>*4/19/15 at 4:59 AM - A "change of condition assessment - seemed lathargic [sic] confused and unsteady on her feet. Is arouseable [sic], but for just enough time" to get to the bathroom and back. This was documented by a caregiver</p> <p>*4/23/15 at 5:17 PM - The RN assessed the wound on her right arm. There were no signs and symptoms of infection present. "Wound scabbed over healing appropriately. Wound considered healed." This was documented 7 days after the resident initially sustained the skin tear. There was no follow-up by the RN regarding Resident #4 being lethargic, unsteady on her feet and confused on 4/19/15.</p> <p>*4/30/15 at 5:39 PM - A "Follow-up" on skin tear to Resident #4's left leg from self-transferring. "Delegated staff dressed appropriately, dressing clean and intact." This was documented by the RCC.</p> <p>*5/1/15 at 8:29 PM - Staff "noticed" the right side of the resident's face, from her eye to the bottom of her jaw was swollen. Staff notified the nurse and RCC and were told to monitor and watch if swelling increased. There was no documentation the facility RN assessed the swelling.</p>	R 008		
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R 008	<p>Continued From page 27</p> <p>*5/2/15 at 1:01 PM - "Follow-up" on possible swelling on left side of the resident's face. "Minimal swelling and slight droop in upper lip, no slurred speech, no complaints of pain." This was documented by the RCC, not the facility RN.</p> <p>*5/7/15 at 12:41 PM - The resident was self-transferring after breakfast and hit her shin on her chair causing bruising and a small skin tear. Nurse notified. There was no documentation the nurse assessed the resident.</p> <p>*5/17/15 at 4:15 PM - Resident #4 was found lying on her back in her bedroom. The resident was bleeding from the left lower side of her lip. The RCC, daughter and home health were called.</p> <p>*5/24/15 at 8:49 PM - Seven days later, the RN "followed-up" on "resident incident due to being out of office. No signs of abuse or neglect found. Lip healed. No other signs of bruising or abrasions."</p> <p>On 5/26/15 at 8:40 AM, Resident #4 was observed asleep in bed. There was a bruise observed around her right wrist, a bandage was on her left elbow and there were two small round bruises on her upper right arm.</p> <p>A Chart note, dated 5/26/15 at 12:47 PM, documented the RN entered a "late entry for 5/25/15" assessment on a skin tear on Resident #4's upper left arm. However, there was no documentation regarding when or how the skin tear occurred. Further, there was no documentation regarding the discoloration of the resident's right wrist or two spots on her right upper arm.</p>	R 008		

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R 008	<p>Continued From page 28</p> <p>On 5/26/15 at 3:05 PM, when asked about the bruising on her wrist and upper arm, a caregiver stated the resident has "extra sensitive skin and could be from someone touching her." The caregiver looked at the bruising on the resident's wrist and said, "She's super, super sensitive."</p> <p>On 5/28/15 at 11:55 AM, the facility RN stated she thought the bruising on Resident #4's wrist was related to a fall. The RN read through her documentation and stated there was no documentation regarding the wrist and upper arm bruising.</p> <p>On 5/29/15 at 3:56 PM, a caregiver stated Resident #4 had recent changes. The resident was "hell on wheels last week." When asked about the bruise on her wrist, she replied the resident had "bruises all over, you should see her legs."</p> <p>The facility administrator did not provide supervision when unlicensed caregivers were "assessing" Resident #4 after she had falls, skin tears and other changes of condition. Further, the facility administrator did not provide supervision to ensure the facility nurse assessed Resident #4 in a timely manner after changes in her physical condition.</p> <p>D. Not Implementing Diet As Ordered</p> <p>According to her record, Resident #8 was a 64 year-old female who was admitted to the facility on 9/1/14, with diagnoses of Pick's disease and dysphagia.</p> <p>A nursing assessment, dated 3/30/15, documented Resident #8 had a "poor appetite, had a 13.4 pound weight loss, had difficulty</p>	R 008		
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R 008	<p>Continued From page 29</p> <p>swallowing at times, and was independent with eating. There were no further nursing assessments found in Resident #8's record.</p> <p>An NSA, not signed or dated, did not address what kind of assistance Resident #8 required for eating or what type of food texture she received.</p> <p>A "Telephone Order" received from hospice by the facility RN, dated 5/14/15, documented an order for a mechanical soft diet.</p> <p>A "Diet Prescription Order" from the facility RN, dated 5/14/15, documented the resident was to receive a "mechanical soft" diet.</p> <p>According to the Idaho Dietary Manuel, 11th Edition, 2015, a mechanical soft diet is designed to provide texture modifications of the regular diet for patients with chewing or swallowing difficulty. Meats are in the ground form. All raw and hard to chew foods are omitted. It further documented, meats should be "minced, ground, tender, and well-moistened..."</p> <p>An order from hospice, dated 5/20/15, documented to change Resident #8's diet to "mechanical soft finger food" and to use a plate with high sides, serving patient one food at a time. This was signed by the facility RN on 5/24/15. There was no clarification how the facility could provide mechanical soft, finger foods.</p> <p>A hospice note, dated 5/20/15, documented the hospice staff member "walked with the pt from her room to the dining area. The pt sat at the table and tried to eat her breakfast. I had to remind the staff the pt is only supposed to be given one food at a time. The med tech said she did it yesterday and it did not help. I explained to</p>	R 008		
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R 008	<p>Continued From page 30</p> <p>her again that taking care of this pt is more difficult than caring for regular dementia pts. The pt was given her scrambled eggs. She does not know how to use eating utensils any longer, so she is trying to eat with her hands. I let the staff know there is an order for different diet again, mechanical soft finger foods and is to only be served one food at a time."</p> <p>On 5/26/15 at 12:00 PM, a caregiver stated there were five residents in Bld #1 who were on mechanical soft diets and Resident #8 was one of them. The "mechanical soft" food items were observed in four small bowls which included: ground noodles and beef, ground cauliflower and broccoli, garlic bread cut into 1 inch pieces and a piece of spice cake with frosting. When asked how Resident #8 was going to eat what was served with her fingers, the staff replied, "That's why we gave her the cake first."</p> <p>On 5/26/15 at 12:03 PM, Resident #8 was observed sitting at the dining room table with a piece of cake in a small bowl. Her head was observed hanging down and she had frosting on the side of her nose. The caregiver stated Resident #8 was served "finger foods, one at a time, something she can pick up and eat herself."</p> <p>On 5/26/15 at 12:20 PM, Resident #8 appeared asleep with her head resting on her left arm which was laying on the table. At 12:24 PM, a caregiver rattled the bowl and said, "Here's your cake." The resident continued sitting with her head down.</p> <p>On 5/27/15 at 12:22 PM, a caregiver stated the resident was to have "finger food only."</p> <p>On 5/28/15 at 10:36 AM, a caregiver stated Resident #8 was given "mainly finger foods."</p>	R 008		
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R 008	<p>Continued From page 31</p> <p>When asked about the mechanical soft diet, the caregiver replied, "They tried that, but the resident wasn't eating" so it was changed to finger foods. The caregiver stated she was unsure who initiated the "finger foods" diet.</p> <p>On 5/28/15 at 10:38 AM, a plate of food labeled with Resident #8's name was observed in the refrigerator. The plate contained three whole sausage links and a boiled egg. Another plate, labeled with Resident's #8's name, contained two large breaded chicken breast cutlets, tater tots, carrot and celery sticks. The caregiver stated the plate of with the chicken was for Resident #8 and was left over from her supper the night before.</p> <p>On 5/28/15 at 11:55 AM, the facility RN confirmed the resident was on a mechanical soft diet.</p> <p>On 5/29/15 at 3:56 PM, a caregiver stated Resident #8 was "suppose to be" on a mechanical soft diet.</p> <p>Resident #8 did not consistently receive a mechanical soft diet as ordered. Further, when the order was changed to "mechanical soft finger foods," the order was not clarified and there were no clear instructions to staff regarding how Resident #8's food was to be prepared and presented to her.</p> <p>This resulted in Resident #8 being served foods she could not eat, and foods that she could have choked or aspirated on.</p> <p>E. Temporary Care Plans Not Followed</p> <p>1. According to her record, Resident #8 was a 64 year-old female admitted to the facility on 9/1/14, with diagnoses of Pick's disease and dysphagia.</p>	R 008		

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R 008	<p>Continued From page 32</p> <p>An NSA, not signed or dated, documented the resident was able to ambulate independently, was continent of bowel and bladder, was independent with dressing, and her behavior/mood problem symptoms would be managed by staff.</p> <p>A "Temporary Service Plan," dated 5/1/15, documented that physical therapy was discontinued and staff were to walk Resident #8 around the building with a gait belt and walker "at least 1 time each shift." While surveyors were in the building between 5/26/15 through 5/28/15, the resident was not observed using a walker and staff were not observed using a gait belt when they were walking with her.</p> <p>A "Temporary Service Plan," dated 5/11/15, documented to notify the nurse with any increased behaviors and "eyes must be on resident at all times while in common areas to ensure safety to other residents." From 5/26/15 through 5/28/15, there were numerous times the caregivers were attending to other residents or tasks and were not able to keep Resident #8 in their line of sight.</p> <p>A "Temporary Service Plan," dated 5/12/15, documented the staff were to provide a "one on one." Staff were to "have a one on one aide" with Resident #8 "at all times. Unless family or hospice is present. Per nurse..." There was no ending date to the TSP.</p> <p>A "Temporary Service Plan," dated 5/26/15, documented the staff were to conduct 15 minute checks while the resident was in her apartment and a "staff member must" be with resident "at all times" while she is in the common area to "ensure safety to self and other residents....Per</p>	R 008		

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R 008	<p>Continued From page 33</p> <p>RCC..." This was signed by the facility RN on 5/26/15. There was no ending date to the TSP.</p> <p>On 5/27/15 at 12:22 PM another caregiver stated staff were to have their "eyes on" Resident #8 "at all times" when she was in the common area.</p> <p>On 5/28/15 at 10:17 AM, a caregiver was in a resident's room with the door closed. There were no other caregivers observed in the building. The activity person was setting up for exercise. At 10:23 AM, the activity person, took another resident to her room, leaving Resident #8 to ambulate independently. Resident #8 was observed with her head bent down, ambulating with a very slow, unsteady gait. Resident #8 was stooped over as if picking at something and eventually she kneeled on the floor. Resident #8 got herself off the floor and with her head hanging down went over to the table and rested her head on the dining room table. At 10:28 AM, there were no staff members in the common area. Resident #8 began shuffling about the facility again and got down on her hands and knees and was observed picking at something on the floor. At 10:36 AM a caregiver approached the resident to assist her to standing position. The resident then tried to sit in the middle of the activity group. The activity person stopped the activity and assisted Resident #8 to a chair.</p> <p>On 5/28/15 at 11:55 AM, the facility RN she stated Resident #8 was not on a one to one. Staff were to "just keep and eye on her when she was in the living room."</p> <p>On 5/28/15 at 2:30 PM, a caregiver stated, "I was told to go lay eyes on her. We have to do 15 minute checks on her."</p>	R 008		
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R 008	<p>Continued From page 34</p> <p>On 5/29/15 at 3:56 PM, when asked about when TSP's ended, a caregiver stated, that is a "good question." Further, the caregiver stated, Resident #8 was never on a one to one.</p> <p>Four different "Temporary Service Plans" were put into place for Resident #8 without any ending dates. No one monitored these plans to ensure they were being implemented.</p> <p>This resulted in Resident #8 not being provided appropriate supervision and assistance to ensure she did not fall or injure herself or other residents.</p> <p>2. According to Resident #7's record, she was a 76 year-old female who was admitted to the facility on 5/14/14 with a diagnosis of cerebral palsy.</p> <p>On 5/26/15, during a tour of the facility, Resident #7 was interviewed. She stated she was receiving physical therapy to help her improve her walking ability. She stated staff were to assist her with walking daily, but they were not. The resident stated, staff told her they were "too busy" to assist her with walking.</p> <p>A "Temporary Service Plan," dated 5/5/15, documented, "Staff to assist resident with walking once a shift. Staff to document in progress notes if resident was walking with staff. Also if resident refuses, staff to notify RCC or RN and then document refusal. Chart every shift."</p> <p>Resident #7's progress notes from 4/1/15 through 5/27/15 were reviewed. The progress notes documented Resident #7 had not been assisted with walking. Further, there was no documentation the resident had refused to be walked.</p>	R 008		

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R 008	<p>Continued From page 35</p> <p>On 5/27/15 at 1:35 PM, the facility nurse was interviewed. She stated she was not aware Resident #7 had not been assisted with walking by staff. She stated she was unsure why staff had not assisted her with walking.</p> <p>On 5/27/15 at 2:50 PM, the administrator stated she was not aware residents had "Temporary Service Plans." When asked how she ensured sufficient staff were available to implement residents' care plans, she stated she could not.</p> <p>On 5/28/15 at 2:48, Resident #7 stated, staff still had not assisted her with her walking program and that she needed to practice walking to get her strength back. She stated the physical therapist was the only one that helped her work on her walking program.</p> <p>On 5/29/15 at 2:54 PM, a night shift staff member stated there were not enough staff scheduled to consistently assist Resident #7 with her walking program.</p> <p>The facility did not monitor Resident #7's care plan to ensure sufficient staff were scheduled to implement the plan.</p> <p>The facility did not provide adequate supervision to ensure Resident #8 and #7's "Temporary Service Plans" were implemented.</p> <p><b>III. RESIDENTS' RIGHTS</b></p> <p><b>A. Residents' Right To Be Free Of Chemical Restraints</b></p> <p>According to IDAPA 16.03.22.550.10 - Each resident must have the right to be free</p>	R 008	<p><b>3. Resident Rights:</b></p> <p>Resident #8. Training of proper documentation and management with outside agencies. Ensure that all outside agencies report to RN after visit with a face to face or written note. Ensure proper documentation representing resident and resident family and plan of care. Training on 24 hour log book for reporting. RN assess and implement specific behavior log, ISP and service care plan specific to each resident. Service care plan reviews with families, outside agency to ensure all agree to treatments, and that documentation supports that. Regarding pharmacy letter sent out previously and a new one is being sent to ensure families are aware that they have a choice in pharmacies.</p>	
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R 008	<p>Continued From page 36</p> <p>from...chemical restraints.</p> <p>According to her record, Resident #8 was a 64 year-old female with diagnoses of Pick's disease and dysphagia.</p> <p>A fax from Resident #8's nurse practitioner, dated 3/23/15, documented the facility was to discontinue "all" of Resident #8's medications. It was signed by the facility RN on 3/25/15.</p> <p>According to Resident #8's incident reports, chart notes and hospice and nursing progress notes, from 4/16/15 to 6/2/15, Resident #8 had several behaviors. The behaviors included: hitting, biting, scratching, grabbing, digging fingernails into arms, pushing, pulling, urinating in inappropriate places, hurting other residents, and grabbing other residents around their necks and throats. (See section I under Retention for Resident #8).</p> <p>A chart note, dated 4/16/15 at 5:15 PM, documented Resident #8 had "increased confusion, increased incontinence and decreased appetite. The family was "concerned" the resident "may need extra care" and requested to set up a meeting to discuss possible options. The doctor sent orders for Risperdal.</p> <p>According to Nursing 2016 Drug Handbook, Risperdal is used for schizophrenia. The side-effects included: abnormal posture, somnolence, agitation, and anxiety.</p> <p>A chart note, dated 5/4/15 at 1:24 PM, documented Resident #8 was enrolled in hospice.</p> <p>A telephone order received by the facility RN from hospice, dated 5/7/15, documented to give the resident Risperdal 1 ml, twice a day.</p>	R 008		

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R 008	<p>Continued From page 37</p> <p>*5/10/15 at 9:16 PM - The facility RN spoke with hospice about "getting" Resident #8 "some Ativan."</p> <p>According to Nursing 2016 Drug Handbook, Ativan is used for anxiety. The side-effects included: drowsiness, sedation, agitation, dizziness, weakness, and unsteadiness.</p> <p>A telephone order received by the facility RN from hospice, dated 5/12/15, documented an order for Depakote 2.5 ml, twice a day mixed with juice. Another order received by the facility RN from hospice with the same date, documented an order for lorazepam (Ativan) 0.25 ml, every 4 hours PRN, can mix with fluid.</p> <p>According to Nursing 2016 Drug Handbook, Depakote is used for seizures and mania. The side-effects include dizziness, insomnia, nervousness, somnolence and ataxia (muscle weakness causing difficulty standing upright).</p> <p>Hospice physician orders, dated 5/13/15, documented an order for Risperdal 1 ml, sublingually daily as need for increased behaviors. It further documented, an order for lorazepam 0.25 ml, sublingually every 4 hours as need for agitation. It was signed by the facility nurse on 5/14/15.</p> <p>A "Telephone Order" received by the facility RN from hospice, dated 5/14/15, documented the resident was to receive Haldol 0.5 ml every 4 hours PRN.</p> <p>According to Nursing 2016 Drug Handbook, Haldol is used for psychotic disorders. The side-effects include: sedation, drowsiness,</p>	R 008		
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R 008	<p>Continued From page 38</p> <p>confusion and lethargy.</p> <p>After hospice was started, Resident #8's medications were initiated, changed or discontinued multiple times in the month of May to address the resident's behaviors.</p> <p>Chart notes documented the following:</p> <p>*5/14/15 at 12:23 PM - The facility RN called the hospice nurse requesting Haldol. It "may be more effective" for Resident #8 as the "lorazepam has not been effective."</p> <p>*5/14/15 at 2:49 PM - Late entry to follow-up on incident on 5/9/15. Staff directed to monitor Resident #8 for "restlessness and agitation and to provide one on one care" to ensure the resident is separated from other residents while agitated and ensure resident safety. A new order for lorazepam was received for "agitation and restlessness."</p> <p>*5/17/15 at 11:33 AM - Resident #8 tried to take another resident's walker away. Resident #8 grabbed the wrist of the other resident and tried to pull her out of her chair. Staff separated the two residents and gave Resident #8 a PRN lorazepam per the RN's instructions.</p> <p>*5/18/15 at 4:42 PM - Resident #8 fell out of bed and landed on the floor next to her bed. "Called hospice and was directed to give lorazepam if needed."</p> <p>*5/18/15 at 10:58 AM - Late entry for fall on 5/16/15. The medication aide heard a "loud thump" and found resident on the floor with her pants pulled down to her ankles.</p>	R 008		

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R 008	<p>Continued From page 39</p> <p>*5/18/15 at 1:18 PM - Late entry for fall on 5/17/15. The medication aide heard a "loud thump" and found Resident #8 on the floor stretched out next to her bed.</p> <p>A hospice note, dated 5/18/15, documented Resident #8 was "restless" The resident was provided one to one for about 2 hours to keep her from falling and out of other residents' rooms. The resident was "not steady on her feet, but is unable to sit still." The administrator was approached about using a Merry Walker as a safety measure. The administrator stated the "charge nurse" did not like Merry Walkers in the facility. It was "explained" to the administrator "this is a serious safety issue. Pt. requires one-to-one attention most of the time now due to her unsteadiness and recent history of falling."</p> <p>An order from hospice, dated 5/19/15, documented an order to increase Risperdal from 1 ml to 1.5 ml twice a day and PRN. It further documented, to give a dose of Risperdal before giving lorazepam.</p> <p>A hospice note, dated 5/20/15, documented Resident #8 was "groggy" sitting on the side of the bed. The resident was "finally" able to stand up, "though unsteady on her feet." The facility medication technician reported the resident had not had her morning medications because she was asleep and did not want to awaken her. "I instructed her to give the medications immediately, which she did...Even without the lorazepam she walks very unsteady on her feet. She is making significant declines over the last week."</p> <p>A hospice note, dated 5/23/15, documented the resident was "beginning to have aggressive</p>	R 008		
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R 008	<p>Continued From page 40</p> <p>behaviors and would like to know if she can give the PM scheduled risperidone approximately" 30 minutes early or if she could give the PRN dose now and the scheduled dose in 30 minutes. Instructed staff to give scheduled dose 30 minutes early. The hospice nurse documented the facility nurse was discontinuing the night time dose of Ativan, but a PRN dose was available if the staff would "call hospice RN 1st."</p> <p>A hospice note, dated 5/25/15, documented the facility staff reported the resident "was found in her room behind the door with her head leaning on the wall. The staff member reported the resident "looked like she was a Zombie." The note further documented, the resident "still appears to be too sleepy. She is very calm, but unable to keep her eyes open or in any way interact with me." The staff had not been giving the increased dose of 1.5 mg. Risperdal, but were "still giving the 1 mg dose." Further, the hospice nurse documented, staff were not using the decreased lorazepam dose of 0.25 mg. "I discussed this with the RN of the facility. She said she would address the issue."</p> <p>A hospice note, dated 5/25/15, documented Resident #8 had "increasing agitation and behaviors" and was scratching staff. The hospice RN gave permission to give PRN Risperdal.</p> <p>On 5/26/15 at 12:28 PM, Resident #8 was observed standing up from the dining room table. A caregiver took her hand and said, "Let's go this way." The resident's head was hanging down, and the caregiver told the resident, "There's a wall there" as she led her to a chair in the common area. Shortly after, the resident stood up and was observed giving a caregiver a hug and began ambulating unsteadily around the common</p>	R 008		

Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13R1087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  06/01/2015
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NAME OF PROVIDER OR SUPPLIER  COPPER SPRINGS SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 3570 EAST AMITY ROAD MERIDIAN, ID 83642
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 008	<p>Continued From page 41</p> <p>area with the caregiver. At 12:41 PM, the caregiver stated, "I can't get her to sit down."</p> <p>On 5/26/15 at 12:35 PM, a hospice nurse stated they were "getting" Resident #8's behaviors "under control." She said they (the hospice agency) had started her on risperidone and were gradually increasing it. She stated the resident was "agitated" and was biting, kicking and scratching staff. She stated, Resident #8 was "out of control," but now was smiling and she was seeing "great improvement." When asked about her "wobbly, stooped gait," she replied it was "part meds and part she doesn't eat." She stated the risperidone worked best because the lorazepam "zombied" her. "Risperidone works best for these kind of residents."</p> <p>A hospice nursing progress note, dated 5/28/15 at 11:05 AM, documented the medication technicians reported the resident was not "groggy" in the morning when she gets up. "There continues to be a problem changing pt's clothes, but even that is a little easier...Pt. still has not had a bath or her hair washed. She won't let anyone do it."</p> <p>On 5/28/15 at 11:55 PM, the facility RN stated Resident #8 was doing "really well" in the smaller environment, was taken off Seroquel and eventually all her medications. The facility RN stated Resident #8 began having behaviors again, Risperdal was tried and they attempted to find her other placement. She stated hospice came on board and started her on the psychotropic medications. "I didn't agree with that, but that's what family wants."</p> <p>On 5/29/15 at 3:56 PM, a caregiver stated Resident #8 had some changes, was more</p>	R 008		

Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13R1087</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/01/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>COPPER SPRINGS SENIOR LIVING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3570 EAST AMITY ROAD MERIDIAN, ID 83642</b>
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R 008	<p>Continued From page 42</p> <p>"lethargic" and liked to curl up on the floor with pillows.</p> <p>A hospice nursing note, dated 6/1/15 at 2:50 PM, Resident #8 is "somewhat steadier" when walking and usually walks with her hand touching the wall for balance. The resident "tends to bend over a lot, and put her head down."</p> <p>The facility did not have an effective behavior management plan in place to address Resident #8's behaviors. After hospice was initiated, the facility used chemical means to control Resident #8's behaviors. The facility failed to monitor the medication side-effects of those medications. Resident #8 went from wandering in and out of the facility and running after staff, to falling, being "groogy," "lethargic," stooped over with her head hanging down and ambulating with a very unsteady gait.</p> <p>B. Residents' Right To Choose A Pharmacy</p> <p>IDAPA 16.03.22.03, documents, "The facility must assure quality services by providing choices..."</p> <p>IDAPA 16.03.22.550.12.b, documents residents have the right to "...select the pharmacy of his choice..."</p> <p>A letter, dated 11/14/14, signed by the "Director of Vendor and Client Services" from "Frontier Management" documented the following:</p> <p>"Dear Residents and Family Members, We wanted to provide you with an update regarding a change in pharmacy services at your community. Over the next 90 days, we will be transitioning our preferred pharmacy services to Consonus</p>	R 008		
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Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13R1087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  06/01/2015
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NAME OF PROVIDER OR SUPPLIER  COPPER SPRINGS SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 3570 EAST AMITY ROAD MERIDIAN, ID 83642
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R 008	<p>Continued From page 43</p> <p>Pharmacy based in Boise, ID."</p> <p>The letter did not document that residents were informed they had the right to select a pharmacy other than the "preferred" pharmacy.</p> <p>On 5/29/15 at 1:49 PM, the administrator confirmed the facility changed pharmacies in February 2015.</p> <p>The facility's admission agreements, revised dates of 12/15/14 and 2/4/15, documented the following:</p> <p>"If the resident elects to use his/her own pharmacy and not the preferred community pharmacy, there will be a charge of \$75 per month per Resident (charge not applicable to State clients). This fee helps to cover the additional administrative and labor costs including consulting services, ordering, tracking, coordination, medication administration records forms, training, and other items."</p> <p>On 6/3/15 at 2:30 PM, the administrator stated she did not have evidence the facility experienced any "additional administrative and labor costs" if a resident chose a pharmacy other than the preferred pharmacy. Additionally, she confirmed the added monthly charge of \$75.00 would make some residents choose the preferred pharmacy.</p> <p>On 5/26/15 at 8:48 AM, a resident stated when the facility changed pharmacies he had to stop getting his medications from Costco. He stated his medications were more expensive now.</p> <p>On 5/26/15, a resident stated the facility changed pharmacies, and she did not have a choice. She stated, "it would have been nice to know" it was</p>	R 008		

Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13R1087</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/01/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>COPPER SPRINGS SENIOR LIVING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3570 EAST AMITY ROAD MERIDIAN, ID 83642</b>
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R 008	<p>Continued From page 44</p> <p>going to be changed.</p> <p>On 5/26/15 at 10:38 AM, a resident stated she felt she had to go with the new pharmacy when they changed.</p> <p>On 5/26/15, a resident stated she did not receive a "warning" the facility was changing pharmacies and she did not have a choice in switching to the new pharmacy.</p> <p>On 5/26/15, Resident #2 stated the facility "forced her to go with a new pharmacy."</p> <p>On 6/1/15 at 9:30 AM, Resident #2's family member stated, the facility told her she had to go with the new pharmacy and was not given a choice or options of other pharmacies.</p> <p>On 6/1/15 at 1:05 PM, a family member stated they were not offered a choice of pharmacies. She stated, "we were just told it was changed."</p> <p>On 6/3/15 at 2:30 PM, the administrator stated there was a meeting in September 2014 informing residents/families of the change of the preferred community pharmacy. She stated she could not remember who was in attendance, or if residents/families were told they could choose a pharmacy other than the "new" preferred pharmacy.</p> <p>The facility did not protect the residents' rights to select a pharmacy of their choice when they did not inform residents of their right to select a different pharmacy or offer an alternative to the preferred community pharmacy and charged residents a penalty if they used a different pharmacy. This failure had the potential to affect 100% of the residents.</p>	R 008		

Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13R1087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  06/01/2015
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R 008	Continued From page 45  The facility retained Residents #4 and #8, who were a danger to self or others. The facility also failed to provide appropriate supervision to Residents #3, #4, #6 and #7. Additionally, the facility failed to protect Resident #8's right to be free from chemical restraints. The facility failed to protect residents' right to choose their own pharmacy which had the potential to affect 100% of the residents. These failures resulted in inadequate care.	R 008		
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Facility COPPER SPRINGS SENIOR LIVING	License # RC-1087	Physical Address 3750 EAST AMITY ROAD	Phone Number (208) 888-7030
Administrator Shannon Skidmore	City MERIDIAN	ZIP Code 83642	Survey Date June 1, 2015
Survey Team Leader Rae Jean McPhillips, BSN	Survey Type Initial Licensure and Complaint Investigation	RESPONSE DUE: July 1, 2015	
Administrator Signature 	Date Signed 6-1-15		

**NON-CORE ISSUES**

Item #	IDAPA Rule #	Description	Department Use Only	
			EOR Accepted	Initials
1	009.01	One of ten employees did not have a Department Criminal History Background Check.	7/23/15	Rm
2	009.06.c	Four of six employees did not have a State Police Background Check.	7/23/15	Rm
3	152.05.b.iii	Two residents were observed to have side rails attached to their beds.	7/14/15	Rm
4	220.02	Residents #1, #7 and #8 did not have signed admission agreements. In addition, the admission agreements did not contain all required elements.	7/14/15	Rm
5	225.01	The facility did not evaluate Resident #3, #4 and #8's behaviors.	7/23/15	Rm
6	225.02	The facility did not develop interventions for Resident #3, #4 and #8's behaviors.	7/14/15	Rm
7	300	The facility RCC's (unlicensed staff) were directing medical care when residents' had changes of condition.	7/23/15	Rm
8	305.01	The facility nurse did not assess Resident #6's continued need for TED hose nor clarify Resident #8's diet.	7/23/15	Rm
9	305.02	The facility did not ensure residents received medications as ordered.	7/23/15	Rm
10	305.03	The facility nurse did not assess Residents' changes of condition. For example: Resident #1 and #3's wound status.	7/14/15	Rm
11	305.05	The facility nurse did not follow-up on previous recommendations. For example: Resident #7's physical therapy plan was not implemented nor was Resident #8's safety plan implemented.	7/14/15	Rm
12	305.06.a	The facility nurse did not assess residents ability to self-medicate. For example: Resident #2 and #5's ability to safely self-inject.	8/3/15	Rm
13	310.04.d	The facility nurse did not monitor Resident #4 and #8 for side-effects from their psychotropic medications.	7/23/15	Rm
14	310.04.e	The facility did not conduct 6 month psychotropic medication reviews, to include behavioral updates for Residents #1, #2, #4 and #8.	8/3/15	Rm
15	320.01	Residents' NSAs were not updated to reflect current needs. In addition, when temporary care plans were developed, they were not implemented.	7/23/15	Rm
16	320.03	Residents #3, #7 and #8's NSAs were not signed or dated by the resident or their representative.	7/14/15	Rm





IDAHO DEPARTMENT OF HEALTH & WELFARE

# Food Establishment Inspection Report

Residential Assisted Living Facility Program, Medicaid L & C  
3232 W. Elder Street, Boise, Idaho 83705  
208-334-6626

**Critical Violations**

**Noncritical Violations**

Establishment Name <u>Copper Springs Senior Living</u>		Operator <u>Shannon Skidmore</u>	
Address <u>3570 East Amity Road</u>			
County <u>Ada</u>	Estab #	EHS/SUR#	Inspection time: _____ Travel time: _____
Inspection Type: <u>STANDARD</u>	Risk Category: <u>High</u>	Follow-Up Report: OR On-Site Follow-Up: Date: _____ Date: _____	
Items marked are violations of Idaho's Food Code, IDAPA 16.02.19, and require correction as noted.			

# of Risk Factor Violations <u>0</u>	# of Retail Practice Violations <u>0</u>
# of Repeat Violations <u>0</u>	# of Repeat Violations <u>0</u>
Score <u>0</u>	Score <u>0</u>
A score greater than 3 Med or 5 High-risk = mandatory on-site reinspection	A score greater than 6 Med or 8 High-risk = mandatory on-site reinspection

**RISK FACTORS AND INTERVENTIONS (Idaho Food Code applicable sections in parentheses)**

The letter to the left of each item indicates that item's status at the inspection.

	Demonstration of Knowledge (2-102)	COS	R
(Y) N	1. Certification by Accredited Program, or Approved Course, or correct responses; or compliance with Code	<input type="checkbox"/>	<input type="checkbox"/>
<b>Employee Health (2-201)</b>			
(Y) N	2. Exclusion, restriction and reporting	<input type="checkbox"/>	<input type="checkbox"/>
<b>Good Hygienic Practices</b>			
(Y) N	3. Eating, tasting, drinking, or tobacco use (2-401)	<input type="checkbox"/>	<input type="checkbox"/>
(Y) N	4. Discharge from eyes, nose and mouth (2-401)	<input type="checkbox"/>	<input type="checkbox"/>
<b>Control of Hands as a Vehicle of Contamination</b>			
(Y) N	5. Clean hands, properly washed (2-301)	<input type="checkbox"/>	<input type="checkbox"/>
(Y) N	6. Bare hand contact with ready-to-eat foods/exemption (3-301)	<input type="checkbox"/>	<input type="checkbox"/>
(Y) N	7. Handwashing facilities (5-203 & 6-301)	<input type="checkbox"/>	<input type="checkbox"/>
<b>Approved Source</b>			
(Y) N	8. Food obtained from approved source (3-101 & 3-201)	<input type="checkbox"/>	<input type="checkbox"/>
(Y) N	9. Receiving temperature / condition (3-202)	<input type="checkbox"/>	<input type="checkbox"/>
(Y) N N/A	10. Records: shellstock tags, parasite destruction, required HACCP plan (3-202 & 3-203)	<input type="checkbox"/>	<input type="checkbox"/>
<b>Protection from Contamination</b>			
(Y) N N/A	11. Food segregated, separated and protected (3-302)	<input type="checkbox"/>	<input type="checkbox"/>
(Y) N N/A	12. Food contact surfaces clean and sanitized (4-5, 4-6, 4-7)	<input type="checkbox"/>	<input type="checkbox"/>
(Y) N	13. Returned / reservice of food (3-306 & 3-801)	<input type="checkbox"/>	<input type="checkbox"/>
(Y) N	14. Discarding / reconditioning unsafe food (3-701)	<input type="checkbox"/>	<input type="checkbox"/>

	Potentially Hazardous Food Time/Temperature	COS	R
(Y) N N/O N/A	15. Proper cooking, time and temperature (3-401)	<input type="checkbox"/>	<input type="checkbox"/>
Y N N/O N/A	16. Reheating for hot holding (3-403)	<input type="checkbox"/>	<input type="checkbox"/>
Y N N/O N/A	17. Cooling (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
(Y) N N/O N/A	18. Hot holding (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
(Y) N N/O N/A	19. Cold Holding (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
(Y) N N/O N/A	20. Date marking and disposition (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
Y N N/O N/A	21. Time as a public health control (procedures/records) (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
<b>Consumer Advisory</b>			
Y N N/A	22. Consumer advisory for raw or undercooked food (3-603)	<input type="checkbox"/>	<input type="checkbox"/>
<b>Highly Susceptible Populations</b>			
(Y) N N/O N/A	23. Pasteurized foods used, avoidance of prohibited foods (3-801)	<input type="checkbox"/>	<input type="checkbox"/>
<b>Chemical</b>			
Y N N/A	24. Additives / approved, unapproved (3-207)	<input type="checkbox"/>	<input type="checkbox"/>
(Y) N	25. Toxic substances properly identified, stored, used (7-101 through 7-301)	<input type="checkbox"/>	<input type="checkbox"/>
<b>Conformance with Approved Procedures</b>			
Y N N/A	26. Compliance with variance and HACCP plan (8-201)	<input type="checkbox"/>	<input type="checkbox"/>

Y = yes, in compliance  
N = no, not in compliance  
N/O = not observed  
N/A = not applicable  
COS = Corrected on-site  
R = Repeat violation  
 = COS or R

Item/Location	Temp	Item/Location	Temp	Item/Location	Temp	Item/Location	Temp
<u>Steak/Grill</u>	<u>174</u>	<u>Potatoes/Skillet</u>	<u>174</u>	<u>Hot Shrimp/Grill</u>	<u>179</u>		
<u>Asparagus/Hot Hold</u>	<u>173</u>	<u>Turkey/Grill</u>	<u>38</u>				

**GOOD RETAIL PRACTICES (X = not in compliance)**

	COS	R		COS	R		COS	R
<input type="checkbox"/> 27. Use of ice and pasteurized eggs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 34. Food contamination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 42. Food utensils/in-use	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 28. Water source and quantity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 35. Equipment for temp. control	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 43. Thermometers/Test strips	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 29. Insect/rodent/animals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 36. Personal cleanliness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 44. Warewashing facility	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 30. Food and non-food contact surfaces: constructed, cleanable, use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 37. Food labeled/condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 45. Wiping cloths	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 31. Plumbing installed; cross-connection; back flow prevention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 38. Plant food cooking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 46. Utensil & single-service storage	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 32. Sewage and waste water disposal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 39. Thawing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 47. Physical facilities	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 33. Sinks contaminated from cleaning maintenance tools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 40. Toilet facilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 48. Specialized processing methods	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/> 41. Garbage and refuse disposal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 49. Other	<input type="checkbox"/>	<input type="checkbox"/>

**OBSERVATIONS AND CORRECTIVE ACTIONS (CONTINUED ON NEXT PAGE)**

Person in Charge (Signature) <u>Shannon Skidmore</u> (Print) <u>Shannon Skidmore</u> Title <u>ED</u> Date <u>6-1-2015</u>	Follow-up: (Circle One) <u>Yes</u> <u>No</u>
Inspector (Signature) <u>Matt Hauser</u> (Print) <u>MATT HAUSER</u> Date <u>6/1/2015</u>	



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

C.L. "BUTCH" OTTER – GOVERNOR  
RICHARD M. ARMSTRONG – DIRECTOR

TAMARA PRISOCK – ADMINISTRATOR  
DIVISION OF LICENSING & CERTIFICATION  
JAMIE SIMPSON – PROGRAM SUPERVISOR  
RESIDENTIAL ASSISTED LIVING FACILITY PROGRAM  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: 208-364-1962  
FAX: 208-364-1888

June 11, 2015

Shannon Skidmore, Administrator  
Copper Springs Senior Living  
3570 East Amity Road  
Meridian, Idaho 83642

Provider ID: RC-1087

Ms. Skidmore:

An unannounced, on-site complaint investigation survey was conducted at Copper Springs Senior Living between May 26, 2015 and June 1, 2015. During that time, observations, interviews or record reviews were conducted with the following results:

**Complaint # ID00006508**

Allegation #1: The facility did not ensure residents received medications as ordered.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.305.02 for not ensuring residents received their medications. The facility was required to submit evidence of resolution within 30 days.

If you have questions or concerns regarding our visit, please call us at (208) 364-1962. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,

RAE JEAN MCPHILLIPS, RN, BSN  
Health Facility Surveyor  
Residential Assisted Living Facility Program

RM/sc

c: Jamie Simpson, MBA, QMRP, Supervisor, Residential Assisted Living Facility Program



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June 11, 2015

Shannon Skidmore, Administrator  
Copper Springs Senior Living  
3570 East Amity Road  
Meridian, Idaho 83642

Provider ID: RC-1087

Ms. Skidmore:

An unannounced, on-site complaint investigation was conducted at Copper Springs Senior Living between May 26, 2015 and June 1, 2015. During that time, observations, interviews or record reviews were conducted with the following results:

**Complaint # ID00006597**

Allegation #1: The facility did not ensure residents received medications as ordered.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.305.02 for not ensuring residents received their medications. The facility was required to submit evidence of resolution within 30 days.

If you have questions or concerns regarding our visit, please call us at (208) 364-1962. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,

RAE JEAN MCPHILLIPS, RN, BSN  
Health Facility Surveyor  
Residential Assisted Living Facility Program

RM/sc

c: Jamie Simpson, MBA, QMRP, Supervisor, Residential Assisted Living Facility Program



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P.O. Box 83720  
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EMAIL: ralf@dhw.idaho.gov  
PHONE: 208-364-1962  
FAX: 208-364-1888

June 11, 2015

Shannon Skidmore, Administrator  
Copper Springs Senior Living  
3570 East Amity Road  
Meridian, Idaho 83642

Ms. Skidmore:

An unannounced, on-site complaint investigation survey was conducted at Copper Springs Senior Living between May 26, 2015 and June 1, 2015. During that time, observations, interviews, and record reviews were conducted with the following results:

**Complaint # ID00006638**

**Allegation #1:** Residents' records did not contain Physician Order for Scope of Treatment (POST) forms.

**Findings:** Unsubstantiated. This does not mean the incident did not take place; it only means that the allegation could not be proven.

**Allegation #2:** The facility "stock piled" residents' unused medications.

**Findings:** Substantiated. However, the facility was not cited because the facility was under new ownership and the deficient practice was corrected by the current administration.

As no deficiencies were cited as a result of our investigation, no response is necessary to this report. Thank you to you and your staff for the courtesies extended to us on our visit.

Sincerely,

RAE JEAN MCPHILLIPS, RN, BSN  
Health Facility Surveyor  
Residential Assisted Living Facility Program

RM/sc

c: Jamie Simpson, MBA, QMRP, Supervisor, Residential Assisted Living Facility Program



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

C.L. "BUTCH" OTTER – GOVERNOR  
RICHARD M. ARMSTRONG – DIRECTOR

TAMARA PRISOCK – ADMINISTRATOR  
DIVISION OF LICENSING & CERTIFICATION  
JAMIE SIMPSON – PROGRAM SUPERVISOR  
RESIDENTIAL ASSISTED LIVING FACILITY PROGRAM  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: 208-364-1962  
FAX: 208-364-1888

June 11, 2015

Shannon Skidmore, Administrator  
Copper Springs Senior Living  
3570 East Amity Road  
Meridian, Idaho 83642

Ms. Skidmore:

An unannounced, on-site complaint investigation survey was conducted at Copper Springs Senior Living between May 26, 2015 and June 1, 2015. During that time, observations, interviews or record reviews were conducted with the following results:

**Complaint # ID00006801**

**Allegation #1:** The facility had strong urine odors.

**Findings:** The facility's campus consisted of four buildings with a licensed capacity of 119 beds. Only three of the buildings were currently occupied with a licensed capacity of 103 beds. The three occupied buildings were toured multiple times between 5/28 and 5/30/15. Three residents' rooms were observed to be clean, however the rooms were noted to have urine odors.

**Substantiated.** The facility was provided written technical assistance to ensure measures were taken to alleviate the urine odors in the three rooms.

**Allegation #2:** Residents were not assessed by the facility RN when they had changes in their conditions.

**Findings:** Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.305.03 for the facility nurse not assessing residents when they had changes in their conditions. The facility was required to submit evidence of resolution within 30 days.

If you have questions or concerns regarding our visit, please call us at (208) 364-1962. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,

RAE JEAN MCPHILLIPS, RN, BSN  
Health Facility Surveyor  
Residential Assisted Living Facility Program

RM/sc



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June 11, 2015

Shannon Skidmore, Administrator  
Copper Springs Senior Living  
3570 East Amity Road  
Meridian, Idaho 83642

Provider ID: RC-1087

Ms. Skidmore:

An unannounced, on-site complaint investigation survey was conducted at Copper Springs Senior Living between May 26, 2015 and June 1, 2015. During that time, observations, interviews, and record reviews were conducted with the following results:

**Complaint # ID00006836**

**Allegation #1:** The facility did not appropriately address residents' behaviors.

**Findings:** Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.225.01 and 225.02 for not evaluating and developing interventions for resident's behaviors. The facility was required to submit evidence of resolution within 30 days.

**Allegation #2:** The facility over-sedated residents.

**Findings:** Unsubstantiated. However, the facility was issued a citation for the nurse not assessing the resident after he had a change in condition.

If you have questions or concerns regarding our visit, please call us at (208) 364-1962. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,

RAE JEAN MCPHILLIPS, RN, BSN  
Health Facility Surveyor  
Residential Assisted Living Facility Program

RM/sc

c: Jamie Simpson, MBA, QMRP, Supervisor, Residential Assisted Living Facility Program



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June 11, 2015

Shannon Skidmore, Administrator  
Copper Springs Senior Living  
3570 East Amity Road  
Meridian, Idaho 83642

Provider ID: RC-1087

Ms. Skidmore:

An unannounced, on-site complaint investigation was conducted at Copper Springs Senior Living between May 26, 2015 and June 1, 2015. During that time, observations, interviews, and record reviews were conducted with the following results:

**Complaint # ID00006876**

**Allegation #1:** Physician's orders were not implemented.

**Findings:** Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.305.02 for not ensuring residents received their medications as ordered. The facility was required to submit evidence of resolution within 30 days.

**Allegation #2:** Staff did not know what to do when residents became ill.

**Findings:** Unsubstantiated. This does not mean the incident did not take place; it only means that the allegation could not be proven.

**Allegation #3:** The facility did not implement interventions when a resident developed a pressure ulcer.

**Findings:** Unsubstantiated. This does not mean the incident did not take place; it only means that the allegation could not be proven.

If you have questions or concerns regarding our visit, please call us at (208) 364-1962. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,

RAE JEAN MCPHILLIPS, RN, BSN  
Health Facility Surveyor  
Residential Assisted Living Facility Program

RM/sc