# 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

September 21, 2015

Administrator
Regency Columbia Village, LLC
3521 East Lake Forest Drive
Boise, Idaho 83716

Provider ID: RC-787

Administrator:

On June 12, 2015, a state licensure/follow-up and complaint investigation were conducted at Regency Columbia Village, LLC. 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 plan of correction and evidence of resolution 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 Polly Watt-Geier, MSW, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 364-1962.

Sincerely,

Polly Watt-Geier, MSW

POLLY WATT-GEIER, MSW
Team Leader
Health Facility Surveyor

PWG/sc

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

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July 7, 2015

**CERTIFIED MAIL #: 7007 3020 0001 4050 8951**

Mary Lewerenz
Regency Columbia Village
3521 East Lake Forest Drive
Boise, Idaho 83716

Ms. Lewerenz:

Based on the state licensure/follow-up survey and complaint investigation conducted by Department staff at Regency Columbia Village, LLC between May 29, 2015 and June 12, 2015, it has been determined that the facility failed to retain a licensed administrator responsible for the day-to-day operations of the facility for a period of more than 30 days. Additionally, the facility failed to protect residents from abuse after an allegation of abuse was received. The facility also failed to provide assistance and monitoring of medications. Finally, the facility failed to protect a resident's right to be free of chemical restraint. These deficiencies are described in the enclosed survey report.

These core issue deficiencies substantially limit the capacity of Regency Columbia Village, LLC 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 27, 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 **July 20, 2015,** and keep a copy for your records. Your license depends npon the corrections made and the evaluation of the Plan of Correction you develop.

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* 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 12, 2015**.

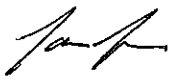
If, at the follow-up survey, the core deficiencies still exist or a new core deficiency is identified, the Department will have no alternative but to initiate an enforcement action against the license held by Regency Columbia Village, LLC.

Enforcement actions may include:

- imposition of civil monetary penalties;
- issuance of a provisional license;
- limitation or ban on admissions 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: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 13R787 | | 06/12/2015 |

NAME OF PROVIDER OR SUPPLIER: REGENCY COLUMBIA VILLAGE

STREET ADDRESS, CITY, STATE, ZIP CODE: 3521 EAST LAKE FOREST DRIVE, BOISE, ID 83716

| (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 |
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| R 000 | Initial Comments<br><br>The following deficiencies were cited during the licensure/follow-up and complaint investigation survey conducted between May 29, 2015 and June 12, 2015 at your residential care/assisted living facility. The surveyors conducting the survey were:<br><br>Polly Watt-Geier, MSW<br>Team Coordinator<br>Health Facility Surveyor<br><br>Jamie Simpson, QMRP, MBA<br>Program Supervisor<br><br>Gloria Keathley, LSW<br>Health Facility Surveyor<br><br>Karen Anderson, RN<br>Health Facility Surveyor<br><br>Lisa Bennett, RN<br>Health Facility Surveyor<br><br>Rae Jean McPhillips, RN, BSN<br>Health Facility Surveyor<br><br>Donna Henscheid, LSW<br>Health Facility Surveyor<br><br>Jeremy Walker, LSW<br>Health Facility Surveyor<br><br>Survey Abbreviations & Definitions:<br><br>ADL = Activity of Daily Living<br>BMP = Behavior Management Plan<br>COPD = Chronic obstructive pulmonary disease<br>hr = hour<br>HS = hospice | R 000 | Submission of this response and Plan of Correction is NOT legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also NOT to be construed as an admission against interest by the facility, or any employees, agents or other individuals who drafted or may be discussed in the Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the trust of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.<br>PLAN OF CORRECTION for Core Citations<br><br>16.03.22.215.03:<br>1. The facility is currently operated by a licensed administrator that works full time and has the ability to be on site within 2 hours.<br>2. Regional Clinical and Operations staff were educated regarding the Idaho licensing regulations.<br>3. In the event of an emergency or an Administrator position opening, the facility will ensure that a licensed ALF administrator is hired either in an interim or full-time capacity within 30 days.<br>4. Furthermore the administrator will work at the facility full time and be able to be on site within 2hours. The Regional Director of Operations will ensure compliance.<br>Date of Completion: July 27, 2015.<br><br>16.03.22.510: The administrator must assure that policies and procedures are implemented to assure that all residents are free from abuse.<br>1. Staff A was suspended pending investigation. Terminated on July 8, 2015. The Administrator did a complete and thorough investigation for resident 1 who no longer resides at the facility.<br>2. The Administrator conducted interviews of staff, residents and family members/POAs. Any identified issues were investigated and reported per regulation.<br>3. The Vice President of Operations has in-serviced the Administrator on the Abuse/Neglect/Exploitation Policy, Reporting Harassment/Complaints and Internal Reporting Guidelines on June 17, 2015. Additionally current staff have been in-serviced by the Administrator and Director of Clinical Services on the Abuse/Neglect/Exploitation | |

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<br><br>MAR = Medication Assistance Record<br>mg = milligrams<br>NSA = Negotiated Service Agreement<br>PRN = As Needed<br>RCC = Resident Care Coordinator<br>RN = Registered Nurse<br>UAI = Uniform Assessment Instrument<br>UTI = Urinary Tract Infection | R 000 | Policy, Reporting Harassment/Complaints and Internal Reporting Guidelines. Additionally First Choice Home Health & Hospice did training on do's and don'ts when communicating with residents with Alzheimer's or dementia.<br>4. The Business Office Manager, Administrator and/or designee will train new staff members on Abuse/Neglect/Exploitation Policy, Reporting Harassment/Complaints and Internal Reporting Guidelines which is now part of the new hire orientation. This will be monitored for compliance on an ongoing basis by the Business Office Manager, Administrator and/or designee on the Personnel Tracking Tool. The Administrator will investigate all allegations of abuse, report to Adult Protection Services and suspend identified perpetrator pending investigation. Abuse investigations will be reviewed by the Director of Clinical Services for three (3) months.<br>5. The Administrator is ensuring incident reports are thoroughly investigated, interventions implemented, signed and proper reporting has been conducted. During stand up meetings the managers will be asked if they have any reports of abuse.<br>Date of Completion: July 27, 2015. | |
| R 004 | 16.03.22.215.03 Licensed Administrator Requirement - 30 Days<br><br>The facility may not operate for more than thirty (30) days without a licensed administrator.<br><br>This Rule is not met as evidenced by:<br>Based on interview and record review, it was determined the facility failed to retain a licensed administrator responsible for the day-to-day operations of the facility for a period of more than 30 days. This had the potential to impact 100% of the facility's residents.<br><br>According to IDAPA 16.03.22.010.05, an administrator is defined as, "an individual, properly licensed by the Bureau of Occupational Licensing, who is responsible for day to day operation of a residential care or assisted living facility."<br><br>According to IDAPA 16.03.22.215.02, an administrator must be on-site sufficiently to provide for safe and adequate care of the residents....The facility administrator...must be on-site at the facility within two hours.<br><br>A review of the facility's correspondence | R 004 | 16.03.22.520<br>1. An in-service was done on July 1, 2015 to review following behavior plans as there should be behavior plans on any residents with psychoactive medications, PRN psychoactive medications and PRN pain management. This in-service included how to avoid chemical restraints, doing non-pharmacological interventions first before medication, following behavior plans, alerting the nurse with changes and documentation on the behavior tracking tool.<br>2. The RN, while in building, is reviewing the behavior management tracking tool daily and updating behavior plan and care plan as needed.<br>3. The RN, while in building, is reviewing the progress notes daily for change of condition and follow through.<br>4. The RN, while in building, is printing out PRN medication report to review PRN psychoactive and pain management given. With this information LN will monitor, update behavior plans, update care plans and make recommendations based on this review which will include notifying physician and family.<br>5. The RN is doing 90 day quarterly assessment reviews | |

Residential Care/Assisted Living

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| R 004 | Continued From page 2<br>maintained at Licensing and Certification on 6/8/15, documented Barbara Jeanne McCrary had been the licensed administrator from 7/9/12 through 7/15/14.<br><br>On 6/11/15 at 8:23 AM, Barbara Jeanne McCrary confirmed her last day at the facility was 7/15/14.<br><br>A review of the facility's correspondence maintained at Licensing and Certification on 6/8/15, documented JoAnne Mohrland e-mailed Licensing & Certification on 7/24/14. The e-mail documented Jeanne McCrary was no longer the licensed administrator. The e-mail documented JoAnne had applied for her provisional license.<br><br>A letter from an anonymous writer, dated 7/22/14, documented the previous administrator left on July 15 and "took her license with her." The letter documented, the person working as the administrator, JoAnne, was not licensed and lived in "Walla Walla, Washington." The letter documented JoAnne commuted to the facility and was on-site Tuesday through Thursdays (3 days a week).<br><br>An e-mail from an anonymous writer, dated 7/29/14, documented the former administrator had left and the company had brought "in a corporate employee to act as the administrator; however, she does not possess a license and she commutes from Walla Walla, Washington,"<br><br>According Google Maps, Walla Walla, Washington is 253 miles and approximately 4 hours and 10 minutes away from Boise, Idaho.<br><br>A review of the facility's correspondence maintained at Licensing and Certification on 6/8/15, documented JoAnne Mohrland e-mailed | R 004 | 4. The Executive Director reviewed and signed current care plans, behavior plans, psychotropic reviews, interim service plans and assessments. The Executive Director will perform weekly MAR audits and Wellness Director and/or RCC will review MAR's weekly while in the community for three months.<br><br>Resident's Right to be Free from Chemical Restraints<br>1. Resident 7 is no longer in the facility. Wellness Director and/or designee completed a chart review, updated the service plan, and completed a behavior management plan and psychotropic review on residents 2 and 4.<br>2. The Wellness Director reviewed current care plans, psychotropic medications and behavior plans on current residents to ensure they are free from chemical restraints and updated as necessary.<br>3. The Executive Director and Wellness Director, while both are in the building, is conducting a daily clinical meeting using the clinical meeting tool which will include reviewing assessments, care notes, incident reports, behavior plans, psychotropic reviews, care plans, medication reviews and resident/family concerns. This is daily effective July 6, 2015. After one month, effective August 6, 2015, the meeting will be held weekly and as needed.<br>4. Going forward the Executive Director will review current care notes and MARs weekly and documentation completion on the Executive Director Weekly/Monthly Task sheet. The Executive Director is conducting monthly quality checks to observe residents care is provided adequately.<br>Date of Completion: July 27, 2015. | |

Residential Care/Assisted Living

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| R 004 | Continued From page 3<br>Licensing & Certification on 9/3/14, stating she had received her provisional license, which was attached to the e-mail. The provisional license documented it was issued on 8/29/14. The e-mail also documented "in the interim, Debbie Smith oversaw our operation from July 25th to Sept 1."<br><br>On 6/8/15 at 11:17 AM, The Idaho Board of Occupational Licenses Website documented there was a Residential Care Administrator license for Debbie Smith, which was issued on 7/30/09.<br><br>On 6/10/15 between 11:25 AM and 1:10 PM, Debbie Smith confirmed she was licensed as an administrator in Idaho. She stated she "hung" her license, but was never "physically" at the facility. She stated, she was providing "oversight" while JoAnne worked on obtaining her license in Idaho. She stated JoAnne received her provisional license on 7/1/14. Additionally, she stated she lived in Prosser, Washington.<br><br>According Google Maps, Prosser, Washington is 304 miles and approximately 4 hours and 48 minutes away from Boise, Idaho.<br><br>On 6/10/15 at 1:15 PM, a member of the Idaho Board of Occupational Licenses confirmed, JoAnne Mohrland was not issued her provisional license until 8/29/14.<br><br>On 6/8/15 at 11:17 AM, the Idaho Board of Occupational Licenses Website documented there was a Residential Care Administrator license for JoAnne Mohrland, who resided in Walla Walla, Washington, issued on 9/10/14.<br><br>On 6/10/15 at 10:48 AM, the Vice President of Operations stated the facility had the following | R 004 | | |

Residential Care/Assisted Living

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| R 004 | Continued From page 4<br><br>administrator changes:<br><br>* From 6/6/2013 through 7/25/14, Barbara Jeanne McCrary was the licensed administrator.<br><br>* From 7/1/14 through 2/20/15, JoAnne Mohrland was the licensed administrator.<br><br>He stated JoAnne overlapped the time from when Jeanne left the position. He stated Debbie Smith worked for the company as a "traveling" executive director and may have been at the facility, but that was prior to his time as Vice President.<br><br>The facility did not have a licensed administrator running the day to day operations of the facility from 7/16/14 through 8/28/14 (43 days), as Debbie Smith "hung" her license, but was never at the facility and JoAnne Mohrland acted as the administrator, but was not licensed during that time. In addition, both Debbie Smith and JoAnne Mohrland resided in Washington and would not have been able to be on-site within two hours. | R 004 | | |
| R 006 | 16.03.22.510 Protect Residents from Abuse.<br><br>The administrator must assure that policies and procedures are implemented to assure that all residents are free from abuse.<br><br>This Rule is not met as evidenced by:<br>Based on observation, interview and record review, it was determined that after receiving a report of a male caregiver being sexually inappropriate with a female resident, the facility failed to take steps to protect female residents | R 006 | | |

Residential Care/Assisted Living

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| R 006 | Continued From page 5<br>from further abuse. This had the potential to affect 100% of the 32 female residents in the facility. The facility also failed to report the incident to adult protection, complete a thorough investigation and they failed to document the incident, investigation or response. The findings include:<br><br>Idaho Statute 39-5303 requires that a residential care facility, serving vulnerable adults, must immediately report the allegation of abuse to Adult Protection Services/APS.<br><br>IDAPA 16.02.33.510 documents, "The administrator must assure that policies and procedures are implemented to assure that all residents are free from abuse."<br><br>IDAPA 16.03.22.153.01 documents, "The facility must develop policies and procedures to assure that allegations of abuse, neglect and exploitation are identified, reported, investigated, followed-up with interventions to prevent reoccurrence and assure protection, and documented."<br><br>The facility's Resident Abuse/Neglect/Exploitation Policy, undated, specified the following steps needed to be completed when an allegation of abuse was made known:<br><br>*Administrator to immediately report to Adult Protective Services<br><br>*All allegations of abuse will be treated as serious and will be investigated, documented and reported<br><br>*Administrator will investigate all cases of alleged abuse | R 006 | | |

Residential Care/Assisted Living

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| R 006 | Continued From page 6<br>*Initiate an incident report on the "Incident/Accident Form"<br><br>*Suspend the alleged abuser and remove him/her from the premises until the investigation is completed<br><br>*Interview all staff who might have witnessed or have knowledge of the alleged abuse<br><br>1. According to her record, Resident #1 was a 90 year-old female with a diagnosis of COPD, who was admitted to the facility on 8/16/13.<br><br>On 5/29/15 at 3:30 PM, Resident #1 stated that a couple weeks ago, a male staff member (Staff A), made her uncomfortable when he would come into her room and just sit and "play busy." She said he kept coming in and out of her room "all the time," and then one evening, she felt he had "gone too far." According to the resident, Staff A kept calling her "Sweetie and Honey" and rubbed her back and hugged her around the shoulders. She said he then proceeded to sit on her bed and pat the bed with his hand saying, "You know where I am going to sleep tonight" and mumbled something else about "sex." According to the resident, she immediately reported this to two staff members and requested Staff A, be kept away from her. She also said "I understand he went further with some of the other ladies than he did with me." Throughout the forty minute interview, Resident #1 was observed to answer questions and track the conversation appropriately.<br><br>On 6/1/15 at 1:23 PM, during a telephone conversation, Resident #1's daughter stated she visited her mom several days a week at the facility. The resident's daughter stated she had | R 006 | | |

Residential Care/Assisted Living

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| R 006 | Continued From page 7<br>been on vacation when the incident happened. She said when her mom told her what happened, she called the police. She stated the facility did not contact her about the allegation of abuse until 5/29/15, after an adult protection investigator came to the facility to investigate.<br><br>On 5/29/15 at 3:10 PM, the facility RN stated a staff member reported the allegation to her on 5/19/15 and she reported it immediately to the administrator. The RN stated she did not report the allegation to adult protection. Additionally, the RN stated she did not interview any other residents to see if they had experienced similar problems. The nurse also stated she did not interview any other staff to determine if they had witnessed any inappropriate interactions between Staff A and residents. The RN stated she had moved Staff A to a different house where he was currently providing direct care to residents. She confirmed an incident report had not been completed.<br><br>On 5/29/15, the RN was unable to locate a copy of the facility abuse policy and procedure. The RN stated she was not aware of what the facility's policies were regarding abuse. The RN provided an untitled, typed statement. The actual date the statement was written was unknown, as it was dated April 19, 2015 (four weeks prior to the incident). The written statement indicated the RN took the alleged perpetrator with her to interview Resident #1. The statement documented the nurse told Resident #1 that Staff A would "protect her and keep her safe and be her security guard for the nights when he worked."<br><br>On 5/29/2015 at 5:00 PM, Staff A was observed working with residents in another building at the facility. | R 006 | | |

Residential Care/Assisted Living

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NAME OF PROVIDER OR SUPPLIER: REGENCY COLUMBIA VILLAGE

STREET ADDRESS, CITY, STATE, ZIP CODE: 3521 EAST LAKE FOREST DRIVE, BOISE, ID 83716

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| R 006 | Continued From page 8<br><br>On 5/29/2015 at 5:50 PM, the facility administrator stated she did not report the allegation of abuse to adult protection. She also stated other residents and staff had not been interviewed. The administrator was unable to locate the facility's abuse policy and procedure. She confirmed an incident report had not been completed.<br><br>On 5/29/15, another resident stated Staff A repeatedly suggested she go into her room and put her night clothes on. She stated Staff A would open her door at various times and ask if she was ready to get undressed. The resident said she did not require any assistance with dressing and felt uncomfortable around him because he had a "sexual edge." The resident was able to give an accurate physical description of Staff A.<br><br>The facility was cited with an Immediate Danger deficiency on 5/29/2015. As a part of the immediate correction, the alleged perpetrator, Staff A, was placed on administrative leave effective 5/29/2015 at 6:00 PM.<br><br>The facility failed to protect Resident #1 and other female residents when they allowed Staff A to continue providing direct care to female residents. The facility also failed to notify adult protection, failed to properly document and failed to conduct a complete investigation after an allegation of abuse was reported. These failures left 100% of the female residents at risk for sexual abuse. | R 006 | | |
| R 008 | 16.03.22.520 Protect Residents from Inadequate Care.<br><br>The administrator must assure that policies and | R 008 | | |

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| R 008 | Continued From page 9<br>procedures are implemented to assure that all residents are free from inadequate care.<br><br>This Rule is not met as evidenced by:<br>Based on observation, record review and interview it was determined the facility failed to assist and monitor medications for 3 of 9 sampled residents (Resident #1, #7 and #9). The facility also failed to protect 3 of 5 sampled residents (Resident #1, #2 and #3), who were on behavior modifying medications, right to be free from chemical restraints. The findings include:<br><br>I. Assistance & Monitoring Of Medications<br><br>IDAPA 16.03.22.011.08, states inadequate care is "When a facility fails to provide...assistance and monitoring of medications."<br><br>A) Medications were not available and given as ordered<br><br>1. Resident #7's record documented she was a 94 year-old female, admitted to the facility on 2/17/15 with a diagnosis of dementia.<br><br>A physician's order, dated 2/17/15, documented Resident #7's was to receive the following doses of Seroquel:<br><br>*25 mg at 3:00 PM<br>*50 mg at bedtime<br><br>The February and March 2015 MARs, from 2/18 through 3/5, documented Resident #7, received 50 mg of Seroquel (twice the prescribed dose) at 3:00 PM, for a total of 16 days and received 100 mg (twice the prescribed dose) at bedtime, for a | R 008 | | |

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| R 008 | Continued From page 10<br>total of 8 days.<br><br>Resident #7 received twice the prescribed dose of Seroquel a total of 24 times from 2/18 through 3/5/15.<br><br>A physician's order, dated 3/5/15, documented Resident #7's was to receive the following doses of Seroquel:<br><br>*25 mg at 3:00 PM<br>*100 mg at bedtime - an increase of 50 mg<br><br>The March 2015 MAR documented Resident #7 received 50 mg of Seroquel (twice the prescribed dose) at 3:00 PM from 3/6 through 3/31, for a total of 26 days.<br><br>The March 2015 MAR also documented Resident #7 received only 50 mg of Seroquel at bedtime (half the prescribed dose) on 3/6, 3/8, 3/17, 3/29 and 3/31.<br><br>From 3/5 through 4/22/15, Resident #7 received received a total of 69 incorrect doses of Seroquel.<br><br>The April 2015 MAR, documented from 4/1 through 4/20, Resident #7 received 75 mg of Seroquel at 3:00 PM (three times the prescribed dose) for 18 days. The MAR documented Resident #7 also received 125 mg of Seroquel at bedtime, which was 25 mg more than the prescribed amount for 18 days.<br><br>A physician's order, dated 4/24/15, documented Resident #7 was to receive the following doses of Seroquel:<br><br>*25 mg at 3:00 PM<br>*50 mg at bedtime - a reduction of 50 mg | R 008 | | |

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| R 008 | Continued From page 11<br><br>The 4/25, through 4/30/15 MAR, documented Resident #7 received 50 mg (twice the prescribed dose) of Seroquel at 3:00 PM for 6 days. On 4/23 and 4/24/15, Resident #7 received 100 mg (twice the prescribed dose) of Seroquel at bedtime for 6 days.<br><br>Medication aides documented on 4/6, 4/20, 4/21 and 4/22, they had concerns regarding the accuracy of the MAR, and the amount of Seroquel Resident #7 was receiving. There was no documentation the facility nurse was advised of the medication concerns or what attempts were made to clarify Resident #7's orders.<br><br>The 5/1 through 5/14/15 MAR documented Resident #7 received 50 mg (twice the dose) at 3:00 PM of Seroquel for 19 days. Further, the MAR, dated 5/1 through 5/5, documented she received 100 mg at bedtime (twice the prescribed dose) of Seroquel for a total of 5 days.<br><br>From 4/25 through 5/14/15, Resident #7 received twice the prescribed dose of Seroquel 36 times.<br><br>From 2/18 until 5/31/15, approximately 102 days, Resident #7 received an incorrect amount of Seroquel, 126 times and received half the amount prescribed 5 times.<br><br>In addition to the above concerns there were numerous times the Seroquel was documented as not available or staff were told to hold the medications. There was no indication the facility nurse monitored the amount of Seroquel Resident #7 received, or ensured the medication was available.<br><br>On 6/11/15 at 2:30 PM, the facility nurse | R 008 | | |

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| R 008 | Continued From page 12<br><br>confirmed that according to the MARs, Resident #7 received the wrong dose of Seroquel multiple times from 2/18 through 5/14/15. She stated, she did not review MARs for accuracy. After the RN reviewed the MARs on 6/11/15, she confirmed the documentation regarding the availability of the Seroquel was inconsistent. Additionally, she stated she was unaware of a time the Seroquel was unavailable or staff were told to hold the medication.<br><br>On 6/11/15 at 2:35 PM, the RCC stated, she was sure Resident #7 did not receive more Seroquel than prescribed, it was just documentation errors. She confirmed that neither she, nor the RN, reviewed the MARs in February, March or April, to ensure Resident #7 received the correct dose of Seroquel.<br><br>The facility did not provide appropriate monitoring of medications for Resident #7, which resulted in 131 medication errors, 126 of which were more than the prescribed dosage, which at the potential to cause adverse side-effects.<br><br>2. According to her record, Resident #1 was a 90 year-old female, admitted to the facility on 8/16/13, with diagnoses of COPD, migraine headaches and chronic pain.<br><br>On 6/8/15 at 3:17 PM, Resident #1 was observed in her room sitting in her wheelchair. Resident #1 stated, "I've never hurt so bad." She stated, she had a history of migraines since childhood, but nothing as bad as the pain she had experienced over the past 4 days and 3 nights. The resident stated her pain radiated from her shoulder, up her neck and to the top of her head. Resident #1 stated she was told by medication aides her pain medication "Norco" ran out and the pharmacy | R 008 | | |

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| R 008 | Continued From page 13<br>and physician had not refilled the order. Resident #1 said on a pain scale from 1 to 10, she rated her pain as an 8. She stated, eight was "severe pain."<br><br>A physician's order, dated 5/5/15, documented Resident #1 was to receive "Norco," 1 tablet, four times daily as needed.<br><br>The May 2015, "Controlled Drug Record," documented 30 tablets of Norco were delivered to the facility on 5/6. According to the record Resident #1 received her last dose of Norco on 5/26 at 7:20 AM.<br><br>On 6/8/15 at 3:57 PM, the facility RN stated, "I've called her physician and the pharmacy several times since the 5th of June, and still haven't received her Norco." The RN stated, "What am I suppose to do. I guess I will call the pharmacy again."<br><br>On 6/8/15 at 4:00 PM, the administrator stated, "I only found out this morning [Resident #1's name] had run out of her Norco." She stated the resident's daughter called to tell her the resident had been in pain for days and wanted to find out why the medication was not available.<br><br>According to the June 2015, "Controlled Drug Record," the medication was delivered on 6/8 at 8:10 PM. The record also documented Resident #1 was not given Norco for 14 days.<br><br>On 6/9/15 at 12:11 PM, Resident #1 stated, "I never had so much pain as I did yesterday. I had to wait until 8:00 PM, for my Norco to arrive."<br><br>The facility failed to reorder Resident #1's narcotic pain medication on 5/26/15. There was | R 008 | | |

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| R 008 | Continued From page 14<br><br>no documented evidence the pharmacy or physician were notified until 6/4/15. As a result, Resident #1 experienced severe pain. The facility failed to provide the necessary oversight to ensure medications were available and given as ordered.<br><br>3. Resident #9's record documented she was an 85 year-old female, admitted to the facility on 5/22/15 with a diagnosis of dementia.<br><br>Resident #9's physician ordered the following medications on 5/12/15:<br><br>*Aricept 10 mg, 1 tablet every morning<br>*Aricept 10 mg, 1 tablet every morning<br>*Seroquel 25 mg, take 0.5 - 1 tablet every evening<br>*alprazolam 0.25 mg, 0.5 mg to 1 mg every 6 hours as needed<br><br>There was no documentation in Resident #9's record, the facility attempted to clarify with the physician, if Resident #9 was to take 10 mg or 20 mg of Aricept every morning.<br><br>The May and June 2015 MARs, from 5/23 through 6/10 documented the following:<br><br>*Aricept - received 10 mg daily, from 5/23 through 5/31, for a total of 9 days. There was no documentation for 6/1 and 6/2. The medication was unavailable (waiting for a refill) from 6/3 through 6/6/15. Aricept was given on 6/7 and 6/8, but was again unavailable on 6/9 and 6/10. According to the MARs, Resident #9 only received 3 doses of Aricept in June.<br><br>*Seroquel - received 25 mg daily, from 5/23 through 5/30, for a total of 8 days. Staff | R 008 | | |

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| R 008 | Continued From page 15<br>documented the medication was unavailable (waiting for a refill) on 5/31, 6/1, 6/3, 6/5, 6/6 and 6/9. The remaining days, staff documented Resident #9 was out of the facility.<br>Resident #9 did not receive any Seroquel from 5/31 through 6/10, a total of 10 missed doses.<br><br>*Alprazolam - was given for anxiety 14 times, from 5/26 through 6/10. Eleven of those times, Resident #9 only received 0.25 mg, half of the prescribed dosage.<br><br>On 6/11/15 at 11:30 AM, a medication aide stated they were responsible to reorder residents' medications. She stated when there were 7 pills left in the "bubble" card, they were to reorder the medication through the computer. She stated the reorder went directly to the pharmacy, facility nurse and the RCC. She stated the medication had been ordered, but she did not know why it had not been delivered.<br><br>On 6/11/15 at 2:30 PM, the facility nurse stated, when Resident #9 moved into the facility, she "bubble packed," approximately a week's worth of medications brought from home. The nurse stated she did not contact Resident #9's pharmacy to order more medications. Additionally, the nurse stated, she was unaware Resident #9 received only half the prescribed dose of alprazolam.<br><br>On 6/11/15 at 2:40 PM, the RCC stated the pharmacy could not refill Resident #9's Aricept and Seroquel because "it had already been filled by another pharmacy." She stated Resident #9's insurance would not pay for the prescription until the end of June 2015. The RCC provided printouts from the computer that documented the medications were not reordered until 6/5/15, six | R 008 | | |

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| R 008 | Continued From page 16<br>days after Resident #9 ran out of the medications.<br><br>On 6/11/15 at 2:55 PM, the facility nurse stated, she had not contacted Resident #9's physician or family regarding the problem obtaining Resident #9's medications.<br><br>Resident #9 was not assisted with her Aricept, Seroquel or alprazolam as ordered by the physician in May and June 2015. This occurred because the facility failed to reorder medications until 6/5/15. The medications were still not available as of 6/12/15.<br><br>The facility failed to provide the necessary oversight to ensure residents' medications were available and given as ordered for Resident #1, #7 and #9.<br><br>II. Residents' Right To Be Free From Chemical Restraints<br><br>According to IDAPA 16.03.22.550.10 - Each resident must have the right to be free from...chemical restraints.<br><br>According to IDAPA 16.03.22.010.16, a chemical restraint is defined as: A medication used to control behavior or to restrict freedom of movement and is not a standard treatment for the resident's condition<br><br>1. According to her record, Resident #4 was an 84 year-old female with a diagnosis of dementia who was admitted to the facility on 7/10/07.<br><br>An NSA dated, 2/12/15, documented Resident #4 had a history of refusing showers and changing into clean clothes. | R 008 | | |

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| R 008 | Continued From page 17<br><br>Resident #4's record did not contain a behavior management plan.<br><br>A nursing assessment, dated 5/15/15, documented Resident #4 was on hospice. The assessment documented the resident had "several falls this quarter." The assessment documented, "Resident is impulsive and will get up from chair or bed without using call light or staff assist." Additionally, the assessment documented the resident had anxiety, but "rarely" needed an anti-anxiety medication.<br><br>A Nurse Practitioner's order, dated 12/12/14, documented Resident #4 was to take the following behavior modifying medications:<br><br>* fluphenazine 5 mg twice daily (10 mg)<br>* fluphenazine 5 mg as needed for mood or agitation<br>* Haldol 1 ml every hour as needed.<br>* lorazepam 0.5 ml every four hours as needed.<br>* Xanax 0.25 mg every 4 hours as needed<br><br>a) fluphenazine and Haldol<br><br>According to the 2016 Nursing Drug Handbook, fluphenazine and Haldol are anti-psychotic medications, usually prescribed for psychotic disorders.<br><br>*** On 6/16/08, the FDA issued a warning stating, fluphenazine and Haldol were not indicated for the use in elderly patients with dementia-related psychosis because of increased risk of death.<br><br>b) Xanax and lorazepam<br><br>According to the 2016 Nursing Drug Handbook, Xanax and lorazepam are anti-anxiety | R 008 | | |

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| R 008 | Continued From page 18<br>medications.<br><br>Resident #4 received four behavior modifying medications, including one scheduled anti-psychotic (fluphenazine), two PRN anti-psychotics (Haldol and fluphenazine) and two PRN anti-anxiety medications (Xanax and lorazepam) over the course of seven months. The 2016 Nursing Drug Handbook documented the medications had the following common side-effects: higher frequency of movement disorders, unsteadiness, drowsiness, dizziness, blurred vision, insomnia, confusion, urinary retention, irritability, impaired coordination and disorientation.<br><br>The 12/12/14 through 1/5/15 MAR documented, Resident #4 received 10 mg a day of her scheduled fluphenazine, 12 PRN doses of Xanax, 4 PRN doses of lorazepam and 2 PRN dose of Haldol.<br><br>Resident #4's record contained facility notes and hospice notes between 12/22/14 and 1/5/15, which documented the following:<br><br>* 12/22 - 12/29: Resident #4 slept more than "usual" and fell after she received doses of PRN Xanax.<br><br>*1/1: Resident #4 was very confused and physically unstable<br><br>*1/2: Resident #4 had increased weakness, was unsteady on her feet and required a two-person assist with transfers and ambulation."<br><br>A Nurse Practitioner's order, dated 1/5/15, documented to increase the 5:00 PM fluphenazine dose from 5 mg to 10 mg, totaling | R 008 | | |

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| R 008 | Continued From page 19<br>15 mg a day.<br><br>According to the 2016 Nursing Drug Handbook, the side-effects for fluphenazine included a higher frequency of movement disorders (including muscle contractions or spasms, motor restlessness, tremors and irregular, jerky movements), drowsiness and dizziness. The handbook also documented for adults the dosage of fluphenazine should be started between 2.5 mg to 10 mg daily in divided doses every six to eight hours. The handbook also documented that the dosage "may" be increased "cautiously to 20 mg." In addition the handbook documented for "elderly patients" the dosage should be 1 mg to 2.5 mg daily.<br><br>The increase of fluphenazine to 15 mg was approximately 10 times the minimum suggested dose of 1 mg for Resident #4's age of 84 years.<br><br>The 1/6/15 through 1/9/15 MAR, documented the resident received 20 mg of fluphenazine on 1/6 and 15 mg of fluphenazine from 1/7 through 1/9/15. The MAR also documented Resident #4 received 1 PRN dose of Xanax, 4 PRN doses of lorazepam, 1 PRN dose of Haldol and 1 PRN dose of fluphenazine.<br><br>Resident #4's record contained facility notes and hospice notes, dated 1/6/15 and 1/8/15, which documented the following:<br><br>*1/6/15: "tripped over her own feet" and fell to the floor on her right side.<br><br>*1/8/15: hands were observed to be "shaking."<br><br>* 1/9/15: the resident's agitation and restlessness had increased from a week and a half ago. The | R 008 | | |

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NAME OF PROVIDER OR SUPPLIER: REGENCY COLUMBIA VILLAGE

STREET ADDRESS, CITY, STATE, ZIP CODE: 3521 EAST LAKE FOREST DRIVE, BOISE, ID 83716

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| R 008 | Continued From page 20<br><br>HS nurse documented the PRN medications did not sedate Resident #4 and were "effective at managing her anxiety and agitation." However, the note documented Resident #4's primary care provider "would like to increase her fluphenazine to TID."<br><br>A Nurse Practitioner's order, dated 1/9/15, documented to increase Resident #4's fluphenazine to 20 mg a day, approximately 10 times the maximum suggested dose for Resident #4's age of 84 years.<br><br>The 1/10/15 through 1/31/15 MAR, documented Resident #4 received 20 mg of fluphenazine, 2 PRN doses of lorazepam and 5 PRN doses of Haldol.<br><br>Resident #4's record contained facility notes and hospice notes, dated 1/15/15 and 1/19/15, which documented the following:<br><br>* 1/12/15: A HS nurse documented Resident #4 was "having restless nights and not sleeping well" and her fluphenazine had been increased "to help with anxiety in the afternoon."<br><br>* 1/13/15: had an unknown bruise on her right hip.<br><br>* 1/14/15: slept after eating breakfast.<br><br>* 1/15/15: went to bed at 7:00 PM, but "got up about 4 times from bed."<br><br>* 1/18/15: refused to get into bed and was brought into the dining room. She "became very restless" and was moving from chair to chair and refused assistance. The caregiver noted, "this happens frequently during the evening." | R 008 | | |

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| R 008 | Continued From page 21<br><br>* 1/19/15: refused to get out of bed "...this morning."<br><br>* 1/19/15: had difficulty "sleeping at night" and had gotten up at night three to four nights out of the week.<br><br>* 1/20/15: "woke up at 2:30" and tried getting out of her bed frequently.<br><br>* 1/26/15: HS nurse documented the resident was in bed, which was "unusual...." The nurse documented the fluphenazine "dosing is effective at this time."<br><br>* 1/26/15: HS nurse documented the resident was in bed and "appears to be tired and lethargic."<br><br>The February, March and April 2015 MARs, documented Resident #4 continued to receive 20 mg of her scheduled fluphenazine, as well as 3 PRN doses of fluphenazine and one unknown PRN.<br><br>Resident #4's record contained facility notes and hospice notes, dated between 2/1/15 and 4/28/15, which documented the following:<br><br>* 2/2/15: "did not want to get out of bed today and has not been eating as much."<br><br>* 2/4/15: was sleeping through the mornings, often until lunch time. The HS nurse noted the current dose of fluphenazine "is effective at this time."<br><br>* 2/6/15: responses to questions had diminished to "one or two" words and she was having "difficulty...swallowing her medications at times." | R 008 | | |

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| R 008 | Continued From page 22<br><br>* 2/14/15: almost fell when she dragged her left foot while walking.<br><br>* 2/14/15: the facility RN documented the resident was "stable' and had one recent medication change.<br><br>* 2/18/15: was not "...attempting to get up and down as much as she has in the past."<br><br>* 2/25/15 through 3/4/15: "sleeping more than usual."<br><br>* 3/5/15: staff noticed a "large bruise" and Resident #4 said, "she fell yesterday."<br><br>* 3/9/15: HS RN could not arouse Resident #4 by "touch or voice" when she was sleeping.<br><br>* 3/11/15: the resident fell and complained of right hip pain.<br><br>* 3/17/15: "has become more unsteady on her feet and is requiring more assistance with transfers and ambulation."<br><br>* 3/18/15: fell and hit the left side of her head. The resident sustained "a goose egg" on the her head.<br><br>* 3/25/15: a bruise was found on Resident #4's right upper arm.<br><br>* 3/30/15: did "not engage in" an activity that was going on around her.<br><br>* 3/30/15: would not actively engage in conversation and was "...sleeping more." | R 008 | | |

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| R 008 | Continued From page 23<br>* 4/6/15: was observed to "stumble" and was assisted to the floor.<br><br>* 4/8/15: was found on the floor at the foot of her bed. She sustained a laceration, which was bleeding.<br><br>* 4/15/15: did not engage during the visit and fell asleep twice. Additionally, staff reported the resident slept through the night and the medications were "working good."<br><br>* 4/17/15: did not engage in conversation and had a "flat affect."<br><br>* 4/18/15: "was up & down" between 1:00 - 4:30 AM.<br><br>* 4/24/15: "was tired all day! Slept through breakfast & lunch...."<br><br>* 4/25/15: a skin tear was found on Resident #4's right lower leg, which had not been cleaned or dressed.<br><br>* 4/28/15: a bruise was found on Resident #4's left hip and a bandage was on her right knee and "staff stated they were not aware of a fall."<br><br>* 4/28/15: participated in "some activities," but "no longer engages unless prompted." Also had "difficulty at times getting the food on her fork" when she was eating.<br><br>The 5/1/15 through 6/9/15 MAR, documented Resident #4 received 20 mg of fluphenazine, 6 PRN doses of fluphenazine, 8 PRN doses of lorazepam and 2 unknown PRNs.<br><br>Resident #4's record contained facility notes and | R 008 | | |

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| R 008 | Continued From page 24<br>hospice notes, dated between 5/1/15 and 6/9/15, which documented the following:<br><br>* 5/1/15 at 3:00 AM: fell and had no injuries.<br><br>* 5/1/15: HS RN came in to treat a "skin tear of unknown origin" on Resident #4.<br><br>* 5/2/15 at 3:30 AM: fell "near her bed" and had no injuries.<br><br>* 5/4/15: HS RN noted the resident "was antsy last night."<br><br>* 5/12/15: continued "to have frequent falls..." and "has been engaging less and not speaking as much."<br><br>* 5/18/15 at 4:35 AM: fell in her room and had skin tears on her left arm.<br><br>* 5/19/15: "was up and down for 2 hrs tonight. Constantly saying she needed to use the bathroom but never went..."<br><br>* 5/20/15: "was up and down again, gave PRN, didn't kick in for an hr. She continued to try and get out of bed. Had to sit near door."<br><br>* 5/23/15: "was very aggatated [sic] and had a lot [sic] of anlexty [sic] tonight. Early on up and down out of bed. I gave her PRN lorazapam [sic] it was effective."<br><br>* 5/25/15: "was up and down for a little while around 4 am. Managed to keep her in bed."<br><br>* 5/30/15: "fell on her bottom getting out of bed."<br><br>* 5/31/15: "was up and down arrival to shift, given | R 008 | | |

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| R 008 | Continued From page 25<br>PRN.<br><br>* 6/3/15: "was very confused and agitated." The caregiver noted they called hospice as the resident "was up and down" and could not "hold still."<br><br>* 6/9/15: had a shower and ate breakfast, then went to bed and "took a nap." The note documented the staff "asked several times if she wanted to get up, she said she only wanted to sleep. She got up at 12:40...."<br><br>On 6/9/15 between 9:20 AM and 11:49 AM, Resident #4 was observed laying in her bed asleep.<br><br>On 6/9/15 at 3:35 PM, Resident #4 was observed sitting at the dining room table with a plate of cut-up bananas in front of her, she was not observed to eat. The resident said she had a good rest and responded to questions.<br><br>For approximately seven months Resident #4 received four behavior modifying medications for symptoms associated with a diagnosis of dementia and/or potential side-effects from the use of psychotropic medications. During this time Resident #4 exhibiting potential side-effects, which were never evaluated nor were medication reductions attempted.<br><br>On 6/9/15 at 10:41 AM, a caregiver stated Resident #4 "sleeps a lot" and her sleeping has increased recently.<br><br>On 6/9/15 at 3:00 PM, the facility nurse confirmed she had not assessed Resident #4 for potential side-effects. | R 008 | | |

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| R 008 | Continued From page 26<br><br>On 6/9/15 at 3:55 PM, a caregiver stated they thought the PRN lorazepam was used when the resident was anxious, but they had not seen her anxious in awhile. The caregiver stated the resident was so unstable, if staff were not right there, "she's down." The caregiver could not locate a behavior management plan for the resident.<br><br>On 6/9/15 at 4:35 PM, the facility nurse stated, she "had never written a behavior plan for her." The nurse stated the resident did not have behaviors. She stated the resident was "very docile and sweet."<br><br>On 6/10/15 at 9:29 AM, a hospice nurse stated the resident was beginning to get her nights and days "mixed up" and was up more during the night. The nurse stated the resident was often "restless," anxious, "impulsive at night" and had "poor safety awareness." The nurse stated staff would call and then she or the on call nurse would advise which PRN medication to give to Resident #4. The nurse stated she was new as the resident's nurse and did not know why the resident was on an anti-psychotic medication.<br><br>On 6/10/15 at 3:13 PM, a caregiver stated Resident #4 had behaviors during the night, as she becomes "agitated," and gets up and down and does not want to stay in bed. The caregiver stated the resident was a fall risk and staff "just call hospice" and ask them, "what do you want us to do" and they normally direct them to "give Lorazepam." The caregiver stated they tried to do what they could before calling hospice, but were never provided instructions from the facility. The caregiver also stated the resident was difficult to re-direct as "nothing will distract her, when she's like that." | R 008 | | |

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| R 008 | Continued From page 27<br><br>On 6/10/15 at 4:05 PM, another caregiver stated Resident #4 was very quiet, polite and was a "sweet thing." Additionally, the caregiver stated the resident would become agitated, restless and would "endanger" herself as she was unsteady when she walked. The caregiver confirmed Resident #4 did not have a behavior management plan.<br><br>On 6/11/15 at 4:38 PM, another caregiver stated we "lately give lorazepam to sleep." The caregiver said Resident #4 was a fall risk, so the plan was for staff to call hospice and request a lorazepam, when she became restless. The caregiver further stated, the PRN fluphenazine was given when the resident became "agitated, cranky" or when she would not stand up to be toileted.<br><br>The administrator and nurse failed to protect Resident #4's right to be free from chemical restraints between 12/12/14 and 6/9/15, for approximately seven months. Resident #4's scheduled fluphenazine, an anti-psychotic medication, was utilized to treat Resident #4's "agitation," even though fluphenazine is prescribed to treat "psychotic disorders." In addition, the fluphenazine was increased to 20 mg a day, which was approximately 10 times the recommended dose for elderly patients. The facility also gave Resident #4 ten doses of PRN Fluphenazine, 8 doses of PRN Haldol, 13 doses of PRN Xanax, 20 doses of PRN Lorazepam and 3 doses of unknown PRN's to manage her "restlessness," "agitation," "mood," and "anxiety." The "behaviors" Resident #4 exhibited are symptoms associated with a diagnosis of dementia and/or potential side-effects from the use of psychotropic medications. There was no documentation non-drug interventions were | R 008 | | |

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| R 008 | Continued From page 28<br>attempted prior to giving Resident #4 behavior modifying medications. Over the seven month period, Resident #4 exhibited potential side-effects, which included:<br>* sleeping more than "usual," during the night<br>* sleeping through the morning and sleeping after breakfast<br>* being "lethargic"<br>* decreased ability to arouse her when she was asleep<br>* more confused than "normal"<br>* would not "hold still" and moving from chair to chair<br>* decreased appetite<br>* difficulty using utensils while eating<br>* occasional difficulty swallowing pills<br>* urinary retention<br>* decreased ability to converse with others<br>* not engaging in activities<br>* "unstable" when ambulating<br>* ambulation requiring a two-person assist with transfers<br>* 10 falls, including one where Resident #4 "dragged" her foot while walking.<br>* 6 injuries (bruises or skin tears) of unknown origin<br><br>The facility nurse did not assess Resident #4's changes of condition to rule out she was experiencing side-effects from the medications. The facility administrator or the nurse failed to advocate for a reduction in the amount of medications Resident #4 received.<br><br>2. Resident #7's record documented she was a 94 year-old female who was admitted to the facility on 2/9/15 with a diagnosis of dementia.<br><br>Resident #7's record did not contain a behavior management plan. | R 008 | | |

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| R 008 | Continued From page 29<br><br>An authorized provider's order, dated 2/12/15, documented Resident #7 was to receive the following doses of Seroquel:<br><br>* 25 mg at 3:00 PM<br>* 50 mg at bedtime<br><br>**According to the FDA, August 2008, Seroquel, an antipsychotic medication, is not approved for the treatment of patients with dementia-related psychosis due to the increase risk of death.**<br><br>*According to the 2015 Nursing Drug book, Seroquel was an antipsychotic mediations used primarily to treat Schizophrenia. A Black Box Warning, documented the drug was not an approved treatment for patients with dementia-related psychosis due to the increase risk of death. The side effects listed were dizziness, anxiety, agitation and panic attacks.<br><br>The NSA/UAI, dated 3/4/15, documented Resident #7 did not "exhibit any maladaptive behaviors." There was no documentation why Resident #7 was prescribed Seroquel.<br><br>An authorized provider's order, dated 3/12/15, documented Resident #7's bedtime Seroquel was increased from 50 mg to 100 mg.<br><br>Progress notes, dated from 3/27/15 through 4/27/15, documented Resident #7 was up wandering and walking independently with a walker.<br><br>An authorized provider's order, dated 4/27/15, documented Resident #7's bedtime dose of Seroquel was reduced to 50 mg. | R 008 | | |

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| R 008 | Continued From page 30<br><br>Progress Notes, dated from 5/2/15 through 5/25/15, documented the following:<br><br>*5/2/15 - wanders constantly<br>*5/3/15 - walking around for almost 2 hours, would not sit down for very long, got mad for no reason and tried to get into the kitchen<br>*5/10/15 - very agitated, trying to take things off the medication cart, hit staff with a book and her walker, called staff vulgar names, and refused to put on her pajamas<br>*5/12/15 - extremely agitated, pushed, shoved and punched staff in the arm<br>*5/14/15 - really agitated and refused to put on pajamas<br>*5/20/15 - very disruptive, delusional and made another resident cry<br>*5/25/15 - refused to put on pajamas and ignored staff "when spoken to"<br><br>A fax to Resident #7's authorized provider, dated 5/14/15, documented, "...is exhibiting aggressive behaviors, she is being combative with staff and residents." The fax documented Resident #7's Seroquel was increased to 50 mg at 3:00 PM.<br><br>A fax to Resident #7's authorized provider, dated 5/22/15, documented, "...is having behaviors almost all day - delusional, aggressive with others in the house. Concerned. The increase in Seroquel has not changed anything with behaviors." An appointment was scheduled for 5/26/15.<br><br>An authorized provider's order, dated 5/26/15, documented to change Resident #7's Seroquel to 75 mg twice a day and an anti-depressant was added.<br><br>Progress Notes, dated 5/30/15 through 6/2/15, | R 008 | | |

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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 | Continued From page 31<br>documented the following:<br><br>*6/1/15 - very difficult to work with, called staff names and hit staff<br>*6/2/15 - extremely hostile when staff attempted to "clean her up," and yelled at them to leave her alone<br><br>A fax from the RCC to the authorized provider, dated 6/2/15, documented Resident #7 was "...still exhibiting behaviors even after the increase dose of quetiapine [Seroquel]. Please advise."<br><br>An authorized provider's order, dated 6/5/15, documented to discontinue Seroquel and start risperidone 0.5 mg at 3:00 PM and bedtime.<br><br>** On 6/16/08, the FDA issued a warning stating, risperidone was not indicated for the use in elderly patients with dementia-related psychosis because of increased risk of death.<br><br>*According to the 2016 Nursing Handbook, documented risperidone was an anti-psychotic prescribed to treat psychosis, acute agitation, depression or mania. The handbook also documented potential side-effects included: akathisia (inability to sit still), dizziness and drowsiness.<br><br>A Staff Communication Log, dated 6/6/15, documented "[Resident #7's name] had a fall at 1 AM. Check for bruise and swelling. The Communication Log was initialed by 4 caregivers. The nurse documented on 6/8/15, Resident #7 had a fall in her bathroom. The nurse also noted, Resident #7 had recent "medication changes due to bizarre behaviors." | R 008 | | |

Residential Care/Assisted Living

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____ | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 13R787 | | 06/12/2015 |

NAME OF PROVIDER OR SUPPLIER: REGENCY COLUMBIA VILLAGE

STREET ADDRESS, CITY, STATE, ZIP CODE: 3521 EAST LAKE FOREST DRIVE, BOISE, ID 83716

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|---|---|---|---|---|
| R 008 | Continued From page 32<br><br>A progress note, dated 6/7/15, documented Resident #7 was "very upset after dinner and said she was depressed."<br><br>A progress note, dated 6/10/15, documented Resident #7 was "unresponsive" this morning and was sent to the hospital.<br><br>A reportable incident, dated 6/14/15, documented Resident #7, had "...broken her pelvis" on 6/7/15, when she fell.<br><br>From 6/8/15 through 6/12/15, Resident #7 was observed either sleeping in her wheelchair, or the dining room table at meals or sleeping in bed. During the week of observations, Resident #7 did not exhibit any behaviors.<br><br>On 6/8/15 at 3:21 PM, Resident #7 was observed sleeping in her wheelchair in the living room, with her head resting on the right arm of her wheelchair. The resident was in her night dress and her hair had not been combed.<br><br>On 6/8/15 at 4:30 PM, Resident #7 was observed grimacing in pain while she was assisted by 1 caregiver to transfer from her wheelchair to a dining room chair. The caregiver stated Resident #7 had declined and now required 2 caregivers for transfers. During an observation of a transfer, Resident #7 was observed crying, moaning and was unable to bear weight.<br><br>On 6/9/15 at 11:32 AM, Resident #7 was observed sitting in the dining room, sleeping with her head resting on the table. A kitchen staff member stated, the resident could exhibit behaviors, but she was too weak and slow to actually be capable to hit anyone. | R 008 | | |

Residential Care/Assisted Living

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|---|---|---|---|---|
| R 008 | Continued From page 33<br><br>On 6/9/15 at 4:30 PM, a caregiver was observed transferring Resident #7 from her bed into her wheelchair. The resident was observed moaning and unable to bear her weight<br><br>On 6/8/15 at 3:30 PM, a caregiver stated, Resident #7 required total assistance of 1 caregiver to meet her ADLs, and now required 2 caregivers for mobility and transfers.<br><br>On 6/9/15 at 10:00AM, a caregiver stated Resident #7 had a fall on 6/7/15 at 1:00 AM. She stated, the night shift had 1 caregiver and "it got very rough on the night shift." The caregiver stated, Resident #7 required 2 caregivers for transfers and was not sure how 1 caregiver could assist when working alone at night.<br><br>On 6/10/15 at 9:10 AM, a caregiver stated Resident #7 was sent to the emergency room this morning because her toe was black from hitting it on something or from "stubbing her toe."<br><br>On 6/10/15 at 11:15 AM, Resident #7's family member stated, staff called her this morning to let her know they sent the resident to the hospital because her toe had turned black. The family member said, "I just brought her back, and let staff know her toe was broken."<br><br>On 6/10/15 at 11:47 AM, a "float" caregiver arrived from another house to help assist Resident #7 off the toilet. She stated the resident had declined and required 2 caregivers to transfer her from the toilet to her wheelchair.<br><br>On 6/10/15 at 2:00 PM, a caregiver stated Resident #7 could get aggressive. She stated Resident #7 hit a caregiver a "few weeks ago." | R 008 | | |

Residential Care/Assisted Living

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|---|---|---|---|---|
| R 008 | Continued From page 34<br><br>On 6/10/15 at 2:15 PM, the facility RN stated Resident #7 "was a sweetheart" and did not have behaviors. She stated, "I don't know why she is on Seroquel" nor did she know why Resident #7's Seroquel had been increased. The RN confirmed Resident #7 did not have a behavior management plan in place.<br><br>On 6/10/15 at 3:13 PM, a caregiver stated Resident #7 could be "disoriented" and "combative."<br><br>On 6/11/15 at 10:24 AM, the facility RCC stated Resident #7, would not use her walker when she was ambulating, was resistive to cares and was becoming aggressive toward other residents. She stated the physician had tried different doses of Seroquel but it was not effective so Resident #7 was changed to a different antipsychotic medication.<br><br>The administrator and nurse failed to protect Resident #7's right to be free from chemical restraints when Resident #7's Seroquel was increased between 2/12 and 5/26/15, without non-drug interventions. Resident #7 was then placed on risperidone on the evening of 6/5/15, another anti-psychotic medication, without attempts at non-drug interventions. Within 24 hours of switching the medications, Resident #7 had a fall that resulted in a fractured pelvis and toe. On 6/10/15, she became "unresponsive." At no time did the facility nurse, during the three month period, monitor or assess Resident #7's response to the behavior modifying medications or rule out potential side-effects. The facility nurse also failed to advocate for a reduction in the amount of medications Resident #7 was receiving. | R 008 | | |

Residential Care/Assisted Living

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|---|---|---|---|---|
| R 008 | Continued From page 35<br><br>3. According to her record, Resident #2 was a 75 year-old female, admitted to the facility on 3/10/15, with diagnoses of dementia and Parkinson's disease.<br><br>A UAI/NSA, dated 2/25/15, documented Resident #2 required the assistance of one caregiver to meet her ADL needs. The resident required a caregiver to provide "escort via wheelchair" for mobility, and she "is very fearful of falling and will stiffen up when trying to assist with transfers." The NSA additionally documented the resident "is very pleasant with no maladaptive behaviors. Is always confused but is pleasant."<br><br>Physician's orders, dated 3/10/15, documented Resident #2 was to receive Seroquel 25 mg, one tablet every evening for dementia and hallucinations.<br><br>**According to the FDA, August 2008, Seroquel, an antipsychotic medication, is not approved for the treatment of patients with dementia-related psychosis due to the increase risk of death.**<br><br>*According to the 2015 Nursing Drug book, Seroquel was an antipsychotic mediations used primarily to treat Schizophrenia. A Black Box Warning, documented the drug was not an approved treatment for patients with dementia-related psychosis due to the increase risk of death. The side effects listed were dizziness, anxiety, agitation and panic attacks.<br><br>An initial Comprehensive Nursing Assessment, dated 3/10/15, documented Resident #2 was admitted from a skilled nursing facility, related to a fractured pelvis from a fall. The nurse documented, the resident required assistance to meet her ADL needs, and required assistance of | R 008 | | |

Residential Care/Assisted Living

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|---|---|---|---|---|
| R 008 | Continued From page 36<br>1 caregiver for mobility and transfers.<br><br>A progress note written by the facility RN, dated 3/10/15, documented "start behavior mapping tool using the behavior mapping tool, and chart on [Resident #2's name] acclimation to new surroundings for 72 hours."<br><br>A Behavior Tracking Tool was not implemented for seven days.<br><br>The behavior tracking tool, documented the following behaviors staff observed:<br><br>*3/17/15 at 8:00 PM, refused to put on her night gown when asked 3 times.<br>*3/19/15 at 7:45 AM, became "confused and refused" to be changed.<br>*3/21/15 at 7:00 AM, had an attitude and made comments that "I was bossy and that she knew what she had to do."<br><br>The MARs for March, April, May and June 2015, documented, Resident #2 received Seroquel 25 mg, every day at 4:30 PM.<br><br>Incident and accident reports, for March and April 2015, documented the following falls:<br><br>*3/17/15 at 2:15 PM, fall without injury laying on floor in bedroom.<br>*3/19/15 at 12:30 PM, fall out of wheelchair to the floor in her bedroom.<br>*3/30/15 untimed, found on floor in her room trying to self-transfer from toilet.<br>*4/3/15 at 4:00 PM, bruise near center of resident's back, not swollen but looks like "something happened recently due to the colors."<br>*4/13/15 at 7:00 AM, staff trying to open the door to resident's apartment, but resident was on the | R 008 | | |

Residential Care/Assisted Living

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| R 008 | Continued From page 37<br>floor with her wheelchair by the door... "more pain in the pelvis, more than usual. More bruising." *4/30/15 at 1:45 PM, found laying on her right side near the foot of her bed.<br><br>The facility nurse, documented in the incident reports, she believed the contributing factor of the resident having 6 falls was related to the resident's diagnosis of "severe dementia." There was no documented evidence the facility nurse had considered the side effects of Seroquel which included, dizziness, orthostatic hypotension and sedation. Additionally, there was no documentation the nurse had assessed a need to continue Seroquel for Resident #2 when she had not exhibited behaviors.<br><br>On 6/8/15 at 2:45 PM, Resident #2 was observed sitting in her room in a recliner. The resident stated she had experienced several falls and was not able to self-propel her wheelchair or transfer without assistance from caregivers. During the observation and interview, the resident answered questions and her demeanor was pleasant and polite.<br><br>On 6/8/15 at 3:00 PM, a day shift caregiver stated Resident #2 had not exhibited any behaviors. She stated, the resident's only hallucination was thinking she had more than one cat in her room.<br><br>On 6/9/15 at 9:18 AM, a kitchen employee and the dietary manager stated, they had never observed Resident #2 exhibit behaviors. They said she would get upset after her son left, but nothing like hitting, biting or throwing things.<br><br>On 6/9/15 at 10:00 AM, a caregiver stated Resident #2 became anxious because she did not want her son to leave. The caregiver stated, | R 008 | | |

Residential Care/Assisted Living

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| R 008 | Continued From page 38<br>the resident was easily redirected by changing the subject and spending time with her.<br><br>On 6/9/15 at 10:10 AM, a medication aide stated, Resident #2 had no behaviors but had some anxiety. The medication aide stated, her physician prescribed Ativan for her to take as needed for anxiety.<br><br>On 6/9/15 at 4:10 PM, the RN stated, "I don't know why [Resident #2's name] is taking Seroquel." She stated the resident had not exhibited any behaviors since her admission. The RN further stated, "I wondered why she was taking Seroquel and guessed it was started when she was in the hospital for her fractured pelvis."<br><br>The administrator and nurse failed to protect Resident #2's right to be free from chemical restraints when Resident #2 received a daily dose of Seroquel from 3/10 through 6/12/15, approximately 3 months. During that time, Resident #2 had 6 documented falls. The facility failed to protect Resident #2's right to be free from chemical restraints when the facility did not evaluate or identify any behaviors to warrant the continued use of Seroquel. Resident #2's anti-psychotropic medication was not monitored for potential side-effects.<br><br>The facility failed to assist and monitor medications Residents #1, #7 and #9. The facility also failed to protect Resident #1, #2 and #3's rights to be free from chemical restraints. These failures led to inadequate care. | R 008 | | |

IDAHO DEPARTMENT OF HEALTH & WELFARE

DIVISION OF LICENSING & CERTIFICATION
P.O. Box 83720
Boise, ID 83720-0036
(208) 364-1962 Fax: (208) 364-1888

# ASSISTED LIVING
## Non-Core Issues Punch List



| Facility | License # | Physical Address | | Phone Number |
|---|---|---|---|---|
| REGENCY COLUMBIA VILLAGE, LLC | RC-787 | 3521 EAST LAKE FOREST DRIVE | | (208) 344-2954 |
| **Administrator** | **City** | | **ZIP Code** | **Survey Date** |
| Mary Lewerenz | BOISE | | 83716 | June 12, 2015 |
| **Survey Team Leader** | **Survey Type** | | | **RESPONSE DUE:** |
| Polly Watt-Geier, MSW | Licensure and Complaint Investigation | | | July 12, 2015 |
| **Administrator Signature** | **Date Signed** | | | |
| | 6-12-15 | | | |

## NON-CORE ISSUES

| Item # | IDAPA Rule # 16.03.22. | Description | Department Use Only: EOR Accepted | Initials |
|---|---|---|---|---|
| 1 | ~~009.06.c~~ | ~~One employee did not have a State Police Background Check.~~ error PWG | | |
| 2 | 215.07 | The administrator did not report to Adult Protection when an allegation of abuse was made. | 9/3/15 | PWG |
| 3 | 220.02 | The residents' admission agreements did not provide a complete reflection of the facility's charges. | 9/18/15 | PWG |
| 4 | 220.03.c | The residents' admission agreements did not disclose all prices, formulas and calculations used to determine the residents' rates. | 9/18/15 | PWG |
| 5 | 221.01.a | The facility did not provide Resident #10 with a 30 written notice of discharge. | 7/17/15 | PWG |
| 6 | 225.01 | The facility did not evaluate Resident #4, #5 and #7's behaviors. | 9/18/15 | PWG |
| 7 | 225.02. | The facility did not develop interventions for Resident #7 and #10's behaviors. | 9/3/15 | PWG |
| 8 | 225.05.c | The facility did not evaluate Resident #10's interventions to ensure their effectiveness. | 9/3/15 | PWG |
| 9 | 300.02 | The facility nurse did not ensure orders were implemented. For example: Resident #1, #5 and #7's vital signs were not monitored as instructed, Resident #2's specialized wheelchair was never implemented, Resident #1's Spiriva instructions to rinse after use and assistance with nebulizer was not being monitored. | 9/3/15 | PWG |
| 10 | 305.03 | The facility nurse did not assess residents when they had changes of condition. For example: Resident #4 and #8's wound status, Resident #13's possible ingestions of cleaning solution, Resident #1's uncontrolled pain, Resident #2's edematous bilateral legs, Resident #4's fever and cough, Resident #5 and other residents' falls. | 9/3/15 | PWG |
| 11 | 305.08 | There was no documented evidence the facility nurse educated staff on the importance of rinsing Resident #1's mouth after the use of Spiriva, resulting in thrush. Additionally, there was no evidence the facility nurse educated staff on the importance of parameters around blood pressure, blood glucose levels, heart rate, etc. | 9/18/15 | PWG |
| 12 | 310.04.e | The facility's psychotropic medication reviews did not include behavioral updates to the physicians. | 9/3/15 | PWG |
| 13 | 320.01 | The NSAs did not include the use of positioning devices for Resident #2 and Resident #6. | 9/3/15 | PWG |
| 14 | 350.02 | The facility administrator did not investigate all incidents, accidents, complaints or allegations of abuse. | 9/3/15 | PWG |
| 15 | 350.04 | The facility administrator did not respond to complaints within 30 days with a written report of findings. ***Previously cited 10/13/11*** | 7/29/15 | PWG |

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| **Administrator** | **City** | | **ZIP Code** | **Survey Date** |
| Mary Lewerenz | BOISE | | 83716 | June 12, 2015 |
| **Survey Team Leader** | **Survey Type** | | | **RESPONSE DUE:** |
| Polly Watt-Geier, MSW | Licensure and Complaint Investigation | | | July 12, 2015 |
| **Administrator Signature** | **Date Signed** | | | |
| Mary | 6-12-15 | | | |

## NON-CORE ISSUES

| Item # | IDAPA Rule # 16.03.22. | Description | Department Use Only: EOR Accepted | Department Use Only: Initials |
|---|---|---|---|---|
| 16 | 405.05 | The facility did not ensure the dryer lint traps were free of build-up, as observed in the Rose House. | 7/29/15 | PWG |
| 17 | 630.04 | Seven out of ten employees did not have specialized training for Traumatic Brain Injury. | 9/18/15 | PWG |
| 18 | 711.01 | The facility did not document the date, time, interventions and the effectiveness of the interventions, when residents' exhibited behaviors. | 9/18/15 | PWG |
| 19 | 711.04 | The facility did not notify Resident #7's physician of her pattern of medication refusals. | 9/3/15 | PWG |
| 20 | 711.08.e | There was no documentation the facility staff notified the facility RN of residents' changes of condition. | 9/3/15 | PWG |
| 21 | 711.11 | The facility staff did not document the reason why medications were not given. | 9/3/15 | PWG |

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

July 7, 2015

Mary Lewerenz, Administrator
Regency Columbia Village
3521 East Lake Forest Drive
Boise, Idaho 83716

Provider ID: RC-787

Ms. Lewerenz:

An unannounced, on-site complaint investigation survey was conducted at Regency Columbia Village between May 29, 2015 and June 12, 2015. During that time, observations, interviews, and record reviews were conducted with the following results:

**Complaint # ID00006560**

Allegation #1: The facility nurse did not assess residents when they experienced changes in their condition.

Findings #1: 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 of condition. The facility was required to submit evidence of resolution within 30 days.

Allegation #2: The facility's former nurse was falsifying documentation.

Findings #2: Unsubstantiated. This does not mean the incident did not take place; it only means that the allegation could not be proven.

Allegation #3: The former facility nurse coerced residents into signing papers, which documented staff were mean to them.

Findings #3: Unsubstantiated. This does not mean the incident did not take place; it only means that the allegation could not be proven.

Allegation #4: Residents who resided at the facility were not compatible.

Findings #4: Substantiated. However, the facility was not cited as they currently had residents who were compatible with each other and had taken appropriate actions to move residents into more appropriate settings,

when their health had declined or their needs had increased.

Allegation #5: The facility did not schedule adequate staff to supervise residents or to meet their needs.

Findings #5: Substantiated. However, not cited as currently, most residents, families and caregivers felt there was adequate staffing to meet the needs of the residents.

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,

Polly Watt-Geier, MSW

POLLY WATT-GEIER, MSW
Health Facility Surveyor
Residential Assisted Living Facility Program

PWG/sc

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

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July 7, 2015

Mary Lewerenz, Administrator
Regency Columbia Village
3521 East Lake Forest Drive
Boise, Idaho 83716

Provider ID: RC-787

Ms. Lewerenz:

An unannounced, on-site complaint investigation survey was conducted at Regency Columbia Village, LLC between May 29, 2015 and June 12, 2015. During that time, observations, interviews or record reviews were conducted with the following results:

**Complaint # ID00006576**

Allegation #1: The facility did not have a licensed administrator to oversee the day to day operations.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.215.03 for not having a licensed administrator for greater than 30 days. The facility was required to submit a plan of correction.

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,

Polly Watt-Geier, MSW

POLLY WATT-GEIER, MSW
Health Facility Surveyor
Residential Assisted Living Facility Program

PWG/sc

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

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P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: 208-364-1962
FAX: 208-364-1888

July 7, 2015

Mary Lewerenz, Administrator
Regency Columbia Village
3521 East Lake Forest Drive
Boise, Idaho 83716

Provider ID: RC-787

Ms. Lewerenz:

An unannounced, on-site complaint investigation was conducted at Regency Columbia Village, LLC between May 29, 2015 and June 12, 2015. During that time, observations, interviews or record reviews were conducted with the following results:

**Complaint # ID00006587**

Allegation #1: The facility did not have a licensed administrator to oversee the day to day operations.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.215.03 for not having a licensed administrator for greater than 30 days. The facility was required to submit a plan of correction.

Allegation #2: The facility did not schedule adequate staff to supervise residents or to meet their needs.

Findings: The facility was observed on 6/8/15, to be comprised of four 16 bed buildings (Iris, Sunflower, Rose and Lilac) that were connected by a secured courtyard. Two houses were staffed with two caregivers and the other two houses were observed to have one caregiver.

The as-worked staffing schedule was reviewed on 6/9/15. The schedule documented on the day and evening shifts, two of the houses (Lilac and Iris) had two caregivers scheduled all the days of the week. One house (Sunflower) had only one employee scheduled for the week. The last house (Rose) had two employees scheduled, except for on Monday's and Tuesday's, when only one caregiver was scheduled. The schedule further documented, on the night shift, all four houses had one caregiver and there was also one additional "float" position that assisted the other caregivers in all of the houses, when needed.

Between 6/8/15 and 6/12/15, twenty-three caregivers, one hospice aide, a hospice nurse and six family members of current residents were interviewed. All but one of the current family members stated they felt the staffing was "better" now than it was a few months ago. Two of the 23 caregivers stated they felt there was not enough caregivers scheduled on each shift, in each of the buildings. However, the remainimg caregivers stated there had

been problems with staffing in the past, but currently there was adequate numbers of caregivers scheduled to meet the residents' needs.

Between 6/8 and 6/12/15, twelve residents were interviewed and all but three stated there was enough staff at the facility. The three residents stated the caregivers worked hard and were always running. They stated, the staff were often so busy, it was hard for them to take care of all of the residents.

Substantiated. However, not cited as currently, most residents, families and caregivers felt there was adequate staffing to meet the needs of the residents.

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,

Polly Watt-Geier, MSW

POLLY WATT-GEIER, MSW
Health Facility Surveyor
Residential Assisted Living Facility Program

PWG/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
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**Complaint # ID00007034**

Allegation #1: The facility did not protect residents when they allowed an identified male staff member to continue to work after allegations of sexual harassment were made by female residents.

Findings: Substantiated. The facility was initially issued an immediate danger on 5/29/15, requiring them to correct the situation immediately. Additionally, the facility was also issued a deficiency at IDAPA 16.03.22.510 for failing to protect residents from abuse. The facility was required to submit a plan of correction on how they would protect residents, if allegations of abuse arose.

Allegation #2: The facility administrator and the RN did not report sexual inappropriateness to AP or the police.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.215.07 for the administrator not reporting allegations of abuse to Adult Protection immediately. The facility was required to submit evidence of resolution within 30 days.

Allegation #3: The administrator did not conduct an investigations after residents complained.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.350.02 for the administrator not investigating all incidents, accidents, complaints or allegations of abuse. The facility was required to submit evidence of resolution within 30 days.

Allegation #4: The administrator did not respond in writing to complainants.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.350.04 for the administrator not responding to all complainants within 30 days with a written report. 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,

Polly Watt-Geier, MSW

POLLY WATT-GEIER, MSW
Health Facility Surveyor
Residential Assisted Living Facility Program

PWG/sc

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

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July 7, 2015

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Regency Columbia Village
3521 East Lake Forest Drive
Boise, Idaho 83716

Provider ID: RC-787

Ms. Lewerenz:

An unannounced, on-site complaint investigation was conducted at Regency Columbia Village between May 29, 2015 and June 12, 2015. During that time, observations, interviews, and record reviews were conducted with the following results:

**Complaint # ID00007053**

Allegation #1: Residents were given inappropriate emergency discharges.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.221.01.a for not giving an identified resident a 30 day discharge notice. The facility was required to submit evidence of resolution within 30 days.

Allegation #2: Staff used PRN (as needed) behavior modifying or psychotropic medications prior to attempting non-drug interventions.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.520 for inadequate care because the staff used behavioral modifying medications without attempting non-drug interventions. The facility was required to submit a plan of correction within 10 days.

Allegation #3: The facility did not evaluate the effectiveness of interventions for residents' behaviors.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.225.02.c, for not evaluating the effectiveness of interventions tried for residents' behaviors. The facility was required to submit evidence of resolution within 30 days.

Allegation #4: The facility did not provide adequate staffing to meet the residents needs.

Findings: The facility was observed on 6/8/15, to be comprised of four 16 bed buildings (Iris, Sunflower, Rose and Lilac) that were connected by a secured courtyard. Two houses were staffed with two caregivers and the other two houses were observed to have one caregiver.

The as-worked staffing schedule was reviewed on 6/9/15. The schedule documented on the day and evening shifts, two of the houses (Lilac and Iris) had two caregivers scheduled all the days of the week. One house (Sunflower) had only one employee scheduled for the week. The last house (Rose) had two employees scheduled, except for on Monday's and Tuesday's, when only one caregiver was scheduled. The schedule further documented, on the night shift, all four houses had one caregiver and there was also one additional "float" position that assisted the other caregivers in all of the houses, when needed.

Between 6/8/15 and 6/12/15, twenty-three caregivers, one hospice aide, a hospice nurse and six family members of current residents were interviewed. All but one of the current family members stated they felt the staffing was "better" now than it was a few months ago. Two of the 23 caregivers stated they felt there was not enough caregivers scheduled on each shift, in each of the buildings. However, the remaining caregivers stated there had been problems with staffing in the past, but currently there was adequate numbers of caregivers scheduled to meet the residents' needs.

Between 6/8 and 6/12/15, twelve residents were interviewed and all but three stated there was enough staff at the facility. The three residents stated the caregivers worked hard and were always running. They stated, the staff were often so busy, it was hard for them to take care of all of the residents.

Substantiated. However, not cited as currently, most residents, families and caregivers felt there was adequate staffing to meet the needs of the residents.

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Health Facility Surveyor
Residential Assisted Living Facility Program

PWG/sc

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

326-1997

Date 6/11/15 Page 1 of 1

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

Kitchen Fantastic Inspection General Chong

| Establishment Name | Operator |
|---|---|
| Rose House Regency Columbia Village | Mary Lawrence |
| Address: 3521 E Lake Forest Dr | Boise, Id 83716 |
| County: Ada; Estab #; EHS/SUR #: 20828 | Inspection time: ; Travel time: |
| Inspection Type: ; Risk Category: High | 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.

| Critical Violations | Noncritical Violations |
|---|---|
| # of Risk Factor Violations: 0 | # of Retail Practice Violations: 0 |
| # of Repeat Violations: | # of Repeat Violations: |
| Score: 0 | Score: 0 |
| 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.

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

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

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 |
|---|---|---|---|---|---|---|---|
| meat balls | 170° | Potato Salad | 41° | meatloaf | 41.5° | | |
| Noodles | 170.1° | Salad green | 41° | | | | |

## GOOD RETAIL PRACTICES (☒ = not in compliance)

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

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

Person in Charge (Signature) (Print) Mary Lawrence Title SD Date 6/11/15

Inspector (Signature) Karen Anderson (Print) KAREN Anderson Date 6/11/15

Follow-up: (Circle One) Yes No