



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 23, 2015

Becky Stenkamp, Administrator  
Streamside Assisted Living  
1355 South Edgewater Circle  
Nampa, Idaho 83686

Provider ID: RC-862

Ms. Stenkamp:

On July 1, 2015, a complaint investigation was conducted at Streamside Assisted Living. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level(s):

- Non-core issues, which are described on the Punch List, and for which you have submitted evidence of resolution.

Your submitted evidence is 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 Donna Henscheid, LSW, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 364-1962.

Sincerely,

Donna Henscheid, LSW  
Team Leader  
Health Facility Surveyor

DH/sc

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



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July 7, 2015

Administrator  
Streamside Assisted Living  
1355 South Edgewater Circle  
Nampa, Idaho 83686

Provider ID: RC-862

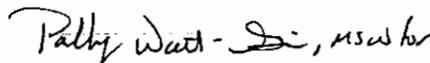
Administrator:

A complaint investigation was conducted at Streamside Assisted Living between June 29, 2015 and July 1, 2015. The facility was found to be in substantial compliance with the rules for Residential Care or Assisted Living Facilities in Idaho. No core issue deficiencies were identified. The enclosed survey document is for your records and does not need to be returned to the Department.

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, on **July 1, 2015**. The completed punch list form and accompanying evidence of resolution (e.g., receipts, pictures, policy updates, etc) are to be submitted to this office by July 31, 2015.

Our staff is available to answer questions and to assist you in identifying appropriate corrections. Should you require assistance or have any questions about our visit, please contact us at (208) 364-1962. Thank you for your continued participation in the Idaho Residential Care Assisted Living Facility program.

Sincerely,

  
DONNA HENSCHIED, LSW  
Health Facility Surveyor  
Residential Assisted Living Facility Program

DH/sc



June 29<sup>th</sup>  
July 1<sup>st</sup>

Facility STREAMSIDE ASSISTED LIVING	License # RC-862	Physical Address 1355 SOUTH EDGEWATER CIRCLE	Phone Number (208) 442-0097
Administrator	City NAMPA	ZIP Code 83686	Survey Date July 1, 2015
Survey Team Leader Donna Henscheid	Survey Type Complaint Investigation	RESPONSE DUE: July 31, 2015	
Administrator Signature <i>Donna Henscheid</i>	Date Signed <del>6/30</del> 7/1/15		

**NON-CORE ISSUES**

Item #	IDAPA Rule #	Description	Department Use Only	
			EOR Accepted	Initials
1	215	The facility did not have a licensed administrator who was responsible for the operation of the facility.	8/13/15	DH
2	215.05	The administrator retained a resident who had inappropriate behaviors.	8/13/15	DH
3	225.01	The facility did not evaluate residents' behaviors.	9/22/15	DH
4	225.02	The facility did not develop interventions for each behavioral symptom.	9/22/15	DH
5	310.04.a	The facility utilized behavior modifying medications prior to attempting non-drug interventions.	8/27/15	DH
6	320.03	NSA's were not signed and dated.	8/13/15	DH
7	330.02	The facility did not safeguard resident records.	8/13/15	DH
8	350.02	The facility did not provide documented evidence that they investigated an incident regarding Resident #1.	8/27/15	DH
9	350.04	The facility did not provide written responses to complaint within 30 days.	8/27/15	DH
10	600.05	The facility administrator did not provide supervision to ensure residents were not left unattended for 4 hours.	8/13/15	DH
11	725.01	The admission discharge register was not current.	9/13/15	DH
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July 7, 2015

Administrator  
Streamside Assisted Living  
1355 South Edgewater Circle  
Nampa, Idaho 83686

Provider ID: RC-862

Administrator:

An unannounced, on-site complaint investigation was conducted at Streamside Assisted Living between June 29, 2015 and July 1, 2015. During that time, observations, interviews or record reviews were conducted with the following results:

**Complaint # ID00006514**

**Allegation #1:** The facility did not protect residents' rights to choose what they wanted to wear in the dining room.

**Findings:** On 6/29/15 a tour of the facility was conducted. Between 6/29/15 and 7/1/15, resident, family and staff interviews were conducted. Twenty-seven residents, one family member, six caregivers, and the facility nurse were interviewed.

Two residents stated they were told they could not wear shorts in the dining room a year ago, but the problem was corrected immediately and they were able to wear shorts now. Twenty-five residents stated they were not aware of any rules limiting what they could or could not wear in the dining room.

The facility nurse and all the caregivers stated they were expected to ensure residents were dressed and well-groomed prior to bringing them to meals. Further, the nurse stated for dignity purposes, they preferred residents were not in night clothes when they came to the dining room. However, the staff denied there were any other clothing restrictions.

Unsubstantiated.

**Allegation #2:** The facility required all residents to go to the dining room for meals.

**Findings:** On 6/29/15 a tour of the facility was conducted. At 1:15 PM, one resident was observed with a meal tray in her room. A staff member stated it was not unusual for the resident to remain in her room for meals.

Administrator

July 7, 2015

Page 2 of 3

Between 6/29/15 and 7/1/15, resident and staff interviews were conducted. Twenty-seven residents, six caregivers, the kitchen manager and the facility nurse were interviewed. All of the residents stated they felt they could get a meal tray if they wanted one. The facility nurse stated when the residents were not feeling well, they could get a tray in their rooms free of charge. The nurse further stated, if the residents were not ill, the facility preferred they ate in the dining room, but a tray would be provided at a cost. Three of the six caregivers stated whenever residents were sick, they could have meal trays. One caregiver stated, residents could have three meal trays for free and after the third would be charged. Two caregivers stated that irregardless of whether residents were sick, meal trays were provided to them. The kitchen manager stated meal trays were sent to all residents who did not show up at the dining room. The kitchen manager stated it was especially important for the residents who had diabetes.

Unsubstantiated. However, due to conflicting information regarding the rules for when meal trays were or were not provided and the charges associated with them, technical assistance was provided to ensure room trays and associated cost were carried out consistently.

Allegation #3: The facility did not provide appropriate supervision to ensure residents' needs were met.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.600.05 for the administrator not ensuring residents were not left unattended for extended periods of time. The facility was required to submit evidence of resolution within 30 days.

Allegation #4: Staff pre-poured medications. (Dispensing more than one residents' medications at a time).

Findings: On 6/29/15 at 10:50 AM, a caregiver was observed assisting residents with medications. The caregiver was observed to assist one resident with medications at a time.

Between 6/29/15 and 7/1/15, six caregivers and the facility nurse were interviewed. All caregivers and the facility nurse stated they were not aware of any staff members pre-pouring medications. The facility nurse stated that practice was not allowed and any staff member caught doing that, would receive disciplinary action. The one caregiver observed assisting with medications stated, she dispensed medications for one resident at a time and stayed with them while they took their medications.

Eight staff records were reviewed and none of them contained any disciplinary action regarding pre-pouring medications.

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

Allegation #5: The facility did not schedule an appropriate number of staff to meet the needs of the residents.

Findings #5: Between 6/29/15 and 7/1/15, as-worked schedules for May, June and July 2015 were compared to the as-worked schedules for May, June, July and August of 2014. For both 2014 and 2015 there were six caregivers scheduled on the day shift, four on the evening shift and three on the night shift. However, the 2014 as-worked schedules showed more open shifts than the 2015 schedule, but overall the staffing patterns remained the same.

On 6/29/15, twenty-seven residents and two family members were interviewed. None of them expressed any concerns with current staffing levels. Two residents stated they had seen quite a bit of staff turnover, but they felt it was getting better.

Administrator

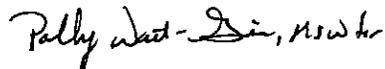
July 7, 2015

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

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

Sincerely,



DONNA HENSCHIED, LSW  
Health Facility Surveyor  
Residential Assisted Living Facility Program

DH/sc

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



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-July 7, 2015

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Provider ID: RC-862

Administrator:

An unannounced, on-site complaint investigation was conducted at Streamside Assisted Living between June 29, 2015 and July 1, 2015. During that time, observations, interviews, and record reviews were conducted with the following results:

**Complaint # ID00006847**

Allegation #1: The facility was not maintained in a clean and orderly manner.

Findings: Unsubstantiated. However, the facility was provided technical assistance regarding the odors found in the rooms.

Allegation #2: The facility retained residents who were not appropriate.

Findings: Substantiated. The facility was issued the following deficiencies regarding the identified resident:

- IDAPA 16.03.22.215.05 for retaining a resident who had inappropriate behaviors.
- IDAPA 16.03.22.225.01 and 02 for not evaluating a resident's behaviors and for not developing interventions for each behavioral symptom.
- IDAPA 16.03.22.310.04.a for utilizing behavior modifying medications prior to attempting non-drug interventions.

Allegation #3: Residents' pain medications (hydrocodone) were not available as ordered.

Findings: Unsubstantiated.

Administrator

July 7, 2015

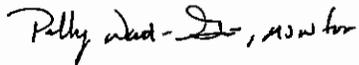
Page 2 of 2

Allegation #4: Staff did not receive 16 hours of orientation.

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

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Sincerely,



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Administrator:

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**Complaint # ID00006599**

**Allegation #1:** The facility call light system was not functional.

**Findings:** Substantiated. However, the facility was not cited as the current call system was tested and functioned appropriately.

**Allegation #2:** The facility did not schedule sufficient staff to meet the residents' needs.

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

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

Sincerely,

DONNA HENSCHIED, LSW  
Health Facility Surveyor  
Residential Assisted Living Facility Program

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