



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

Alyssa Peterson, Administrator
Heritage Assisted Living of Twin Falls
622 Filer Avenue West
Twin Falls, Idaho 83301

Provider ID: RC-1091

Ms. Peterson:

On July 31, 2015, an initial state licensure survey was conducted at Heritage Assisted Living of Twin Falls - Bridgestone Living, 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 Matt Hauser, QIDP, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 364-1962.

Sincerely,



MATT HAUSER, QIDP
Team Leader
Health Facility Surveyor

MH/sc

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



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August 17, 2015

Alyssa Peterson, Administrator
Heritage Assisted Living of Twin Falls
622 Filer Avenue West
Twin Falls Idaho 83301

Provider ID: RC-1091

Ms. Peterson:

Based on the initial state licensure survey conducted by Department staff at Heritage Assisted Living of Twin Falls - Bridgestone Living, LLC between July 30, 2015 and July 31, 2015, it has been determined that the facility failed to protect residents from inadequate care.

This core issue deficiency substantially limits the capacity of Heritage Assisted Living of Twin Falls - Bridgestone Living, 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 **September 14, 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 **August 28, 2015**, and keep a copy for your records. Your license depends upon the corrections made and the evaluation of the Plan of Correction you develop.

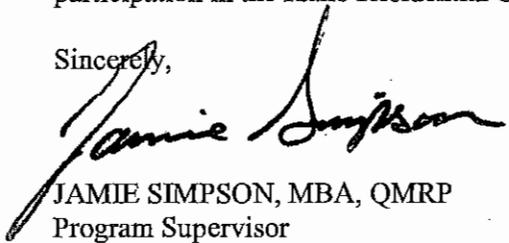
Alyssa Peterson
August 17, 2015
Page 2 of 2

Pursuant to IDAPA 16.03.22.003.02, you have available the opportunity to question the core issue deficiency through an informal dispute resolution process. If you disagree with the survey report findings, you may make a written request to the Supervisor of the Residential Assisted Living Facility Program for an IDR meeting. The request for the meeting must be in writing and must be made within ten (10) business days of receipt of the Statement of Deficiencies. The facility's request must include sufficient information for Licensing and Certification to determine the basis for the provider's appeal, including reference to the specific deficiency to be reconsidered and the basis for the reconsideration request. If your request for informal dispute resolution is received more than ten (10) days after you receive the Statement of Deficiencies, your request will not be granted. Your IDR request must be made in accordance with the Informal Dispute Resolution Process. The IDR request form and the process for submitting a complete request can be found at www.assistedliving.dhw.idaho.gov 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, on July 30, 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 **August 30, 2015**.

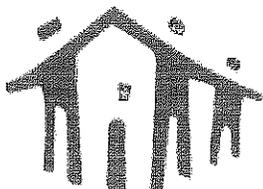
Our staff is available to answer questions and to assist you in identifying appropriate corrections to avoid further enforcement actions. Should you have any questions, or if we may be of assistance, please contact us at (208) 364-1962 and ask for the Residential Assisted Living Facility program. Thank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



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P.O. Box 83720
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Core Items

Survey Date: 07/30/2015

16.03.22.000 Initial Comments

The following deficiencies were cited during the initial survey conducted between 7/30/15 and 7/31/15 at Heritage Assisted Living of Twin Falls. The surveyors conducting the survey were:

Matt Hauser, QMRP
Team Coordinator
Health Facility Surveyor

Karen Anderson, RN
Health Facility Surveyor

Jeremy Walker, LSW
Health Facility Surveyor

Donna Henscheid, LSW
Health Facility Surveyor

Maureen McCann, RN
Health Facility Surveyor

Lisa Bennett, RN
Health Facility Surveyor

Survey Abbreviations & Definitions:

ADL = Activity of Daily Living
BMP = Behavior Management Plan
hr = hour
HS = hospice
LPN = licensed practical nurse

MAPAP/Mapap (acetaminophen) = a drug used to treat mild to moderate pain and to reduce fever
 MAR = Medication Assistance Record
 mcg = micro grams
 mg = milligrams
 NSA = Negotiated Service Agreement
 o2/O2 = oxygen saturation level
 PRN = As Needed
 Ra/ra = Resident assistant/staff
 Res/res = resident
 RN = Registered Nurse
 S.O.B. = shortness of breath
 temp/tem. = temperature
 UTI = Urinary Tract Infection

16.03.22.520 Requirements To Protect Residents From Inadequate Care.

The administrator must assure that policies and procedures are implemented to assure that all residents are free from inadequate care.

Based on observation, interview and record review it was determined the facility did not seek appropriate or timely medical interventions for 1 of 1 sampled residents (#8) who experienced a medical emergency and retained 2 of 2 sampled residents (#9 and #11) who were a danger to themselves or others. These failures constituted inadequate care and had the potential to affect 100% of the facility's residents.

IDAPA 16.03.22.011.08 defines inadequate care as "When a facility fails to provide...emergency intervention..."

Mayoclinic.org defines hypoxemia (low blood oxygen) as follows: "Normal pulse oximeter readings range from 95 to 100 percent, under most circumstances. Values under 90 percent are considered low."

Webmd.com states, "When your body doesn't have enough oxygen, you could get hypoxemia or hypoxia. These are dangerous conditions. Without oxygen, your brain, liver, and other organs can be damaged just minutes after symptoms start."

Resident #8's record documented she was 90 year-old female who was admitted to the facility on 4/24/14, with a diagnoses of dementia, unspecified, without behavior disturbance.

The resident's record contained progress notes which documented the following:

- * 6/26/15 at 5:38 AM - Resident yelled most of the night, staff offered snack and resident refused.
- * 6/26/15 at 6:53 AM - "Resident has been yelling all morning in the dining room."
- * 6/26/15 at 10:44 AM - "Resident is persistently yelling and calling out unable to be consoled."
- * 6/26/15 at 4:19 PM - Resident #8 started Cipro for a UTI.
- * 6/26/15 at 4:23 PM - Change in resident's acetaminophen (MAPAP).
- * 6/26/15 at 9:48 PM - "Res has been running a temp of 101.8. After 2 hours res temp was checked again no change even though she was given mapap. Called nurse [RN's name] she said to start antibiotic and to watch temp for 24 hours. If it goes up call her [sic]."
- * 6/27/15 at 5:34 AM - "Resident slept all night. No concerns at this time."
- * 6/27/15 at 2:41 PM - "Ra went to check on res she wanted to get out of bed. Took temp 100.4, O2-93, p-66. Res seems unaware of what is happening but knows that she is having pain in her back and neck. Res was taken to dining room."

* 6/27/15 at 9:45 PM - "Res has been running a temp for about 30 hours. Temp is still 101.3, O2-85, Res seems weak [sic] and is having trouble feeding herself, sitting up and walking. She has been using her wheelchair today. She has been eating well but seems to be having trouble swallowing her pills. ra tried to break them but she is still having trouble...nurse said to crush and she would get an order. Nurse also said to keep and [sic] eye on her through the night if her temp and O2 do not change to send her out. Also, she keeps calling out for help and is talking in her sleep."

* 6/28/15 at 5:42 AM - "Resident slept all night. Resident was assisted with toileting 3 times. Ra took residents O2 and Temperature this morning it was 94% and Tem. 99.7" [sic]

* 6/28/15 at 1:04 PM - "Res was sent to ER with an [sic] 102 temp. Res will possibly be out of the community for 1 or 2 days."

On 7/30/15 at 3:35 PM, the facility LPN was shown the progress notes from 6/26 through 6/28/15. She stated she would have sent Resident #8 out "way sooner." She stated she was off that weekend, but had been trained to "err on the side of caution with low O2" (oxygen saturation) and would have immediately sent Resident #8 to the emergency room with the drastic change of condition and low O2 saturation.

On 7/30/15 at 4:20 PM, the caregiver who documented the progress notes on 6/26 and 6/27/15 regarding Resident #8's temperature and low O2 levels was interviewed. She stated that on 6/26/15, Resident #8 experienced a major change in condition and went from being able to walk, talk, eat and let staff know when she needed assistance, to not being able to walk, talk, eat or let staff know if she needed assistance. She stated she felt that Resident #8 should have been sent to the emergency room on 6/26/15, due to her change in condition, fever and low oxygen saturation. She stated she had contacted the facility RN throughout Resident #8's change of condition, but felt the facility RN had not responded appropriately. When asked if there was any documentation of her contacting the facility RN, she displayed a series of text messages between her and the facility RN.

The text messages between the caregiver and the facility RN, dated 6/27/15, documented the following:

*The facility RN asked the caregiver, what was Resident #8's O2? The caregiver replied, "When she is laying down it is 90...When she gets up it drops to 81."

*The facility RN asked if Resident #8 was on oxygen, or on home health or hospice and the caregiver replied no to both questions. The caregiver informed the facility RN that Resident #8 usually fed herself but had to be fed and also usually asked for assistance with toileting, but had been incontinent that evening.

*The facility RN asked if Resident #8 had anything for breathing and if she had taken her medications. The caregiver replied, "No," adding she did not have anything for breathing and had only taken some of the "smaller pills" and Resident #8 had spit out some of the pills.

*The caregiver also messaged the facility RN that Resident #8's O2 was 85 and her temperature was 101.3 and the RN instructed her to "keep an eye on her through the night..." [sic]

On 7/30/15 at 4:50 PM, the facility RN stated, "I was the nurse on-call the weekend of 6/26/15." She stated she was informed that Resident #8 still had a fever, was not able to swallow and was refusing her medication, on 6/27/15. She stated on 6/28/15, staff reported the residents O2 saturation was 82%, and she told staff to send her to the emergency room. She stated she had never assessed Resident #8 prior to or after the incident.

On 8/5/15 at 2:44 PM, the administrator was interviewed. She stated on 7/21/15 a caregiver told her an allegation of abuse/neglect had been turned in to Adult Protection regarding the facility RN and Resident #8. She stated she felt there was a delay in treatment for Resident #8, and in her opinion the facility RN should have sent Resident #8 to the emergency room on 6/27/15. The administrator further stated the facility RN had never assessed Resident #8 prior to or since the incident occurred.

Resident #8 experienced a change in condition on 6/26/15 and was not assessed or treated until 6/28/15,

when she was sent to the emergency room. This delay in treatment resulted in inadequate care.

16.03.22.520-11 Acceptable Admission and Retention

IDAPA 16.03/22.152.05.d - "A resident will not be admitted or retained who has physical, emotional, or social needs that are not compatible with the other residents in the facility;"

IDAPA 16.03.22.152.05.e - "A resident that is violent or danger to himself or others."

Admission/Retention:

1. According to her record, Resident #9 was an 89 year-old female who was admitted to the facility on 4/16/14 with a diagnosis of dementia. The resident was originally admitted to the facility on 8/13/14, but on 4/16/15 there was a change of ownership and the resident remained at the facility.

On 7/30/15 the following observations were made:

*At 2:33 PM - Resident #9 was sitting in a wheelchair participating in an activity. The resident was visibly agitated and was making loud comments. The resident was heard making a statement directed towards the surveyors sitting in another area of the room. Resident #9 shouted, "Can you (caregiver) tell them to keep it down, I can't hear you with them making noises over there." A few minutes later, Resident #9 confronted Resident #10, chased him and repeatedly told him to "sit down and shut up." He responded by saying "oh, go to hell." Resident #9 grabbed his arm as he was walking by. When Resident #10 tried to get away, he nearly lost his balance. Two caregivers came running in from different directions to separate the two residents. Resident #9 continued to chase Resident #10, again yelling at him to "sit down and shut up." Resident #9 then angrily asked the surveyors if they had a phone she could use, as she wanted to sue the facility.

*At 3:03 PM, Resident #9 started pushing around chairs in an effort to get outside through a sliding glass door. A caregiver tried to assist the resident get through the door, but the resident shouted "get your hands off me!" She did manage to get outside and stayed out for approximately 15-20 minutes. A Behavior Plan, dated 10/3/14, documented Resident #9 had behaviors which included going into other resident's rooms and becoming possessive once in the room, resisting staff and becoming combative when staff attempted to redirect her. Interventions for the behaviors included redirecting the resident to an activity, involving her in conversation about her family, talking about bowling, having her watch a movie and encouraging her to play the piano. The "goal" of the interventions was for staff to be able to control Resident #9's behaviors to prevent escalation and harm to herself or others.

Behavior tracking for Resident #9 prior to her admission documented the following:

*3/3/15 at 4:10 PM – Resident #9 “came out of her room and got very angry at other residents” because she thought they were in her house. The resident yelled at the residents and banged on the tables and doors, upsetting some of the residents.

*3/8/15 at 4:16 PM – Resident #9 chased another resident down the hall, yelling at her.

*3/9/15 at 6:23 PM – Resident #9 kicked and hit the door while a caregiver was assisting another resident in the bathroom. The resident “found” brooms and swung them at other residents.

*3/15/15 at 5:02 PM - Resident #9 began yelling at other residents and telling them to “get the hell out of her house.” She was “especially mean” to another female resident calling her “stupid and pathetic multiple times and telling her that she might as well kill herself because she was so dumb and worthless.”

*3/22/15 at 8:00 AM – Resident #9 yelled at the men in the dining room to which a male resident responded by cursing at her.

*3/22/15 at 12:30 PM – Resident #9 grabbed a full bottle of juice and threw it against the wall stating if

someone did not let her out of the building she was going to "burn the building down." She then grabbed another bottle of juice and attempted to throw it at other residents. When a caregiver attempted to take the bottle away, Resident #9 began starting kicking and yelling at the two caregivers, "Let's see how you like this! I hope you die!" After obtaining the bottle of juice from Resident #9, she kicked the food cart knocking plates of food onto the floor and started pushing the cart into a table where other residents were sitting. Later, the caregivers heard "crashing and things hitting the wall." They found the resident had thrown pictures, a lamp, a potted plant and had turned over her nightstand.

*3/22/15 at 2:30 PM – Resident #9 was found in her room "stabbing" a prosthetic leg with a "metal finger nail file." The resident told the caregiver to leave her alone.

*3/22/15 at 3:15 PM – Resident #9 was kicking at another resident's door yelling, "Open this door before I call the cops to kill you." The resident opened the door and Resident #9 yelled at him.

Faxes to the Resident #9's physician documented the following:

*3/24/15 - Resident #9 had been having a lot of behavioral issues including several resident to resident incidents as well as hitting and kicking the staff. The nurse requested the physician's help to try to resolve the issue. The physician documented at the bottom of the fax to start Seroquel 50 mg by mouth every night.

*3/26/15 - The resident's behaviors have "escalated to the point we are unable to keep her here due to the violence of her behavior that we are unable to control...we have temporarily placed her on a 1 on 1, but will be unable to do this consistently for very long."

*3/26/15 - "We are having difficulty even handling her behaviors today with the 1 on 1 and it is a large disturbance to the other residents on Memory Care and causing a lot of agitation with them. Can we have a prn Haldol or something we can give her to calm her now and give medications that are onboard [sic] now to get therapeutic?" The physician responded, "No Haldol."

Incident Reports documented the following:

*2/19/15 - Resident #9 yelled at another resident, "Don't you sit down you haven't done any work today to deserve a break." Resident #10 went to take a seat and Resident #9 kicked him stating, "I told you not to sit down." Resident #10 walked off to the end of the hall while an aide tried to calm Resident #9 down. Resident #9 proceeded to tear down the hall, found Resident #10 near the door and kicked him yelling "Get your ass out that door, you haven't done anything today."

*3/21/15 at 8:00 PM - Resident #9 became "very irritated" and went into Resident #10's room. Resident #10 screamed at her and she went out of the room and into the common area. Resident #9 then went through a caregiver's purse, took her wallet and make-up out of the purse, claiming it was hers. When the caregiver confronted her, Resident #9 became angry and said, "You need to let me out of here." Resident #9 kicked the caregiver twice and another resident got mad and grabbed Resident #9. The caregiver separated the two residents and took Resident #9 to her room.

*4/29/15 - Resident #9 was given her pills in the dining room, but took the pills and headed down the hallway. In an attempt to ensure the resident took her pills, the caregiver followed the resident. The resident was "agitated" and "yelled" at the caregiver to leave her alone. Resident #9 threw water on the caregiver, punched the caregiver multiple times in the stomach, and grabbed her arm attempting to bite her. At the same time was kicking and scratching at the caregiver. Another, male caregiver attempted to intervene and Resident #9 hit him "multiple" times and kicked him while he was looking for the pills the resident threw on the floor. An admission agreement, dated 4/16/15, documented the facility would not "accept or retain" residents with a history of aggressive behaviors. However, Resident #9 had multiple behaviors prior to her admission that were "aggressive" in nature when the facility admitted her.

Progress Notes documented the following:

*5/30/15 at 9:02 PM - Resident #9 tried to help another resident leave the facility. She became "upset and cussed at staff" because she could not help the other resident leave.

*6/3/15 at 3:05 PM - Resident #9 "seems to be thrusting authority" over other residents, telling the resident to "answer me or else." The caregiver removed Resident #9 from the situation and she tried to "run" the caregiver down with her wheelchair.

*6/7/15 at 12:51 PM - The resident was "very abusive" and "yelled" at the caregiver. She also pushed and tried to bite the caregiver.

*6/11/15 at 3:51 PM - Resident #9 was holding onto another resident's hand and three caregivers were trying to take the other resident away from Resident #9. Resident #9 "grabbed" onto one of the caregivers arms, pinched and kicked her.

*6/21/15 at 8:57 PM - The resident "started undressing" in the dining room. When asked if she needed to go to the bathroom, Resident #9 "yelled, I need you to back off and leave me alone! I do not need your help nor do I want your help!"

*6/23/15 at 1:30 PM - Resident #9 was "barricading" another resident in her room.

*6/27/15 at 4:15 PM - The resident displayed "possessive behaviors over other residents and facility." The resident tried to get into another resident's room looking for her children. Resident #9 became aggressive and started kicking the caregiver when told not to go in the room. The resident followed another caregiver into the hall and began yelling at another resident.

*7/3/15 at 8:38 AM - The resident seemed to be "taking ownership over" another resident, calling her a servant. Resident #9 would not let the other resident leave her side.

*7/6/15 at 9:49 AM - The resident came out of her room "agitated" and started yelling at another resident telling her she needed to brush her hair properly.

*7/16/15 at 2:15 PM - Resident #9 "demanded she leave this place" and told the administrator that if she "didn't find the manager..., there would be some very dead people."

*7/16/15 at 5:56 PM - Resident #9 was assisted with a pain medication. Later, when asked if she was still in pain, Resident #9 stated, she was still in "pain and angry." She further stated there would be "murder in the first degree" if the caregiver did not get out her way.

*7/19/15 at 4:14 PM - Resident #9 yelled at a caregiver to let her out of the facility or she was "going to burn it down." The caregiver then attempted to help the resident, but the resident started swinging the broom and hit the caregiver. The resident also hit the pull-down fire alarm cover with the broom and knocked it off.

*7/24/15 at 1:11 PM - Resident #9 was "agitated" and went into other resident's rooms, asking for her money back.

On 7/30/15 at 3:05 PM, two caregivers were interviewed about Resident #9's behaviors. One caregiver stated Resident #9's medications were changed about 3 months ago, and since then, her behaviors had been more frequent. The caregiver estimated Resident #9 had behavioral incidents at least once a week. The caregiver stated, "typically" Resident #9 became agitated with Resident #10, who was the same resident she yelled at and physically grabbed during survey observations. The caregiver stated staff had to get between them and split them up in order to protect Resident #10. The other caregiver stated Resident #9 grabbed her leg a week prior to the survey and left a bruise.

On 7/30/15 at 6:05 PM, the nurse stated Resident #9 became agitated and was hard to redirect. She stated the physician did not want to make any further medication changes.

On 7/30/15 at 6:50 PM, the administrator stated, Resident #9's physician changed her medications to help with her behaviors. She stated, "I had noticed an increase in her behaviors, such as, chasing and yelling and being aggressive, with both residents and staff." The administrator stated sudden increases in movement of people or furniture in the common area seemed to trigger her behaviors. The administrator stated, "I wasn't

aware people were getting hurt until today." The administrator further stated, "I haven't been reading my notes like I should."

Although the facility's admission agreement clearly documented the facility would not "accept or retain" residents with aggressive behaviors. Resident #9, who had a known history of physical abuse towards others, was retained. For three months the facility retained Resident #9 when she was a danger to others.

16.03.22.520 Requirements To Protect Residents From Inadequate Care.

The administrator must assure that policies and procedures are implemented to assure that all residents are free from inadequate care.

2. According to his record, Resident #11 was an 82 year old male with a diagnosis of non-Alzheimer's dementia. The resident was originally admitted to the facility on 3/18/15, but on 4/16/15 there was a change of ownership and the resident remained at the facility.

On 7/30/15 at approximately 2:33 PM, Resident #11 was observed sitting at a table in the common area holding a cane. Resident #11 was looking down the hallway from where he was sitting and looked visibly upset with Resident #10 who was wandering in the hallway and in and out of the common area. Resident #11 stated, "I just want to sit here and watch my door, he's (referring to Resident #10) just wandering around looking for a place to go lay down." Resident #11 further stated, "I'm watching him like a hawk." At this time, Resident #9 became involved and proceeded to begin yelling at Resident #10 to "sit down and shut up."

An admission agreement, dated 4/16/14, documented the facility would not "accept or retain" residents with a history of aggressive behaviors.

A UAI from 4/9/15 documented the following:

Under the disruptive/socially inappropriate behavior section it documented Resident #11 "becomes loud and tells people to stop doing something if he does not like it - does not get physical."

Under the assaultive/destructive behavior section it documented Resident #11 had no history of combative or destructive behaviors.

An initial assessment/interim plan of care, dated 5/31/15, acknowledged Resident #11 did have a history of physical injury to staff and others. However, other applicable boxes were not checked, including aggressive/intimidating and easily irritated/upset/agitated.

An NSA, initiated on 6/5/15, documented Resident #11's behaviors included delusions, belief he could live alone, wandering and was "disruptive." The interventions for the behaviors were for staff to offer support, re-direction and comfort as needed. Staff were to report any concerns to facility nurse and the nurse would inform the primary care physician.

Incident reports documented the following:

*On 5/5/15 at 7:30 PM, a caregiver observed Resident #11 pushing Resident #10 to the floor. Resident #11 then used his cane to hit Resident #10 in the chest. The caregiver ran into the room just as Resident #11 was about to hit Resident #10 again. Resident #10 did develop discoloration to his chest from the incident.

*On 5/14/15 at 1:54 PM, Resident #10 entered Resident #11's room uninvited. Resident #10 became agitated and began yelling at Resident #10 to get out. A caregiver witnessed Resident #11 hitting Resident #10 on the head with his cane. Resident #10 was heard saying if the caregiver did not remove Resident #10, "he was going to kill him!"

Progress notes documented the following:

* 5/7/15 at 4:08 PM, a caregiver walked into Resident #11's room to make his bed. Resident #11 tried to push the door into the caregiver with his cane raised. Resident #11 told the caregiver he was "trying to hurt" the

other residents that come into his room.

* 5/7/15 at 9:18 PM, Resident #11 was getting "very irritated" by other residents." Resident #11 was using the door and his cane as a weapon.

* 5/17/15 at 2:37 PM, Resident #11 was yelling at another resident for touching his shoulder. Resident #11 stood up and raised his cane and yelled "don't touch me you S.O.B."

* 7/1/15 at 9:35 PM, Resident #11 "seems to snap at other residents for nothing." The resident became "agitated" when spoken to or touched by another resident.

* 7/21/15 at 9:31 PM, Resident #11 told a caregiver some items had been stolen out of his room. He could not recall what was taken, but did accuse another resident of doing so. The caregiver documented the other resident had not been in Resident #11's room.

*7/22/15 at 8:45 PM, Resident #11 seemed to become easily agitated with other residents whenever he emerged from his room.

On 7/30/15 at around 6:40 PM, Resident #11 was observed sitting near the dining area. When asked what he was doing, the resident stated he was keeping an eye on his bedroom to make sure no one would go in there to steal anything. He was seen yelling "I mean it" to another resident while using his cane in an intimidating fashion. When surveyors were speaking with another resident and a caregiver, Resident #11 began to vocalize his agitation and banged his cane on the floor.

On 7/30/15 at 6:45 PM, a caregiver stated Resident #11 had "angry outbursts" where he became verbal and used foul language. She said there was one occasion in which Resident #11 was "very aggressive" with Resident #10 who had walked into Resident #11's room. Resident #11 reacted by yelling at the resident and hitting him with his cane. The caregiver stated the resident stayed in his room most of the time and slept a lot. The caregiver added the resident acted paranoid, thinking people were taking things from his room.

On 7/30/15 at 6:50 PM, the administrator stated Resident #11 had been aggressive towards Resident #10 on multiple occasions.

Resident #11 attacked Resident #10 with a cane on two separate occasions and was witnessed being angry with Resident #10 on the first day of the survey. Although the facility's admission agreement clearly documented the facility would not "admit or retain" residents who had a history of aggression, Resident #11 remained at the facility.

The facility failed to seek timely medical attention for Resident #8. Further, the facility admitted and retained Residents #9 and #11 who had behaviors that were dangerous to others. These failures resulted in inadequate care.



Phone: 208-733-9064 Fax: 208-733-0343

September 9, 2015

Dear Jamie Simpson,

This letter is a follow up to the survey completed July 30th & 31st, 2015 at Heritage Assisted Living of Twin Falls where it had been determined that we had a core deficiency that we failed to protect residents from inadequate care.

This is the follow up with resident #8.

- What corrective action will be accomplished for those specific residents/personnel/areas found to have been affected by the deficient practices:
 - Admin requested that compliance come in and assist with the investigation. It was substantiated that this nurse was neglectful and was terminated as an employee and put as not rehire able for the entire company.
 - Training has been completed with the aides on when to notify the Administrator of concerns or when they disagree with the nurse decision.
- How will you identify other resident's/personnel/ areas that may be affected by the same deficient practice and what corrective action will be taken.
 - Administrator and facility nurse communicate on a regular basis and also have implemented a weekly meeting established on Friday's which includes the Woodstone nurse as. During this meeting, we discuss the residents and identify any issues that may have arisen throughout the week that may require the weekend nurse on call to have knowledge of.
 - Staff have been trained to recognize change of condition and to communicate with the nurse on call. Should the staff believe a resident needs immediate attention, they have been instructed to call 9-1-1 to ensure that attention is acquired. Staff also know if a resident is having a change of condition and they are not sent to be evaluated, the nurse must come in and assess the resident and document her findings.
- What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?
 - We will use this incident to do further training with our nurses that work at the facility to show them the importance vitals, when to send a residents out, what a change of condition is, and when to come in and assess a resident.
 - Again weekly the nurse and admin will get together to go over residents and incidents to see what we can change or do better and to discuss how all of the residents are doing. If it is a more emergent situation we will meet immediately to discuss the situation and find a resolve/plan then.
- How will the corrective action be monitored and how often will monitoring occur to ensure that the deficient practice will not recur?
 - The weekly meeting will be documented and reviewed by both the Administrator and

the Wellness Director to ensure residents with change of condition are cared for appropriately and timely.

- By what date will the corrective action be completed.
 - The system outlined above was implemented on August 28th and will continue on an on-going basis.

This is the follow up for Resident #9.

- What corrective action will be accomplished for those specific residents/personnel/areas found to have been affected by the deficient practices?
 - Resident/ Family was given an emergency discharge notice. Family provided 1 on 1 for this resident to help keep her busy and redirected to avoid any further resident to resident incidents.
- How will you identify other resident's/personnel/ areas that may be affected by the same deficient practice and what corrective action will be taken.
 - Staff have been educated on recognizing and reporting behaviors. All current residents with known behaviors have had their behavior plans implemented and/or updated.
 - A system has been implemented to document any and all behaviors noted. Once behaviors are noted, interventions are implemented then a follow up review is conducted in 72 hrs.
- What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?
 - For those residents who have altercations with others, the following will be notified: Family members, Adult Protective Services, the Physician, and the Health and Welfare department if warranted. An internal investigation will be launched to determine if the resident is appropriately placed. For those residents who are no longer appropriate, the discharge process will be implemented.
- How will the corrective action be monitored and how often will monitoring occur to ensure that the deficient practice will not recur?
 - The Administrator and the Wellness Director have implemented a weekly meeting in which all incidents are reviewed and tracked.
 - Behavior monitoring sheets will also be reviewed weekly to ensure appropriate interventions are in place for all residents with behaviors, as well as to ensure continued appropriate placement.
- By what date will the corrective action be completed.
 - This resident was discharged as of August 7th, 2015.
 - The system outlined above was implemented on August 28th and will continue on an on-going basis.

This is the follow up to resident #11

- What corrective action will be accomplished for those specific residents/personnel/areas found to have been affected by the deficient practices?
 - This resident has been discharged from the facility.

- How will you identify other resident's/personnel/ areas that may be affected by the same deficient practice and what corrective action will be taken.
 - Staff have been educated on recognizing and reporting behaviors. All current residents with known behaviors have had their behavior plans implemented and/or updated.
 - A system has been implemented to document any and all behaviors noted. Once behaviors are noted, interventions are implemented then a follow up review is conducted in 72 hrs.
- What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?
 - For those residents who have altercations with others, the following will be notified: Family members, Adult Protective Services, the Physician, and the Health and Welfare department if warranted. An internal investigation will be launched to determine if the resident is appropriately placed. For those residents who are no longer appropriate, the discharge process will be implemented.
- How will the corrective action be monitored and how often will monitoring occur to ensure that the deficient practice will not recur?
 - The Administrator and the Wellness Director have implemented a weekly meeting in which all incidents are reviewed and tracked.
 - Behavior monitoring sheets will also be reviewed weekly to ensure appropriate interventions are in place for all residents with behaviors, as well as to ensure continued appropriate placement.
- By what date will the corrective action be completed.
 - This resident was discharged as of August 7th, 2015.
 - The system outlined above was implemented on August 28th and will continue on an on-going basis.

Please let me know if there is anything else you require.

Sincerely,



Alyssa Peterson
Administrator



Facility HERITAGE ASSISTED LIVING OF TWIN FALLS	License # RC-982	Physical Address 622 FILER AVE W	Phone Number (208) 733-9064
Administrator Alyssa Peterson	City TWIN FALLS	ZIP Code 83301	Survey Date July 31, 2015
Survey Team Leader Matt Hauser	Survey Type Initial Licensure	RESPONSE DUE: August 30, 2015	
Administrator Signature <i>Alyssa Peterson</i>	Date Signed 7/31/15		

NON-CORE ISSUES

Item #	IDAPA Rule # 16.03.22.	Description	Department Use Only	
			EOR Accepted	Initials
1	215.09	The administrator did not identify and monitor patterns for incidents and accidents.	9/23/15	M
2	225.01	The facility did not evaluate all Residents with behaviors.	9/23/15	M
3	225.02	The facility did not develop interventions for all Residents with behaviors.	9/23/15	M
4	260.06	The facility was not maintained in a clean, safe manner, to include stained and worn carpet throughout, urine odors in rooms.	9/23/15	M
5	300.01	The facility nurse failed to assess residents every 90 days and when residents had changes in condition.	9/23/15	M
6	310.02	The facility did not have a system in place to document medication disposals.	9/23/15	M
7	310.04.c	The facility did not monitor Resident #8 to determine the continued need for Haldol based on her behaviors.	9/23/15	M
8	310.04.e	Psychotropic medication reviews were not completed every six months for Residents #6 and #10.	9/23/15	M
9	320.01	NSAs did not clearly identify Resident #5, #4, #1, and #11.	9/23/15	M
10	350.07	The facility did not report all required incidents to Licensing and Certification.	9/23/15	M
11	711.01	The facility did not track residents' behaviors.	9/23/15	M
12	711.13	The facility nurse signed and dated assessments; however, stated she had not conducted face-to-face assessments.	9/23/15	M
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