



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
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February 03, 2016

Sondra Winter, Administrator
Meadow View Assisted Living & Memory Care
1013 South Johns Avenue
Emmett, Idaho 83617

Provider ID: RC-1082

Sondra Winter:

On October 08, 2015, a healthcare initial licensure survey was conducted at Meadow View Assisted Living & Memory Care. 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, QMRP, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 364-1962.

Sincerely,

Matt Hauser, QMRP
Team Leader
Health Facility Surveyor

MH/sc



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October 29, 2015

Sondra Winter, Administrator
Meadow View Assisted Living & Memory Care
1013 South Johns Avenue
Emmett, Idaho 83617

Provider ID: RC-1082

Ms. Winter:

Based on the Healthcare Initial Licensure survey conducted by Department staff at Meadow View Assisted Living & Memory Care between 10/06/2015 and 10/08/2015, it has been determined that the facility failed to protect residents from abuse.

This core issue deficiency substantially limits the capacity of Meadow View Assisted Living & Memory Care 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 December 2, 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 November 11, 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.

Sondra Winter
October 29, 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.

A core issue deficiency was identified during the complaint investigation. Please review the cover letter, which outlines how to develop a Plan of Correction. The Plan of Correction must be submitted to our office within 10 (ten) calendar days of receiving the Statement of Deficiencies.

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 October 18, 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 within thirty (30) days from the exit date.

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

CORE ISSUES

Facility	License #	Physical Address	Phone Number
Meadow View Assisted Living & Memory Care	RC-1082	1013 South Johns Avenue	208-365-1122
Administrator	City	Zip Code	Survey Date
Sondra Winter	Emmett	83617	10/8/2015
Survey Team Leader	Survey Type		Response Due
Hauser, Matt	healthcare initial licensure		11/07/2015
Administrator Signature			Date Signed

Rule: 16.03.22.510 Requirements To Protect Residents From Abuse.

The following core deficiency was cited during the initial licensure survey conducted between 10/6/15 and 10/8/15 at your residential care/assisted living facility. The surveyors conducting the survey were:

Jeremy Walker, LSW
 Team Coordinator
 Health Facility Surveyor

Donna Henscheid, LSW
 Health Facility Surveyor

Matt Hauser, QIDP
 Health Facility Surveyor

Karen Anderson, RN
Health Facility Surveyor

Lisa Bennett, RN
Health Facility Surveyor

Survey Definitions:

NSA= Negotiated Service Agreement

BMP= Behavior Management Plan

pt= Patient

Rule: 16.03.22.510 Requirements To Protect Residents From Abuse.

This rule is not met as evidenced by:

Based on record review and interviews, it was determined the facility did not implement their abuse policy and procedures. As a result, 3 of 7 sampled residents (Residents #11, #12 and #13) who resided in the memory care unit were not protected from abuse. The findings include:

According to IDAPA 16.03.22.153.01, "The facility must develop policies and procedures to assure allegations of abuse, neglect and exploitation are identified, reported, investigated, followed-up with interventions to prevent re-occurrence and assure protection, and documented."

The facility's abuse policy documented the following: "All abuse or suspected abuse must be reported to the facility administrator. The administrator will assure [abuse] is reported to the proper agencies. An incident report must be filled out with information including the time, place, details of the occurrence and action taken by the facility." The policy did not mention reporting abuse to Adult Protection.

1. Resident #4's record documented she was a 83 year old female, admitted to the facility on 8/5/15, with a diagnosis of severe dementia and insomnia. Resident #4's NSA, dated 8/5/15, documented she had "no negative behaviors" and received 4 safety checks "throughout the night by staff."

Resident #11's record documented she was a 79 year old female, admitted to the facility on 8/3/15, with a diagnosis of dementia, depression and general weakness.

According to their records and the administrator, Resident #4 and Resident #11 shared a room from 8/5/15 through 9/24/15.

A) On 10/7/15 from 2:30 PM through 2:57 PM, three staff who worked in the memory care unit were interviewed. Two of the staff stated they had heard that Resident #4 had attempted to smother Resident #11 by placing a pillow over her face during the night. The third staff stated she had heard that Resident #4 was standing over Resident #11 with a rolled up blanket which made Resident #11 feel unsafe.

On 10/8/15 at 9:20, the staff member who witnessed the smothering incident was interviewed. The caregiver stated she entered the residents' room around midnight on 8/5/15 and observed Resident #4 placing and holding a pillow on Resident #11's face. The caregiver took the pillow away from Resident #4 and attempted to redirect her. Resident #4 slapped the caregiver and walked out of the room. The caregiver called the administrator to report what she had observed. The administrator told the caregiver to keep the two residents separated. The caregiver stated she did not document anything.

On 10/8/15 at 10:07 AM, the administrator stated the staff who witnessed the incident on 8/5/15 told her Resident #4 was observed standing over Resident #11 with a rolled up blanket. The administrator further stated the staff member told her Resident #11 was afraid because Resident #4 was standing over her.

On 10/9/15 at 3:01 PM, Resident #11's family members were interviewed. They stated [Resident #11] had told them her roommate attempted to smother her with a pillow on the evening of 8/5/15. They stated it happened again on 8/6/15. They further stated they informed the facility of both incidents and that Resident #11 had stated she was afraid to sleep in the room with her roommate.

On 10/9/15 at 1:20 PM, the facility administrator provided a report by a local primary care health provider, dated 8/7/15, documented Resident #4 "moved to facility on 8/5/15 and staff reports pt. has not adjusted well. The first night at Meadow view, pt had attempted to smother her

roommate with a comforter. The patient is now monitored at all times until a single room becomes available for the patients and other residents protection."

On 10/9/15 at 1:24 PM, the administrator stated she had not seen or read the report by the local primary care health provider, dated on 8/7/15. When asked what the report meant by "monitored at all times," she stated Resident #4 was provided 15 minute checks instead of the usual 30 minutes checks at night. When asked if there was any documentation or investigation, the administrator stated she had not done either. The administrator further stated she had not reported the incident to Adult Protection or followed the facility's abuse policy.

On 8/5 and 8/6/15, Resident #4 attempted to smother Resident #11 with a pillow. The facility failed to document or investigate the incident and failed to report the incident to Adult Protection. The facility failed to protect Resident #11 by continuing to allow Resident #4 to share a room with Resident #11 until 9/24/15, 48 days after Resident #4 attempted to smother Resident #11. This resulted in a failure to protect residents from abuse.

B) Resident #4's record contained a "Service Performed" sheet which documented on 9/20/15 at 10:59 PM, Resident #4 had "Inappropriate Sexual Behaviors." There was no other documentation regarding what the inappropriate sexual behavior was, what the staff did to intervene, who was notified or how the facility responded.

On 10/8/15 at 11:29 AM, the staff who documented Resident #4 had "Inappropriate Sexual Behaviors" was interviewed. She stated, Resident #11's family had dropped her off during the evening of 9/20/15. The staff member stated Resident #11 had told her family she had been sexually molested by Resident #4. The staff member stated Resident #11's family told her Resident #4 (her roommate) had groped her breasts and "made out with her." Resident #11's family then reported what they heard to staff. The staff member stated she immediately called the administrator and reported the situation to her. She further stated, the administrator directed her to "attempt to keep the residents apart" and "keep a close eye on the residents."

On 10/7/15 at 11:20 AM the administrator was interviewed regarding the allegation of sexual inappropriateness. According to the administrator, Resident #11's family had only mentioned past concerns regarding sexual inappropriateness by others. The administrator further stated she did not think there had been a more recent allegation of inappropriateness. The administrator stated she had not documented or investigated anything related to the current allegation of inappropriate sexual behaviors. The administrator further stated she had not reported the incident to Adult Protection, nor had she followed the facility's abuse policy and procedures.

On 10/9/15 at 3:01 PM, Resident #11's family members were interviewed. They stated Resident #11 had reported to them that she had been kissed and her breasts were groped by "her roommate." They stated they reported it to the facility on 9/20/15. They further stated a caregiver at the facility had told them she had witnessed the groping and kissing. They stated Resident #11 was moved to a new room three or four days later.

Resident #11's family made an allegation Resident #11 had been sexually molested by Resident #4 on 9/20/15. The facility failed to document, investigate or report the allegation to Adult Protection. The facility also failed to provide protection for Resident #11 when they allowed Resident #4 to continue to reside in the same room until four days after the allegation was reported.

2. Resident #5's record documented she was a 80 year old female, admitted to the facility on 10/5/15, with a diagnosis of dementia with behavioral disturbances.

Resident #12's record documented she was a 83 year old female, admitted to the facility on 6/17/15 with diagnoses including dementia.

Resident #13's record documented she was a 79 year old female, admitted to the facility on 12/5/14 with diagnoses including Alzheimer's dementia.

Resident #5's NSA, dated 10/5/15, documented the resident's behaviors included verbal and physical aggression against staff and other residents. It also documented "she had hit 2 staff members on day of admit and verbally abused a resident."

On 10/7/15 at 2:41 PM, a caregiver stated she heard Resident #5 was physically and verbally aggressive towards other residents. The caregiver further stated she heard Resident #5 kicked Resident #12 in the shin.

On 10/7/15 at 2:57 PM, another caregiver stated she heard Resident #5 hit another resident the day she was admitted, but did not know the specifics.

On 10/8/15 at 9:20 AM, a caregiver was interviewed by phone. The caregiver stated she heard Resident #5 had slapped one staff, punched another staff, and kicked a third staff member. The caregiver further stated she also heard Resident #5 had slapped a resident, but the caregiver did not know who that resident was. The caregiver was certain the administrator had been made aware of the incident.

On 10/7/15 at 3:25 PM, the nurse and administrator were interviewed. When asked, they both stated they were unaware of Resident #5 being physically abusive towards other residents. They added they had only been notified of verbal abuse. The nurse stated the Resident did not have a formal BMP implemented prior to the incident, nor had there been one implemented since. The administrator acknowledged there were issues with documentation and communication among staff. The administrator further stated she did not investigate or report the allegations of abuse.

On 10/8/15 at 11:24 AM, the "administrator in-training" (AIT) of the facility where Resident #5 previously resided was interviewed. The AIT stated Resident #5 was immediately discharged from their facility due to her behaviors. She stated Resident #5 had been combative towards others on several occasions which included hitting, yelling, kicking and biting staff. She stated Resident #5 then started doing the same things towards other residents. The AIT stated the most recent incident occurred on 9/30/15 when Resident #5 was "agitated" and "grabbed" another resident around the neck and started shaking her. The AIT stated prior to Resident #5's discharge, she offered a copy of the BMP and monitoring sheets to the staff of Meadow View. However, she was told Meadow View did not need it as they would put their own into place.

In three separate instances, the facility failed to conduct an abuse investigation. In all three instances, the facility also failed to report allegations of abuse to Adult Protection. This resulted in a failure to protect Resident's #11, #12 and #13 from abuse and had the potential to effect all 13 residents who resided in the memory care unit.

NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
Meadow View Assisted Living & Memory Care	RC-1082	1013 South Johns Avenue	208-365-1122
Administrator	City	Zip Code	Survey Date
Sondra Winter	Emmett	83617	10/8/2015
Survey Team Leader	Survey Type		Response Due
Hauser, Matt	healthcare initial licensure		11/07/2015
Administrator Signature			Date Signed

Item #	Rule	Description
0	16.03.22.153.01. Response of Staff to Abuse, Neglect or Exploitation of Residents.	The facility's abuse policy did not include procedures for protecting residents and contacting Adult Protection following incidents of abuse.
1	16.03.22.220.02. Written Agreement.	The facility did not complete new admission agreements after a change in ownership.
2	16.03.22.220.03.a. Services, Supports, and Rates.	The facility's admission agreement did not identify the assessment tool, the assessor, or the frequency of the assessment.
3	16.03.22.225.01. Evaluation for Behavior Management.	The facility did not evaluate behaviors for each resident.
4	16.03.22.225.02. Intervention	The facility did not develop interventions for each behavioral symptom.
5	16.03.22.260.05.a. Linen and Laundry Facilities and Services.	The facility did not maintain an adequate linen supply.
6	16.03.22.300.01. Licensed Professional Nurse (RN).	There was no documented evidence the RN provided delegation to all appropriate staff. Additionally, the RN did not provide written delegation regarding insulin.
7	16.03.22.305.03. Resident Health Status.	The facility did not assess residents change of condition in the following instances: Residents' #1,2,3,4,7 and 10's wound

		status; Resident #7's weight loss; Resident #1'a high blood sugars and unresponsive episode; Resident #3's unresponsive episode and rashes.
8	16.03.22.305.04. Recommendations.	The facility RN did not have any documentation of recommendations made to staff regarding residents' health needs.
9	16.03.22.305.08. Resident and Facility Staff Education.	The RN did not provide education to staff for residents health care needs.
10	16.03.22.310.04.a. Psychotropic or Behavior Modifying Medication.	The facility failed to attempt non-drug interventions prior to beginning psychotropic medications.
11	16.03.22.310.04.d. Psychotropic or Behavior Modifying Medication.	Facility staff were not trained to monitor side-effects of residents' psychotropic medication.
12	16.03.22.310.04.e. Psychotropic or Behavior Modifying Medication.	The facility failed to provide behavioral update to residents' physicians. Additionally, the facility did not complete a psychotropic medication review for Resident #4.
13	16.03.22.320.01. Use of Negotiated Service Agreement.	NSA's did not clearly identify 4 of 10 sampled residents.
14	16.03.22.320.03. Signature, Date and Approval of Agreement.	Residents' NSA's were not signed by the facility administrator.
15	16.03.22.335.02. Staff With Infectious Disease.	The memory care unit did not have paper towels and soap available in residents rooms to promote infection control practices.
16	16.03.22.350.02. Administrator or Designee Investigation Within Thirty Days.	The facility did not investigate all incidents and allegations of abuse.
17	16.03.22.350.03. Resident Protection.	The facility failed to protect residents following incidents or allegations of abuse.
18	16.03.22.350.04. Written Response to Complaint Within Thirty Days.	The administrator did not provide a written response for all incidents, accidents and complaints.
19	16.03.22.350.06. Corrective Action for Known Allegations.	The facility did not document corrective actions taken following an allegation of abuse.
20	16.03.22.451.02. Snacks.	The facility did no offer snacks between meals and at bedtime.
21	16.03.22.625.01. Number of Hours of Training.	The facility did not have documentation 16 hours of orientation was completed by all staff.
22	16.03.22.630.01. Dementia:	5 of 10 sampled staff did not have documentation of dementia training.
23	16.03.22.630.02. Mental Illness:	7 of 10 sampled staff did not have documentation of mental

		illness training.
24	16.03.22.630.03. Developmental Disability:	10 of 10 sampled staff did not have documentation of developmental disability training.
25	16.03.22.710.04. Prior History and Physical.	Resident #5 did not have an H&P prior to admission.
26	16.03.22.711.08.b. Care Notes.	The facility did not document nursing tasks such as: treatments and wound care.
27	16.03.22.711.08.c. Care Notes.	The facility did not document all incidents and altercations.
28	16.03.22.711.08.d. Care Notes.	The facility did not document call to physicians.
29	16.03.22.711.08.e. Care Notes.	Facility staff did not document when they notified the facility nurse.
30	16.03.22.711.01. Ongoing Resident Care Records	the facility did not track residents' behaviors to include: the date and time a behavior occurred, interventions attempted the the effectiveness of the interventions.
31	16.03.22.711.08. Care Notes.	Care notes were not documented, dated, or signed by the person doing the care.
32	16.03.22.705.02. Written Admissions Agreement.	The admission agreements were not signed by the administrator.
33	16.03.22.350.05. Facility Notification to Appropriate Agencies.	The facility did not notify appropriate agencies following an allegation of abuse.
34	16.03.22.730. Facility Administrative Records For Personnel And Staffing.	Facility records did not document personnel on duty at any given time (nurse and administrative staff).