

# HEALTH & WELFARE

C.L, "BUTCH" OTTER - Governor RICHARD M. ARMSTRONG - Director LESLIE M. CLEMENT - Administrator DIVISION OF MEDICAID Post Office Box 83720 Boise, Idaho 83720-0036 PHONE: (208) 334-6626 FAX: (208) 364-1888

January 13, 2010

Administrator Kuna Living Center 194 West White Way Kuna, Idaho 83634 FILE COPY

Dear Ms. Gooding:

On January 6, 2010, a complaint investigation was conducted at Kuna Living Center.

The enclosed form, stating no core issue deficiencies were cited during the survey, is for your records only and need not be returned.

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. 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 February 5, 2010.

Should you have any questions about our visit, please contact me at (208) 334-6626.

Sincerely,

JAMIE SIMPSON, MBA, QMRP

Program Supervisor

Residential Assisted Living Facility Program

JS/sc

Enclosure

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED  C 01/06/2010	
NAME OF P	ROVIDER OR SUPPLIER	1010.00	STREET A	DDRESS, CITY,	STATE, ZIP CODE	01/0	70/2010	
KUNA LIVING CENTER			194 WEST WHITE WAY KUNA, ID 83634					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE	
	The residential car found to be in subs Rules for Resident Facilities in Idaho. were cited during that your facility. The survey were:  Matt Hauser, QMR Team Coordinator Health Facility Sundaren Anderson, Find Health Facility Sundaren Keathley, LS Health Facility Sundaren Rachel Corey, RN Health Facility Sundaren Facility Sundaren Rochel Corey, RN Health Facility Sundaren Facility Sundar	veyor RN veyor SW veyor	ith the ₋iving encies conducted	R 000				
sureau of Ha	cility Standards				TITI E		(YE) DATE	

STATE FORM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

6899

YGD911

If continuation sheet 1 of 1



BUREAU OF FACILITY STANDARDS P.O. Box 83720 Boise, ID 83720-0036 (208) 334-6626 fax: (208) 364-1888 ASSISTED LIVING Non-Core Issues Punch List

Facility Name	Physical Address	Phone Number
Kuna Living Center	194 West White Way	208-922-3536
Administrator	City	ZIP Code
KERRY MCLEOD	KUNA	83634
Survey Team Leader	Survey Type	Survey Date
M. HAUSER!	Complaint	1/6/2010
NON-CORE ISSUES		
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Response Required Date   Signature of Facility Representative	( )	Date Signed
215/10 Cms W/X	80	1/6/10
		4



# DEPARTMENT HEALTH & WELFARE

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January 14, 2010

Administrator Kuna Living Center 194 West White Way Kuna, Idaho 83634

### Dear Administrator:

On January 6, 2010, a complaint investigation survey was conducted at Kuna Living Center. The survey was conducted by Gloria Keathley, LSW, Matthew Hauser, OMRP, Rachel Corey, RN and Karen Anderson, RN. This report outlines the findings of our investigation.

## **Complaint # ID00004372**

The facility did not give a resident two evening doses of insulin. Allegation #1:

Findings: An unannounced onsite complaint investigation was conducted from January 5, 2010 - January 6, 2010. Record reviews were conducted with the following results:

> Substantiated. However, the facility was not cited as they acted appropriately by following physician orders regarding the resident's insulin dosing. Although the resident had been discharged from the facility, the medication administration record was reviewed and documented that evening doses of insulin were not given because the resident's blood glucose levels were at a level that did not require or allow insulin to be given. Therefore, although the allegation did occur, no deficient practice was identified because the facility acted appropriately.

The facility does not prepare diabetic meals according to physician orders for Allegation #2:

diabetic residents.

Findings: On January 5, 2010 between 9:15 AM and 12:00 PM, five residents with a

> diagnosis of diabetes were interviewed and stated they did not have physician orders for specialized diabetic diets. They stated the facility provided choices including

sugar free food options and fresh fruit.

Administrator January 14, 2010 Page 2 of 3

Findings:

Allegation #5:

Findings:

On January 5, 2010 between 9:30 AM and 10:40 AM, three cooks stated the diabetic residents were offered sugar free options for desserts or fresh fruits. They further stated none of the residents had a specialized diet.

On January 5, 2010, four resident who had diabetes records were reviewed for specialized diabetic diets and there was no documented evidence of physician orders for diabetic or specialized diets.

On January 5, 2010 at 12:05 PM, the lunch meal was served according to a dietician approved menu.

Unsubstantiated.

Allegation #3: Medication aides improperly assisted residents with insulin.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.310.01.d for caregivers dialing the dose on insulin pens. The facility was required to submit evidence of resolution within 30 days. Findings #3:

Allegation #4: A resident was left sitting at a table all day and was not repositioned.

On January 5, 2010 through January 6, 2010, an identified resident was observed sitting in the dining room and living room. Throughout both days staff were observed to assist him in and out of his wheelchair and in and out of the sofa.

On January 5, 2010 at 10:45 AM, three caregivers stated they make sure to change the resident's postition at least every one to two hours. They further stated the resident was able to make his needs known and he preferred sitting at the table in the dining room.

On January 5, 2010 at 10:05 AM, the resident stated the caregivers took good care of him and he liked sitting at the dining room table.

Unsubstantiated. Although the allegation may have occurred, it could not be determined during the complaint investigation.

The facility caregivers did not clean resident rooms on a weekly basis.

An unannounced onsite complaint investigation was conducted from January 5, 2010 - January 6, 2010. Observations, record review, and interviews were conducted with the following results:

Observations were conducted throughout the facility and resident rooms were found to be clean and tidy.

On January 5, 2010 between 10:00 AM and 12:00 PM, twenty residents were interviewed and stated their rooms were cleaned twice weekly when they were assisted with showers.

On January 5, 2010 at 10:10 AM, a caregiver stated, they clean rooms twice weekly when assisting residents with showers unless there was an emergency or unusual event. Most days they were able to clean residents' rooms as scheduled.

The facility's cleaning schedule was reviewed and documented residents' rooms were cleaned at least twice a week.

Unsubstantiated. Although the allegation may have occurred, it could not be determined during the complaint investigation.

If you have questions or concerns regarding our visit, please call us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerel

MATT HAUSER, QMRP

Team Leader

Health Facility Surveyor

Residential Assisted Living Facility Program

MH/sc

c:

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



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January 13, 2010

Administrator Kuna Living Center 194 West White Way Kuna, Idaho 83634

#### Dear Administrator:

On January 6, 2010, a complaint investigation survey was conducted at Kuna Living Center. The survey was conducted by Gloria Keathley, LSW, Matthew Hauser, QMRP, Rachel Corey, RN and Karen Anderson, RN. This report outlines the findings of our investigation.

### Complaint # ID00004411

Allegation #1:

Residents with diabetes were inappropriately given insulin when their blood glucose (BG) levels

were low.

Findings:

On January 5, 2010, four residents were observed being assisted with insulin. Residents were able to self inject their own insulin. Residents who were on sliding scale insulin were able to take their blood glucose, determine the units of insulin needed, dial the insulin pen and self inject their own insulin.

On January 5, 2010, five residents' records and medication assistance records (MAR) were reviewed. There was no documented evidence residents were given insulin when their BG was low.

On January 5, 2010 at 10:00 AM, 1 of 5 diabetic residents stated he had a low BG at one time and paramedics were called. He stated he took his set dose of insulin, but staff did not assist him with his sliding scale dose of insulin, because it was not required. He further stated he was capable of self-injecting insulin and would determine the needed dosage based on his sliding scale.

On January 5, 2010 at 11:40 AM, a caregiver stated she did not administer insulin to residents. She stated all residents who required insulin were able to self inject their medication.

On January 5, 2010 at 1:25 PM, the facility administrator stated she was not aware of insulin being administered when BG levels were low.

On January 5, 2010 at 12:10 PM, the facility nurse stated she was not aware of an incident where a resident was given insulin when the BG was low. She further stated residents received their set dose of insulin, but a sliding scale dose would not be given if their BG were low.

Administrator January 13, 2010 Page 2 of 2

On January 6, 2010 at 2:30 PM, another caregiver stated she did not administer insulin to residents. She stated residents self inject their own insulin. She further stated, if a resident's BG was low she would follow facility protocol of alerting 911 and the facility nurse. Additionally she stated, there was one instance when a resident required the paramedics to be called due to a low BG. The resident had been given his set dose of insulin prior to dinner, causing his BG to drop before dinner could be consumed. She denied assisting the resident with additional insulin futher stating, "unless he did it himself; we don't poke anyone. They must do it themselves."

Unsubstantiated. Although the allegation may have occurred, it could not be determined during the complaint investigation.

Allegation #2:

Staff were not delegated on insulin assistance by the nurse.

Findings:

On January 5, 2010, five staff records were reviewed and contained nurse delegation for assisting residents with insulin according to the facility's insulin protocol.

On January 5, 2010 at 10:10 AM, a caregiver stated she had been trained on diabetes and insulin issues during in-services held monthly. At 2:00 PM, the facility RN stated she delegates assistance with insulin after the caregivers had completed teaching modules on diabetes. Also, in-services are held monthly to ensure caregivers are continually educated.

On January 6, 2010 at 2:30 PM, a caregiver stated she had received diabetes education and delegation upon hire and periodically.

Unsubstantiated.

Allegation #3:

Staff administered injectable medications to residents.

Sfor

Findings:

Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.310.01.d for caregivers dialing the dose on insulin pens. 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) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,

MATT HAUSER, OMRP

Team Leader

Health Facility Surveyor

Residential Assisted Living Facility Program

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