IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

LESLIE M. CLEMENT - Administrator
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-5747
FAX: (208) 364-1811

August 25, 2010 **CERTIFIED MAIL #: 7009 0820 0000 2807 0074**

Lisa Fay, Administrator
Touchmark at Meadowlake Village – Touchmark of the Treasure Valley, LLC
650 South Arbor Lane
Meridian, ID 83642

Dear Ms. Fay:

Based on the state relicensure, follow-up, and complaint investigation survey conducted by our staff at Touchmark at Meadowlake Village - Touchmark of the Treasure Valley, LLC on **July 22, 2010,** we have determined that the facility failed to protect residents from inadequate care by failing to provide a secure environment for residents who were at risk for wandering and by failing to provide assistance and monitoring of medications.

This is the third time Touchmark at Meadowlake Village - Touchmark of the Treasure Valley, LLC has been cited for failing to provide assistance and monitoring of medications since 2008. The facility was first found to be providing inadequate care during the initial survey conducted on April 17, 2008. The facility was again found to be providing inadequate care during the follow-up survey conducted on December 3, 2008. The third instance of inadequate care was cited at the state relicensure, follow-up, and complaint investigation survey of July 22, 2010.

This core issue deficiency substantially limits the capacity of Touchmark at Meadowlake Village – Touchmark of the Treasure Valley, LLC to furnish services at an adequate level to ensure that residents' health and safety are safe-guarded. The deficiency is described on the enclosed Statement of Deficiencies. As a result of the survey findings, and the repeat nature of the deficiency, the Department is issuing the facility a **provisional license, effective August 30, 2010, through February 28, 2011**. The following administrative rule for Residential Care or Assisted Living Facilities in Idaho (IDAPA 16.03.22) gives the Department the authority to issue a provisional license:

> ***935. ENFORCEMENT REMEDY OF PROVISIONAL LICENSE.***
> *A provisional license may be issued when a facility is cited with one (1) or more core issue deficiencies, or when noncore issues have not been corrected or become repeat deficiencies. The provisional license will state the conditions the facility must follow to continue to operate. See Subsections 900.04, 900.05 and 910.02 of these rules.*

The conditions of the provisional license are as follows:

1. A registered nurse consultant, with considerable experience working as a residential care or assisted living facility nurse and/or a nurse in a long term care facility, will be obtained and paid for by the facility, and approved by the Department. This registered nurse consultant may not also be employed by the facility as a regular employee. The registered nurse consultant is to be allowed unlimited access to the facility and its systems for the provision of care to residents. The name of the consultant with the person's qualifications shall be submitted to the Department for approval no later than **September 4, 2010.**

2. The Department-approved consultant will submit a weekly written report to the Department commencing on September 10, 2010, and every Friday thereafter. The reports will address progress on correcting the deficiencies on the Statement of Deficiencies and the Non-Core Issues Punch List. When the consultant and the administrator agree the facility is in full compliance, they will notify the Department and a follow-up survey will be conducted.

3. The facility will maintain, on an ongoing basis, the deficient area in a state of compliance in accordance with the submitted Plan of Correction.

4. The provisional license shall be prominently displayed in the facility. Upon receipt of this provisional license, return the full license currently held by the facility to the Department.

5. Payment of imposed civil monetary penalties as described below:

   The following Administrative Rule for Residential Care or Assisted Living Facilities in Idaho gives the Department the authority to impose a civil monetary penalty for this violation:

   IDAPA 16.03.22.925. ENFORCEMENT REMEDY OF CIVIL MONETARY PENALTIES.

   01. Civil Monetary Penalties. *Civil monetary penalties are based upon one (1) or more deficiencies of noncompliance. Nothing will prevent the Department from imposing this remedy for deficiencies which existed prior to the survey or complaint investigation through which they are identified. Actual harm to a resident or residents does not need to be shown. A single act, omission or incident will not give rise to imposition of multiple penalties, even though such act, omission or incident may violate more than one (1) rule.*

   02. Assessment Amount for Civil Monetary Penalty. *When civil monetary penalties are imposed, such penalties are assessed for each day the facility is or was out of compliance. The amounts below are multiplied by the total*

number of occupied licensed beds according to the records of the Department at the time non-compliance is established.

b. *Repeat deficiency is ten dollars ($10).*

Based on the findings of the state relicensure, follow-up, and complaint investigation survey that Touchmark at Meadowlake Village – Touchmark of the Treasure Valley, LLC failed to protect residents from inadequate care, the Department is imposing the following penalty for the period of November 24, 2009, (see survey report) through July 22, 2010 (survey exit date):

Penalty	Number of Deficiencies	Times Number of Occupied Beds	Times Number of Days of Non-Compliance	Amount of Penalty
$10.00	1	63	235	$148,050

The maximum penalty allowed is $10,800 for each 90 day period. Two ninety day periods multiplied by $10,800 equals $21,600.

Send payment of $21,600.00 by check or money order, made payable to:

Medicaid Licensing and Certification
Department of Health and Welfare
P.O. Box 83720
Boise, ID 83720-0009

Payment must be received in full within (30) calendar days from the date this notice is received. Interest accrues on all unpaid penalties at the legal rate of interest for judgments. Failure of a facility to pay the entire penalty, together with any interest, is cause for revocation of the license.

Please be advised that you may contest this decision by filing a written request for administrative review pursuant to IDAPA 16.05.03.300 **no later than twenty-eight (28) days after this notice was mailed.** Any such request should be addressed to:

Randy May, Deputy Administrator
Division of Medicaid - DHW
P.O. Box 83720
Boise, ID 83720-0009

If you fail to file a request for administrative review within the time allowed, this decision shall become final.

You have an opportunity to make corrections and thus avoid further enforcement action. Correction of this deficiency must be achieved by **September 30, 2010.** **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 **September 9, 2010,** and keep a copy for your records. Your license depends upon the corrections made and the evaluation of the Plan of Correction you develop.

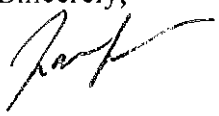
You have available the opportunity to question cited deficiencies through an Informal Dispute Resolution (IDR) process. If you disagree with the survey report findings, you may make a written request to the supervisor of the Residential Assisted Living Facility Program for an IDR meeting. The request for the meeting must be made within ten (10) business days of receipt of the statement of deficiencies (**September 9, 2010**). The specific deficiencies for which the facility asks reconsideration must be included in the written request, as well as the reason for the request for reconsideration. The facility's request must include sufficient information for Licensing & Certification to determine the basis for the provider's appeal. If your request for IDR is received after **September 9, 2010,** your request will not be granted. Your IDR request must me 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. The completed punch list form and accompanying proof of resolution (e.g., receipts, pictures, policy updates, etc.) are to be submitted to this office by **September 10, 2010**.

If at the follow-up survey it is found that the facility is not in compliance with the rules and standards for residential care or assisted living facilities, the Department will impose further enforcement actions which may include limiting admissions to the facility, additional civil monetary penalties, requiring the facility to hire additional consultants, and revocation of the license held by Touchmark at Meadowlake Village – Touchmark of the Treasure Valley, LLC.

Should you have any questions, or if we may be of assistance, please call our office at (208) 334-6626.

Sincerely,



JAMIE SIMPSON, MBA, QMRP
Supervisor
Residential Assisted Living Facility Program

JS/sm

Enclosures

cc: Randy May, Deputy Administrator, Division of Medicaid
Peg Dougherty, Deputy Attorney General, Office of the Attorney General
Cathy Hart, State Long-Term Care Ombudsman, Idaho Commission on Aging

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Post Office Box 83720
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PHONE: (208) 334-6626
FAX: (208) 364-1888

August 10, 2010

Lisa Fay, Administrator
Touchmark at Meadowlake Village
650 South Arbor Lane
Meridian, ID 83642

Dear Ms. Fay:

On July 22, 2010, a state relicensure and complaint investigation survey was conducted at Touchmark at Meadowlake Village - Touchmark of the Treasure Valley, LLC. The survey was conducted by Maureen McCann, RN; Donna Henscheid, LSW; and Karen Anderson, RN. This report outlines the findings of our investigation.

Complaint # ID00004484

Allegation #1: Medications were not given per physician's orders.

Findings #1: Substantiated. The facility received a core issue citation at IDAPA 16.03.22.520 for failure to provide appropriate assistance and monitoring of medications for an identified resident.

Allegation #2: The facility nurse did not review medication orders or notify the physician when orders needed to be clarified.

Findings #2: Substantiated. The facility received a core issue citation at IDAPA 16.03.22.520 for failing to provide appropriate assistance and monitoring of medications for an identified resident.

Allegation #3: The facility administrator did not investigate or follow-up on a family complaint.

Findings #3: Substantiated. The facility was cited at IDAPA 16.03.22.350.02 for the facility administrator failing to complete an investigation and failing to provide a written report of a complaint. Further, the facility was cited at IDAPA 16.03.22.350.04 for the administrator failing to provide the complainant a written response 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,

Karen Anderson, RN

KAREN ANDERSON, RN
Health Facility Surveyor
Residential Assisted Living Facility Program

KA/sm

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

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Dear Ms. Fay:

On July 22, 2010, a state relicensure and complaint investigation survey was conducted at Touchmark at Meadowlake Village - Touchmark of the Treasure Valley, LLC. The survey was conducted by Maureen McCann, RN; Donna Henscheid, LSW; and Karen Anderson, RN. This report outlines the findings of our investigation.

Complaint # ID00004581

Allegation #1: The facility nurse was not notified when an identified resident experienced a change in condition.

Findings #1: On July 21, 2010, at 11:07 a.m., the administrator stated that at the time of the incident the nurse was not in the building. The administrator stated she was called to the identified resident's room, believed the resident was in distress, and directed staff to call 911.

Substantiated. However, the facility was not cited as they responded appropriately by calling 911 and having the resident assessed by the EMTs.

Allegation #2: The facility did not appropriately supervise a cognitively impaired resident.

Findings #2: Substantiated. The facility received a core issue citation at IDAPA 16.03.22.520 for failure to appropriately supervise an identified resident with cognitive impairment.

Allegation #3: The facility gave a verbal report regarding a resident's health condition to an identified resident's family member that conflicted with the written report.

Findings #3: The complainant stated she was informed verbally via a phone call, by a facility representative on March 23, 2010, that the identified resident had been taken to the

hospital for a low grade fever. Further, she stated she was informed by a facility representative the next day, March 24, 2010, that the identified resident had been taken to the hospital because he was convulsing, turning purple and shaking violently.

On July 21, 2010, the identified resident's record was reviewed. There was no documented evidence of the verbal report given to the family member. However, a resident progress note, dated March 23, 2010, documented that the resident "was in fetal position, covered partially by a blanket looking as if he was having a convulsion."

A paramedics "Patient Care Form," dated March 24, 2010, at 11:57 a.m., documented, "Prior to arrival the PT (patient) oral temp was taken 99.1 degrees." The resident was found by EMTs "lying face down in bed covered with a heavy blanket. PT appears to be in no acute distress, shivers from time to time is somnolent but opens eyes when told to do so and responds to name." The resident was assessed to have "altered mental status secondary to viral syndrome. Hypotension secondary to dehydration or adverse reaction to medication." The EMTs assessed the resident and made the decision to transport the resident to the emergency department.

On July 21, 2010, at 11:10 a.m., the administrator stated she was called to the identified resident's room and observed the resident and thought he was having a convulsion. She directed staff to call 911. Further, she stated that the EMTs assessed him and made the decision to transport him to the hospital.

Unsubstantiated. Although the allegation may have occurred, it could not be verified by reviewing the facility documentation.

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,

Karen Anderson, RN

KAREN ANDERSON, RN
Health Facility Surveyor
Residential Assisted Living Facility Program

KA/sm

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

PRINTED: 08/24/2010
FORM APPROVED

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R894	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 07/22/2010
NAME OF PROVIDER OR SUPPLIER: TOUCHMARK AT MEADOWLAKE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE: 650 SOUTH ARBOR LANE MERIDIAN, ID 83642		

(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 000	Initial Comments The following deficiencies were cited during the standard survey, follow-up survey and complaint investigation conducted at your residential care/assisted living facility. The surveyors conducting the survey were: Karen Anderson, RN Team Coordinator Health Facility Surveyor Donna Henscheid, LSW Health Facility Surveyor Maureen McCann, RN Health Facility Surveyor Abbreviations: 0100 = 1:00 AM 0145 = 1:45 AM 0200 = 2:00 AM 0215 = 2:15 AM 0245 = 2:45 AM 0330 = 3:30 AM 0400 = 4:00 AM 0800 = 8:00 AM 1300 = 1:00 PM 1400 = 2:00 PM 1515 = 3:15 PM 1900 = 7:00 PM 2000 = 8:00 PM 2445 = 12:45 AM am = morning avabl = available BMP = behavior management plan BON = board of nursing BR = bathroom cart = medication cart CNA = certified nursing assistant	R 000	RECEIVED SEP 10 2010 FACILITY STANDARDS Karen Anderson 9/10/10	

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE ____ TITLE Administrator (X6) DATE 9/13/10

FOR 9/10/10

STATE FORM E00611 If continuation sheet 1 of 26

Bureau of Facility Standards

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R 000	Continued From page 1 EMT = emergency medical technician eve = evening LPN = licensed practical nurse MAR = medication assistance record med = medication meq = milliequivalents mg = milligrams noc = night NSA = Negotiated Service Agreement OOF = out of facility PDR = physician's desk reference PRN = as needed pt = patient / resident res = resident RN = Registered Nurse tab = tablet UAP = unlicensed assistive personnel w = with w/c = wheelchair wt = weight	R 000		
R 008	16.03.22.520 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. This Rule is not met as evidenced by: Based on observation, interview and record review, it was determined the facility did not provide an interior environment and exterior yard which was secure for 1 of 1 sampled residents who were cognitively impaired and at risk for elopement (Resident #1) and had the potential to affect six other sampled residents who were cognitively impaired. The facility did not appropriately assist with and monitor medications for 7 of 10 sampled residents (Residents #2, 3, 6,	R 008		

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R 008	Continued From page 2 7, 8, 9 and 10). Additionally, the facility did not provide adequate supervision to 1 of 7 sampled residents who were cognitively impaired (Resident #13). The findings include: I. SECURE ENVIRONMENT IDAPA 16.03.22.250.14 documents, "Secure Environment. If the facility accepts and retains residents who have cognitive impairment, the facility must provide an interior environment and exterior yard which is secure and safe." During two previous surveys, on 2/4/09 and 11/12/09, the facility's administrator was provided technical assistance regarding providing a "safe living environment" for residents that were cognitively impaired. Resident #1 was admitted to the facility on 2/2/08 with diagnoses which included Parkinson's disease and dementia. The facility nurse sent a fax, dated 4/13/10, to the resident's physician which documented the resident had increased confusion and the facility would like the physician to consider starting something for his "increasing dementia like Namenda or Aricept." Resident care notes were reviewed and the following was documented: *4/13/10, "...resident had displayed increased confusion. The physician was notified and new orders were received." *4/25/10, "...resident's confusion is not improving. He wakes up frequently in the middle of the night and thinks it's time to get up for the day. He will	R 008	Effective 9/9/2010 all fire exit doors ,dining room and resident patio doors are alarmed with audible alarm. Staff inservices are schedule for 9/10/2010 (Safe and Secure environment Exhibit 1). The facility will adhere to their admission, discharge and transfer criteria for appropriate resident placement (please see Exhibit 2 & 3) At the documentation in-service conducted on 8/10/2010, all staff have been instructed on the importance of notification of the nurse for any change of condition please see non core punch list submitted 8/20/2010 item 19. In addition the nursing consultant will give an inservice to all staff on BMP's/ COC the week on 9/15/2010. The BMP inservice will be given annually and at orientation.	

Bureau of Facility Standards

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	13R894		07/22/2010

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R 008	Continued From page 3	R 008		

get out of his wheelchair and lay on his closet floor."

*5/1/10, "...resident's confusion continues, frequently disoriented to time and place."

*5/16/10, "Resident was found in the back parking lot at 1:30 AM. He was confused why he was there or how he got there. CNA assisted him back to bed."

*5/22/10, "Resident was getting himself dressed at 3:00 AM and said he was leaving for home. It took staff several minutes to reorient him to place."

*6/12/10, "Resident had a fall at 24:45 [1:30 AM], outside his room in the parking lot." The resident was sent to emergency room with diagnosis of a hip fracture.

*7/13/10, "Resident readmitted to facility from (name of skilled nursing facility). Reoriented to room, activities, meals and call system."

On 4/13/10, the facility nurse sent a fax to Resident #1's physician requesting medication for the resident's increased confusion. Additionally, the facility implemented 30 minute safety checks. However, Resident #1 still managed to leave his room on two separate occasions, 5/16/10 and 6/12/10, unsupervised. When the resident wandered from his room on 6/12/10, he was found laying in the facility's parking lot by himself, confused, and injured with a fractured hip.

A surveyor from Licensing and Certification called the administrator, on 6/14/10, to provide technical assistance regarding the incident report sent on 6/12/10. The surveyor informed the administrator

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R 008	Continued From page 4 of the importance of re-assessing the resident to determine if the resident was appropriate for re-admission due to his increased confusion as the facility did not provide a secure interior and exterior yard. On 7/19/10 at 10:00 AM, during a tour of the facility, observation was made of Resident #1's room. A recliner was observed blocking the door leading from the resident's room to the patio. The patio area was open to the parking lot. There was no fence observed around the facility or parking lot to prevent the resident from wandering away. On 7/19/10 at 2:30 PM, an interview was conducted with Resident #1 and the resident's family member. The family member stated the recliner chair was placed in front of the door to prevent the resident from leaving the building through that door. The family member further stated, the resident would not be strong enough to move the chair to get outside using that door. On 7/19/10 at 2:50 PM, the administrator was informed the recliner chair could not block the door leading outside as it was against fire code. The administrator was further informed the facility must provide a secure environment when accepting and or retaining residents who had cognitive impairment. On three previous occasions, Licensing and Certification provided technical assistance to the facility regarding admitting or retaining residents with cognitive impairment. The last discussion occurred on 6/14/10 after Resident #1 had been found in the back parking lot at 1:30 AM with a fractured hip. The facility failed to provide Resident #1 with a secure interior and exterior environment. This failure resulted in inadequate	R 008	The recliner has been moved from in front of the patio door and an audible alarm has been placed	

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R 008	Continued From page 5 care and had the potential to affect all residents with cognitive impairment. II. ASSISTANCE AND MONITORING OF MEDICATIONS: A. Medications incorrectly transcribed on the MAR and incorrectly received by an identified resident. Resident #7 was admitted to the facility on 9/23/08 with diagnoses which included hypertension and primary open-angle glaucoma. An ophthalmologist's order, dated 11/24/09, documented the resident was to receive the following ophthalmic medications: *Trusopt 2%, 1 drop in both eyes twice daily *Lumigan, 1 drop in both eyes at bedtime *Combigan, 1 drop in both eyes twice daily The November 2009 MAR documented the following ophthalmic medications: *Trusopt 2%, 1 drop in both eyes three times daily *Lumigan, 0.03%, 1 drop in both eyes in the morning *brimonidine 0.2%, 1 drop in both eyes three times daily The MAR did not reflect the ophthalmologist's orders, when the Trusopt was changed from three to two times a day and the Lumigan was changed from the morning to the evening and a new medication, Combigan was added. A family practice physician order, dated 12/01/09, documented the resident was to receive the	R 008	All residents have been evaluated as of 9/6/2010 for cognitive skills for daily decision making to establish a base line. On a going forward basis nursing will be notified ~~for~~ of any residents change in condition and a comprehensive assessment will be completed by nursing to include the residents cognition status.	

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R 008	Continued From page 6 following orders: *Trusopt 2%, 1 drop in both eyes three times daily *Lumigan, 0.03%, 1 drop in both eyes in the morning The December 2009 MAR documented the following ophthalmic medications: *Trusopt 2%, 1 drop in both eyes three times daily *Lumigan, 0.03%, 1 drop in both eyes at 8:00 PM *brimonidine 0.2%, 1 drop in both eyes three times daily The MAR did not reflect the physician's order that the Lumigan be given in the morning. An ophthalmologist's order, dated 1/18/10, documented the following ophthalmic medications: *Trusopt 2%, 1 drop in both eyes twice daily *Lumigan 0.03%, 1 drop in both eyes at bedtime *Combigan, 1 drop in both eyes twice daily *Discontinue brimonidine (right eye) The January 2010 MAR documented the following ophthalmic medications: *Trusopt 2%, 1 drop in both eyes three times daily *Lumigan, 0.03%, 1 drop in both eyes in the PM *brimonidine 0.2%, 1 drop in both eyes three times daily The January MAR still did not reflect the physician's order, dated 12/1/09, that the Lumigan be given in the morning. The resident	R 008		

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NAME OF PROVIDER OR SUPPLIER TOUCHMARK AT MEADOWLAKE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 650 SOUTH ARBOR LANE MERIDIAN, ID 83642		

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R 008	Continued From page 7 continued to receive the medication in the evening instead of the morning. The January 2010 MAR, after the ophthalmologist's order dated 1/18/10, documented the following ophthalmic medications: *Trusopt 2%, 1 drop in both eyes twice daily *Lumigan, 0.03%, 1 drop in both eyes in the pm *Combigan, 1 drop in both eyes twice daily *brimonidine completely discontinued The January MAR did not reflect the ophthalmologist's order, that brimonidine be discontinued in the right eye only. A copy of the ophthalmologist's order was printed on 5/31/2010. Although the order was not dated, "2/24/10" was documented on the form as the last date one of the medications was filled. These orders documented: *Trusopt, 1 drop in both eyes twice daily *Lumigan 0.03%, 1 drop in both eyes at bedtime *Combigan, 1 drop in both eyes twice daily *brimonidine was not listed as a current medication. The February through May 2010 MARs documented the following ophthalmic medications: *Trusopt 2%, 1 drop in both eyes twice daily *Lumigan 0.03%, 1 drop in both eyes at bedtime *Combigan, 1 drop in both eyes twice daily *brimonidine was not documented on the MAR at all. From January 18, 2010 through May 31, 2010,	R 008		

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R 008	Continued From page 8 Resident #7's MARs did not reflect the ophthalmologist's order, dated 1/18/10, that brimonidine was to be discontinued in the right eye only. On 7/20/10 at 3:50 PM, a family member stated she had contacted the facility administrator and nurse several times trying to get Resident #7's medication changes correct after the new physician's order on 11/24/09. She stated the facility was receiving ophthalmic medication orders from the resident's primary provider who did not have current information from the resident's ophthalmologist; therefore, the orders had gotten mixed up. She stated she spoke to the nurse again on 1/11/10, trying to clarify the November orders. On 7/20/10, between 9:35 AM and 10:15 AM, the facility administrator and nurse stated a family member had voiced concerned about Resident #7 not receiving the correct eye drops. They further stated there was some confusion when trying to clarify the orders because the ophthalmologist and primary care physician had the same last name. The nurse stated he finally called both physicians to clarify the orders. The facility failed to appropriately assist with and monitor Resident #7's medication for at least 3 months, from 11/24/09 through 2/24/10, despite several attempts by a family member to get the facility to correct the situation. This failure resulted in inadequate care and had the potential to affect all residents assisted with medications. B. Unlicensed assistive personnel assisting with a non-routine medication without a required nurse assessment and documenting the wrong drug	R 008		

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R 008	Continued From page 9 name. Per the BON rules, IDAPA 23.01.01.490.06.a & b, unlicensed assistive personnel may not be delegated procedures involving acts that require nursing assessment or diagnosis, establishment of a plan of care or teaching, or the exercise of nursing judgment. Further, the BON rules documented "examples of procedures that should not be delegated to unlicensed assistive personnel include but are not limited to: vii. Assisting with either preparation or administration of non-routine medications." 1. Resident #10 was admitted to the facility on 7/25/09 with diagnoses which included dementia and depression. An NSA, dated 6/15/10, documented the resident had short-term memory loss and "age-related dementia." It further documented the resident required safety checks at night every 2 hours. A physician's order, dated 3/22/10, documented the resident was to receive the following medication: *lorazepam (Ativan) 0.5 mg, 1/2 tablet by mouth every four hours PRN. There was no documented evidence in the record the resident had an order for PRN Xanax. The resident's MAR documented the following from May to June, 2010: *5/06 - The resident received Ativan at 5:00 PM for being "restless."	R 008	The facility standard practice is to comply with the Board of Nursing rules, IDAPA 23.01.01.490.06 a & b "unlicensed personnel may not be delegated procedure involving acts that requires nursing assessments and diagnosis, establishment of a plan of care or teaching, or exercise nursing judgement".Nursing personel will review all residents on BMP's and their MAR's to ensure that PRN's are not given without nursing authorization. This audit will be conducted 1 x per week for the next three months and every quarter thereafter. This monitoring program is effective immediately. Point of clarification; resident number 10 did not receive Xanax. This was an error in the med tech documentation. Resident number 10 received Loarazapam (Ativan) 0.5 mg as ordered. Follow up has been done directly with those that charted incorrectly and pharmacy has been requested to include both generic and trade name on the MAR and med card to eliminate confusion.	

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R 008	Continued From page 10 *5/13 - The resident received Ativan at 0245 for being "restless." *5/15 - The resident received Xanax at 0145 for being "restless." *5/23 - The resident received Ativan at 0100 for being "restless." *6/07 - The resident received lorazepam at 0215 per her request for being "restless." *6/10 - The resident received lorazepam at 1.30 per family request for being "restless." *6/15 - The resident received Xanax at 1515 for "anxiety." *6/18 - The resident requested Ativan at 1900 for "anxiety." Caregiver notes documented the following from April to June, 2010: *4/01 - "Did not sleep good at all!!!! Was up off and on all night and paged (used pendent to call for staff) repeatedly!" "Paged several times about a program she was supposed to be to [sic] outside...confused. Came to dinner. After dinner she continued to page several times for no reason at all." *4/09 - "Went to dinner. Had a PRN adivan [sic]." *4/22 - "Had a PRN Ativan was on a roll this afternoon." *4/25 - "Was having a hard time falling asleep, kept paging & trying to get up to get dressed early in the night so I gave her a Xanax to help relax	R 008		

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R 008	Continued From page 11 and calm her down." *4/27 - "Did not sleep good at all, I gave her a Xanax and did not affect her a bit!!! Page off and on all night!!!" *5/06 - "...Put her to bed at 2000. She would not stop paging!!! As soon as someone would go in her room she would page 2 minutes later and not even need anything." *5/13 - "Up once to BR, 0400." *5/14 - "Did not sleep good at all, she wanted to get up at 0200, Every time I did her safety check she was sitting on the side of her bed." *5/23 - "Slept until 11:00. I let her sleep because NOC shift rpt (report) said she did not get to sleep until 0200." *6/06 - "Slept good until 0200 and assisted to restroom & she wanted to get up for the day and said was not tired. I gave her a lorazepam to help relax her and help sleep." *6/10 - "Pretty restless this evening. Paged several times for random things and she was wide awake every time I went in." *6/10 - "Our little Ms. [Resident #10's name] paged all stinkin [sic] night! Did not sleep at all." *6/15 - "Lots of pages this afternoon, had PRN Xanax." *6/18 - "Slept all day until about 1800. Paged sooo [sic] much today! Very confused." There was no documented evidence the nurse	R 008		

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R 008	Continued From page 12 had been contacted to assess the resident before the unlicensed assistive personnel assisted the resident with a non-routine medication. There was no documentation elaborating what behavior the resident was displaying when she was "anxious" or "restless". On 7/21/10, there was no Xanax observed in the medication cart for Resident #10. Between 7/19/10 and 7/21/10, three caregivers interviewed stated stated they did not contact the nurse prior to giving non-routine medications to residents. On 7/20/10 at 9:40 AM, the facility RN stated, he was not aware caregivers were not allowed to give non-routine medication to a cognitively impaired resident who was unable to request the medication herself. 2. Resident #3 was admitted on 9/22/08 with diagnoses which included dementia. The resident's NSA, dated 5/20/10, documented the following: "Behavioral Health: [Resident's name] has become verbally aggressive towards staff and will need to be redirected...She has a behavior log." A physician's order, dated 12/17/09, documented the following medication: *Alprazolam [Xanax] 0.5 mg. Take 1 tab by mouth twice daily as needed." Between 5/1/10 and 7/20/10, Resident #3's MARs documented the resident received PRN Xanax 49 times in 75 days. The reasons	R 008	Nursing personnel will monitor the facilities communication tool daily to be aware of any resident changes and follow up appropriately. At the documentation in-service conducted on 8/10/2010, all staff have been instructed on the importance of notification of the nurse for any change of condition please see non core punch list submitted 8/20/2010 item 19. In addition the nursing consultant will give an inservice to all staff on BMP's/ COC the week on 9/15/2010. The BMP inservice will be given annually and at orientation.	

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R 008	Continued From page 13 documented were the resident had anxiety, confusion, aggression and was weepy, moody and crying. Care notes, dated 4/7/10 through 6/23/10, documented the following: *4/7/10, "Went to bed at 9. Had a prn Xanax before bedtime because she was really agitated and crabby." *4/15/10, "Really emotional this morning, (caregiver's name) had to give her a Xanax at 6:30. Better at 7 when I got her up and ready..." *4/21/10, "Holy Cow, was she in a mood. Told (caregiver's name) and I off after she had a Xanax about an hour earlier." *4/2/10, "Confused and doing the fake cry thing a couple of times, but she is ok." *4/27/10, "Oh just swell. Thought she was going to have a conniption about making it to talk group...She got there just fine!" *4/28/10, "Doing the fake cry thing a couple times, but she is fine, Xanax at 0330 because she wanted to get outta here and couldn't remember living here." *5/10/10, "(Resident's family member) requested a PRN for her." *5/14/10, "...Got mad and yelled at me to be fired. So I walked out for a min while she was in her w/c. Then she yelled for a cup and I got her water then she all but threw it back at me. Anyway...long story short...she got a Xanax!!!"	R 008		

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R 008	Continued From page 14 *5/16/10, "...Had a pretty good day until this afternoon, when she was getting angry with (caregiver's name), so she bought herself a Xanax!" *5/17/10, "Grumpy today, had a Xanax this evening..." *5/19/10, "Was having kinda a rough night and then got a Xanax..." *5/20/10, "...Grumpy and had a Xanax..." *5/21/10, "...Really emotional tonight, was upset about not going on bus ride...Gave Xanax with evening pills." *5/22/10, "...Paged all night, think she was very confused, more than normal, gave her a Xanax, did not give her anxiety much relieve (sic) tonight." *5/25/10, "Gave Xanax at lunch...Eve had a Xanax..." *5/26/10, "Xanax didn't seem to phase her. Very confused..." *6/8/10, "She is agitated verbally but not physically. She almost acts like she is drunk, she is slurring her words, can't bare (sic) wt, and just plain acting weird..." *6/22/10, "Took a shower early this morning, was not happy about not attending the 9:30 activity. Had a Xanax at lunch..." There was no documented evidence the nurse had been contacted to assess the resident before the unlicensed assistive personnel assisted the	R 008		

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R 008	Continued From page 15 resident with a non-routine medication. Additionally, there was no documentation elaborating what behavior the resident was displaying when she was "anxious, confused, aggressive, grumpy or was weepy, moody or crying." Between 7/19/10 and 7/21/10, three caregivers interviewed stated when Resident #3 got really anxious and/or aggressive they would give her a Xanax and most of the time it helped. They further stated they did not contact the nurse prior to giving the resident Xanax. On 7/20/10 at 9:40 AM, the facility RN stated, Resident #3 had a lot of anxiety and could be difficult. He stated the resident had an order for Xanax that could be given twice daily as needed for anxiety. He further stated, caregivers did not call him before using Xanax. He confirmed he was not aware caregivers were not allowed to give PRN Xanax to a cognitively impaired resident who was unable to request the medication herself. The facility failed to appropriately assist and monitor Resident #3's and #10's medications when UAPs assisted cognitively impaired residents with non-routine medications without seeking direction from the facility nurse. Further, there was no evidence Resident #10 had an order for PRN Xanax although it was repeatedly documented by the UAPs. This failure resulted in inadequate care and had the potential to affect all cognitively impaired residents assisted with medications. C. Medications were not available in the facility	R 008	Nursing personnel will monitor the facilities communication tool daily to be aware of any resident changes and follow up appropriately. At the documentation in-service conducted on 8/10/2010, all staff have been instructed on the importance of notification of the nurse for any change of condition please see non core punch list submitted 8/20/2010 item 19. In addition the nursing consultant will give an inservice to all staff on BMP's/ COC the week on 9/15/2010. The BMP inservice will be given annually and at orientation.	

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R 008	Continued From page 16 per physician's orders. 1. Resident #6 was admitted to the facility on 2/5/08 with diagnoses which included hypertension, coronary artery disease and status post coronary artery bypass graft. Physician orders, dated 6/8/10, documented the resident was to receive the following medications: *isosorbide mononitrate 30 mg., one tablet daily *glucosamine 500 mg., one capsule twice daily *potassium chloride 8 meq., one tablet daily *Oyst-Cal 500 mg., one tablet twice daily The July 2010 MAR documented the resident did not receive the following medications: *7/1 through 7/16 - isosorbide mononitrate *7/1 - potassium chloride *7/3 (PM dose) - glucosamine *7/4 (AM & PM dose) - glucosamine *7/5 (AM dose) - glucosamine *7/6 (AM dose) - glucosamine and Oyst-Cal *7/7 (AM & PM dose) - glucosamine The back of the July MAR contained the following documentation from medication assistants: *7/1 - isosorbide mononitrate and potassium chloride - waiting for pharmacy to deliver *7/3 - glucosamine - medication not available *7/4 - glucosamine - medication not available *7/5 - glucosamine - medication not available *7/5 - isosorbide - medication not available, waiting for pharmacy *7/6 - glucosamine and Oyst-Cal - medications not available *7/7 - isosorbide - waiting for medication to be delivered	R 008	It is the standard practice that all Physician orders are received by licensed nursing personnel. Nursing personell will monitor new or changes in medication orders daily to confirm receipt of medications in a 24 hour period once the order has been faxed to pharmacy. Medication tech's will notify nursing personnel of any medications not given. Nursing personnel will notify the residents physician that medication had not been received. Administration will randomly audit MARS for compliance	

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R 008	Continued From page 17 *7/7 - glucosamine - medication not delivered yet - not given *7/7 - glucosamine - waiting on doctor order - waiting on pharmacy - not given *7/12 - isosorbide - medication not delivered, reordered today A fax from the pharmacy, dated 7/8/10, documented the resident's physician would not authorize a refill of the isosorbide because the physician hadn't "seen pt. in a long time." This fax came 7 days after the resident had been without the isosorbide. Isosorbide mononitrate is used to treat hypertension and when not given, a resident is at risk to have an elevated blood pressure. According to the "PDR 2010 Edition Nurse's Handbook", anyone taking this medication should be counseled to "carefully follow the dosing regimen." There was no documented evidence the facility nurse had been notified the resident had not received the medications. There was no documented evidence the nurse provided instruction to staff or contacted the physician regarding the missed medications. A July 2010 vitals sheet documented the resident's blood pressure was to be taken weekly on Thursday evenings. No blood pressure readings were documented for the first two weeks in July during the time the isosorbide was not given. On 7/20/10 at 9:30 AM, a caregiver stated she had a "hard time" getting the resident's isosorbide.	R 008	It is the standard practice that all Physician orders are received by licensed nursing personnel. Nursing personell will monitor new or changes in medication orders daily to confirm receipt of medications in a 24 hour period once the order has been faxed to pharmacy. Medication tech's will notify nursing personnel of any medications not given. Nursing personnel will notify the residents physician that medication had not been received. Administration will randomly audit MARS for compliance	

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R 008	Continued From page 18 On 7/20/10 at 9:50 AM, a caregiver stated there was "no sheet for blood pressure on her. They've been missed." On 7/21/10 at 3:15 PM, the facility LPN confirmed the resident had not received medications as ordered. The LPN stated there should be a vitals sheet in the resident's record with her blood pressure readings. On 7/21/10 at 3:50 PM, the administrator stated the facility was having difficulty getting medications from the pharmacy. 2. Resident #2 was admitted to the facility on 4/22/10 with diagnoses which included atrial fibrillation, osteoporosis and hypertension. A physician's order, dated 6/4/10, documented the resident was to receive the following medications: *Mucinex ER 600 mg., one to two tablets every 12 hours A physician orders, dated 6/22/10, documented the resident was to receive the following medications: *carvedilol 6.25 mg., one tablet twice daily *alendronate 70 mg., one tablet once each week on Saturday The June 2010 MAR documented the resident did not receive the following medications: *6/1 - carvedilol *6/19 - alendronate *6/25 (PM dose) - Mucinex *6/26 (AM & PM dose) - Mucinex	R 008	It is the standard practice that all Physician orders are received by licensed nursing personnel. Nursing personell will monitor new or changes in medication orders daily to confirm receipt of medications in a 24 hour period once the order has been faxed to pharmacy. Medication tech's will notify nursing personnel of any medications not given. Nursing personnel will notify the residents physician that medication had not been received. Administration will randomly audit MARS for compliance	

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	13R894		07/22/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHMARK AT MEADOWLAKE VILLAGE	650 SOUTH ARBOR LANE MERIDIAN, ID 83642

(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 19 *6/27 (AM & PM dose) - Mucinex *6/28 (AM dose) - Mucinex The back of the June 2010 MAR contained the following documentation from medication assistants: *6/1 - carvedilol - medication not delivered - not given *6/5 - Mucinex - not available - not given *6/19 - alendronate - not available - not given *6/25 - Mucinex - waiting on pharmacy - not given *6/26 - Mucinex - medication not available - not given *6/26 - Mucinex - medication not available - not given *6/27 - Mucinex - medication not available - not given *6/28 - Mucinex - medication not available - not given There was no documented evidence the facility nurse had been notified the resident had not received the medications. There was no documented evidence the nurse provided instruction to staff or contacted the physician regarding the missed medications. 3. Resident #3 was admitted on 9/22/08 with diagnoses which included dementia, osteoporosis and right tibia fracture. Physician's orders, dated 12/17/09, documented the resident was to receive the following medications: *Advair 100/50 diskus, inhale 1 puff twice daily Physician's orders, dated 11/30/09, documented the resident was to receive the following	R 008	It is the standard practice that all Physician orders are received by licensed nursing personnel. Nursing personell will monitor new or changes in medication orders daily to confirm receipt of medications in a 24 hour period once the order has been faxed to pharmacy. Medication tech's will notify nursing personnel of any medications not given. Nursing personnel will notify the residents physician that medication had not been received. Administration will randomly audit MARS for compliance	

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	13R894		07/22/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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R 008	Continued From page 20 medications: *Tramadol 50mg every 4 hours for 7 days Physician's orders, dated 6/4/10, documented the resident was to receive the following medications: *Celexa 10mg by mouth daily Physician's orders, dated 6/4/10, documented the resident was to receive the following medications: *triamcinolone 0.17% apply to affected area three times daily *6/18 - Advair *6/7 - Tramadol - (4:00 PM and 8:00 PM doses) *6/6 - triamcinolone (2:00 PM and 8:00 PM) *6/7 - triamcinolone (8:00 AM and 2:00 PM) The back of the June 2010 MAR contained the following documentation from medication assistants: *6/18 - Advair - "not in cart" *6/7 - Tramadol (3 doses, no times documented) - "med not avabl" *6/6 - Celexa - "not avabl" *6/6 - triamcinolone (2:00 PM and 8:00 PM) - "not avabl" *6/7 - triamcinolone (8:00 AM) - "not delivered yet" *6/7 - triamcinolone (2:00 PM and 8:00 PM) - "not avabl" There was no documented evidence the facility nurse had been notified the resident had not received the medications. There was no documented evidence the nurse provided instruction to staff or contacted the physician	R 008	It is the standard practice that all Physician orders are received by licensed nursing personnel. Nursing personell will monitor new or changes in medication orders daily to confirm receipt of medications in a 24 hour period once the order has been faxed to pharmacy. Medication tech's will notify nursing personnel of any medications not given. Nursing personnel will notify the residents physician that medication had not been received. Administration will randomly audit MARS for compliance	

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NAME OF PROVIDER OR SUPPLIER: TOUCHMARK AT MEADOWLAKE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE: 650 SOUTH ARBOR LANE MERIDIAN, ID 83642		

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R 008	Continued From page 21 regarding the missed medications. 4. Resident #8 was admitted to the facility on 4/1/10 with diagnoses which included deep vein thrombosis and myocardial infarction with stent. Physician's orders, dated 3/11/10, documented the resident was to receive the following medications: *Plavix 75 mg., by mouth once daily Physician's orders, dated 4/6/10, documented the resident was to receive the following medications: *simvastatin 10 mg., by mouth once daily *Seroquel 25 mg., by mouth at bedtime The May 2010 MAR documented the resident did not receive the following medications: *5/1 - Plavix and simvastatin *5/2 - Plavix *5/4 & 5/5 - Plavix *5/7 - Plavix *5/9 through 5/12 - Plavix *5/28 - Seroquel The back of the May MAR contained the following documentation from medication assistants: *5/1 - Plavix - no documentation and simvastatin - no documentation *5/2 - Plavix - no documentation *5/4 & 5/5 - Plavix - "waiting on pharmacy" *5/7 - Plavix - no documentation *5/9 through 5/12 - Plavix - no documentation *5/29 - Seroquel - "med not available" There was no documented evidence the facility	R 008	It is the standard practice that all Physician orders are received by licensed nursing personnel. Nursing personell will monitor new or changes in medication orders daily to confirm receipt of medications in a 24 hour period once the order has been faxed to pharmacy. Medication tech's will notify nursing personnel of any medications not given. Nursing personnel will notify the residents physician that medication had not been received. Administration will randomly audit MARS for compliance	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHMARK AT MEADOWLAKE VILLAGE	650 SOUTH ARBOR LANE MERIDIAN, ID 83642

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R 008	Continued From page 22 nurse had been notified the resident had not received the medications. There was no documented evidence the nurse provided instruction to staff or contacted the physician regarding the missed medications. 5. Resident #9 was admitted to the facility on 9/1/09 with diagnoses which included stroke with right sided weakness. Physician's orders, dated 3/11/10, documented the resident was to receive the following medication: * Forical 200 units nasal spray - use 1 spray alternating nostrils daily The June 2010 MAR documented the resident did not receive the following medication: *6/1 through 6/4 - Forical *6/29 and 6/30 - Forical The back of the June MAR contained the following documentation from medication assistants: *6/1 through 6/3 - Forical - "waiting on pharmacy" *6/4- Forical - no documentation *6/29 and 6/30 - "waiting on pharmacy" There was no documented evidence the facility nurse had been notified the resident had not received the medications. There was no documented evidence the nurse provided instruction to staff or contacted the physician regarding the missed medications. On 7/21/10 at 4:55 PM, the facility administrator confirmed, the facility was changing pharmacies	R 008	It is the standard practice that all Physician orders are received by licensed nursing personnel. Nursing personell will monitor new or changes in medication orders daily to confirm receipt of medications in a 24 hour period once the order has been faxed to pharmacy. Medication tech's will notify nursing personnel of any medications not given. Nursing personnel will notify the residents physician that medication had not been received. Administration will randomly audit MARS for compliance	

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NAME OF PROVIDER OR SUPPLIER: TOUCHMARK AT MEADOWLAKE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE: 650 SOUTH ARBOR LANE MERIDIAN, ID 83642		

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R 008	Continued From page 23 due to problems they had been having with one particular pharmacy. The facility failed to assure medications were available per physicians' orders for Resident's #2, 3, 6, 8 and 9. This failure resulted in inadequate care and had the potential to affect all residents assisted with medications. THIS IS THE THIRD TIME THE FACILITY HAS BEEN CITED FOR ASSISTANCE AND MONITORING OF MEDICATION. III. SUPERVISION Residents #13 and #14 were a married couple admitted to the facility on 4/26/09. Resident #13 was admitted with diagnoses which included dementia. Resident #14 was admitted with diagnoses which included Type I diabetes mellitus and angina. On 12/10/09, the court appointed guardians for Resident #13 and Resident #14 after each had been found to be an "Incapacitated Person." Resident #13's NSA, dated 2/11/10, documented the resident was oriented to time and place, had modified independence with decision-making and had difficulty in new situations. Resident #14's NSA, dated 2/12/10, documented the resident was oriented to time and place. Caregiver notes documented the following regarding Resident #13: 3/5/10 - "...confused when I took her her 1300 pill. Didn't understand why she had to take it."	R 008	Touchmark Regional Nurse Consultant will perform a quarterly audit for the next 12 months to assure compliance with the above stated POC. As a result of this incident the facility has implemented a policy to ensure staff members will accompany a resident to the hospital and stay with them until a family member or designee arrives. Please see exhibit 4	

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NAME OF PROVIDER OR SUPPLIER TOUCHMARK AT MEADOWLAKE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 650 SOUTH ARBOR LANE MERIDIAN, ID 83642		

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R 008	Continued From page 24 3/10/10 - "Was slightly confused this morning but [Resident spouse's name] redirected her without staff input." 3/11/10 - "Other than some confusion, she is doing well." 3/15/10 - "Very confused today on times and different things going on." 3/16/10 - "Very confused this morning!" 3/18/10 - "Everyday she seems a little more off." 3/23/10 - "Good this am then went OOF with husband." A care note, dated 3/23/10, documented "Before notifying [caregiver's name], I did tell [Resident #13's name] we had to send him (the resident's spouse) to the hospital is that OK with you? She stated yes but can I go w' (with) him. I told her yes." A "Caregiver Incident" note, dated 3/23/10, documented Resident #14 had a "massive tremor, clenched up and groaned." The administrator was contacted and instructed the caregiver to send him out by non-emergency transport. The resident was transported to the hospital and Resident #13 "accompanied them." An e-mail from a staff member to the administrator, dated 3/24/10, documented a family member "was extremely irate stating no one was at the hospital with her parents when she arrived..." Further it documented the family member "was told a staff member from the [name of facility] would stay with her parents until she got there. To my knowledge no one from the	R 008		

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R 008	Continued From page 25 [name of facility] ever stated that a staff member would accompany the [last name of Residents #13 and #14] to the hospital." On 7/21/10 at 11:07 AM, the administrator stated Resident #13 asked to go with her husband, which she had done in the past. The administrator stated she met with the family after the event and confirmed the family was "not happy" the facility allowed the resident to go to the hospital unsupervised. The administrator confirmed the resident was not appropriate to be left unsupervised but thought is was "okay" because the resident was with her husband and the EMTs. Resident #14, who was deemed legally incapacitated by the court, was treated for "altered mental status" by the EMTs and hospital emergency department and was not capable of supervising Resident #13. The facility did not provide appropriate supervision to Resident #13 when they allowed her to leave the facility without facility staff. This failure resulted in inadequate care. The facility retained a cognitively impaired resident (Resident #1) and failed to provide him with a secure interior and exterior environment. The facility failed to appropriately assist with and monitor medications for Resident's #2, 3, 6, 8, 9 and 10. Further, the facility did not provide appropriate supervision to Resident #13 deemed to be an incapacitated individual by the court. These failures resulted in inadequate care.	R 008		

IDAHO DEPARTMENT OF HEALTH & WELFARE

MEDICAID LICENSING & CERTIFICATION - RALF
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
Touchmark at Meadowlake	650 S. Arbor Lane	319-5400
Administrator	**City**	**Zip Code**
Lisa Fay	Meridian	83642
Team Leader	**Survey Type**	**Survey Date**
Karen Anderson	Relicensure + Complaint	~~07/22/10~~ 8/22/10

NON-CORE ISSUES

Item #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	L&C USE
1	.009	One of 10 staff records reviewed did not have evidence of a criminal history background check. REPEAT PUNCH12/3/08	8/20/10 KA	
2	.009.06.c	One of 10 staff did not have a state police only background check	8/20/10 KA	
3	225	Resident #'s 1, 6 & 10 did not have behavior management plans. REPEAT PUNCH 11/12/09	9/10/10 KA	
4	300.01	Five of 5 caregivers did not have delegation for nursing tasks. REPEAT PUNCH 4/17/08	9/10/10 KA	
5	305.02	Eight of 10 sampled residents did not have all PRN medications available as ordered. REPEAT PUNCH 4/17/08	8/20/10 KA	
6	305.03	The facility nurse did not assess Resident #1 when he had a change in condition, and when he was re-admitted to the facility. The	9/10/10 KA	
		facility contacted the hospice nurse when resident #10 had a fall. Resident #5's hospice record directed caregivers to call hospice		
		nurse for falls		
7	310.04.3	Resident #'s 1, 3, 10 did not have a six month psychotropic medication review by the physician or authorized provider	8/20/10 KA	
8	320	The facility did not update Resident #1's NSA when he had a significant change in condition. Nor did they have an interim plan of	8/20/10 KA	
		care or updated NSA when he was re-admitted to the facility. Resident #4's NSA did not include her use of a walker. REPEAT PUNCH		
		4/17/08, 12/3/08, 2/4/08,		
9	335.03	The facility did not provide liquid hand soap or paper towels for caregiver to wash hands between resident care.	9/10/10 KA	
10	350.02	The facility administrator did not complete an investgation and written report of complaints.	8/20/10 KA	
11	350.04	The administrator did not provide a written response to complainants.	8/20/10 KA	

Response Required Date	Signature of Facility Representative	Date Signed
~~8/20/10~~ 8/21/10		7/22/10

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Administrator	**City**	**Zip Code**
Lisa Fay	Meridian	83642
Team Leader	**Survey Type**	**Survey Date**
Karen Anderson	Relicensure + Complaint Follow-ups	~~07/21/10~~ 7/22/10

NON-CORE ISSUES

Item #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	L&C USE
12	451.02	The facility did not offer snacks in between meals and at night.	8/20/10	KA
13	625.01	A new hired caregiver was providing unsupervised personal assistance to residents before completing 16 hours of orientation	8/20/10	KA
14	625.03	Ten of 10 staff records did not contain all required contents for orientation training	8/20/10	KA
15	630.01	Ten of 10 staff did not have dementia training REPEAT PUNCH 4/17/08	8/20/10	KA
16	630.02	Ten of 10 staff did not have mental illness training	8/20/10	KA
17	630.03	Ten of 10 staff did not have developmental disability training	8/20/10	KA
18	640	Six o f 10 staff did not have documented evidence of 8 hours of CEUs	8/20/10	KA
19	711.08	All documentation on care notes were not consistently signed and dated	8/20/10	KA
20	305.06	The nurse did not assess Resident #7's ability to self administer his own medication REPEAT PUNCH 4/17/08	8/20/10	KA

Response Required Date	Signature of Facility Representative	Date Signed
~~8/20/10~~ 8/21/10		7/22/10

Date 7/21/10 Page 1 of 1

IDAHO DEPARTMENT OF HEALTH & WELFARE

Food Establishment Inspection Report

Food Protection Program, Office of Epidemiology
450 West State Street, Boise, Idaho 83702 208-334-5938

Establishment Name: Meadowlake Touchmark at	Operator: Lisa Fay
Address: 650 S Arbor LN	City: Meridian Zip: 83642
County: ADA Estab #: EHS/SUR.#: 208238	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	Good Retail Practices
# 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

	Demonstration of Knowledge (2-102)	COS	R
(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	☐	☐
(Y) N	6. Bare hand contact with ready-to-eat foods/exemption (3-301)	☐	☐
(Y) N	7. Handwashing Facilities (5-203 & 6-301)	☐	☐
	Approved Sources		
(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)	☐	☐

	Potentially Hazardous Food Time/Temperature	COS	R
(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 (3-401)	☐	☐
(Y) N N/O N/A	17. Cooling (3-403)	☐	☐
(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)	☐	☐
Y N N/O N/A	**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 (3-202.12)	☐	☐
(Y) N	25. Toxic substances properly identified, stored, used (7-101 through 7-301)	☐	☐
	Conformance with Approval 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
soup	140	fruit	40				
hashbrowns	138	chicken salad	40				

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 cooking	☐	☐	☐	46. Utensils & 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): [signature] (Print): Lisa Fay Title: HSA Date: 7/22/10

Inspector (Signature): Karen Anderson (Print): Karen Anderson Date: 7/21/10

Follow-up: (Circle One) Yes No