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 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888

January 11, 2010

CERTIFIED MAIL #: 7005 1160 0000 1506 8325

Heather Halverson, Administrator
Overland Court Generations Memory Care
10172 West Smoke Ranch Drive
Boise, Idaho 83709

Dear Ms. Halverson:

Based on the complaint investigation conducted by our staff at Overland Court Generations Memory Care on **December 28, 2009,** we have determined that the facility failed to protect residents from inadequate care. Based on record review and staff interview it was determined the facility failed to ensure resident rights to privacy for 1 of 18 sampled residents (#18) whose medical treatment and personal information was provided to other residents' family members.

This core issue deficiency substantially limits the capacity of Overland Court Generations Memory Care to furnish services of an adequate level or quality to ensure that residents' health and safety are safe-guarded. 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 **February 11, 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)?
- What date will the corrective action(s) be completed by?

Return the **signed** and **dated** Plan of Correction to us by **January 24, 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 process. If you disagree with the survey report findings, you may make a written request to the Supervisor of the Residential Care Program for a Level 1 IDR meeting. The request for the meeting must be made within ten (10) business days of receipt of the statement of deficiencies (**January 24, 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 informal dispute resolution is received after **January 24, 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 **January 27, 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 have no alternative but to initiate an enforcement action against the license held by Overland Court Generations Memory Care.

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
Program Supervisor
Residential Assisted Living Facility Program
Medicaid Licensing & Certification

JS/sc

Enclosure

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13R972	A. BUILDING _____ B. WING _____	C 12/28/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OVERLAND COURT GENERATIONS MEMORY	10172 WEST SMOKE RANCH DRIVE BOISE, ID 83709

(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 deficiency was cited during the complaint investigation conducted at your residential care/assisted living facility. The surveyors conducting the survey were: Rae Jean McPhillips, RN Team Coordinator Health Facility Surveyor Karen Anderson, RN Health Facility Surveyor Matt Hauser, QMRP Health Facility Surveyor Polly Watt-Geier, MSW Health Facility Surveyor Rachel Corey, RN Health Facility Surveyor Gloria Keathley, LSW Health Facility Surveyor Abbreviations used in the report: apt = apartment apts = apartments conf = conference Dec = December i.e. = in other words med = medication meds = medications Oct = October w/ = with	R 000		
R 008	16.03.22.520 Protect Residents from Inadequate Care.	R 008		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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R 008	Continued From page 1 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 record review and staff interview it was determined the facility failed to ensure resident rights to privacy for 1 of 18 sampled resident (#18) whose medical treatment and personal information was provided to other residents' family members. The findings include: Resident #18 was admitted to the facility on 10/23/09. Licensing and Certification received a copy of a document, on 12/15/09, that was titled "[Resident #18's name] Log". The "Log" was written by another resident's family member which documented staff conversations that revealed Resident #18's personal and medical information. The "Log" documented the following statements made by the facility's staff to another resident's family: * 10/31/09 - "Conf w/caregivers: [Resident #18's name] cannot be redirected; takes 2-3 care givers to handle her; combative, harassing other residents, takes walkers away from residents, takes food off their plates, takes their drinks, will not stay seated at dining table; state that family in denial; caregivers have reported facts and concerns to nursing staff." Also "...facility is addressing issues; faxed request for medication order to [Resident #18's name] doctor late Friday afternoon; [staff's name] will call doctor's on call to see if medication was prescribed..."	R 008		

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R 008	Continued From page 2 * 11/1/09 - "[Staff's name] said other family members had also contacted [staff's name] on Saturday afternoon complaining about [Resident #18's name] harassing their loved ones in the memory unit." * 11/2/09 - "...facility received med from pharmacy and she is monitoring [Resident #18's name] condition/behavior, [Resident #18's name] is angry; [Resident #18's name] has a two week 'window' for temporary stay at facility..." * 11/7/09 - "...caregiver said she heard today [Resident #18's name] was only staying at facility for one week?" * 11/8/09 - "...caregiver said [Resident #18's name] is not a good fit with other residents..." and "...[Resident #18's name] has been taking residents' name plates from apt doors..." * 11/9/09 - "...have to wait to see if meds will calm [Resident #18's name] and keep her from harassing other residents." * 11/10/09 - "...caregiver said everyday is a different situation with [Resident #18's name] anti-social behavior, caregivers are documenting everything, says [Resident #18's name] is in the wrong type of facility." * 11/11/09 - "...caregivers report she still is taking walkers and food from plates of other residents..." * 11/13/09 - "...per caregivers, [Resident #18's name] is still harassing other residents taking walkers, going into other apts..." * 11/20/09 - "...facility is working hard on the issue	R 008		

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R 008	Continued From page 3 and with [Resident #18's name] doctor for increased medications and giving caregivers more training to re-direct [Resident #18's name] more 'effectively'." * 11/27/09 - "...[staff's name] said that [Resident #18's name] had ransacked [random resident's name] apt yesterday; [Resident #18's name] wandering; tried to take lamp again, could not be re-directed; [staff's name] agreed that behaviors have not changed since Oct 31." * 11/30/09 - "...[Resident #18's name] doctor is reluctant to increase the meds..." * 12/4/09 - "[Staff's name] said [Resident #18's name] medication was increased from 1 to 3 doses a day on Dec 3 but her behavior continues to be anti-social, i.e., no change." And "[Staff's name] said difficult residents with behaviors that are untreated or meds are not calming are a threat to all the other residents, i.e., a safety issue. She wondered why the State had not been contacted about these problems that have been going on with [Resident #18's name] for almost 6 weeks." * 12/6/09 - "...this weekend was [Resident #18's name] last chance, the increase in medications has not decreased anti-social behaviors and [Resident #18's name] will be moved to [geriatric psychiatric hospital name] on Monday or Tuesday." * 12/8/09 - "...caregiver said [Resident #18's name] was moved to [geriatric psychiatric hospital name] on Monday for supposedly at least two weeks..." On 12/23/09 at 11:35 AM, both the facility's	R 008		

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R 008	Continued From page 4 administrator and director confirmed staff had relayed confidential and private information about Resident #18 to other residents' families. The facility failed to ensure Resident #18's right to privacy and confidentiality. This failure 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
Overland Court Generations Memory Care	10172 west Smoke ranch Drive	322-0955
Administrator	**City**	**Zip Code**
Heather Halverson	Boise	83709
Team Leader	**Survey Type**	**Survey Date**
RaeJean McPhillips	Complaint	12/28/09

NON-CORE ISSUES

Item #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	L&C USE
1	250.04	Laundry detergent and cleaning supplies were not stored in a locked area.	Rm 2/4/10	
2	305.02	The facility did not consistently assist residents with medications as ordered by their physicians.	Rm 2/4/10	
3	310.01.d	The medication aide did not observe a resident take their medication and did not appropriately assist with an insulin injection.	Rm 2/4/10	
4	335.03	The facility did not use universal precautions. The facility did not provide soap, gloves and paper towels for staff when they		
		provided personal cares for residents.	Rm 2/4/10	
5	350.02	The administrator did not complete an investigation of each complaint, including complaints by employees, within 30 days.	Rm 2/4/10	
6	350.04	The administrator did not provide each complainant with a written response within 30 days.	Rm 2/4/10	
~~7~~	~~625.01~~	~~The facility did not consistently document that all new employees had completed 16 hours of orientation.~~	CQS	

Response Required Date	Signature of Facility Representative	Date Signed
01/27/10	Heather Halverson	12/28/2009

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January 12, 2010

Heather Halverson, Administrator
Overland Court Generations Memory Care
10172 West Smoke Ranch Drive
Boise, Idaho 83709

Dear Ms. Halverson:

On December 28, 2009, a complaint investigation survey was conducted at Overland Court Generations Memory Care. The survey was conducted by Gloria Keathley, LSW, Matthew Hauser, QMRP, Rachel Corey, RN, Polly Watt-Geier, MSW, Rae Jean McPhillips, RN and Karen Anderson, RN. This report outlines the findings of our investigation.

Complaint # ID00004450

Allegation #1: The facility did not protect residents' rights to privacy, regarding medical treatments.

Findings #1: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.520 for not protecting residents' rights to privacy in regards to medical treatment. The facility was required to submit a plan of correction.

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,

Jamie Simpson for

RAE JEAN MCPHILLIPS, RN
Team Leader
Health Facility Surveyor
Residential Assisted Living Facility Program

RM/sc

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

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January 12, 2010

Heather Halverson, Administrator
Overland Court Generations Memory Care
10172 West Smoke Ranch Drive
Boise, Idaho 83709

Dear Ms. Halverson:

On December 28, 2009, a complaint investigation survey was conducted at Overland Court Generations Memory Care. The survey was conducted by Gloria Keathley, LSW, Matthew Hauser, QMRP, Rachel Corey, RN, Polly Watt-Geier, MSW, Rae Jean McPhillips, RN and Karen Anderson, RN. This report outlines the findings of our investigation.

Complaint # ID00004422

Allegation #1: The facility did not obtain emergency services for a resident who had been injured during a fall.

Findings: An unannounced onsite complaint investigation was conducted from 12/22 to 12/24/09. During that time record review, and staff interviews were conducted with the following results:

The facility's incident and accident reports from 9/09 through 12/23/09 were reviewed. None of the incidents or accidents reviewed documented that emergency services were not obtained for residents that required them.

- September 2009, there were a total of 9 incidents and accidents, 2 of which the facility appropriately obtained emergency services for residents involved.

- October 2009, there were a total of 13 incidents and accidents, 1 of which the facility appropriately obtained emergency services for residents involved.

- November 2009, there were a total of 5 incidents and accidents, 1 of which the facility appropriately obtained emergency services for the resident involved the next day.

- December 1 through December 23, 2009, there were a total of 5 incidents and accidents, 1 of which the facility appropriately obtained emergency services for residents involved.

Eighteen resident records were reviewed. One resident's record documented that he had sustained a fall in November. The incident and accident report contained in the record documented he was able to complete a range of motion assessment and was able to ambulated after the fall. The report also documented the resident's physician was notified of the fall.

On 12/23/09 at 3:52 PM, the facility nurse was interviewed. She stated that in November, a resident a fallen in the middle of the night and received a skin tear and bumped his head. The facility nurse said the resident appeared to have normal range of motion and reported no signs of pain or discomfort, so the resident's skin tear was dressed and first aid was given. The resident was not sent to the emergency room that night. The facility nurse stated the next day the resident's home health nurse observed a bump on his head and also noticed the resident's chronic edema had worsened and was higher up on his leg. The facility nurse stated she and the home health nurse then decided to send the resident to the emergency room for evaluation. She stated the resident was admitted to the hospital due to his congestive heart failure.

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

Allegation #2: There were not enough caregivers scheduled to meet the needs of the residents.

Findings: Throughout 12/22 to 12/24/09, residents were observed to have their needs met by caregivers. All residents were observed to be clean and well-groomed.

Four residents were interviewed from 12/22 through 12/23/09, all stated they were satisfied with the care they received. All residents interviewed stated they liked the caregivers and indicated their needs were being met.

On 12/22/09 at 9:12 AM, a private paid aide for one resident was interviewed. She stated that in comparison to other facilities that she had provided services in, she felt the staffing and cares provided to residents was satisfactory.

Eight family members were interviewed in person and by phone from 12/23 through 12/24/09. They stated their family members needs were being met. The family members interviewed indicated the residents were being well cared for and the facility was doing a "good job" providing care for the residents. One family member, who was interviewed on 12/24/09 at 11:45 AM, stated the care

his family members received was very good and the facility staff attended to residents' issues quickly.

On 12/22/09 at 7:25 AM, a Hospice nurse who provided care for two of the facility's residents was interviewed. She stated whenever she had been in the facility there were at least two caregivers on each side of the facility and residents were observed being assisted appropriately.

On 12/23/09 at 11:23 AM, another Hospice nurse who provided care for two of the facility's residents was interviewed. He stated he felt the residents' care needs were being met by the facility. He said that when he was in the facility there was always two caregivers on each side of the building.

The facility administrator was interviewed on 12/23/09 at 1:15 PM and stated she was aware of one overnight shift in December which the facility was short staffed; however, staff from a sister facility located next door had been trained and oriented to work at both facilities and a staff member was sent over to cover during the shift. The administrator added that trained and oriented staff from the sister facility was always available at all times if needed.

The facility's as-worked staffing schedules for 10/09, 11/09, and 12/09 were reviewed and documented that at least four staff were scheduled on days (6:30 AM - 2:30 PM), four staff on evening shifts (2:30 PM - 10:30 PM), and two staff on night shifts (10:30 PM - 6:30 AM). The as-worked schedules documented that staff from the sister facility, located next door, had worked six night shifts in November 2009.

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.

Sincerely,

Jamie Simpson for

RAE JEAN MCPHILLIPS, RN
Team Leader
Health Facility Surveyor
Residential Assisted Living Facility Program

RM/sc

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January 11, 2010

Heather Halverson, Administrator
Overland Court Generations Memory Care
10172 West Smoke Ranch Drive
Boise, Idaho 83709

Dear Ms. Halverson:

On December 28, 2009, a complaint investigation survey was conducted at Overland Court Generations Memory Care. The survey was conducted by Gloria Keathley, LSW, Matthew Hauser, QMRP, Rachel Corey, RN, Polly Watt-Geier, MSW, Rae Jean McPhillips, RN and Karen Anderson, RN. This report outlines the findings of our investigation.

Complaint # ID00004436

Allegation #1:	There was no running water in parts of the facility, including some residents' rooms.
Findings:	Substantiated. However, the facility was not cited as they acted appropriately by contracting with a plumbing company to address the issue. The facility provided copies of the plumbing company's invoices, which described the work and repairs performed, as evidence during the survey.
Allegation #2:	The facility caregivers must wash their hands in the kitchen area or go out through the locked door, to use the public restroom.
Findings:	Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.335.03 for not providing staff with necessary supplies to be compliant with universal precautions. The facility was required to submit evidence of resolution within 30 days.
Allegation #3:	Facility staff do not wear gloves when serving ready to eat foods.
Findings:	On December 22, 2010 through December 24, 2010, observations were made of staff working in the kitchen and serving residents their meals. Staff were observed to wash their hands and use gloves when placing ready to eat items on resident's plates. Staff stated they used gloves whenever they had to place items such as rolls on resident's plates.
	Unsubstantiated. Although the allegation may have occurred, it could not be determined during the complaint investigation.

Allegation #4: There were not enough caregivers scheduled to meet the needs of the residents.

Findings: Throughout December 22 to December 24, 2010, residents were observed to have their needs met by caregivers. All residents were observed to be clean and well-groomed.

Four residents were interviewed from December 22 through December 23, 2009, all stated they were satisfied with the care they received. All residents interviewed stated they liked the caregivers and indicated their needs were being met.

On December 22, 2010 at 9:12 AM, a private paid aide for one resident was interviewed. She stated that in comparison to other facilities that she had provided services in, she felt the staffing and cares provided to residents was satisfactory.

Eight family members were interviewed in person and by phone from December 23 through December 24, 2010. They stated their family members needs were being met. The family members interviewed indicated the residents were being well cared for and the facility was doing a "good job" providing care for the residents. One family member, who was interviewed on December 24, 2010 at 11:45 AM, stated the care his family members received was very good and the facility staff attended to residents' issues quickly.

On December 22, 2010 at 7:25 AM, a Hospice nurse who provided care for two of the facility's residents was interviewed. She stated whenever she had been in the facility there were at least two caregivers on each side of the facility and residents were observed being assisted appropriately.

On December 23, 2009 at 11:23 AM, another Hospice nurse who provided care for two of the facility's residents was interviewed. He stated he felt the residents' care needs were being met by the facility. He said that when he was in the facility there was always two caregivers on each side of the building.

The facility administrator was interviewed on December 23, 2009 at 1:15 PM and stated she was aware of one overnight shift in December which the facility was short staffed; however, staff from a sister facility located next door had been trained and oriented to work at both facilities and a staff member was sent over to cover during the shift. The administrator added that trained and oriented staff from the sister facility was always available at all times if needed.

The facility's as-worked staffing schedules for 10/09, 11/09, and 12/09 were reviewed and documented that at least four staff were scheduled on days (6:30 AM - 2:30 PM), four staff on evening shifts (2:30 PM - 10:30 PM), and two staff on night shifts (10:30 PM - 6:30 AM). The as-worked schedules documented that staff from the sister facility, located next door, had worked six night shifts in November 2009.

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

Allegation #5: The facility did provide new employees with 16 hours of orientaion.

Findings: On December 23, 2009 between 8:00 AM and 11:30 AM, five caregivers were interviewed. Four of the caregivers interviewed had worked at the facility for less than six months. All five caregivers stated they had completed far more than 16 hours of orientation prior to being allowed to work with residents unsupervised.

On December 24, 2010 eight caregivers' personnel records were reviewed. Five of the records contained evidence of 16 hours of orientation. On December 24, 2010 at 10:45 AM, the administrator stated caregivers kept their orientation documentation until their 30 day orientation was complete. The administrator stated that no new employee was allowed to work unsupervised until they had completed a "basic" orientation by "shadowing" an experienced employee for at least 16 hours. The administrator provided documented evidence of 16 hours orientation for the three employees prior to the survey exit on December 28, 2009.

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

Allegation #6: Dirty water was observed below the steam table in the kitchen.

Findings: On December 22, 2010 through December 24, 2010, six observations were made of the steam table and the overall cleanliness of the kitchen. During these observations, the water in the steam table was clean and at no time was dirty water observed below the steam table. The kitchen equipment was maintained and observed to be clean.

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.

Sincerely,

RAE JEAN MCPHILLIPS, RN
Team Leader
Health Facility Surveyor
Residential Assisted Living Facility Program

RM/sc

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

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Complaint # ID00004403

Allegation #1: Caregivers were not serving residents their breakfast and lunch promptly; which resulted in the meals being served cold.

Findings: On December 22, 2009, between 8:25 and 8:32 AM, the hot breakfast food items, scrambled eggs and oatmeal, were observed to be covered on a heated steam table. The temperature of the scrambled eggs was 131.8 degrees Farenheit and the oatmeal was 134.4 degrees Farenheit. Caregivers were observed to dish the food from the steam table onto plates and then serve the residents at 8:35 AM.

On December 22, 2009 between 8:00 AM and 9:00 AM, four residents were interviewed. All four residents stated the hot food was served at a palatable temperature.

On December 23, 2009 at 12:00 PM, salisbury steak and chicken were observed to be covered on a heated steam table. The temperature of salisbury steak was 140 degrees Farenheit and the chicken was 148 degrees Farenheit. Caregivers were observed to dish the food from the steam table onto plates and then serve the residents at 12:05 PM.

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

Allegation #2: There are not enough caregivers to assist residents with breakfast and lunch.

Findings: On December 22, 2009 at 8:35 AM, the breakfast meal was observed. Four caregivers were observed to serve residents' meals and beverages. Residents who were independent with eating or who required minimal assistance were served their meals first. Residents who

required more assistance were served shortly after the other residents. The caregivers were observed sitting and assisting the residents who required help. Residents that required assistance with eating were observed to received the assistance needed to complete their meals.

On December 23, 2009 at 12:00 PM at 12:00 PM, the lunch meal was observed. Four caregivers were observed to serve residents' meals and beverages. Additionally, there were two residents' family members, and two hospice personnel assisting the meal. Again, residents who were independent with eating or who required minimal assistance were served their meals first. The residents who required more assistance were served shortly after the other residents. The caregivers were observed to sit and assist the residents who required help. Residents that required assistance with eating were observed to received the assistance needed to complete most their meal.

Between December 23 and December 24, 2009, seventeen residents' records were reviewed for significant weight loss. Sixteen of the records did not document any weight loss. One resident's record documented that she had a significant loss over the last two months. The record documented the resident was on hospice and the weight loss was not unexpected. The record further documented the facility had started the resident on a supplemental nutrition drink three times a day. On December 23, 2009 at 11:23 AM, the hospice nurse for the resident was interviewed. He stated the resident had lost but it was not unexpected. He additionally, stated his client received appropriate assistance with eating.

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.

Sincerely,

RAE JEAN MCPHILLIPS, RN
Team Leader
Health Facility Surveyor
Residential Assisted Living Facility Program

RM/sc

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

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

LESLIE M. CLEMENT - Administrator
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January 12, 2010

Heather Halverson, Administrator
Overland Court Generations Memory Care
10172 West Smoke Ranch Drive
Boise, Idaho 83709

Dear Ms. Halverson:

On December 28, 2009, a complaint investigation survey was conducted at Overland Court Generations Memory Care. The survey was conducted by Gloria Keathley, LSW, Matthew Hauser, QMRP, Rachel Corey, RN, Polly Watt-Geier, MSW, Rae Jean McPhillips, RN and Karen Anderson, RN. This report outlines the findings of our investigation.

Complaint # ID00004442

Allegation #1: The facility did not respond appropriately when a resident received the wrong dose of an identified medication.

Findings: On 12/22/09, a sampled resident's medication record and physician's orders were reviewed from September 2009 through December 22, 2009. Records verified the resident had been assisted with all medications appropriately and according to physician orders. There was a physician's order to discontinue use of the identified medication on 10/12/09. The order was noted by the RN and the medication assistance record reflected the medication had been discontinued on the same date. There was no documentation in the medication error log to indicate the resident had received the wrong dose of the identified medication or any other of the prescribed medications.

On 12/23/09 at 12:10 PM, a family member stated, in October and November 2009, their loved one had changes in medications orders including the identified medication. However, they did not have concerns regarding any medication errors.

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

Allegation #2: Several residents did not recieve their medications as ordered.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22305.02 for not consistently assisting residents with medications as prescribed by their physicians. The facility was required to submit evidence of resolution within 30 days.

Allegation #3: The facility had plumbing difficulties; which lead to no water in some of the resident rooms, the shower room in the south side of the building had no water and several residents' toilets were clogged for several days.

Findings: Substantiated. However, the facility was not cited as they acted appropriately by contracting with a plumbing company to address the issue. The facility provided copies of the plumbing company's invoices, which described the work and repairs performed, as evidence during the survey.

Allegation #4: There were not sufficient staff scheduled to meet the needs of the residents.

Findings: Throughout 12/22 to 12/24/09, residents were observed to have their needs met by caregivers. All residents were observed to be clean and well-groomed.

Four residents were interviewed from 12/22 through 12/23/09, all stated they were satisfied with the care they received. All residents interviewed stated they liked the caregivers and indicated their needs were being met.

On 12/22/09 at 9:12 AM, a private paid aide for one resident was interviewed. She stated that in comparison to other facilities that she had provided services in, she felt the staffing and cares provided to residents was satisfactory.

Eight family members were interviewed in person and by phone from 12/23 through 12/24/09. They stated their family members needs were being met. The family members interviewed indicated the residents were being well cared for and the facility was doing a "good job" providing care for the residents. One family member, who was interviewed on 12/24/09 at 11:45 AM, stated the care his family members received was very good and the facility staff attended to residents' issues quickly.

On 12/22/09 at 7:25 AM, a Hospice nurse who provided care for two of the facility's residents was interviewed. She stated whenever she had been in the facility there were at least two caregivers on each side of the facility and residents were observed being assisted appropriately.

On 12/23/09 at 11:23 AM, another Hospice nurse who provided care for two of the facility's residents was interviewed. He stated he felt the residents' care needs were being met by the facility. He said that when he was in the facility there was always two caregivers on each side of the building.

The facility administrator was interviewed on 12/23/09 at 1:15 PM and stated she was aware of one overnight shift in December which the facility was short staffed; however, staff from a sister facility located next door had been trained and oriented to work at both facilities and a staff member was sent over to cover during the shift. The administrator added that trained and oriented staff from the sister facility was always available at all times if needed.

The facility's as-worked staffing schedules for 10/09, 11/09, and 12/09 were reviewed and documented that at least four staff were scheduled on days (6:30 AM - 2:30 PM), four staff on evening shifts (2:30 PM - 10:30 PM), and two staff on night shifts (10:30 PM - 6:30 AM). The as-worked schedules documented that staff from the sister facility, located next door, had worked six night shifts in November 2009.

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.

Sincerely,

Jamie Simpson for

RAE JEAN MCPHILLIPS, RN
Team Leader
Health Facility Surveyor
Residential Assisted Living Facility Program

RM/sc

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

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January 12, 2010

Heather Halverson, Administrator
Overland Court Generations Memory Care
10172 West Smoke Ranch Drive
Boise, Idaho 83709

Dear Ms. Halverson:

On December 28, 2009, a complaint investigation survey was conducted at Overland Court Generations Memory Care. The survey was conducted by Gloria Keathley, LSW, Matthew Hauser, QMRP, Rachel Corey, RN, Polly Watt-Geier, MSW, Rae Jean McPhillips, RN and Karen Anderson, RN. This report outlines the findings of our investigation.

Complaint # ID00004439

Allegation #1: Residents' hygiene needs were not being met, due to not having hot running water in parts of the building.

Findings #1: Between 12/22 and 12/24/09, the building was observed to have both hot and cold running water in residents' rooms and shower rooms. All residents were observed to be clean and well-groomed.

Six family members were interviewed in person and by phone from 12/23 through 12/24/09. They stated their family members' hygiene needs were being met. The family members interviewed indicated the residents were being well cared for and the facility was doing a "good job" providing care for the residents. One family member, who was interviewed on 12/24/09 at 11:45 AM, stated he was aware the facility did not have hot water for a couple of days, but hot water was available on the other side of the building and the facility attended to residents and hot water issues quickly.

Four residents were interviewed from 12/22 through 12/23/09; all stated they were generally satisfied with the care they received. All residents interviewed stated their hygiene needs had been met.

On 12/23/09 at 3:25 PM, the administrator stated that from 12/6 through 12/17/09, there had been areas of the building without hot water. She stated hot water was available in other areas of the building and residents were bathed in the other areas while the water issues were being taken care of. She also stated residents whose rooms were without water pressure were asked if they wanted to temporarily move into other rooms, until the water issues could be corrected.

Unsubstantiated. Although areas of the facility did not have hot ruming water, it could not be determined during the complaint investigation that any residents' hygiene needs were not being met.

Allegation #2: Several residents did not receive medications as ordered.

Findings #2: ubstantiated. The facility was issued a deficiency at IDAPA 16.03.22.305.02 for not consistently having medications available as ordered. The facility was required to submit evidence of resolution within 30 days.

Allegation #3: The facility medication technicians were administering insulin to residents.

Findings #3: On 12/22/09, between 8:20 AM and 9:45 AM, three residents were observed being assisted with insulin. All residents were observed to be able to self-inject their insulin.

On 12/22/09 from 7:00 AM to 9:45 AM, four medication aides were interviewed. All stated they did not administer insulin to residents. They stated all residents who required insulin were able to self-inject their own insulin.

On 12/23/09 at 3:48 PM, two facility RNs were interviewed. They stated that since their last survey in September 2009 all residents, who required insulin, had been assessed by them to be able to self-inject the medication.

On 12/23/09 the records for the residents who required insulin were reviewed. All three records were observed to contain self-administration assessment conducted by the facility's RNs.

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

Allegation #4: There were not enough caregivers scheduled to meet the needs of the residents.

Findings #4: Throughout 12/22 to 12/24/09, residents were observed to have their needs met by caregivers. All residents were observed to be clean and well-groomed.

Four residents were interviewed from 12/22 through 12/23/09, all stated they were satisfied with the care they received. All residents interviewed stated they liked the caregivers and indicated their needs were being met.

On 12/22/09 at 9:12 AM, a private paid aide for one resident was interviewed. She stated that in comparison to other facilities that she had provided services in, she felt the staffing and cares provided to residents was satisfactory.

Eight family members were interviewed in person and by phone from 12/23 through 12/24/09. They stated their family members needs were being met. The family members interviewed indicated the residents were being well cared for and the facility was doing a "good job" providing care for the residents. One family member, who was interviewed on 12/24/09 at 11:45 AM, stated the care his family members received was very good and the facility staff attended to residents' issues quickly.

On 12/22/09 at 7:25 AM, a Hospice nurse who provided care for two of the facility's residents was interviewed. She stated whenever she had been in the facility there were at least two caregivers on each side of the facility and residents were observed being assisted appropriately.

On 12/23/09 at 11:23 AM, another Hospice nurse who provided care for two of the facility's residents was interviewed. He stated he felt the residents' care needs were being met by the facility. He said that when he was in the facility there was always two caregivers on each side of the building.

The facility administrator was interviewed on 12/23/09 at 1:15 PM and stated she was aware of one overnight shift in December which the facility was short staffed; however, staff from a sister facility located next door had been trained and oriented to work at both facilities and a staff member was sent over to cover during the shift. The administrator added that trained and oriented staff from the sister facility was always available at all times if needed.

The facility's as-worked staffing schedules for 10/09, 11/09, and 12/09 were reviewed and documented that at least four staff were scheduled on days (6:30 AM - 2:30 PM), four staff on evening shifts (2:30 PM - 10:30 PM), and two staff on night shifts (10:30 PM - 6:30 AM). The as-worked schedules documented that staff from the sister facility, located next door, had worked six night shifts in November 2009.

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

Allegation #5: The administrator did not investigate or follow-up on complaints.

Findings #5: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.350.02 for providing a written report of findings within thirty days to complainants. 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,

RAE JEAN MCPHILLIPS, RN
Team Leader
Health Facility Surveyor
Residential Assisted Living Facility Program

RM/sc

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

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January 12, 2010

Heather Halverson, Administrator
Overland Court Generations Memory Care
10172 West Smoke Ranch Drive
Boise, Idaho 83709

Dear Ms. Halverson:

On December 28, 2009, a complaint investigation survey was conducted at Overland Court Generations Memory Care. The survey was conducted by Gloria Keathley, LSW, Matthew Hauser, QMRP, Rachel Corey, RN, Polly Watt-Geier, MSW, Rae Jean McPhillips, RN and Karen Anderson, RN. This report outlines the findings of our investigation.

Complaint # ID00004416

Allegation #1: There are not enough staff on night shift to meet the resident's care needs.

Findings #1: Throughout 12/22 to 12/24/09, residents were observed to have their needs met by caregivers. All residents were observed to be clean and well-groomed.

Four residents were interviewed from 12/22 through 12/23/09, all stated they were satisfied with the care they received. All residents interviewed stated they liked the caregivers and indicated their needs were being met. They stated their needs were being during the night shift as well.

On 12/22/09 at 9:12 AM, a private paid aide for one resident was interviewed. She stated that in comparison to other facilities that she had provided services in, she felt the staffing and cares provided to residents was satisfactory. She stated her client was always up, washed and dressed appropriately when she came in at 8:30 AM to sit with her.

Eight family members were interviewed in person and by phone from 12/23 through 12/24/09. They stated their family members needs were being met. The family members interviewed indicated the residents were being well cared for and the facility was doing a "good job" providing care for the residents. One family member, who was interviewed on 12/24/09 at 11:45 AM, stated the care his family members

received was very good and the facility staff attended to residents' issues quickly. None of the interviewed family members had concerns about care needs being met during the night shift.

On 12/22/09 at 7:25 AM, a Hospice nurse who provided care for two of the facility's residents was interviewed. She stated whenever she had been in the facility there were at least two caregivers on each side of the facility and residents were observed being assisted appropriately.

On 12/23/09 at 11:23 AM, another Hospice nurse who provided care for two of the facility's residents was interviewed. He stated he felt the residents' care needs were being met by the facility. He said that when he was in the facility during the day there was always two caregivers on each side of the building. He stated he had no concerns regarding the care being provided on night shift.

The facility administrator was interviewed on 12/23/09 at 1:15 PM. She was aware of one overnight shift in December which the facility was short staffed; however, staff from a sister facility located next door had been trained and oriented to work at both facilities and a staff member was sent over to cover during the shift. The administrator added that trained and oriented staff from the sister facility was available at all times if needed.

The facility's as-worked staffing schedules for 10/09, 11/09, and 12/09 were reviewed and documented that at least four staff were scheduled on days (6:30 AM - 2:30 PM), four staff on evening shifts (2:30 PM - 10:30 PM), and two staff on night shifts (10:30 PM - 6:30 AM). The as-worked schedules documented that staff from the sister facility, located next door, had worked six night shifts in November 2009.

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.

Sincerely,

RAE JEAN MCPHILLIPS, RN
Team Leader
Health Facility Surveyor
Residential Assisted Living Facility Program

RM/sc

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January 12, 2010

Heather Halverson, Administrator
Overland Court Generations Memory Care
10172 West Smoke Ranch Drive
Boise, Idaho 83709

Dear Ms. Halverson:

On December 28, 2009, a complaint investigation survey was conducted at Overland Court Generations Memory Care. The survey was conducted by Gloria Keathley, LSW, Matthew Hauser, QMRP, Rachel Corey, RN, Polly Watt-Geier, MSW, Rae Jean McPhillips, RN and Karen Anderson, RN. This report outlines the findings of our investigation.

Complaint # ID00004435

Allegation #1: The facility had no running water in several residents' rooms; the sinks, toilets and showers could not be used.

Findings #1: Substantiated. However, the facility was not cited as they acted appropriately by contracting with a plumbing company to address the issue. The facility provided copies of the plumbing company's invoices, which described the work and repairs performed, as evidence during the survey.

Allegation #2: The facility medication technicians were administering insulin to residents.

Findings #2: On 12/22/09, between 8:20 AM and 9:45 AM, three residents were observed being assisted with insulin. All residents were observed to be able to self-inject their insulin.

On 12/22/09 from 7:00 AM to 9:45 AM, four medication aides were interviewed. All stated they did not administer insulin to residents. They stated all residents who required insulin were able to self-inject their own insulin.

On 12/23/09 at 3:48 PM, two facility RNs were interviewed. They stated that since their last survey in September 2009 all residents, who required insulin, had been assessed by them to be able to self-inject the medication.

On 12/23/09 the records for the residents who required insulin were reviewed. All three records were observed to contain self-administration assessment conducted by the facility's RNs.

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

Allegation #3: The facility nurse instructed the medication technicians to inject insulin.

Findings #3: On 12/22/09 from 7:00 AM to 9:45 AM, four medication aides were interviewed. All four stated they had never been instructed by the facility's RNs to inject insulin to residents. They stated that all residents who required insulin were able to self-inject themselves and if they needed more help they would contact the nurse.

On 12/23/09 at 3:48 PM, the facility's two RNs were interviewed. They stated they had not instructed medication aides to inject resident's insulin. They said they had made it very clear to staff that if a resident needed insulin injected it had to be done by a nurse. Both RNs stated that residents who required insulin had to be able to self-inject the medication.

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

Allegation #4: The facility nurse did not train the caregivers on how to appropriately obtain urine samples, fill out laboratory orders or transcribe new medication orders onto the residents' medication assistance records (MARs).

Findings #4: On 12/23/09 at 3:25 PM, one of the facility's RN stated that she had trained staff on how to collect a clean catch urine sample and how to fill out laboratory orders. She stated that she or the other facility RN reviewed all laboratory orders prior to sending them out. Additionally, she stated that medication aides were trained on how to properly document on MAR.

On 12/22/09 from 7:00 AM to 9:45 AM, four medication aides were interviewed. All stated they did not administer insulin to residents. They stated all residents who required insulin were able to self-inject their own insulin.

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

Allegation #5: Several residents went without medications as they were not re-ordered nor available.

Findings #5: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.305.02 for not consistently having medications available as ordered. The facility was required to submit evidence of resolution within 30 days.

Allegation #6: The facility did not have enough staff to meet all residents' care needs.

Findings #6: Throughout 12/22 to 12/24/09, residents were observed to have their needs met by caregivers. All residents were observed to be clean and well-groomed.

Four residents were interviewed from 12/22 through 12/23/09, all stated they were satisfied with the care they received. All residents interviewed stated they liked the caregivers and indicated their needs were being met.

On 12/22/09 at 9:12 AM, a private paid aide for one resident was interviewed. She stated that in comparison to other facilities that she had provided services in, she felt the staffing and cares provided to residents was satisfactory.

Eight family members were interviewed in person and by phone from 12/23 through 12/24/09. They stated their family members needs were being met. The family members interviewed indicated the residents were being well cared for and the facility was doing a "good job" providing care for the residents. One family member, who was interviewed on 12/24/09 at 11:45 AM, stated the care his family members received was very good and the facility staff attended to residents' issues quickly.

On 12/22/09 at 7:25 AM, a Hospice nurse who provided care for two of the facility's residents was interviewed. She stated whenever she had been in the facility there were at least two caregivers on each side of the facility and residents were observed being assisted appropriately.

On 12/23/09 at 11:23 AM, another Hospice nurse who provided care for two of the facility's residents was interviewed. He stated he felt the residents' care needs were being met by the facility. He said that when he was in the facility there was always two caregivers on each side of the building.

The facility administrator was interviewed on 12/23/09 at 1:15 PM and stated she was aware of one overnight shift in December which the facility was short staffed; however, staff from a sister facility located next door had been trained and oriented to work at both facilities and a staff member was sent over to cover during the shift. The administrator added that trained and oriented staff from the sister facility was always available at all times if needed.

The facility's as-worked staffing schedules for 10/09, 11/09, and 12/09 were reviewed and documented that at least four staff were scheduled on days (6:30 AM -

2:30 PM), four staff on evening shifts (2:30 PM - 10:30 PM), and two staff on night shifts (10:30 PM - 6:30 AM). The as-worked schedules documented that staff from the sister facility, located next door, had worked six night shifts in November 2009.

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

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Sincerely,

RAE JEAN MCPHILLIPS, RN
Team Leader
Health Facility Surveyor
Residential Assisted Living Facility Program

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