



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  
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January 24, 2011

**CERTIFIED MAIL #: 70090820000028071583**

Julie Tastad, Administrator  
Creekside Inn Al Alzheimer's Community  
111 Market Street Ne, Suite 200  
Olympia, WA 98501

Dear Ms. Tastad:

Based on the State Licensure and Complaint Investigation survey conducted by our staff at Creekside Inn Assisted Living Alzheimer's Community on **January 13, 2011**, we have determined that the facility failed to protect residents' rights to be free from restraints and the right to privacy.

This core issue deficiency substantially limits the capacity of Creekside Inn Assisted Living Alzheimer's Community 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 27, 2011**. **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 **February 6, 2011**, and keep a copy for your records. Your license depends upon the corrections made and the evaluation of the Plan of Correction you develop.

Julie Tastad, Administrator  
January 24, 2011

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 (**February 6, 2011**). 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 **February 6, 2011**, your request will not be granted. Your IDR request must be made in accordance with the Informal Dispute Resolution Process. The IDR request form and the process for submitting a complete request can be found at [www.assistedliving.dhw.idaho.gov](http://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 **February 12, 2011**.

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 Creekside Inn Assisted Living Alzheimer's Community.

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/gk

Enclosure

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13R954</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/13/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>CREEKSIDE INN ASSISTED LIVING ALZHEIME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>240 EAST KATHLEEN AVENUE COEUR D'ALENE, ID 83814</b>		
(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	<p><b>Initial Comments</b></p> <p>The following deficiencies were cited during the licensure, follow-up and complaint investigation conducted on 01/10/2011 through 01/13/2011 at your assisted living facility. The surveyors conducting the survey were:</p> <p>Gloria Keathley, LSW Team Coordinator Health Facility Surveyor</p> <p>Karen Anderson, RN Health Facility Surveyor</p> <p>Matt Hauser, QMRP Health Facility Surveyor</p> <p>Survey Definitions: c/o = complained of meds = medications NSA = negotiated service agreement pn = pain Res. = Resident res = resident</p>	R 000	<p>We write to provide you a written Plan of Correction for the Core citations as required by IDAPA 16.03.22.08. Submission of this Plan of Correction should not be interpreted as an admission that any of the alleged regulatory violations occurred as described in the Department's Statement of Deficiencies.</p> <p><b>(1) Seclusion and Restraints:</b> The Department's Statement of Deficiencies cites the Creekside Inn for "restraining" Residents #4 and #5. The Department alleges violation of IDAPA 16.03.550.10 which provides that "each resident must have the right to be free from...involuntary seclusion, and any physical or chemical restraints." "Physical restraint" is defined as "any device or physical force that restricts the free movement of, or normal functioning of, or normal access to a portion or portions of an individual's body except for treatment of a medical condition." IDAPA 16.03.22.012.04.</p> <p><u>Resident #5.</u> Resident #5 was admitted to the Alzheimer's community on March 16, 2010, suffering from confusion and dementia. Resident #5 has no close family, and has had a Guardian appointed by the courts. Long before the incidents of 9/5/10 and 10/24/10 described in the Statement of Deficiencies, Resident #5 had a history of aggressive and abusive behaviors. Resident #5 would strike out physically and verbally against community staff. Her verbal outburst had the effect of agitating other residents in the community. The community's staff will continue to safeguard other resident's health, safety and well-being while dealing appropriately with Resident #5's intermittent behaviors.</p> <p><u>The following corrective actions will be accomplished for resident/personnel:</u> Staff will receive additional information and direction on the regulatory requirements</p>	
R 008	<p><b>16.03.22.520 Protect Residents from Inadequate Care.</b></p> <p>The administrator must assure that policies and procedures are implemented to assure that all residents are free from inadequate care.</p> <p>This Rule is not met as evidenced by: Based on record review and interview with residents and staff, it was determined the facility failed to protect 2 of 7 sampled residents' right to be free from physical restraints, and 1 of 7 sampled residents' right to privacy. These failures</p>	R 008		

Bureau of Facility Standards

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

FORM

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If continuation sheet 1 of 8

*[Handwritten Signature]* 03/09/11

Bureau of Facility Standards

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R 008	<p>Continued From page 1</p> <p>resulted in inadequate care. The findings include:</p> <p>I. RESTRAINTS</p> <p>A). IDAPA 16.03.22.012.04 defines physical restraint as, "Any device or physical force that restricts the free movement of, normal functioning of, or normal access to a portion or portions of an individual's body except for treatment of a medical condition."</p> <p>IDAPA 16.03.22.550.10 states "Each resident must have the right to be free from... ...involuntary seclusion, and any physical or chemical restraints."</p> <p>Resident #5's record documented she was admitted to the facility on 3/16/10, with diagnoses which included dementia, major depression, chronic neck and back pain and osteoarthritis.</p> <p>On 9/5/10 at 9:00 PM, nurse's notes documented "Several caregivers carried resident (Resident #5) back to her room in a chair to get her away from the other residents. She became angry..." The police and 911 (emergency services) were called and arrived, but did not transport her.</p> <p>On 10/24/10 at 9:45 AM, nurse's notes documented that at 7:35 AM, Resident #5 was "placed", by staff, in a regular straight back chair and the chair was tilted back with her in it and dragged back to her room. The nurse's notes further documented Resident #5 continued yelling and throwing items and was restrained in a chair and the chair was dragged back to her room on two separate occasions on 10/24/10. Further the caregivers locked the outside of the door of the dining room to keep Resident #5 isolated from other residents.</p>	R 008	<p>mandating that each resident must have the right to be free from involuntary seclusion, and any physical or chemical restraints.</p> <p>Staff will also receive additional information alerting them that a "physical restraint" is any device or physical force that restricts the free movement of, or normal functioning of, or normal access to a portion or portions of an individual's body except for treatment of a medical condition.</p> <p>Staff will be reminded that physical restraints should never be used in the community.</p> <p>Staff will further be reminded that physical redirection of the resident should be handled with care and a minimum of physical contact, unless there is risk of physical harm to other residents.</p> <p><u>The following outlines how other residents/personnel/areas that may be affected will be identified:</u> When this resident, or any other resident, experiences future outbursts staff will continue to ensure the health and safety of other residents as well as Resident #5.</p> <p>Staff will take all appropriate action to ensure that the combative resident and other residents are kept safe. During the resident outburst, staff will attempt to redirect the resident without the use of physical force or physical restraints.</p> <p><u>The following measures/systemic changes that will ensure a deficient practice does not occur will be put into place:</u> Staff will also be instructed that some of the actions described in the Statement of Deficiencies are not permitted.</p>	

*JPD 02/09/11*

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	<p>Continued From page 2</p> <p>Resident #5's nurse's notes also documented, on 10/24/10 at 3:00 PM, she was told she could not use the phone and became angry and slammed her walker against the nurse's station and the walls. The notes documented Resident #5 was taken back to her room and later came back to the nurse's station and apologized to the nurse for getting upset. The notes further documented Resident #5 complained of back and hip pain and stated it was from being beat up and thrown around earlier.</p> <p>Resident #5's undated NSA, instructed caregivers to "attempt to isolate resident back in her room" if she continued to escalate with behaviors and agitate other residents.</p> <p>On 1/10/11 at 2:49 PM, Resident #5 stated she had been "racked" by a staff member a few times, but could not remember exactly how many times. When asked to explain, Resident #5 said that she was forcibly wrestled into a chair, while staff "held her head and arms with great pressure and force." She said she was dragged back to her room in a chair.</p> <p>Between 1/10/11 and 1/12/11, all caregivers on duty were interviewed regarding Resident #5's behaviors.</p> <p>On 1/11/11 at 11:30, Staff A stated she witnessed Resident #5 being put into a chair and carried to her room. Staff A stated Resident #5 was upset because she could not go to or get a ride to church and "made a scene" by yelling and throwing things. Staff A further stated one staff member "bear hugged" the resident with both arms, around the waist and forced her into the chair. Staff A also stated Resident #5 told her she</p>		<p>On an ongoing basis staff will be trained on using the Alzheimer's Association's recommended "Positive Physical Approach" with a goal toward minimizing escalation and other behaviors of residents with dementia.</p> <p>Staff will be reminded to interact with demented residents in a manner consistent with their training and state guidelines.</p> <p><b>The following monitoring will ensure a deficient practice does not occur:</b> On an ongoing basis, the Administrator and the Director of Nursing/Resident Services will monitor and/or review how incidents involving Resident #5, or other residents, are addressed. Deficient practices will be brought to the attention of relevant staff members by community management.</p> <p>In addition, if the actions are found to violate a resident's rights, those actions will be reported to the Department, consistent with state reporting requirements.</p> <p>The community Administrator, with the assistance of the Director of Nursing/Resident Services, will have <u>the above described actions completed no later than March 1, 2011.</u></p> <p><b>Resident #4.</b> The Department's Statement of Deficiencies also cites the community for the "restraint" of Resident #4. The Department claims that the use of a lap tray constitutes an impermissible restraint.</p> <p>"Physical restraint" is defined as "any device or physical force that restricts the free movement of, or normal functioning of, or normal access to a portion or portions of an individual's body except for treatment of a medical condition." IDAPA 16.03.22.012.04.</p>	

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R 008	<p>Continued From page 3</p> <p>was very sore the next day due to being forced into the chair.</p> <p>On 1/11/11 at 2:30 PM, Staff B stated she had witnessed Resident #5 being forced into a chair and carried back to her room by four caregivers, at least two times. Staff B said either the second or thrd time, the fire doors outside of Resident #5's room were shut in an attempt to keep the resident from returning to the common area.</p> <p>On 1/12/11 at 9:05 AM, Staff D stated Resident #5 was seen yelling and throwing items and then being forced into a chair by staff. Staff D further stated one staff put a chair behind Resident #5, while another staff "bear hugged" the resident around the waist with both hands and pushed her down into a chair. Four caregivers were seen carrying the chair out of the area with Resident #5's feet dangling in the air.</p> <p>On 1/12/11 at 9:15 AM, the Residential Care Director confirmed caregivers placed Resident #5 in a chair and carried her in the chair to room. Additionally, she confirmed the fire doors were closed to keep the resident in an area by her room. The Residential Care Director stated she did not know this would be considered a restraint.</p> <p>On 1/12/11 at 1:35 PM, Staff F stated Resident #5 was forced into a chair and carried to her room by four caregivers. Further, she stated the caregivers shut the door to her room and shut the fire doors in the hallway near her room. She stated Resident #5 was yelling and throwing items and hitting the nurses station with her walker, until a caregiver took her walker. Staff F stated Resident #5 was pushed into a chair three times that day and carried or pushed (while tilted back in the chair) back to her room.</p>	R 008	<p>Resident #4 has a diagnosis of "Kyphosis." She is unable to walk and requires a wheelchair. She also has extreme weakening of her abdominal muscles as well and is unable to support herself in an upright position. Not allowing use of the lap tray could result in additional serious injury to this Resident. In addition, not allowing the use of the lap tray could have a negative impact upon Resident #4's quality of life. Further, the use of the lap tray has been recommended by the Resident's ARPN.</p> <p><u>The following corrective actions will be accomplished for resident/personnel:</u> Resident #4's lap tray device was modified on 01/17/11 to allow the resident to remove the tray. She has demonstrated the ability to remove the tray on multiple occasions.</p> <p>Under the direction of the Resident's ARPN, the community will continue to allow the use of the lap tray on a limited basis as a medically necessary assistive device, but never as a restraint. Please see Attached statement from the ARPN.</p> <p>Thus, the use of the lap tray will be monitored and only used during those periods when the community's Director of Nursing/Resident Services believes that use of the lap tray is appropriate.</p> <p>Any indications by Resident #4 that she feels confined or agitated will result in the removal of the tray.</p> <p><u>The following outlines how other residents/personnel/areas that may be affected will be identified:</u> Community staff will be reminded that assistive devices, like lap trays and side rails, while supporting a resident's ability to live</p>	01/17/11

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R 008	Continued From page 4  The facility failed to protect Resident #5's right to be free from any physical restraints when she was placed in a chair against her will, and was unable to ambulate freely. This failure resulted in inadequate care.  b) Resident #4 was admitted to the facility on 8/20/09, with diagnoses which included Alzheimer's dementia, osteoarthritis with compression fractures and severe kyphosis.  The NSA, dated 10/10/10, documented the resident required assistance with transfers, could stand for short periods of time with the assistance of a caregiver. Additionally, while the resident was sitting in her wheelchair staff were to place a lap tray on the wheelchair. Staff were to escort the resident to meals, activities and exercise programs.  On 1/10/11 at 2:30 PM, Resident #4 was observed sitting in her wheelchair with a lap tray over the top of the wheelchair arms. The resident was observed sleeping on the lap tray. The lap tray was secured to the wheelchair by use of Velcro straps. The Velcro straps were fastened at the back of the wheelchair's arm rest. The caregiver confirmed the resident could not release the lap tray and caregivers had to put on the tray on and take it off.  On 1/11/11 at 9:00 AM, Resident #4 was observed in the activity room. She was observed sleeping with her head on the lap tray during approximately one hour of activity.  On 1/11/11 at 2:30 PM, staff A stated the lap tray prevented the resident from falling forward out of her wheelchair. Staff A stated, staff were to put	R 008	independently (if determined medically necessary by a physician or ARPN or PA), can also, in some circumstances, constitute "restraints."  <u>The following measures/systemic changes that will ensure a deficient practice does not occur will be put into place:</u> Staff will be instructed to maintain a heightened sense of awareness regarding the use of assistive devices that could be considered restraints.  <u>The following monitoring will ensure a deficient practice does not occur:</u> On an ongoing basis, the Administrator and the Director of Nursing/Resident Services will monitor and/or review how often Resident #4 is using the lap tray.  Overuse will not be allowed. Any deficient practices will be brought to the attention of relevant staff members by community management.  The community Administrator, with the assistance of the Director of Nursing/Resident Services, <u>will have the above described actions completed no later than March 1, 2011.</u>  (2) Telephone and Mail Privacy: The Department's Statement of Deficiencies alleges that the community violated Resident #5's "right to privacy." Specifically, the Department alleges violation of IDAPA 16.03.22.550.02 which provides that "each resident must be assured the right of privacy with regard to written and telephonic communications."  The Department's Statement of Deficiencies alleges that the community prevented the resident from making telephone calls and	03/01/11

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R 008	<p>Continued From page 5</p> <p>the lap tray on whenever she was in the wheelchair. The caregiver confirmed the resident would not be able to release the lap tray because of the way it was secured. The caregiver further stated, the lap tray was the only intervention used and had no further knowledge of the facility's trial of a chair alarm or self releasing seat belt.</p> <p>On 1/12/11 between 8:40 AM and 4:00 PM, three additional caregivers confirmed Resident #4 could not release the lap tray. They stated, the lap tray was the only intervention they had used to help the resident from falling out of her wheelchair.</p> <p>On 1/12/11 at 9:25 AM, the facility RN stated she was not aware that the lap tray would be considered a restraint because it helped the resident not fall out of her wheelchair.</p> <p>There were no nursing notes or assessments found in the resident's record regarding the lap tray or if other methods were tried to prevent the resident from falling out of her wheelchair.</p> <p>The facility failed to protect Resident #4's right to be free from any physical restraints when she had a lap tray secured on her wheelchair which she could not remove herself. This failure resulted in inadequate care.</p> <p>II. TELEPHONE AND MAIL PRIVACY</p> <p>IDAPA 16.03.22.550.02 "Privacy. Each resident must be assured the right to privacy with regard to... written and telephone communications..."</p> <p>Resident #5's nurse's notes documented on 10/24/10 at 3:00 PM, the resident walked up to the nurse's station demanding to use the phone.</p>	R 008	<p>"intercepted mail." What is not noted in the Statement of Deficiencies is that Resident #5 has a Guardian appointed by the District Court. The limitation on access to the telephone was implemented at the Guardian's direction.</p> <p>Under Idaho law, a Guardian has full power and authority over an incapacitated person to the same extent a parent has authority over a child. Accordingly, just as a parent can make decisions for a child that the child, or others, may not like, a Guardian can make decisions for an incapacitated person.</p> <p>In fact, the Guardian has directed the community to do two things. First, the Guardian has asked that Resident #5's mail be directed to the Guardian. The facility does not open the Resident's mail. Rather, the mail is forwarded to the Guardian, who opens the mail. The Guardian then returns the mail to the community for delivery to Resident #5.</p> <p>Similarly, the Guardian has also asked the community to limit the Resident's access to the telephone to generally two calls a day. The limitations imposed by the Guardian are due to Resident #5's behaviors. In the past, Resident #5 has made multiple calls to strangers and church members, which resulted in complaints to the Guardian. Also, Resident #5 has been known to call the local taxi company on several occasions, asking that cabs be dispatched to the community. When the cab arrives, expecting a fare, they have to be sent away. Resident #5 has also been known to call her bank [redacted] to request bank statements, sometimes multiple times in one day. Because of problems caused by the Resident's telephone calls, the Guardian demanded that her access to the telephone be limited.</p>	

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Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER  CREEKSIDE INN ASSISTED LIVING ALZHEIME		STREET ADDRESS, CITY, STATE, ZIP CODE 240 EAST KATHLEEN AVENUE COEUR D'ALENE, ID 83814		
(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 6  The nurse's notes further documented the resident was advised by the nurse that she was not allowed to use the phone.  On 1/10/11 at 2:49 PM, Resident #5 stated she was not permitted to use the phone.  On 1/11/11 at 11:30 AM, Staff A, stated when Resident #5 requested to use the phone, she was told to wait until later, but later would not be allowed.  On 1/11/11 at 2:50 PM, Staff B stated caregivers listened in on Resident #5's phone calls.  On 1/12/11 at 9:05 AM, Staff D stated Resident #5 was not allowed to use the phone and the resident's mail was opened prior to it being delivered to her. Additionally, Staff D stated staff screened Resident #5's incoming calls and mail. Further, Resident #5's family member sent a floral arrangement and a card with it, which were both opened prior to her receiving it.  On 1/12/11 at 9:15 AM, the Residential Care Director stated Resident #5's guardian restricted who the resident could speak to on the phone. She further stated if staff needed to find out the phone restrictions, they would not know of the specific restrictions unless they read all nursing documentation. The Residential Care Director further stated Resident #5's mail was opened because if it involved money, the guardian did not want her to have it. Additionally, the Residential Care Director stated conferences held between the facility and guardian regarding restricting Resident #5's rights were not documented.  On 1/12/11 at 1:35 PM, Staff F stated all of Resident #5's mail was always delivered to her	R 008	The Department's citation places the facility in a very difficult situation. The Guardian, who has legal authority and control over the Resident, is demanding that mail be sent to the Guardian and phone use limited. On the other hand, the Department is demanding full access by the Resident to those very things prohibited by the Guardian. This places the community in an untenable position.  The community believes that the "right of privacy with regards to written and telephonic communication" is ultimately intended to protect the Resident from harm. The community in this instance will do what it believes is in the best interest of the Resident.  <u>The following corrective actions will be accomplished for resident/personnel:</u> At this juncture the community is strongly advocating with the Guardian for a private telephone to be installed in the resident's room. As of 01/25/11, the Guardian and Conservator have agreed to move forward with the installation of a private land line in the resident's apartment. The Region I Long Term Care Ombudsman provided consultation to community staff, Guardian and Conservator regarding documentation of any mis-use of the telephone for submission to the courts for review, should the telephone access prove to be problematic.  As to the mail issue, this community has never opened or reviewed a resident's mail. Effective 01/25/11, the Guardian and Conservator have agreed that a change of address form be submitted to the post office, listing the Conservator's post office box as the resident's current address. The Conservator, in conjunction with the Guardian, will assure they bring the resident's personal mail to her on a regular basis. The Region I Long Term	01/25/11  01/25/11

Bureau of Facility Standards  
 STATE FORM

5889 Y13511

If continuation sheet 7 of 8

*[Handwritten signature]*  
 01/25/11

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13R954	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/13/2011
NAME OF PROVIDER OR SUPPLIER  CREEKSIDE INN ASSISTED LIVING ALZHEIME		STREET ADDRESS, CITY, STATE, ZIP CODE 240 EAST KATHLEEN AVENUE COEUR D'ALENE, ID 83814		
(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	<p>Continued From page 7</p> <p>opened. She further stated staff had to ask the nurse if Resident #5 could use the phone. Staff F further stated these requests were often denied because the nurses stated they were too busy at the time or ignored the request.</p> <p>On 1/12/11 at 9:30 AM, the survey team was handed a "Guideline for [Resident #5's name] phone use" which documented authorization to make two phone calls per day, not to exceed 10 minutes each, and incoming calls are permissible, but not to exceed 10 minutes each. The Residential Care Director stated the facility did not have written instructions from the guardian prior to 1/11/11.</p> <p>Resident #5's right to privacy to written and telephone communications was violated when the facility systematically denied her the use of the phone and opened all of her mail prior to her receiving it. This failure resulted in inadequate care.</p> <p>The facility's nursing notes documented Resident #5 had been put into a chair and moved to her room on 6/27/10, 9/5/10, and at least two times on 10/24/10.</p> <p>The facility failed to protect Resident #4 and Resident #5's rights to be free from physical restraints when they used a lap tray that Resident #4 could not remove, and when they forced Resident #5 into a chair and dragged her in the chair to her room. These failures resulted in inadequate care.</p>	R 008	<p>Care Ombudsman was in agreement that this is reasonable arrangement.</p> <p><u>The following outlines how other residents/personnel /areas that may be affected will be identified:</u>                  On an ongoing basis, staff will make resident representatives aware of resident rights implications related to telephone usage and mail and involve the Region I Long Term Care Ombudsman as necessary.</p> <p><u>The following measures/systemic changes that will ensure a deficient practice does not occur will be put into place:</u>                  The community Administrator and Director of Nursing/Resident Services will review any occurrences related to resident mail and/or telephone usage to determine an appropriate course of action, and document resolutions in the care plan.</p> <p><u>The following monitoring will ensure a deficient practice does not occur:</u>                  The community Administrator and Director of Nursing/Resident Services will review, as noted above, on an ongoing basis.</p> <p><u>Resident #5's private telephone line was activated on 03/03/11, A Change of Address card was submitted to the US Postal Service on 03/03/11.</u></p>	03/03/11 03/03/11

# ASSISTED LIVING Non-Core Issues Punch List

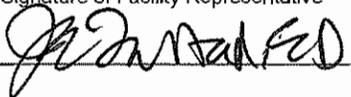


IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

**MEDICAID LICENSING & CERTIFICATION - RALF**  
P.O. Box 83720  
Boise, ID 83720-0036  
(208) 334-6626 fax: (208) 364-1888

Facility Name Creekside Inn Assisted Living Alzheimer's Community	Physical Address 240 East Kathleen Ave	Phone Number 208-665-2444
Administrator Julie Tastad	City Coeur d' Alene	Zip Code 83815
Team Leader Gloria Keathley	Survey Type Relicensure Follow-up + Complaint	Survey Date 01/13/11

## NON-CORE ISSUES

Item #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	L&C USE
1	009.04	One of seven staff did not have a Department criminal history background check within 21 days of hire.	2-14-11 gr	
2	153.07	The facility did not have procedures to assure the least restrictive intervention was used to address behaviors.	2-25-11 gr	
3	220.02	Resident # 6 did not have rates or level of care documented in the admission agreement to provide a reflection of the facilities charges.	2-25-11 gr	
		Resident #5's admission agreement was not signed by the facility administrator or designee.	2-25-11 gr	
4	305.02	Not all PRN medications were available at the facility as ordered.	2-25-11 gr	
5	320.03	Five of seven resident NSAs were not signed by the resident or legal representative. Seven of seven were not signed by the administrator.	2-14-11 gr	
6	350.02	The facility administrator or designee did not complete an investigation and written report of findings within 30 days for each accident,	2-25-11 gr	
		incident or complaint.		
7.	350.04	A complainant did not receive a written response from the facility within 30 days when there was a complaint about the food.	2-25-11 gr	
8.	350.07	Licensing & Certification was not notified of reportable incidents within 24 hours. COS 1-13-11 gr	OK	
9	711.08	Care notes were not documented by caregivers.	2-14-11 gr	
10	711.08.c	Unusual events; such as resident to resident altercations and other reportable incidents were not documented or signed, dated by the	2-14-11 gr	
		caregivers that provided the care and services.		
Response Required Date 02/12/11	Signature of Facility Representative 		Date Signed 01/13/11	



# Food Establishment Inspection Report

Great Job

Establishment Name <u>Wellside</u>	Operator <u>Julio Tostad</u>
Address <u>240 E Kathleen Ave</u>	City <u>Coeur D'Alene</u> Zip <u>83301</u>
County Estab # <u>Kootenai 20</u>	EHS/SUR.# <u>20</u>
Inspection Type: <u>High</u>	Risk Category: <u>High</u>
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 <u>0</u>	# of Retail Practice Violations <u>0</u>
# of Repeat Violations <u>0</u>	# of Repeat Violations <u>0</u>
Score <u>100</u>	Score <u>100</u>
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
<u>Y</u> N	1. Certification by Accredited Program or Approved Course; or correct responses; or compliance with Code	<input type="checkbox"/>	<input type="checkbox"/>
<b>Employee Health (2-201)</b>			
<u>Y</u> N	2. Exclusion, restriction and reporting	<input type="checkbox"/>	<input type="checkbox"/>
<b>Good Hygienic Practices</b>			
<u>Y</u> N	3. Eating, tasting, drinking, or tobacco use (2-401)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N	4. Discharge from eyes, nose and mouth (2-401)	<input type="checkbox"/>	<input type="checkbox"/>
<b>Control of Hands as a Vehicle of Contamination</b>			
<u>Y</u> N	5. Clean hands, properly washed (2-301)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N	6. Bare hand contact with ready-to-eat foods/exemption (3-301)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N	7. Handwashing Facilities (5-203 & 6-301)	<input type="checkbox"/>	<input type="checkbox"/>
<b>Approved Sources</b>			
<u>Y</u> N	8. Food obtained from approved source (3-101 & 3-201)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N	9. Receiving temperature / condition (3-202)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N	10. Records: shellstock tags, parasite destruction, required HACCP plan (3-202 & 3-203)	<input type="checkbox"/>	<input type="checkbox"/>
<b>Protection from Contamination</b>			
<u>Y</u> N	11. Food segregated, separated and protected (3-302)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N	12. Food contact surfaces clean and sanitized (4-5, 4-6, 4-7)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N	13. Returned / reserve of food (3-306 & 3-801)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N	14. Discarding / reconditioning unsafe food (3-701)	<input type="checkbox"/>	<input type="checkbox"/>

	Potentially Hazardous Food Time/Temperature	COS	R
<u>Y</u> N	15. Proper cooking, time and temperature (3-401)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N	16. Reheating for hot holding (3-403)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N	17. Cooling (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N	18. Hot Holding (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N	19. Cold Holding (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N	20. Date marking and disposition (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N	21. Time as a public health control (procedures/records) (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
<b>Consumer Advisory</b>			
<u>Y</u> N	22. Consumer advisory for raw or undercooked food (3-603)	<input type="checkbox"/>	<input type="checkbox"/>
<b>Highly Susceptible Populations</b>			
<u>Y</u> N	23. Pasteurized foods used, avoidance of prohibited foods (3-801)	<input type="checkbox"/>	<input type="checkbox"/>
<b>Chemical</b>			
<u>Y</u> N	24. Additives / approved, unapproved (3-207)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N	25. Toxic substances properly identified, stored, used (7-101 through 7-301)	<input type="checkbox"/>	<input type="checkbox"/>
<b>Conformance with Approval Procedures</b>			
<u>Y</u> N	26. Compliance with variance and HACCP plan (8-201)	<input type="checkbox"/>	<input type="checkbox"/>

Y = yes, in compliance  
N/O = not observed  
COS = Corrected on-site  
N = no, not in compliance  
N/A = not applicable  
R = Repeat violation  
 = COS or R

Item/Location	Temp	Item/Location	Temp	Item/Location	Temp	Item/Location	Temp
<u>Hamburger</u>	<u>192°</u>	<u>Coleslaw</u>	<u>37</u>				
		<u>Cottage Cheese</u>	<u>3/2</u>				

## GOOD RETAIL PRACTICES ( = not in compliance)

	COS	R		COS	R		COS	R
<input type="checkbox"/> 27. Use of ice and pasteurized eggs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 34. Food contamination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 42. Food utensils/in-use	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 28. Water source and quantity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 35. Equipment for temp. control	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 43. Thermometers/Test strips	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 29. Insects/rodents/animals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 36. Personal cleanliness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 44. Warewashing facility	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 30. Food and non-food contact surfaces: constructed, cleanable, use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 37. Food labeled/condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 45. Wiping cloths	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 31. Plumbing installed; cross-connection; back flow prevention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 38. Plant food cooking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 46. Utensils & single-service storage	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 32. Sewage and waste water disposal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 39. Thawing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 47. Physical facilities	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 33. Sinks contaminated from cleaning maintenance tools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 40. Toilet facilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 48. Specialized processing methods	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/> 41. Garbage and refuse disposal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 49. Other	<input type="checkbox"/>	<input type="checkbox"/>

## OBSERVATIONS AND CORRECTIVE ACTIONS (CONTINUED ON NEXT PAGE)

Person in Charge (Signature) <u>Karen Anderson</u>	(Print) <u>Julio Tostad</u>	(Title) <u>FO</u>	Date <u>1/13/11</u>
Inspector (Signature) <u>Karen Anderson</u>	(Print) <u>KAREN Anderson</u>	Date <u>1-13-11</u>	Follow-up: (Circle One) Yes No



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 24, 2011

Julie Tastad, Administrator  
Creekside Inn Al Alzheimer's Community  
111 Market Street Ne, Suite 200  
Olympia, WA 98501

Dear Ms. Tastad:

An unannounced, on-site complaint investigation survey was conducted at Creekside Inn Assisted Living Alzheimer's Community from January 10, 2011 to January 13, 2011. During that time, observations, interviews, and record reviews were conducted with the following results:

Complaint # ID00004806

Allegation #1: A criminal history check was not conducted within 21 days of hire for an identified employee.

Findings #1: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.009.04 for not having an employee obtain a Department criminal history and background check within the required 21 days of hire. 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,

Gloria Keathley  
Health Facility Surveyor  
Residential Assisted Living Facility Program

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