



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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DIVISION OF MEDICAID
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February 24, 2011

CERTIFIED MAIL #: 7009 0820 0000 2807 1651

Stephenie Ellwood, Administrator
Gables Senior Living - Arrowhead Management Company
1405 Curlew Drive
Ammon, ID 83406

Dear Ms. Ellwood:

Based on the licensure/follow-up survey and complaint investigation conducted by our staff at Gables Senior Living - Arrowhead Management Company LLC on **February 11, 2011**, we have determined that the facility failed to provide adequate supervision .

This core issue deficiency substantially limits the capacity of Gables Senior Living - Arrowhead Management Company Llc 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 **March 28, 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?

Stephenie Ellwood, Administrator
February 24, 2011

Return the **signed and dated** Plan of Correction to us by **March 9, 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.

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 (**March 9, 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 **March 9, 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 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 **March 13, 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 Gables Senior Living - Arrowhead Management Company LLC.

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

Sincerely,



JAMIE SIMPSON, MBA, QMRP
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: 13R964	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/11/2011
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NAME OF PROVIDER OR SUPPLIER GABLES SENIOR LIVING - ARROWHEAD MAN	STREET ADDRESS, CITY, STATE, ZIP CODE 1405 CURLEW DRIVE AMMON, ID 83406
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(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
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R 000	<p>Initial Comments</p> <p>The following deficiency was cited during the licensure, follow-up and complaint investigation conducted 2/7/2011 through 2/11/2011 at your residential care/assisted living facility. The surveyors conducting the survey were:</p> <p>Polly Watt-Geier, MSW Team Coordinator Health Facility Surveyor</p> <p>Gloria Keathley, LSW Health Facility Surveyor</p> <p>Karen Anderson, RN Health Facility Surveyor</p> <p>Survey Definitions: carb = carbohydrate cath = catheter CCHO = Consistent Carbohydrate Diet cm = cenimeter CNA = Certified Nursing Assistant gms = grams LPN = Licensed Practical Nurse NSA = Negotiated Service Agreement Pt/pt = patient R = Right RN = Registered Nurse UAI = Uniform Assessment Instrument</p>	R 000		
R 008	<p>16.03.22.520 Protect Residents from Inadequate Care.</p> <p>The administrator must assure that policies and procedures are implemented to assure that all residents are free from inadequate care.</p>	R 008		

Bureau of Facility Standards

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

Stephanie Ellwood

TITLE

Administrator

(X6) DATE

3-7-2011

Bureau of Facility Standards

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R 008	<p>Continued From page 1</p> <p>This Rule is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to provide adequate supervision to 6 of 10 sampled residents (# 1, 2, 3, 5, 6 & 9). These findings include:</p> <p>I. SUPERVISION OF CARES & SERVICES</p> <p>IDAPA 16.03.22.012.25 Supervision - A critical watching and directing activity which provides protection, guidance, knowledge of the resident's general whereabouts, and assistance with activities of daily living. The facility is responsible for providing appropriate supervision based on each resident's Negotiated Service Agreement or other legal requirements.</p> <p>A. Identification and treatment of pressure ulcers</p> <p>1. Resident #9 was admitted on 3/13/09, with diagnoses which included Alzheimer's and Parkinson's disease.</p> <p>The NSA, dated 3/23/10, did not document the resident had any skin issues.</p> <p>A facility nursing assessment, dated 9/1/10, documented the resident had no areas of skin breakdown or any concerns regarding the condition of the resident's skin.</p> <p>A fax (signed by the facility LPN and noted by the RN) was sent to a hospice agency, on 9/1/10, requesting services for "skilled nursing for minor wound care."</p> <p>A hospice nurse assessment, dated 9/15/10, documented the resident had a "reddened coccyx" and was at risk of skin breakdown.</p>	R 008	<p>R008 (A) Resident # 9 was observed to have a pressure ulcer by hospice. A meeting was held with the hospice agency and a plan was put in place to ensure that there will be proper communication between agency & facility. Hospice nurses are to communicate directly with the facility RN in all matters concerning skin breakdown. Our facility RN has been instructed that a full assessment of skin issues is required even if the resident is on services with another agency. The facility nursing supervisor will read all agency notes weekly and will report any issues to the administrator and facility RN. By reviewing all notes and increasing the communication between parties the chance of this issue reoccurring will be minimal.</p>	
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R 008	Continued From page 2 A hospice nurse assessment, dated 9/20/10, documented the resident had developed a pressure ulcer on her right buttock and a pressure ulcer on the inside of her knee. The assessment did not describe or stage the pressure ulcers. A hospice nurse assessment, dated 9/27/10, documented the resident's right buttock pressure ulcer measured 2.0 cm x 2.4 cm. Additionally, it documented the resident had pressure ulcers on the inside of both knees that were "scabbed sores." A hospice nurse assessment, dated 10/11/10, documented the right buttock pressure ulcer had a "white with red" color around the wound bed. A hospice nurse assessment, dated 10/13/10, documented "Stage III pressure ulcer to R buttock; Stage II pressure ulcer to coccyx." The facility RN assessment, dated 12/15/10, documented the resident had a dressing that was dry and intact on her right hip and buttock area. The RN did not address the status of the pressure ulcers. On 2/8/11 at 2:45 PM, the facility RN stated, "I was not aware the resident had a Stage III pressure ulcer." She further stated, "I observed the resident's dressing on her right hip area, but I didn't take the dressing off to assess the wound." On 2/8/11 at 3:40 PM, the hospice nurse stated she had notified the nursing supervisor and the LPN of the status of all the resident's pressure ulcers.	R 008	R008 (A) Each time there is an issue with skin breakdown the facility RN will provide oversight instructions in coordination with hospice or home health. Training will be provided when necessary. Caregivers due to document any issues they see on an RN communication form. The RN will check these forms throughout the week and will provide instruction as needed. This issue was corrected on 2/21/11. Training will be provided quarterly to ensure all staff receive proper training.	

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R 008	<p>Continued From page 3</p> <p>On 2/8/11 at 4:15 PM, the administrator stated she was not aware Resident #9 had a Stage III pressure ulcer. She further stated, "I was not told by the hospice RN or the facility RN the resident had pressure ulcers. The resident fell through the cracks."</p> <p>On 2/8/11 at 4:20 PM, an LPN, who worked at the facility, also confirmed she was not aware of the pressure ulcers and the hospice RN never mentioned Resident #9's pressure ulcers.</p> <p>The facility nurse assessment, dated 9/1/10, documented the resident's skin was intact. However, a fax was sent (by the facility LPN, and dated and initialed by the facility RN) to a hospice agency the same day requesting services for "skilled nursing for minor wound care." Fourteen days later, a hospice nurse documented the resident had a "reddened coccyx" and was at risk of skin breakdown. Nineteen days later the resident had developed pressure ulcers on her right buttock and the inside of her knees. Forty-three days later, the resident was assessed by a hospice RN to have a Stage III pressure ulcer to her right buttock and a Stage II pressure ulcer to her coccyx. There was no documentation by the facility nurse that she had monitored the status of the resident's pressure ulcers.</p> <p>The facility did not provide supervision for Resident #9 when they did not coordinate wound care after initiating hospice services. The facility RN did not assess the resident's pressure ulcers after 9/1/10. The RN did not provide oversight or instructions to the caregivers on what preventative measures to take to prevent further skin breakdown.</p> <p>B. Diets not implemented as ordered by a</p>	R 008	<p>R008 (B) - All diet orders have been reviewed and updated. Training was provided by the facility RN on 3/4/11 to all staff members. Kitchen staff have been instructed on following diet restrictions. All meal cards were reviewed and updated as needed to reflect the proper orders. Upon admission all diet orders will be reviewed and all staff will be educated on the needs of the resident. If thickened liquids are required the facility will ensure this is implemented and the kitchen supervisor, nursing supervisor and facility RN will monitor for any issues or needs. This issue was corrected on 2/14/2011.</p>	

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R 008	<p>Continued From page 4</p> <p>physician</p> <p>1. Resident #6 was admitted to the facility on 9/11/07, with diagnoses of developmental delay, traumatic brain injury and insulin dependent diabetes mellitus.</p> <p>Physician's diet orders upon admission documented, "Pt is to have a diet consisting of 30-45 gms of carbs per meal. He is to have three meals a day and two snacks with 15 gms carbs per day."</p> <p>On 7/24/08, the resident was admitted to the hospital, from the facility, for treatment of possible aspiration pneumonia.</p> <p>On 10/7/10 at 3:30 PM, the resident had a fall at the facility and sustained a fracture. He was discharged to a skilled nursing facility for recovery and rehabilitation.</p> <p>The skilled nursing discharge instructions, dated 12/27/10, documented the resident had difficulty swallowing and the physician's diet order was, "CCHO with chopped meats."</p> <p>The facility RN's Admission Assessment, dated 12/29/10, documented the resident's appetite was "good." There was no documentation concerning the resident's swallowing difficulties or dietary needs.</p> <p>The NSA, dated 1/12/11, documented the resident required "extensive assistance to encourage him to maintain proper nutritional intake." It documented the resident also required standby assistance to ensure he was chewing his food properly because he was at risk for choking and aspiration.</p>	R 008	<p>R008(B) - cont. - Training will be done quarterly to ensure all staff are properly trained.</p>	
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R 008	<p>Continued From page 5</p> <p>Six meals were observed from 2/8/11 through 2/10/11. Resident #6 was observed eating a regular diet including meats that were not chopped. During all observed meals staff did not provide standby assistance to monitor that he chewed his food properly.</p> <p>On 2/8/11 at 12:55 PM, a kitchen staff member stated, Resident #6 received a regular diet. He further stated, the resident's diet used to be mechanical soft, but he no longer was served the diet.</p> <p>On 2/9/11 at 3:30 PM, another kitchen staff member stated, "[The Resident's name] is on a regular diet. His food should be chopped or pureed before being served to him, because he is a choking risk, but I have never seen him choke before." The kitchen staff member further stated, he was not sure why the resident's diet was changed to a regular diet. He "guessed" it was probably the resident's preference.</p> <p>On 2/10/11 at 8:45 AM, the dietary manager stated Resident #6 was served a regular diet and he was not aware of a diet order to restrict or count carbohydrates. He further stated the resident was on thickened liquids, but no longer required a therapeutic diet.</p> <p>On 2/10/11, the facility RN stated, "I hope the dietary manager is taking care of the resident's diet and carb counting. I'm not sure if the resident is to receive a mechanical soft diet or chopped meats, or if a speech therapy evaluation was done."</p> <p>From 9/11/07 through 2/11/11 (over a three year time frame), the facility had not clarified diet</p>	R 008		

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R 008	<p>Continued From page 6</p> <p>orders to ensure Resident #6's received a CCHO diet with chopped meats. Additionally, the facility did not coordinate to ensure Resident #6 received standby assistance with eating to prevent choking or aspiration.</p> <p>2. Resident #2 was admitted to the facility on 2/19/07, with diagnoses which included right frontal temporoparietal and subdural hematoma.</p> <p>A physician quarterly report, dated 6/1/09, documented the resident was to receive a pureed diet with nectar thick liquids.</p> <p>A hospice agency "Medication and Supplies Form," dated 8/30/10, documented a pureed diet was ordered on 8/5/10.</p> <p>The UAI, dated 8/24/10, documented the resident had a mechanical altered diet and required thickened liquids due to "occasional choking and gagging episodes."</p> <p>A facility's "Record Summary," dated 8/26/10, documented all foods needed to be pureed and all liquids were to be nectar thick.</p> <p>A physician's "Quarterly Medication Review Report," dated 1/13/11, documented a pureed diet and nectar thick liquids were required.</p> <p>Resident #2's NSA and nursing progress notes did not document the resident's need for a pureed diet and nectar thickened liquids.</p> <p>On 2/8/11 at 12:15 PM, the resident was observed in the dining room. The resident had chopped chicken with gravy, peas and mashed potatoes with gravy. The resident was drinking regular hot chocolate, which had not been</p>	R 008		

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R 008	<p>Continued From page 7</p> <p>thickened as ordered. Further, the resident's meal was not pureed as ordered.</p> <p>On 2/9/11 at 8:30 AM, the resident was observed in the dining room eating breakfast. Her meal was not pureed and consisted of hot cereal, toast and hot chocolate. The hot chocolate was not observed thickened as ordered.</p> <p>On 2/8/11 at 12:30 PM, a caregiver stated the resident did not eat her food, but would drink her hot chocolate. She further stated, the resident "seemed" to swallow her liquids better when they were hot.</p> <p>On 2/8/11 at 2:30 PM, the facility RN stated she did not know the resident was not receiving a pureed diet and nectar thick liquids.</p> <p>On 2/8/11 at 2:40 PM, the nursing supervisor, who is a CNA, stated she was unaware of the hospice order for a pureed diet and thickened liquids.</p> <p>On 2/8/11 at 2:50 PM, the dietary manager stated he was aware of the pureed diet order. However, he stated the resident did not like pureed foods, so they did not puree her food. Additionally, he stated nectar thickened liquids were not prepared, as the resident liked her hot chocolate thin and "did well" with hot liquids.</p> <p>The facility did not provide supervision to ensure Resident #2's diet had been implemented or clarified. From 6/1/09 to 2/8/11 (9 months), the facility did not serve Resident #2 a pureed diet or thickened liquids.</p> <p>C. Monitoring weights and notifying physician of changes</p>	R 008		

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R 008	<p>Continued From page 8</p> <p>Resident #3 was admitted to the facility on 10/16/08, with diagnoses which included diabetes and water retention.</p> <p>A "Record Summary Report," dated 2/8/11, documented the resident was to have his weight taken daily and to notify the physician if his weight was up three pounds in one day or five pounds in a week.</p> <p>The resident's NSA, dated 12/6/10, did not address the need to weigh the resident daily or the importance of reporting an increase in weight to the physician.</p> <p>The "Record Summary" documented the following weights for the last 60 days:</p> <ul style="list-style-type: none"> * 12/15/10 = 209 * 12/23/10 = 210.6 * 12/27/10 = 216.6 * 12/28/10 = 215.2 * 01/03/11 = 218.4 * 01/10/11 = 205 * 01/14/11 = 197.4 * 01/24/11 = 211.6 * 01/28/11 = 199.8 * 02/04/11 = 212.6 * 02/07/11 = 211.6 <p>The resident's weights were documented 11 times in 60 days, but should have been done daily. Of the 11 times he was weighed, the physician should have been notified twice. As the facility did not weigh the resident daily as ordered, they could not determine if the resident had a weight gain.</p> <p>A facility RN assessment, dated 12/10/10, did not</p>	R 008	<p>R008 (C) - Staff were educated on 3/4/11 of the importance of weights that are ordered to be done daily or weekly. The nursing supervisor will review the weights daily and will report any issues to the facility RN and the resident's physician. If the resident refuses daily weights this will be reported to the facility RN and the physician. All issues will be documented in the resident notes as well as on an RN communication form (see attached form.) This issue was corrected on 3/4/11. Training will be provided quarterly to ensure staff are well aware of all weight issues.</p>	
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R 008	<p>Continued From page 9</p> <p>document that the RN had assessed the resident's weight.</p> <p>On 2/8/11 at 9:45 AM, the medication aide stated at times the resident refused to be weighed. She stated she reported the refusals to the nursing supervisor, who was a CNA. There was no documentation the resident refused to have his daily weight taken.</p> <p>On 2/8/11 at 2:30 PM, the facility RN stated she was not aware the resident's weights were not being documented. She also stated she did not know if the physician was notified of weight gains.</p> <p>On 2/8/11 at 2:40 PM, the nursing supervisor, who was a CNA, stated she was not aware the resident's daily weights were not being done.</p> <p>On 2/9/11 at 9:00 AM, Resident #3 stated he was not aware he had to be weighed daily, he thought it was once a month.</p> <p>The facility did not provide supervision to ensure Resident # 3's order for weights were implemented. The resident's weights were documented 11 times in 60 days, but should have been done daily. Of the 11 times he was weighed, the physician should have been notified twice. As the facility did not weigh the resident daily as ordered, they could not determine if the resident had a weight gain due to increased fluid retention. A fluid increase could have negatively impacted his cardiac status.</p> <p>D. Coordination of catheter care, peri-care and wound care</p> <p>1. Resident #1 was admitted to the facility on 12/4/10, with diagnoses which included a urinary</p>	R 008	<p>R008 (D) - The resident was on home health and was is being treated and followed by that agency. Once she was discharged the facility RN will continue to monitor her catheter and will provide education to the staff on the proper care of the catheter and the peri-area. Training was provided to staff on 3/4/11 on the proper way to complete peri care as well as what to look for as far as skin conditions. The facility RN has been instructed that even if the resident is on services she is to do an assessment and is to follow-up regularly to ensure there are no issues.</p>	
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NAME OF PROVIDER OR SUPPLIER GABLES SENIOR LIVING - ARROWHEAD MAN	STREET ADDRESS, CITY, STATE, ZIP CODE 1405 CURLEW DRIVE AMMON, ID 83406
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(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
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R 008	<p>Continued From page 10</p> <p>tract infection.</p> <p>An emergency room note, dated 12/5/10, documented the resident was treated for urinary retention and was given an antibiotic and a Foley catheter was inserted.</p> <p>The facility RN assessment, dated 12/5/10, documented "Foley cath care instructions given and pt. husband voices understanding." There was no documentation who would be providing the catheter cares for the resident.</p> <p>A home health "Coordination Summary," dated 12/8/10, documented the resident had a Foley catheter placed due to inability to urinate. There was no documentation on how the coordination of catheter care would be implemented.</p> <p>An NSA, dated 12/28/10, documented the resident had a catheter and staff were to assist as needed or requested by the resident. There was no further documented instructions on who was responsible for providing the catheter care or what level of assistance the resident required with her catheter care.</p> <p>There was no coordination or clear directions documenting who would be providing catheter care and/or oversight if the resident had complications with her catheter.</p> <p>Complication: Catheter pain with inflammation of the peri-area</p> <p>A progress note and a home health note, dated 1/5/11, documented the resident complained of pain and discomfort from her catheter. There was no documentation that unlicensed caregivers were instructed on ways to respond if the resident</p>	R 008	<p>R008(b) chkd. — Staff will document any issues on the resident notes as well as on an RN communication form. The facility RN will document and follow up on any issues to ensure that proper procedures are in place to provide appropriate care to residents who have catheters or other per care issues. If there are any issues with pain, discomfort or other signs of an infection the facility RN will be contacted immediately so she can address those issues. This issue was corrected on 3/11/11. Quarterly training will be provided.</p>	
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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R964	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/11/2011
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NAME OF PROVIDER OR SUPPLIER GABLES SENIOR LIVING - ARROWHEAD MAN	STREET ADDRESS, CITY, STATE, ZIP CODE 1405 CURLEW DRIVE AMMON, ID 83406
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R 008	<p>Continued From page 11</p> <p>continued to have pain associated with her catheter.</p> <p>A progress note, dated 1/7/11 at 5:22 PM, documented the resident continued having pain with her catheter.</p> <p>A home health note, dated 1/7/11, documented the resident's labia was "extremely swollen" and they were unable to replace a Foley catheter due to the swelling. The resident was then transferred to the hospital.</p> <p>There was no documentation the facility RN was notified of the resident's change of condition nor were there instructions to the unlicensed caregivers on how to care for the resident's inflamed peri-area. Additionally, there was no documentation, for 5 days, describing the resident's condition.</p> <p>A home health note, dated 1/13/11, documented the resident went to see a physician who took over the resident's catheter care, therefore discontinuing home health services. The home health nurse documented the resident's "irritation" had decreased in the "peri/vaginal areas." There was no documentation the home health nurse provided instructions to the caregivers on how to care for the resident's inflamed peri-area to prevent further irritation and pain.</p> <p>On 2/7/11 at 5:38 PM, the administrator stated that approximately a month prior (January) the resident's peri-area became inflamed and her anatomy was not recognizable due to the swelling. At that time, home health had tried to replace the catheter and they were unsuccessful, so she was sent to the hospital for a catheter change. After that time, home health was</p>	R 008		
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Bureau of Facility Standards

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R 008	<p>Continued From page 12</p> <p>discontinued and the resident was seen at a physician's office.</p> <p>On 2/9/11 at 11:25 AM, the facility RN, stated that about a month ago (January) she had been out of town and two other home health nurses came into the facility and removed the catheter. They both attempted to replace the catheter, but were unsuccessful. After that, the resident's physician began changing her catheter monthly at his office and home health services were discontinued. She stated she had not documented further concerns or pain regarding the resident's peri-area after home health was discontinued. Additionally, she stated she had not instructed the caregivers on how to assist the resident as she was supposed to be independent with everything.</p> <p>On 1/5/11, Resident #1 complained of catheter pain, at that time the home health and/or facility nurse did not instruct unlicensed caregivers on how and when to monitor the resident's pain or what to do if the resident continued to have pain associated with her catheter. On 1/7/11, 2 days later, Resident #1 continued to complain of catheter pain, at that time the catheter was removed, but could not to be replaced due to extreme swelling. After the extreme swelling was noted, there was no documentation of the condition of the resident's peri-area. There also was no documentation providing instructions to the unlicensed caregivers on how to care for the resident's peri-area to prevent further irritation, swelling or pain.</p> <p>Example B: Catheter pain with peri-care and wound care</p> <p>A progress note, dated 2/1/11 at 1:43 PM, documented the resident was having pain</p>	R 008		

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R 008	<p>Continued From page 13</p> <p>associated with her catheter. The caregiver and "nurse" took a look at the resident's catheter and observed the "placement was good." The note further documented the peri-area looked "red and looked like she needed cleaned." There was no documentation the facility RN assessed the resident's peri-area at that time or provided instructions to unlicensed caregivers on how to cleanse the inflamed peri-area.</p> <p>A progress note, dated 2/1/11 at 7:12 PM, documented the resident called in a caregiver before lunch time "to tell me that her catheter was bugging her." The caregiver documented she looked at the peri-area and it "looked ok" except the leg strap for the catheter was "undone and missing." The caregiver documented she asked the resident "if her vagina itched and she said no. She said it was inside that hurt." The progress note documented the caregiver and another caregiver looked at the area and did not "see anything weird." Then they "decided" to call the facility nurse and also made an appointment with the resident's physician. Additionally, the progress note documented a third caregiver would provide peri-care with soap and water before the resident went to bed to "see if that helps."</p> <p>There was no documentation the facility RN assessed the resident's catheter or associated pain. There was no documentation that the unlicensed caregivers obtained instructions by the facility RN on how to properly cleanse the peri-area.</p> <p>A progress note, dated 2/3/11 at 5:34 PM, documented the resident went to the physician's office and had her catheter changed. The note also documented the resident "has a really bad</p>	R 008			

Bureau of Facility Standards

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R 008	<p>Continued From page 14</p> <p>soar [sic] in her peri area [sic]." Additionally, it documented caregivers would put cream on the sore and continue to monitor condition. There was no documentation the facility RN was notified of the resident's wound. There also were no documented instructions to unlicensed caregivers on how to properly cleanse or treat the wound.</p> <p>A progress note, dated 2/7/11 at 3:35 PM, documented the resident had a "sore in her vaginal area. The morning aid [sic] cleaned her up and put cream on her soar [sic]. The morning floor aid [sic] told me that she was very soar [sic]. We will continue to monitor her and put cream on her." There was no documentation the facility RN was notified of the resident's wound, since it was identified on 2/3/11, 5 days earlier. There was also no documented instructions provided to unlicensed caregivers on how to properly cleanse or treat the wound.</p> <p>On 2/8/11 at 10:52 AM, a caregiver stated she was not aware the resident had a wound. She stated the caregivers were supposed to provide peri-care twice a day to the resident. She stated there had been a cream to apply to the wound, but the resident had a reaction and it was no longer used.</p> <p>On 2/9/11 at 11:25 AM, the facility RN, (who had also been the resident's home health nurse), stated she had not documented further concerns or issues regarding the resident's peri-area after home health was discontinued. Additionally, she stated she had not instructed the caregivers on how to provide peri-care as the resident was independent with everything.</p> <p>On 2/9/11 at 1:12 PM, the resident stated the caregivers did not provide peri-care every day.</p>	R 008		

Bureau of Facility Standards

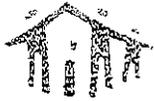
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R 008	<p>Continued From page 15</p> <p>She stated she had to be careful when sitting because it would hurt if she sat down wrong. Additionally, she stated she had pain on and off with the catheter, but if she moved it around, it felt better.</p> <p>On 2/9/11 at 1:20 PM, a caregiver stated she would take the resident to the bathroom every two hours. She stated she would wash the peri-area twice a day and wipe the area as needed. She stated she was not aware of the resident ever having a wound or swollen peri-area.</p> <p>On 2/9/11 at 1:25 PM, a caregiver stated she provided the resident with general peri-care when providing catheter care. She stated she would empty the catheter bag and used wipes to cleanse the peri-area and clean the catheter tubing. She stated she had not seen swelling or a wound in the resident's peri-area. She stated the resident had a little bit of pain with the catheter. Additionally, she stated she had learned how to provide peri-care from a CNA course, but had not received direction from the facility.</p> <p>On 2/9/11 at 1:29 PM, the nursing supervisor, who was a CNA, stated the resident had a catheter inserted after first being admitted to the facility because she could not void. Initially, home health was changing the resident's catheter, but they were unable to replace it due to extreme swelling. During the last catheter placement at the physician's office, a wound was found in the resident's peri-area. She stated the caregivers were to provide peri-care to the resident; however, she stated the caregivers were not provided education on how to provide appropriate catheter, wound and peri-care. She stated if caregiver did not know how to provide</p>	R 008		

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R 008	<p>Continued From page 16</p> <p>appropriate care, they were supposed to come talk with her for direction. Additionally, she stated all of the caregivers had been advised of the resident's wound in the peri-area.</p> <p>On 2/10/11 at 10:11 AM, a caregiver stated that approximately a week ago, 2/3/11, caregivers began applying a cream to the resident's wound. She was not aware of the resident having a medication reaction from the cream.</p> <p>The facility failed to provide adequate supervision for Resident #1's catheter care, peri-care, wound care and pain. There was no coordination between the facility RN, facility caregivers or the home health agency regarding who would be providing catheter care and/or oversight if the resident had complications with her catheter.</p> <p>E. Assistance with mobility and transferring</p> <p>Resident #5 was admitted on 11/5/08, with diagnoses of Parkinson's and Cushing's disease.</p> <p>Resident #5's NSA, dated 12/3/10, documented the resident needed minimal assistance with toileting and moderate assistance with mobility.</p> <p>On 2/7/11 at 4:55 PM, Resident #5 was observed transferring herself from her recliner to her electric wheelchair. The resident stated, "I don't have time to talk. It takes so long to get ready, so now I'm running late to get to dinner."</p> <p>On 2/9/11 at 9:30 AM, a caregiver stated Resident #5 needed assistance with bathing and sometimes assistance with transferring into her wheelchair, or back to her chair or bed.</p> <p>On 2/9/11 at 10:49 AM, a nursing supervisor</p>	R 008	<p>R008 (E) - upon admission and every 90 days the facility RN will assess each resident for transfer needs. Staff will receive education on proper transfer techniques by 4/5/2011. Residents who are resistant to cares will be monitored closely to ensure that they are being transferred properly. Call pendants will be checked weekly to ensure they are functioning properly. Resident #5's NSA was reviewed and ammended to reflect the changes needed with toileting & mobility. Any issues will be documented</p>	

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R 008	Continued From page 17 stated, "Staff are to check on Resident #5 to assist her with transfers." On 2/9/11 at 10:55 AM, the facility RN stated, Resident #5 should be receiving assistance with transferring. On 2/9/11 at 11:15 AM, Resident #5 stated, "I transfer myself because staff are slow to come, if they come at all. I used to put on my call light, but I don't bother now." The resident further stated, "I will show you how the 'Good Lord' helps me get out of this chair." The resident was observed to attempt to get up from her recliner three times before she accomplished the task. She was weak, shaky and had poor balance as she transferred from her recliner, to her walker and then to her electric wheelchair. This task took the resident over five minutes to complete. Resident #5 required assistance with activities of daily living due to her mobility needs. The resident was unable to get assistance from caregivers, when she put on her call light for assistance. The facility did not provide supervision to ensure her mobility, and safety needs were met, according to the NSA. The facility did not provide supervision to identify and coordinate the treatment of Resident #9's pressure ulcers. The facility also failed to provide supervision to ensure diets for Residents #2 and #6 were clarified and implemented as ordered. The facility failed to provide supervision for Resident #1's catheter care, peri-care, wound care and pain. Additionally, the facility failed to provide appropriate assistance with mobility for Resident #5. These failures resulted in inadequate care.	R 008	R008 (E) - cmtd. — on all RN communication form so the facility RN can address them and make needed recommendations. This issue was corrected on 2/14/11 and training will be completed by 4/4/2011. Quarterly training will be provided.	



IDAHO DEPARTMENT OF
HEALTH & WELFARE

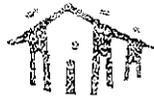
MEDICAID LICENSING & CERTIFICATION - RALF
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-6626 fax: (208) 364-1888

ASSISTED LIVING
Non-Core Issues
Punch List

Facility Name Gables Senior Living	Physical Address 1405 Curlew Dr	Phone Number (208) 535-0090
Administrator Stephanie Ellwood	City Ammon	Zip Code 83406
Team Leader Polly Watt-Geier	Survey Type Licensure, Follow-up and Complaint	Survey Date 02/11/11

NON-CORE ISSUES

Item #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	L&C USE
1	152.05.b.iii	Resident #2, #4, #8, #9 and #10 had bedrails.	3/4/2011	3/25/11 PAG
2	220.03.e	10 of 10 sampled residents' admission agreements did not identify the assessment tool, the frequency of the assessment or when the rates of services would be changed.	3/1/2011	3/25/11 PAG
3	225	Residents #6, #7 and #10 did not have documented behavior management plans which described the residents' behaviors or the interventions being implemented. (e.g. Resident #6's BMP did not describe his verbal and physical aggression, Resident #7 BMP did not describe her resistance to cares and Resident #10's BMP did not describe her resistance to cares or her exit seeking behaviors.)	2/28/11	3/25/11 PAG
4	250.09	The hallway by room 127, the hallway in front of the medication room and the hallway by room 115 had transient urine odor.	2/11/11	3/25/11 PAG
5	250.01	Hot water temperatures exceeded the maximum temperature of 120 degrees. (Rooms 202, 215, 130 and 131). REPEAT	2/11/11	3/25/11 PAG
6	250.15	Facility's call pendants were not always worn or in working condition. Additionally, 9 out 59 residents stated the call lights were occasionally not answered in a timely manner.	2/14/11	3/25/11 PAG
7	260.06	Residents wheelchairs were observed to be dirty.	2/14/11	3/25/11 PAG
8	300.02	A licensed nurse did not address changes in residents health status. (i.e. Resident #1's skin condition, Resident #3's increased weight gain, Resident #2 and #6's diet restrictions and Resident #9's pressure ulcer and decline in health). REPEAT	2/14/11	3/25/11 PAG
9	305.02	The facility did not ensure that all scheduled and PRN medications were available as ordered for Residents #3, #5, #6 and a random resident.	2/14/11	3/25/11 PAG
10	305.06.a	The facility nurse did not assess Resident #'s 6 and #8's ability to self-inject insulin.	2/14/11	3/25/11 PAG
Response Required Date 3/2/11		Signature of Facility Representative <i>Stephanie Ellwood</i>	Date Signed 2/11/11	



IDAHO DEPARTMENT OF
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NON-CORE ISSUES

Item #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	L&C USE
11	305.08	Staff were not provided education regarding the following: sliding scale insulin for Residents #6 and #8, diet restrictions for Resident #6 and catheter care for Resident #1. REPEAT	3/4/11	3/25/11 PWS
12	310.01.d	Unlicensed caregivers dialed Resident #8's insulin pen and did not contact the facility nurse prior to assisting cognitively impaired residents with PRN medications.	2/11/2011	3/25/11 PWS
13	310.04.e	The facility did not ensure physicians reviewed Resident #6 and #8 use of psychotropic medications every six months, nor did they provide behavioral updates to the physicians.	3/1/2011	3/25/11 PWS
14	320.08	The facility did not update residents' NSAs when they had changes in condition. (e.g. Resident #2 increased care needs from minimal to extensive, Resident #4 end of life care. Resident #5's mobility needs, Resident #7's ileostomy care, Resident #9's hospice services, mobility, and eating need, and Resident #10's increased supervision needs.) REPEAT	2/14/11	3/25/11 PWS
15	350.02	The facility administrator did not document complete investigations for all verbal and written complaints within 30 days.	2/14/11	3/25/11 PWS
16	350.04	The facility administrator did not provide a written response to complaints.	2/14/11	3/25/11 PWS
17	451.02	The facility did not offer snacks to residents between meals (i.e. between breakfast and lunch; lunch and dinner).	3/4/11	3/25/11 PWS
18	711.08.a	The facility staff did not document showers as given nor did they document refusals or re-attempts to shower.	2/18/11	3/25/11 PWS
19	711.08.e	The facility staff did not document when they notified the facility nurse of changes of condition.	2/14/11	3/25/11 PWS

Response Required Date
03/02/11

Signature of Facility Representative
Stephanie Ellwood

Date Signed
2/11/11



IDAHO DEPARTMENT OF

HEALTH & WELFARE Food Establishment Inspection Report

Food Protection Program, Division of Health
450 W. State Street, Boise, Idaho 83720-0036
208-334-5938

Congratulations

Establishment Name <u>Livingston Barber Shop</u>		Operator <u>Stephanie Ellwood</u>	
Address <u>705 Canyon</u>		Inspection time: _____ Travel time: _____	
County <u>Boise</u>	Estab # <u>20028</u>	EHS/SUR # <u>20028</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.

# of Risk Factor Violations <u>0</u>	# of Retail Practice Violations <u>0</u>
# of Repeat Violations _____	# of Repeat Violations _____
Score <u>0</u>	Score <u>0</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		Potentially Hazardous Food Time/Temperature	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"/>	<u>(Y)</u> N N/O N/A	15. Proper cooking, time and temperature (3-401)	<input type="checkbox"/>	<input type="checkbox"/>
	Employee Health (2-201)			<u>(Y)</u> N N/O N/A	16. Reheating for hot holding (3-403)	<input type="checkbox"/>	<input type="checkbox"/>
<u>(Y)</u> N	2. Exclusion, restriction and reporting	<input type="checkbox"/>	<input type="checkbox"/>	<u>(Y)</u> N N/O N/A	17. Cooling (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
	Good Hygienic Practices			<u>(Y)</u> N N/O N/A	18. Hot holding (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
<u>(Y)</u> N	3. Eating, tasting, drinking, or tobacco use (2-401)	<input type="checkbox"/>	<input type="checkbox"/>	<u>(Y)</u> N N/O N/A	19. Cold Holding (3-501)	<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"/>	<u>(Y)</u> N N/O N/A	20. Date marking and disposition (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
	Control of Hands as a Vehicle of Contamination			<u>(Y)</u> N N/O N/A	21. Time as a public health control (procedures/records) (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
<u>(Y)</u> N	5. Clean hands, properly washed (2-301)	<input type="checkbox"/>	<input type="checkbox"/>		Consumer Advisory		
<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 N/A	22. Consumer advisory for raw or undercooked food (3-603)	<input type="checkbox"/>	<input type="checkbox"/>
<u>(Y)</u> N	7. Handwashing facilities (5-203 & 6-301)	<input type="checkbox"/>	<input type="checkbox"/>		Highly Susceptible Populations		
	Approved Source			<u>(Y)</u> N N/O N/A	23. Pasteurized foods used, avoidance of prohibited foods (3-801)	<input type="checkbox"/>	<input type="checkbox"/>
<u>(Y)</u> N	8. Food obtained from approved source (3-101 & 3-201)	<input type="checkbox"/>	<input type="checkbox"/>		Chemical		
<u>(Y)</u> N	9. Receiving temperature / condition (3-202)	<input type="checkbox"/>	<input type="checkbox"/>	<u>(Y)</u> N N/A	24. Additives / approved, unapproved (3-207)	<input type="checkbox"/>	<input type="checkbox"/>
<u>(Y)</u> N N/A	10. Records: shellstock tags, parasite destruction, required HACCP plan (3-202 & 3-203)	<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"/>
	Protection from Contamination				Conformance with Approved Procedures		
<u>(Y)</u> N N/A	11. Food segregated, separated and protected (3-302)	<input type="checkbox"/>	<input type="checkbox"/>	<u>(Y)</u> N <u>(N/A)</u>	26. Compliance with variance and HACCP plan (8-201)	<input type="checkbox"/>	<input type="checkbox"/>
<u>(Y)</u> N N/A	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"/>				

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>3 bean salad</u>	<u>38°</u>	<u>potatoes</u>	<u>167°</u>	<u>Squash</u>	<u>168°</u>		
<u>Pork</u>	<u>37.8°</u>	<u>Pork loin</u>	<u>165°</u>	<u>greeny</u>	<u>70°</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. Utensil & engine-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>Stephanie Ellwood</u>	(Print) <u>Stephanie Ellwood</u>	Title <u>Admin.</u>	Date <u>2/11/11</u>
Inspector (Signature) <u>Karen Anderson</u>	(Print) <u>Karen Anderson</u>	Date <u>2/11/11</u>	Follow-up: (Circle One) Yes <input type="checkbox"/> No <input type="checkbox"/>



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

February 24, 2011

Stephenie Ellwood, Administrator
Gables Senior Living - Arrowhead Management Company
1405 Curlew Drive
Ammon, ID 83406

Dear Ms. Ellwood:

An unannounced, on-site complaint investigation was conducted at Gables Senior Living - Arrowhead Management Company LLC from February 7, 2011, to February 11, 2011. During that time, observations, interviews, and record reviews were conducted with the following results:

Complaint # ID00004901

Allegation #1: The fire sprinklers were not working and the facility did not report this to fire life safety or conduct a fire watch.

Unsubstantiated.

Findings #1: The facility provided an incident report to fire life safety on 1/14/11. The report documented a sprinkler pipe froze on 1/7/11 and a fire watch was started under the guidance of the Ammon Fire Department.

Allegation #2: Medications were not available as ordered.

Findings #2: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.305.02 for not ensuring all scheduled and as needed medications were available as ordered. The facility was required to submit evidence of resolution within 30 days.

Allegation #3: Residents ran out of diabetic test strips and staff borrowed from other residents.

Findings #3: On 2/7/11 between 3:30 PM and 5:26 PM, four residents were observed to have a supply of blood glucose test strips and monitors in their rooms. Additionally, a supply of test strips were observed in the medication room.

On 2/8/11 at 9:00 AM, a resident's blood glucose test strips were observed in the medication cart with the resident's name on them.

On 2/8/11 at 9:15 AM, the medication aide stated she had never heard of resident's test strips being used on another resident. She further stated all residents have their own supply of test strips. Additionally, she stated residents' glucose monitors were different and could not be borrowed in between residents.

On 2/9/11 at 1:24 PM, a resident stated her test strips were unique and could only be used with her machine. She stated she had never run out of test strips for her glucometer.

On 2/9/11 at 2:24 PM, another resident stated he had never run out of test strips for his blood glucose machine and did not think staff were borrowing his test strips to test another resident.

Unsubstantiated. This does not mean the incident did not take place; it only means that the allegation could not be proven.

Allegation #4: A bed bug problem, in the facility, was not totally eradicated from the last infestation.

Findings #4: On 2/7/11, a tour of the facility was conducted. Identified rooms which were alleged to still have the bed bugs were observed to be clean and free of bed bugs.

On 2/7/11 at 4:05 PM, the administrator stated there was no longer an issue with bed bugs. She stated the facility had a three week treatment to exterminate the bed bugs. She further stated a pest control company came out monthly and checked the facility for pests, including bed bugs. The entire building was treated, however the focus of treatment was on the infested rooms areas surrounding the infested rooms. Additionally, staff were trained on what to look for and what to do if bed bugs were found.

On 2/8/11 at 10:45 AM, the housekeeper stated bed bugs were eradicated immediately. She further stated a pest control company treated the facility three times. Additionally, she stated staff were trained on identifying bed bugs and what procedures to follow, if a bed bugs were found.

Unsubstantiated.

Allegation #5: The administrator does not respond in writing to resident and family complaints.

Findings #5: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.350.02 for not documenting investigations for all verbal and written complaints and at IDAPA 16.03.22.350.04 for not providing a written response to complainants. The facility was required to submit evidence of resolution within 30 days.

Allegation #6: Staff took smoke breaks together outside, leaving the residents unsupervised.

Findings #6: Substantiated. However, the facility was not cited as they acted appropriately by identifying the problem, implementing a staffing policy of smoke breaks, limiting the number of staff who could take breaks at the same time and providing staff who had not complied with disciplinary actions.

Allegation #7: The call lights were not answered in a timely manner.

Findings #7: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.250.15 for call pendants not always working or being worn by residents. Additionally, 9 out of 59 residents stated call lights were occasionally not answered in a timely manner. The facility was required to submit evidence of resolution within 30 days.

Allegation #8: All residents in wheelchairs were required to sit in one dining room which caused crowding and limited the mobility of residents.

Findings #8: Between 2/7/11 through 2/11/11, residents were observed in the two dining rooms. Residents in wheelchairs were observed in both dining rooms. Pathways were clear for residents to maneuver throughout the two dining rooms.

Between 2/7/11 and 2/11/11, thirty residents were interviewed. The residents stated individuals who went to meals in their wheelchairs were seated throughout the dining room. None of the residents stated they had difficulty maneuvering in the dining room.

Unsubstantiated. This does not mean the incident did not take place; it only means that the allegation could not be proven.

Stephenie Ellwood, Administrator
February 24, 2011
Page 4 of 4

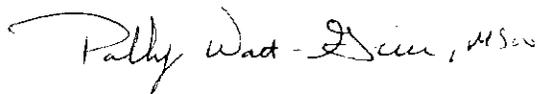
Allegation #9: The maintenance man was working without a criminal history and background check.

Findings #9: The facility's personnel files were reviewed on 2/10/11. Ten personnel files were reviewed, including the maintenance man's. All of the employees had criminal history checks completed within the time requirements.

Unsubstantiated.

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,



Polly Watt-Geier, MSW
Health Facility Surveyor
Residential Assisted Living Facility Program



IDAHO DEPARTMENT OF
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February 24, 2011

Stephenie Ellwood, Administrator
Gables Senior Living - Arrowhead Management Company
1405 Curlew Drive
Ammon, ID 83406

Dear Ms. Ellwood:

An unannounced, on-site complaint investigation was conducted at Gables Senior Living - Arrowhead Management Company LLC from February 7, 2011, to February 11, 2011. During that time, observations, interviews, and record reviews were conducted with the following results:

Complaint # ID00004904

Allegation #1: The sprinkler system was broken and a fire watch was not initiated.

Findings #1: The facility provided an incident report to fire life safety on 1/14/2011. The report documented that a sprinkler pipe froze on 1/7/2011 and a fire watch was started under the guidance of the Ammon Fire Department.

Unsubstantiated.

Allegation #2: Residents did not receive assistance or cueing with eating.

Findings #2: Between 2/7/11 and 2/11/11, residents were observed eating in the dining room. Two residents who required assistance with eating were identified. One of the identified residents was provided a 1:1 caregiver to assist with feeding throughout the meal. The other identified resident, who was on hospice, refused to eat the meals when caregivers offered assistance. The resident was observed being assisted with fluids several times throughout each day of the survey.

An identified resident's closed record was reviewed. The Negotiated Service Agreement, dated 7/14/10 documented the resident was able to feed herself and staff were to assist her as needed. The closed record had documentation of the percentage of food the resident ate at mealtimes, which ranged from 10% to 100% on any given day. There was no documented weight loss.

Between 2/7/11 and 2/11/11, thirty residents were interviewed. They stated they were not aware of residents who were not being assisted with eating as required.

On 2/8/11 at 12:00 PM, a caregiver stated if a resident needed assistance with eating, the resident received the assistance. She further stated if a resident did not want assistance, the resident would either state they did not want help or push the caregiver's hand away.

Unsubstantiated. This does not mean the incident did not take place; it only means that the allegation could not be proven.

Allegation #3: The facility did not follow the menu or provide well balanced meals.

Findings #3: The facility's menu was observed, on 2/7/11, and was signed by a registered dietician. The menu met nutritional guidelines.

Between 2/7/11 and 2/10/11, six meals were observed. The meals followed the planned menu.

Between 2/7/11 and 2/11/11, thirty residents were interviewed. They stated the food had improved and the dietary manager was involved in discussions with the residents on how to continue to improve their meal time experiences. Some of the residents stated they did not always like the meal option, but were given an alternative meal when that occurred.

Unsubstantiated. This does not mean the incident did not take place; it only means that the allegation could not be proven.

Allegation #4: Residents were not receiving showers as needed.

Findings #4: Between 2/7/11 and 2/10/11, residents were observed to be clean and free of odors.

On 2/8/11 and 2/10/11, five caregivers, the nursing supervisor and nurse were interviewed. They stated the residents received their showers as scheduled; however, the documentation of showers was not consistently done. Both the facility nurse and nursing supervisor confirmed they felt it was more of a training issue with documentation, not a care issue.

Between 2/7/11 and 2/11/11, thirty residents were interviewed. The residents stated they received showers as scheduled.

Unsubstantiated. However, the facility was issued a deficiency at IDAPA 16.03.22.711.08.a for not documenting refusals or re-attempts to shower. The facility was required to submit evidence of resolution within 30 days.

Allegation #5: The facility was not maintained in a clean and orderly fashion.

Findings #5: Between 2/7/11 and 2/10/11, the facility was observed to be clean and well-maintained. Housekeeping staff were observed to be cleaning resident's rooms and common areas throughout each day during the survey.

Between 2/7/11 and 2/11/11, thirty residents were interviewed. They stated the facility was always clean and well-maintained.

Between 2/7/11 and 2/11/11, four family members and three outside service providers were interviewed. They stated the facility was always clean and well-maintained.

Unsubstantiated. However, the facility was issued a deficiency at IDAPA 16.03.22.250.09 for hallways having transient urine odors. The facility was required to submit evidence of resolution within 30 days.

Allegation #6: Residents were not clean or well-groomed.

Findings #6: Between 2/7/11 and 2/10/11, residents were observed to be clean and free of odors.

Between 2/7/11 and 2/11/11, thirty residents were interviewed. They stated they were not aware of any residents who were unkempt or frequently dirty.

Between 2/7/11 and 2/11/11, four family members and three outside service providers were interviewed. They stated they were not aware of residents being dirty or unkempt.

Unsubstantiated. This does not mean the incident did not take place; it only means that the allegation could not be proven.

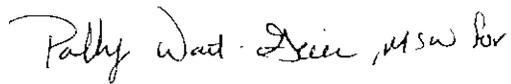
Allegation #7: The administrator does not respond in writing to resident and/or family complaints.

Findings #7: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.350.02 for not documenting investigations for all verbal and written complaints and at IDAPA 16.03.22.350.04 for not providing a written response to complainants. The facility was required to submit evidence of resolution within 30 days.

Stephenie Ellwood, Administrator
February 24, 2011
Page 4 of 4

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,

A handwritten signature in cursive script that reads "Polly Watt-Geier, MSW".

Polly Watt-Geier, MSW
Health Facility Surveyor
Residential Assisted Living Facility Program

/

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