IDAHO DEPARTMENT OF HEALTH & WELFARE

C.L. "BUTCH" OTTER – GOVERNOR
RICHARD M. ARMSTRONG – DIRECTOR

TAMARA PRISOCK – ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
JAMIE SIMPSON – PROGRAM SUPERVISOR
RESIDENTIAL ASSISTED LIVING FACILITY PROGRAM
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: 208-334-6626
FAX: 208-364-1888

April 8, 2013

Eric Collett, Administrator
Emerson House At River Pointe, LLC
8250 West Marigold
Garden City, ID 83714

License #: RC-725

Dear Mr. Collett:

On February 11, 2013, a licensure and complaint investigation survey was conducted at Emerson House At River Pointe, LLC. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level(s):

- Non-core issues, which are described on the Punch List, and for which you have submitted evidence of resolution.

This office is accepting your submitted evidence of resolution.

Should you have questions, please contact Polly Watt-Geier, MSW, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 334-6626.

Sincerely,

Polly Watt-Geier, MSW

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

PWG

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

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March 25, 2013

Eric Collett, Administrator
Emerson House At River Pointe, LLC
8250 West Marigold
Garden City, ID 83714

License #: RC-725

Dear Mr. Collett:

On February 11, 2013, a licensure and complaint investigation survey was conducted at Emerson House At River Pointe, LLC. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level(s):

- Core issues, which are described on the Statement of Deficiencies, and for which you have submitted a Plan of Correction.

This office is accepting your submitted plan of correction.

Should you have questions, please contact Polly Watt-Geier, MSW, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 334-6626.

Sincerely,

Polly Watt-Geier, MSW

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

PWG

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

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February 26, 2013

CERTIFIED MAIL #: 7012 1010 0002 0836 0096

Eric Collett
Emerson House at River Pointe, LLC
8250 West Marigold
Garden City, ID 83714

Dear Mr. Collett:

Based on the complaint investigation and state licensure survey conducted by our staff at Emerson House at River Pointe, LLC on February 11, 2013, we have determined that the facility: failed to provide supervision when they did not schedule sufficient personnel to adequately meet resident needs; did not provide adequate supervision when residents experienced changes of condition; did not provide adequate supervision for residents requiring nectar thickened liquids; and retained a resident who had a wound which did not show signs of improvement on a bi-weekly basis and who had a pressure ulcer beyond a stage II level.

These core issue deficiencies substantially limit the capacity of Emerson House at River Pointe, LLC to furnish services of an adequate level or quality to ensure that residents' health and safety are safe-guarded. The deficiencies are described on the enclosed Statement of Deficiencies.

You have an opportunity to make corrections and thus avoid a potential enforcement action. Correction of these deficiency must be achieved by **March 28, 2013.** **We urge you to begin correction immediately.**

After you have studied the enclosed Statement of Deficiencies, please write a Plan of Correction by answering **each** of the following questions for **each** deficient practice:

- What corrective action(s) will be accomplished for those specific residents/personnel/areas found to have been affected by the deficient practice?
- How will you identify other residents/personnel/areas that may be affected by the same deficient practice and what corrective action(s) will be taken?
- What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?
- How will the corrective action(s) be monitored and how often will monitoring occur to ensure that the deficient practice will not recur (i.e., what quality assurance program will be put into place)?
- By what date will the corrective action(s) be completed?

Return the **signed** and **dated** Plan of Correction to us by **March 11, 2013,** and keep a copy for your records. Your license depends upon the corrections made and the evaluation of the Plan of Correction you develop.

In accordance with Informational Letter #2002-16 INFORMAL DISPUTE RESOLUTION (IDR) PROCESS, 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. See the IDR policy and directions on our website at www.assistedliving.dhw.idaho.gov. If your request for informal dispute resolution is not received within the appropriate time-frame, your request will not be granted.

Please bear in mind that non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference. The completed punch list form and accompanying evidence of resolution (e.g., receipts, pictures, policy updates, etc.) are to be submitted to this office by **March 13, 2013.**

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 in Idaho, the Department will have no alternative but to initiate an enforcement action against the license held by Emerson House at River Pointe, LLC.

Enforcement actions may include:

- imposition of civil monetary penalties;
- issuance of a provisional license;
- limitation on admissions to the facility;
- requirement that the facility hire a consultant who submits periodic reports to Licensing and Certification.

Should you have any questions, or if we may be of assistance, please call our office at (208) 334-6626 and ask for the Residential Assisted Living Facility program.

Sincerely,

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

PWG/tfp

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R725	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 02/11/2013
NAME OF PROVIDER OR SUPPLIER EMERSON HOUSE AT RIVER POINTE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 8250 WEST MARIGOLD BOISE, ID 83714		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	Initial Comments The following deficiencies were cited during the licensure/follow-up survey and complaint investigation conducted on 02/05/13 through 02/11/13 at your residential care/assisted living facility. The surveyors conducting the survey were: Polly Watt-Geier, MSW Team Leader Health Facility Surveyor Matt Hauser, QMRP Health Facility Surveyor Donna Henscheid, LSW Health Facility Surveyor Survey Definitions: AM = morning cm = centimeters L = Left MP = a maintenance person med tech = a medication technician mons pubis = the fatty tissue around the pubic area, where pubic hair grows NSA = Negotiated Service Agreement PM = afternoon Pt - Patient Random Resident = Resident A - X RN = Registered Nurse Tab alarm = A device that attaches to a bed or wheelchair that sounds when a resident attempts to get up Thick-it = a powder that is used to thicken liquids to different consistencies.	R 000		
R 006	16.03.22.510 Protect Residents from Abuse.	R 006		

Bureau of Facility Standards

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R 006	Continued From page 1 The administrator must assure that policies and procedures are implemented to assure that all residents are free from abuse. This Rule is not met as evidenced by: Based on interview and record review it was determined the facility failed to protect 1 of 1 sampled residents (Resident #7), who had a bruise of unknown origin, from abuse. This had the potential to affect 100% of the residents residing in the facility. The findings include: The facility's abuse policy, revised October 2011, documented that "all allegations of abuse will be treated as serious and will be investigated, documented, and reported per the standards set forth in this policy. In addition to immediately reporting abuse, suspected abuse, and injuries of unknown cause to appropriate authorities, the Community will promptly investigate all reports of abuse and suspected abuse, and take measures necessary to protect Residents and prevent the reoccurrence of abuse." The abuse policy also documented, "The Community will investigate injuries of unknown cause and report those incidents if abuse cannot be ruled out. It is expected that a determination about injuries of unknown cause can be made within 24 hours of the incident and if abuse cannot be ruled out, the incident has been reported within that timeframe." Resident #7, a 78 year-old female was admitted to the facility on 2/9/12, with a diagnosis of Alzheimer's dementia. The resident was transferred to the hospital on 8/20/12, with a hip fracture, and returned to the facility on 9/6/12. An incident report, dated 9/25/12, was written by an outside service provider. The incident report	R 006		

Bureau of Facility Standards

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R 006	Continued From page 2 documented the resident had not gotten out of bed that day. The incident report also documented the resident was "crying, wincing, shaking, grabbing low back & hips, and holding knees to chest, rocking side to side frequently." The incident report documented that the outside service provider notified a facility caregiver, who was not responsive to her concerns. Additionally, the incident report documented the resident had bruising "around the pelvic area." The incident report included a diagram of a body, which showed the bruising was located on the front and sides of the mons pubis or pubic area. The incident report was signed and dated by the administrator on 9/26/12. The administrator documented his investigation into the staff issues; however, there was no documentation of an investigation into the resident's bruising of unknown origin. Resident #7's record did not contain a nursing assessment regarding the resident's hip fracture on 8/20/12 or bruising of unknown origin reported on 9/25/12. On 2/8/13 at 10:20 AM, the facility RN stated she did not recall the resident had bruising in her pelvic or pubic region or that the resident had fallen. She further stated, if the resident fell and she knew about the incident, she would have documented on the incident report. She confirmed she had not documented on the 9/25/12 incident report. On 2/8/13 at 10:34 AM, the administrator stated the facility nurse had assessed Resident #7 on 9/25/12 and no bruising was found. The administrator was informed at that time, that facility nurse did not recall the incident and no documentation of the assessment could be	R 006		

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R 006	Continued From page 3 located. The administrator stated that he remembered Resident #7 had fallen and fractured her hip. He stated he thought the bruising could have been a result of that fall. The administrator was asked to supply the surveyor with any documentation of the state of Resident #7's bruising prior to or after her return to the facility on 9/6/13. Resident #7's discharge assessment from a rehabilitation facility, dated 9/6/12, documented the resident had bruising on her outer right hip, her outer left hip/leg and on her inner arms bilaterally. There was no documentation of bruising to Resident #7's pubic area. Resident #7's home health assessment, dated 9/8/12, documented the resident had sustained a fracture on 8/20/12. The assessment also documented the resident had a closed surgical wound that was observed to be a pink scar. There was no documentation the resident had bruising. Resident #7's care notes did not document the resident had bruising prior to or after 9/25/12. On 2/8/13 at 12:19 PM, the administrator stated he had not been able to locate any documentation about Resident #7's bruising in the facility's documentation. The administrator was unable to provide documentation as to how Resident #7 sustained the bruising around her pubic area, which was discovered 36 days after her fall. The facility failed to protect Resident #7 from abuse when they did not follow their abuse policy. They failed to investigate Resident #7's bruises of	R 006		

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R 006	Continued From page 4 unknown origin and failed to report the bruises of unknown origin to the appropriate authorities. The failure to implement the facility's policies and procedures for protecting residents from abuse, placed 100% of the facility residents at risk for abuse.	R 006		
R 008	16.03.22.520 Protect Residents from Inadequate Care. The administrator must assure that policies and procedures are implemented to assure that all residents are free from inadequate care. This Rule is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to provide supervision when they did not schedule sufficient personnel to ensure 8 of 10 sampled residents (Residents #s 1, 2, 3, 5, 6, 7, 8 and 9) and 12 random residents (Residents A, B, C, E, F, G, H, J, K, L, M and N) received adequate assistance with eating, toileting every two hours and safety monitoring. Further, the facility did not provide adequate supervision when 3 of 3 sampled residents (#1, #6 and #8) were not assessed after they experienced a change of condition. The facility also failed to provide supervision for 1 of 1 sampled residents (Resident #5), who had a physician's order for nectar thickened liquids. The facility retained 1 of 1 sampled resident (Resident #8), who had a wound that was not improving bi-weekly and a pressure ulcer which progressed beyond a Stage II. The findings include: I. SUPERVISION According to IDAPA 16.03.22.012.25, supervision	R 008		

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R 008	Continued From page 5 is defined as "a critical watching and directing activity which provides protection, guidance, knowledge of the residents general whereabouts, and assistance with activities of daily living...." A. Sufficient Personnel IDAPA 16.03.22.600.06 - "Sufficient Personnel. The facility will employ and the administrator will schedule sufficient personnel to: Provide care, during all hours, required in each resident's Negotiated Service Agreement, to assure residents' health, safety, comfort and supervision, ..." The facility's "Health Services Staffing Plan" documented it was the policy of the facility "to maintain a staffing system to determine the appropriate number of caregivers needed, based on Residents' needs." It further documented, "The Executive Director has the discretion to adjust staffing within the building based on the Residents' needs and care levels. This may involve changing where staff is scheduled to work and how staff float within the building....Each caregiving staffing pattern is able to manage certain levels of care. Should the levels of care exceed the staffing the Executive Director will be able to add addition [sic] caregiving hours during the appropriate times." The facility was a locked and secured unit for residents with cognitive impairments who were diagnosed with some form of dementia. The building was physically divided into 2 equal sides, the "East" and the "West." Each side had a small kitchenette that opened to a large dining and living room area (common area). A medication room was located off to side of the kitchenette.	R 008		

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R 008	Continued From page 6 There were 36 residents, 18 resided on each side. There were two caregivers on each side who served the meals, assisted residents with eating, all personal cares, toileting, and supervision. Additionally, one of those caregivers assisted residents with their medications. The January and February 2013, as worked schedule, documented the following: *6:00 AM - 2:30 PM, four caregivers, two on each side. *2:00 PM - 10:30 PM, four caregivers, two on each side. *10:00 AM - 6:30 AM, three caregivers, one on each side and a float. Between 2/5 and 2/8/13, thirteen med techs/caregivers were interviewed. They stated there were not enough staff to meet the residents' care needs on the morning and evening shifts. A caregiver stated, it was like "musical chairs" because many residents required help and it was "pretty difficult" getting everything done. The caregivers also stated the following areas of concern: * Toileting: The caregivers stated it was "impossible" to assist each resident with toileting every two hours as their care plans required. * Transfers: The caregivers stated there were four to six residents on each of the two sides who required two-person assistance with transfers. They stated residents who required a two-person assist, had to wait for assistance until two people were available. * Supervision: The caregivers stated when they both were assisting residents in their rooms, they	R 008		

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R 008	Continued From page 7 were unable to provide supervision to any of the other residents. * Eating: The caregivers stated there were five to seven residents on each side, who required assistance with eating. They stated it was difficult to assist all the residents with eating, especially when they had to answer call lights or respond to incidents. *Dressing: The caregivers stated the night shift had been directed to assist six residents on each side with waking, toileting and dressing prior to the day shift starting. A caregiver stated the night shift started doing rounds at 4:00 AM and began getting residents up for the day. The caregivers stated, if residents were tired, they would be placed back into bed fully dressed. They stated if the residents stayed awake after being dressed, they watched television in the common area. The caregivers stated they were required to wake residents up to "help out" the day shift. One caregiver stated, if the night shift did not get residents up, dressed and ready for the day, the day shift would not be able to meet the residents' needs. The caregiver further stated they "barely were meeting their needs now." i. East Side Observations: On 2/5/13 between 9:10 AM and 10:30 AM, the breakfast meal was observed: * Fifteen residents were seated at various tables in the dining area, two residents were in their rooms and one resident was asleep on the couch. Resident #7 was in her room undressed from the waist down, sitting on the edge of her bed, with her comforter wrapped around her waist. A strong urine odor was detected in her room.	R 008		

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R 008	Continued From page 8 * Resident #3 sat at the table between 9:10 AM and 10:05 AM, with a full plate of food in front of her. The resident was assisted with three bites of food at 9:48 AM. Then at 10:05 AM, the med tech removed the resident's plate and assisted the resident away from table. * Resident A sat at the table between 9:10 AM and 10:30 AM. For 1 hour and 20 minutes, she alternated between sleeping and playing with her napkin or fork. At 9:57 AM, she took a bite of food off her fork. After the one bite, the resident was unable to scoop up the food with her fork. She continued to place an empty fork or the handle of the fork into her mouth. At 10:10 AM, she picked up two small bites of food with her fingers. At 10:20 AM, the maintenance person (MP) stood over the resident and fed her a bite of ham. She offered the resident more, but left the table to attend to another resident's alarm. The MP came back and offered the resident a drink and gave her a bite of waffle. At 10:25 AM, the MP moved the plate away from Resident A. The resident continued to sit at the table until 10:30 AM, when a caregiver assisted the resident away from the table. * Between 9:10 AM and 10:30 AM, Resident C had eaten and was wandering around the common area and into the medication room. At 9:27 AM, the resident pulled his pants down to his knees and took his shoes off. The caregiver assisted the resident to pull his pants up then took him to his room. At 9:40 AM, the resident was in his adult briefs in the hallway and the caregiver took him back to his room. Resident C continued to wander around the common area. At 10:30 AM, the resident defecated on another resident's bedroom floor and then shut himself in	R 008		

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R 008	Continued From page 9 the room. Both caregivers were assisting another resident and were not aware this had happened until informed by surveyors. * Resident F was observed between 9:10 AM and 10:30 AM. The resident was sitting at the table in her high back wheelchair, leaning to the right at approximately a 45 degree angle. She repetitively moaned, played with her clothing protector and was not eating. At 9:43 AM, Resident F attempted to take a drink of juice, but could not tip the glass up high enough to drink the fluid and spilled the drink on herself. There was a straw in her water, but not in her juice. At 9:53 AM, the caregiver cleaned up the resident's clothing protector. The caregiver assisted the resident with two spoonfuls of food and left Resident F sitting at the table until 10:30 AM. The resident did not receive any further assistance with eating. * At 9:27 AM, Resident J was in the bathroom off the dining room, with the door open. A call light began sounding from the bathroom. At the same time, the med tech was passing medications and the caregiver was assisting Resident C to redress. * At 9:28 AM, Resident E stated, "I got to get to the restroom." A puddle of liquid was observed on the floor by his wheelchair. The caregivers did not hear his statement or respond. At 9:58 AM, the resident called the administrator over to talk with him. The administrator did not request assistance for the resident. At 10:10 AM, the caregiver came to take Resident E to his room, 42 minutes after he stated he needed to go to the bathroom. At 10:22 AM, the resident was transferred into bed by two caregivers. Once in bed, the caregivers changed the resident's attends which were soiled with urine and feces. The med tech asked what	R 008		

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R 008	Continued From page 10 time the resident had been awakened to be dressed that morning, and the caregiver replied she thought "around 4:00 AM." On 2/5/13 between 11:57 AM and 1:18 PM, the following observations were made: * Resident B sat at the table from 11:57 AM until 12:49 PM, (52 minutes) before he finally received his food. * Resident C was brought into the dining room at 11:57 AM and encouraged to sit down at the table. The resident left the table. At 12:19 PM, a caregiver from the west side brought Resident C back and sat him at the table and gave him coffee. The caregiver returned to the West side. There were nine residents unsupervised in the common area because the two caregivers were assisting a resident in his room. * Resident #3 was asleep at the table when she received her food at 12:32 PM. At 12:44 PM, the resident was awakened by the med tech, but was not cued to eat. For 18 minutes, Resident #3 was not cued or assisted to eat. At 12:50 PM, the med tech awakened the resident again and assisted her with one bite to eat. The resident ate independently until 12:57 PM, when she stopped eating. At 1:05 PM, Jello was placed in front of her and she was not awakened to eat. Six minutes later the med tech spooned a bite of food into her mouth and walked away. Resident #3 ate independently for four minutes, closed her eyes and stopped eating. * Resident A did not receive assistance with eating between 12:46 PM and 1:18 PM. She attempted to eat mashed potatoes and pears with her fingers. Resident A continued to sit with food	R 008		

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R 008	Continued From page 11 in front of her. She picked up a small bowl of pears and sipped a piece of pear out of the bowl. Resident A again tried to eat pears with her fingers. Resident A picked up the bowl of pears again and attempted to get a pear out with her fingers, but was unable to do so. The resident gave up and sat the bowl down. * Resident G was assisted with eating by the laundry person. The resident's meal was completed and the laundry person left at 12:59 PM. At 1:05 PM, Jello was placed in front of the resident. A few minutes later, Resident G's head dropped down and her face almost fell into the Jello. The med tech cued her to eat and walked away. On 2/6/13 between 8:56 AM and 4:03 PM, the following observations were made: * Resident #3 was asleep at the table from 8:56 AM to 9:18 AM (22 minutes), when the administrator awakened her and handed her a spoon. She began eating independently. At 9:21 AM, the administrator left the table to assist another resident. At 9:24 AM, Resident #3 stopped eating. Between 9:36 AM and 9:51 AM, the resident was intermittently assisted with eating. She remained at the table asleep until 11:27 AM (2 hours and 31 minutes). * Resident #9 finished eating at 9:01 AM and continued to sit in his wheelchair at the table until 9:55 AM (54 minutes), when an outside service provider removed him from the table. At 10:15 AM, the outside provider returned the resident to the table, reattached the clothing protector, and left him sitting at the table. * At 9:04 AM, Resident C was wandering	R 008		

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R 008	Continued From page 12 throughout the common area, following closely behind the caregivers and attempting to organize the dirty dishes. At 9:43 AM, the resident approached a table and tried to take Resident #5's coffee cup. The caregiver redirected the resident, but resident tried to pick up Resident #5's juice instead. The caregiver redirected the resident to sit in a chair in the living room area. * At 9:10 Resident F sat at a table in her wheelchair leaning to the right at a 45 degree angle. For 48 minutes, she unsuccessfully attempted 3 times to take a drink of her orange juice. At 9:58 AM, a caregiver placed a straw in the orange juice and walked away. At 10:03 AM, Resident F attempted to drink the orange juice and spilled it on her clothing. For approximately 9 minutes, the resident tried to unsuccessfully move her wheelchair away from the table. In her attempt to move the wheelchair it tipped backwards, but did not fall. At 10:24 PM, Resident F tried to stand up and her tab alarm sounded. * At 9:10 AM, Resident G's head was face down on the table for 11 minutes, until the administrator lifted her head off the table. * At 9:12 AM, 42 minutes after breakfast began, the MP came into the main dining area and asked staff if they needed assistance with breakfast. * Resident #2 came to eat at 9:16 AM and continued to sit at the table until he fell asleep. At 9:56 AM, Resident #2 had a long string of drool hanging out of his mouth. A caregiver verbally cued him to wipe his mouth at 10:03 AM, but did not physically assist him to carry through. Resident #2 continued to sit for an additional eight minutes with drool hanging from his mouth.	R 008		

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R 008	Continued From page 13 * At 10:15 AM, the MP was cleaning a resident's carpet and was asked what happened. She stated another resident had defecated on the floor in the bedroom. * Resident H sat at the table between 9:03 AM and 11:08 AM. He wore a tab alarm which was connected to his shirt and to the dining room chair. At 11:08 AM, he stood up, his tab alarm sounded and no staff responded. Resident H was noted to be unsteady and almost fell twice while walking. The resident was not assisted by staff, until 11:14 AM, six minutes after his alarm went off. * From 10:30 AM to 10:40 AM, no staff were observed in the common area to supervise six residents. The caregiver came back into the common area at 10:40 AM for 6 minutes and then left the common area at 10:46 AM. She was gone until 11:00 AM, leaving the residents unsupervised for another 14 minutes. * At 11:25 AM, Random Resident K asked the med tech, "You're short on help aren't ya?" * From 3:47 PM to 3:58 PM (11 minutes), no staff were in the common area to supervise residents. At 3:48 PM, Resident H attempted to get up from the dining room chair and another resident's elderly family member verbally directed him to sit back down. Resident H stood back up and his chair alarm sounded, but no staff responded. The family member physically attempted to redirect him to sit down and he pushed her away. The family member yelled for a caregiver to come assist her. By the time the caregiver responded, Resident H had walked approximately 15 feet to the corner of the kitchenette.	R 008		

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R 008	Continued From page 14 ii. West Side Observations: On 2/6/13 between 8:57 AM and 10:30 PM the following observations were made: * Between 8:57 AM and 9:15 AM, Resident L and two other residents received intermittent assistance with eating by one caregiver. The caregiver had a spoon in each hand and alternately fed Resident L and another resident. For the 18 minutes Resident L was being fed, she only received 3 spoonfuls of food. The caregiver left the table and Resident L was not assisted with eating for the next 28 minutes. * At 8:57 AM, Resident M attempted unsuccessfully to eat independently for 51 minutes. During this time, one caregiver stopped to spoon a bite of food into her mouth as she walked by. At 9:48 AM, an outside service provider removed her from the table. * Between 9:16 AM and 10:30 AM, Resident #6 wandered about the common area while speaking loudly, making non-stop, repetitive, nonsensical and rhyming comments. For example he stated, "bitch on a bitch, gathered the mothers and the others...." On four separate occasions, the resident was yelled at by other residents to "shut up." One resident asked, "Are you going to shut him up or am I?" At 9:51 AM, the med tech escorted Resident #6 to a reclining chair, physically prompted him to sit down, and put the foot rest up without speaking to the resident. Within seconds, the resident was up wandering around the common area until the nurse took him for a walk. Thirteen minutes later, the resident walked back down the hallway unescorted continuing to make repetitive comments.	R 008		

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R 008	Continued From page 15 * From 9:56 AM to 10:14 AM (18 minutes), no facility staff were in the common area to supervise the 11 residents. On 2/7/13 between 9:01 AM and 9:15 AM, the following observations were made during the breakfast meal: * From 9:01 AM to 9:15 AM, six residents were sitting at four different tables. One caregiver went back and forth between the tables spooning food into residents' mouths, while standing above them. She never stayed long enough with each resident to ensure they swallowed their food, completed their meal or drank their beverages. * At 9:02 AM, Random Resident N called out "help me." Six minutes later, the med tech came to assist her. On 2/5/13 through 2/7/13, five family members were interviewed. All family members stated the facility did not have enough staff to assist residents with eating and cares. A family member stated staff were commonly seen giving a resident a bite of food then "disappearing." Two family members stated caregivers were usually busy in residents' rooms and the other residents were often left unattended, sometimes for "20 minutes or more." Another family member stated, the facility had not increased their staffing to accommodate residents' needs. The family member further stated, she had seen residents still sitting at the dining room table one to two hours after the meal had been served. On 2/6/13 at 11:01 AM, the facility RN stated the administrator and the office manager were responsible for staffing. The RN also confirmed	R 008		

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R 008	Continued From page 16 there was not enough staff to meet residents's needs. On 2/7/13 at 3:35 PM, the facility administrator was informed that staffing had been identified as a potential core issue. He stated it would be useful to have it in writing to persuade the owners that more staff were necessary to properly provide care for the residents. There were 36 residents who required supervision due to cognitive impairments. Due to insufficient staffing, the residents did not receive appropriate assistance with supervision, eating and toileting. There were numerous times residents were left unsupervised because caregivers were assisting one of the 10 residents, who required a two-person assist with transfers. Residents were also not assisted with toileting every 2 hours as directed in their NSAs. Additionally, during the meals residents were left sitting at the tables for extended periods of time and were not provided individual attention or appropriate assistance to ensure adequate nutritional intake. B. Changes of Condition 1. Resident #6's record documented he was an 87 year-old male, with diagnoses that included "altered mental status," renal insufficiency, atrial fibrillation, and delirium. He was admitted to the facility on 8/2/11. The website eHow.com documented, "Normal blood pressure for an elderly person is between 90/65 and 130/90.... Low blood pressure can be caused by dehydration...." (http://www.ehow.com/facts_4826915_normal-blood-pressure-elderly.html)	R 008		

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R 008	Continued From page 17 MayoClinic.com documented, "Although there's a wide range of normal, an unusually high or low heart rate may indicate an underlying problem. Consult your doctor if your resting heart rate is consistently above 100 beats a minute (tachycardia) or below 60 beats a minute (bradycardia) - especially if you have other signs or symptoms, such as fainting, dizziness or shortness of breath." (http://www.mayoclinic.com/health/heart-rate/AN01906) MayoClinic.com documented, "Normal pulse oximeter readings range from 95 to 100 percent, under most circumstances. Values under 90 percent are considered low." (http://www.mayoclinic.com/health/hypoxemia/MY00219) Resident #6's progress notes, dated 9/29/12, documented he had a blood pressure of 88/51 and heart rate of 40. His oxygen level was 40 and he was not responding to staff. The notes documented the resident was sent to a local hospital and returned. There were no other notes or assessments documented in Resident #6's to indicate the facility RN had followed-up on the change of condition or provided direction to staff. Another progress note, dated 9/29/12, documented Resident #6 returned to the facility during the night. The progress note documented his blood pressure was 69/56 and his pulse was 44. There were no other notes or assessments documented in Resident #6's record regarding his low blood pressure or low heart rate. On 2/7/13 at 2:20 PM, the facility RN stated she had not assessed Resident #6 after he had	R 008		

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R 008	Continued From page 18 returned from the hospital. She further stated she had not addressed the low blood pressure, low pulse and low oxygen levels he had on 9/29/12. Resident #6's progress notes, on 10/20/12, AM shift, documented, "... Very unstable on feet, took vitals and notified [facility RN's name] and Hospice. Hospice is ordering a wheelchair... and did check-up." On 2/7/13 at 2:23 PM, the facility RN stated she did not know why Resident #6 lost his ability to ambulate and needed a wheelchair. She stated she had not assessed the resident or when he lost his ability to walk. There was no documentation the facility RN assessed Resident #6 when he had abnormal vital signs and lost his ability to walk. 2. Resident #1, a 90 year-old male was admitted to the facility on 2/9/12 with a diagnosis of Lewey Body dementia. On 2/5/13, a resident roster completed by the facility identified all residents who had pressure ulcers or wounds. Resident #1 was not identified as one of them. A nursing assessment, dated 11/9/12, documented the resident's skin was "warm, dry, intact." A hospice physician notification form, dated 1/18/13, documented the resident had developed a pressure ulcer on his heel. It was signed and dated by the facility nurse on 1/21/13. There was no further documentation by the facility RN regarding the pressure ulcer on the resident's heel.	R 008		

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R 008	Continued From page 19 A hospice physician notification form, dated 1/18/13, documented Resident #1 had a reddened area on his buttocks. It was signed on dated by the facility RN on the same day, but there was no further documentation found in the resident's record regarding the reddened area on his buttocks. A resident progress note, dated 1/22/13, documented the "sore" on the resident's foot was "hurting" him. There was no documentation this had been addressed by the facility RN. On 2/5/13, the administrator stated he was not aware that Resident #1 had any pressure ulcers. On 2/6/13 at 11:01 the facility RN stated she was aware the resident had a pressure ulcer on his heel and buttocks. The RN stated the hospice agency was providing the wound treatments. The facility RN stated she had observed the heel pressure ulcer when hospice did the dressing changes. The nurse confirmed she had not documented on the status of either of Resident #1's pressure ulcers. On 2/6/13 at 11: 50 AM, the hospice RN stated Resident #1 had a Stage II pressure ulcer on his heel and the reddened area on his buttocks had completely healed. The hospice RN stated the facility RN had never been with him to look at the heel. On 2/6/13 at 2:50 PM, the hospice RN stated the wound was unchanged and was "no deeper than a Stage II." However, the hospice RN stated the wound had an odor which they felt was from yeast so the treatment plan had changed.	R 008		

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R 008	Continued From page 20 Resident #1 developed a reddened area on his buttocks and had a pressure ulcer on his heel. The facility RN had not assessed the ulcers to determine if the ulcers had progressed beyond the capability of assisted living. 3. Resident #5, a 78 year-old male was admitted on 6/11/12 with diagnoses which included Alzheimer's Disease and aspiration pneumonia. A nursing assessment, dated 12/11/12, documented the resident's skin was warm, dry and intact. There was no documentation of any concerns regarding the resident's feet or toes. On 2/6/13, current hospice notes were not available in the resident's record and had to be requested from the agency by surveyors. The resident was discharged from hospice services on 1/21/13. Once obtained, the notes were reviewed and did not contain documentation regarding any cares done to the resident's toe. On 2/6/13 at 1:35 PM, the facility RN stated the resident's nail was gone which caused bleeding. The facility RN confirmed she had not heard about the nail until the family member brought it to staff's attention. On 2/6/13 at 4:01 PM, a family member stated while putting lotion the resident's feet, she found a black spot on his toe. On 2/6/13 at 4:03 PM, Resident #5's foot was observed by a surveyor. The resident's second small toe on the left foot had an area of blackened skin where the toenail should have been. There was no documentation in the nurse's	R 008		

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R 008	Continued From page 21 communication book or the staff "pass down" book regarding the resident's toe being black and requiring a bandage. On 2/7/13 at 9:55 AM, the resident's toe was observed by another surveyor. The entire toenail bed was blackened and appeared to have no nail attached. Between 2/6/13 and 2/8/13, four staff members were interviewed and none of them knew anything about the resident's blackened toe prior to the family member bringing it to their attention. Further, none of them knew who had covered it with a bandage. At some point, Resident #5's toe became black and the toenail fell off. It was bandaged, but no one in the facility was aware who had treated it. The resident was bathed by facility staff approximately three times since hospice was discontinued, but no one reported or documented anything about the condition of Resident #5's toe. C. Monitoring of treatments An NSA, dated 6/26/12, documented Resident #5 required extensive assistance with eating, "needs to take a sip or two of liquid between 2-3 bites." There was nothing in the NSA regarding thickened liquids. A physician's order, dated 7/11/12, documented the resident required nectar thickened liquids. It further documented staff were to put one rounded teaspoon in a juice-sized glass of water. On 2/5/13, the following observations were made during Resident #5's meals:	R 008		

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R 008	Continued From page 22 *At 9:40 AM, the Thick-it in Resident #5's glass of water had separated and settled to the bottom of the glass, leaving thin liquid on the top. At 9:47 AM, the caregiver stirred the resident's water, walked away and the Thick-it began to settle to the bottom of the glass again. At 9:48 AM, the resident took a sip of the water and began coughing. The resident took a drink of coffee which did not appear to be thickened, and started to cough. *At 12:59 PM, Resident #5 was sitting at the table with a glass of juice and a glass of water. Both contained Thick-it that had separated and had settled to the bottom of the glasses. This left approximately 3/4 of the fluid in the glass unthickened. On 2/6/13, the following observations were made during meals: *At 9:41 AM, Resident #5 had a cup of coffee and a glass of juice where the Thick-it had settled to the bottom. The resident took a sip of his coffee and immediately started to cough. On 2/6/13 at 4:01 PM, a family member stated the resident had four previous incidents of aspiration pneumonia. She stated his coughing had increased and a bedside x-ray was ordered to rule out aspiration pneumonia. On 2/7/13 at 8:45 AM, a maintenance person stated she was not sure why the Thick-it was separating. On 2/7/14 at 8:47 AM, the facility RN was shown how the Thick-it had separated in the drinks leaving unthickened liquid on top. The nurse stated, "that's not good." A few minutes later, the	R 008		

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R 008	Continued From page 23 facility RN said she had talked to the dietary supervisor about the Thick-it and was told the staff "needed to stir" the liquids. On 2/7/13 at 8:50 AM, staff were observed to stir Resident #5's liquids. After the liquid was stirred, the Thick-it separated and settled to the bottom of the glass. On 2/8/13 at 9:21 AM, Resident #5 was observed sitting at the table with a glass of water. The Thick-it was observed to have separated and settled to the bottom of the glass. The resident coughed after taking a drink. Although staff used Thick-it for most of Resident #5's beverages, they did not stir it to ensure it maintained a nectar thick consistency. Further, after the problem was identified during survey, the facility did nothing to correct it. The lack of supervision contributed to Resident #5 consuming inappropriately thickened liquids for at least 4 days increasing the resident's risk for aspiration. II. RETENTION - WOUNDS IDAPA 16.03.22.152.05 documents that residents with a "Stage III or IV pressure ulcer" and open wounds that are not "improving bi-weekly" cannot be retained. The "National Pressure Ulcer Advisory Panel [NPUAP]" described the following pressure ulcers: * Stage II pressure ulcer - A shallow open ulcer without slough. * Stage III pressure ulcer - Full thickness tissue	R 008		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R725	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 02/11/2013
NAME OF PROVIDER OR SUPPLIER EMERSON HOUSE AT RIVER POINTE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 8250 WEST MARIGOLD BOISE, ID 83714		

(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 24 loss and slough may be present. * Unstageable - Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Resident #8, an 86 year old female was admitted to the facility on 10/5/11 with a diagnosis of Alzheimer's Disease. A nursing assessment, dated 11/25/12, documented the resident's skin was "warm, dry and intact." Wound care orders from the wound center to the hospice agency, documented the following: * 12/12/12 - the resident had an ulcer to the left upper extremity. * 12/26/12 - the resident had wounds on her left heel and left forearm. * 01/21/13 - the resident had wounds on her left forearm, left heel, left 2nd toe and left hand. There was no documentation by the facility RN regarding the resident's skin breakdown. On 2/7/13, surveyors requested the wound clinic reports, because they were not found in the resident's records. The "Wound Care Progress Reports" received on 2/11/13, documented the following: * 11/21/12 - The resident had a left arm ulceration which had been "chronic and non-healing for over a year." It further documented, the left forearm ulceration measured "5.7 x 3 x 0.2 cm with white	R 008		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R725	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 02/11/2013
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R 008	Continued From page 25 tissue in the center and heaped red tissue in the periphery." There was a "medium amount of serosanguinous drainage with no odor." * 12/12/12 - The resident's left arm ulcer had been there for a "couple years...She has a history of picking at the area and not keeping a dressing on. There has been no change in drainage. It periodically shows evidence of healing and then new deterioration. The left heel purple coloration was noted today. The patient does sit up in a chair most of the day...." * 12/26/12 - The resident's left arm ulceration was "rebiopsied" and squamous cell carcinoma was identified. The left heel had a necrotic (dead tissue) area which measured 2.7 x 2.5 cm. * 1/18/13 - The resident had an ulceration on her left arm "for a couple of years...rebiopsied in mid January and was found to be positive for squamous cell carcinoma. She is currently receiving radiation to the forearm." The report further documented, the resident was noted to have left heel bruising "approximately a month ago...the area now has necrotic tissue in the base." It further documented the daughter and power of attorney were instructed to observe for any redness, increased warmth, increased swelling, increased pain, or drainage and return to the clinic. Hospice skilled nursing visit notes documented the following: * 1/1/13 - "Fungoid" lesion to left forearm and pressure ulcer to left heel. "...Dressing changed to L heel and part of wound base has eschar, the other part of wound base is pink and still draining."	R 008		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R725	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 02/11/2013
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R 008	Continued From page 26 * 1/4/13 - "Fungoid" lesion to left forearm and pressure to left heel...Dressing changed to L heel and eschar remains intact to 75% of wound bed. Wound still drainingand tender to the touch." * 1/10/13, 1/14/13 and 1/28/13 - "Fungoid" lesion to left forearm and pressure ulcer to left heel, traumatic wound to inner left 2nd toe. * 2/4/13 - Cancer lesion to the left forearm, pressure ulcer to left heel and traumatic wound to left 2nd toe. "Changed dressings and wounds slowly progressing....Instructed resident to keep dressing dry and intact. Pt. verbalized understanding." Resident #8's pressure ulcer was not staged by the facility nurse or hospice. Additionally, there as no documented evidence the resident's cancerous lesion had been improving bi-weekly. On 2/7/13 at 2:28 PM, the facility RN stated it was "impossible" to get reports from the wound clinic and the administrator was now working on getting them. The RN confirmed she had not assessed or documented the status of the resident's wounds. . The facility retained Resident #8 when she had a cancerous wound on her forearm which had not improved for fourteen months. Further, the left heel pressure ulcer was covered with eschar which according to NPUAP had progressed beyond a Stage II. The facility failed to provide supervision when they did not schedule sufficient personnel to ensure Sampled Residents #1, 2, 3, 5, 6, 7, 8, 9 and Random Residents A, B, C, E, F, G, H, J, K,	R 008		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R725	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 02/11/2013
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R 008	Continued From page 27 L, M and N received adequate assistance with eating, toileting every two hours, and safety monitoring. Further, the facility did not provide adequate supervision to ensure Residents #1, 6 and 8 were assessed after they experienced a change of condition. The facility also failed to provide supervision for Resident #5 to ensure the resident received nectar thickened liquids. Finally, the facility retained Resident #8, who had a wound that was not improving bi-weekly and had a pressure ulcer which progressed beyond a Stage II. This resulted in inadequate care.	R 008		

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

ASSISTED LIVING Non-Core Issues Punch List

Facility Name	Physical Address	Phone Number
Emerson House	8250 West Marigold	377-3177
Administrator	**City**	**Zip Code**
Eric Collett	Garden City	83714
Team Leader	**Survey Type**	**Survey Date**
Polly Watt-Geier	Licensure, Follow-up and Complaint	~~02/18/13~~ 2/11/13

NON-CORE ISSUES

Item #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	L&C USE
1	009.03	One of seven caregivers had unsupervised access to residents prior to a background check being completed.	3/22/13 Pwb	
2	009.04	One of seven caregivers did not submit fingerprints for a criminal history and background check within 21 days of hire.	3/22/13 Pwb	
3	220.03.e	The admission agreements did not disclose what assessment tool the facility would use, how often the assessment would be completed,	3/22/13 Pwb	
~~4~~		nor who would be completing the assessment.		
~~3~~ 4	220.17	The admission agreement did not disclose how/if residents could transfer to Medicaid as a payment source.	3/22/13 Pwb	
~~4~~ 5	225.01	The facility did not evaluate behaviors for residents, for example: when residents hit, resisted cares, had vocalizations that were disruptive	4/8/13 Pwb	
		to others and defecated in inappropriate places.		
~~5~~ 6	225.02	The facility did not develop interventions for residents behaviors (see above 225.01).	4/8/13 Pwb	
~~6~~ 7	225.02.c	The facility did not have documentation that each residents' behavioral interventions were evaluated to ensure they continued to	4/8/13 Pwb	
		be effective.		
~~7~~ 8	250.10	The facility water temperature on the "west side" exceeded 120 degrees Fahrenheit. ***Previously cited 8/19/11***	3/22/13 Pwb	
~~8~~ 9	300.01	The facility RN did not address residents' changes of condition, for example Resident #1and #8's wounds, Resident #6's blood pressure,	4/8/13 Pwb	
		oxygen levels and change in ability to ambulate, Resident #5's oxygen levels and Resident #7's return from rehab and bruising of unknown		
		origin. ***Previously cited 8/19/11***		
~~9~~ 10	305.02	The facility did not ensure medications were available as ordered by a physician. ***Previously cited 8/9/11***	4/8/13 Pwb	

Response Required Date	Signature of Facility Representative	Date Signed
3/13/13	Eric D Collett	2/11/13

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IDAHO DEPARTMENT OF HEALTH & WELFARE

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P.O. Box 83720
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Eric Collett	Garden City	83714
Team Leader	**Survey Type**	**Survey Date**
Polly Watt-Geier	Licensure, Follow-up and Complaint	~~02/18/13~~ 2/11/13

NON-CORE ISSUES

Item #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	L&C USE
~~12~~ 11	305.04	The facility RN did not make recommendations to the administrator regarding medication needs, to include parameters of	4/8/13	PWG
		oxygen, blood pressure and residents increased drowsiness after a medication was given.		
~~13~~ 12	310.01.a	The medication rooms on the East and West side had medications that were not secured.	3/22/13	PWG
~~14~~ 13	310.01.f	Medication aides did not watch residents take all medications they were assisted with and medications were hidden in their food.	3/22/13	PWG
~~15~~ 14	310.04.a	The facility did not document non-drug interventions prior to assisting residents with behavior modifying medications.	4/8/13	PWG
~~16~~ 15	310.04.e	The facility did not have a physician review residents' behavior modifying medications every 6 months and did not provide the physicians'	4/8/13	PWG
		with behavioral updates to facilitate an informed decision on whether the behavior modifying medication should be continued.		
~~17~~ 16	320.08	Residents #5, #6 and #8 NSAs were not reviewed and updated to include changes of conditions.	4/8/13	PWG
~~18~~ 17	335.03	Staff were observed to not always change gloves in between assisting residents with cares. ***Previously cited 8/19/11***	3/22/13	PWG
~~19~~ 18	350.04	The facility did not provide a written response to a complainant that explained the action taken to resolve the complaint or the reason	3/22/13	PWG
		no action was taken.		
~~20~~ 19	350.07	The facility did not report Resident #7's bruise of unknown origin to Licensing and Certification.	3/22/13	PWG
~~21~~ 20	460.02.b	There was more than 14 hours between the evening meal and breakfast.	3/22/13	PWG
~~22~~ 21	630.01	One of seven caregivers did not have specialized training for dementia.	3/22/13	PWG

Response Required Date	Signature of Facility Representative	Date Signed
3/13/13	Eric D. Collett	2/11/13

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Team Leader	**Survey Type**	**Survey Date**
Polly Watt-Geier	Licensure, Follow-up and Complaint	02/11/13

NON-CORE ISSUES

Item #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	L&C USE
~~2522~~	711.01	The facility did not document the time and date a specific behavior was observed; what interventions were used to address	4/8/13 PWh	
		the specific behavior and the effectiveness of those interventions.		
~~2423~~	711.08.b	The medication assistance records did not clearly identify when Resident #4 and #5 received oxygen.	3/22/13 PWh	
~~2524~~	711.08.e	The care notes did not include documentation that the facility RN had been notified of residents changes of condition, for example:	4/8/13 PWh	
		Resident #6 was drowsy, could not walk and began to vocalize loudly. A random resident had a wet cough.		
~~2625~~	711.08.f	The facility did not have outside service care notes for Resident #1 and #8.	4/8/13 PWh	
~~2726~~	711.11	The medication assistance records did not document why a medication was not given.	4/8/13 PWh	

Response Required Date	Signature of Facility Representative	Date Signed
~~02/01/13~~ 3/13/13	Eric D. Collett	2/11/13

Date 2/11/2013 Page 1 of 1

IDAHO DEPARTMENT OF HEALTH & WELFARE

Food Establishment Inspection Report

Residential Assisted Living Facility Program, Medicaid L & C
3232 W. Elder Street, Boise, Idaho 83705
208-334-6626

Establishment Name: Emson House at River Point	Operator: Eric Collett
Address: 8260 West Marigold	
County: Ada; Estab #: ; EHS/SUR #:	Inspection time: ; Travel time:
Inspection Type: Standard; Risk Category: High	Follow-Up Report: OR On-Site Follow-Up: Date: N/A; Date: N/A

Items marked are violations of Idaho's Food Code, IDAPA 16.02.19, and require correction as noted.

Critical Violations		Noncritical Violations	
# of Risk Factor Violations	Ø	# of Retail Practice Violations	Ø
# of Repeat Violations	Ø	# of Repeat Violations	Ø
Score	Ø	Score	Ø
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.

		COS	R
	Demonstration of Knowledge (2-102)		
(Y) N	1. Certification by Accredited Program; or Approved Course; or correct responses; or compliance with Code	☐	☐
	Employee Health (2-201)		
(Y) N	2. Exclusion, restriction and reporting	☐	☐
	Good Hygienic Practices		
(Y) N	3. Eating, tasting, drinking, or tobacco use (2-401)	☐	☐
(Y) N	4. Discharge from eyes, nose and mouth (2-401)	☐	☐
	Control of Hands as a Vehicle of Contamination		
(Y) N	5. Clean hands, properly washed (2-301)	☐	☐
(Y) N	6. Bare hand contact with ready-to-eat foods/exemption (3-301)	☐	☐
(Y) N	7. Handwashing facilities (5-203 & 6-301)	☐	☐
	Approved Source		
(Y) N	8. Food obtained from approved source (3-101 & 3-201)	☐	☐
(Y) N	9. Receiving temperature / condition (3-202)	☐	☐
Y N (N/A)	10. Records: shellstock tags, parasite destruction, required HACCP plan (3-202 & 3-203)	☐	☐
	Protection from Contamination		
(Y) N N/A	11. Food segregated, separated and protected (3-302)	☐	☐
(Y) N N/A	12. Food contact surfaces clean and sanitized (4-5, 4-6, 4-7)	☐	☐
(Y) N	13. Returned / reservice of food (3-306 & 3-801)	☐	☐
(Y) N	14. Discarding / reconditioning unsafe food (3-701)	☐	☐

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

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

Item/Location	Temp	Item/Location	Temp	Item/Location	Temp	Item/Location	Temp
Mayo / Fridge	39°	Meat / Gravy / Oven	188°	Broccoli / oven	175		
Chicken Alfredo / Fridge	37.9°	Noodles / Oven	149°				

GOOD RETAIL PRACTICES (☒ = not in compliance)

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

OBSERVATIONS AND CORRECTIVE ACTIONS (CONTINUED ON NEXT PAGE)

Person in Charge (Signature) Eric D. Collett (Print) Eric D. Collett Title Executive Director Date 2/11/2013

Inspector (Signature) [signature] (Print) MATT HAUSER Date 2/11/2013 Follow-up: (Circle One) Yes No

IDAHO DEPARTMENT OF HEALTH & WELFARE

C.L. "BUTCH" OTTER – GOVERNOR
RICHARD M. ARMSTRONG – DIRECTOR

TAMARA PRISOCK – ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
JAMIE SIMPSON – PROGRAM SUPERVISOR
RESIDENTIAL ASSISTED LIVING FACILITY PROGRAM
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: 208-334-6626
FAX: 208-364-1888

February 26, 2013

Eric Collett, Administrator
Emerson House At River Pointe, LLC
8250 West Marigold
Garden City, ID 83714

Dear Mr. Collett:

An unannounced, on-site licensure/follow-up and complaint investigation survey was conducted at Emerson House At River Pointe, LLC between February 5, 2013 and February 11, 2013. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00005719

Allegation #1: Residents were not appropriately supervised to ensure their care needs were met.

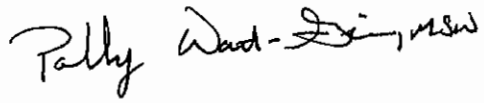
Findings #1: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.520 for not scheduling sufficient staff to provide supervision to ensure residents care needs with eating, toileting and safety monitoring were met. The facility was required to submit a plan of correction.

A core issue deficiency was identified during the complaint investigation. Please review the cover letter, which outlines how to develop a Plan of Correction. The Plan of Correction must be submitted to our office within 10 (ten) calendar days of receiving the Statement of Deficiencies.

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, on **02/11/2013**. The completed punch list form and accompanying evidence of resolution (e.g., receipts, pictures, policy updates, etc) are to be submitted to this office within thirty (30) days from the exit date.

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

PWG

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