

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

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March 26, 2012

James Varnadoe, Administrator Overland Court Senior Living 10250 West Smoke Ranch Drive Boise, ID 83709

Dear Mr. Varnadoe:

An unannounced, on-site complaint investigation survey was conducted at Overland Court Senior Living between March 14, 2012 and March 14, 2012. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00005329

Allegation #1:

Facility caregivers, who worked in the memory care unit, were not trained on

how to properly provide care to residents with dementia.

Findings #1:

On 3/14/12 between 9:35 AM and 12:45 PM, caregivers were observed providing appropriate care to dementia residents. They were observed patiently interacting with the residents and explaining tasks to residents prior to assisting them.

Between 9:50 AM and 12:00 PM, six caregivers were interviewed. They all stated they had received dementia training initially through videos and on the floor training. They also stated the facility had mandatory monthly training that all the caregivers had to complete.

Between 11:15 AM and 12:45 PM, two outside service agency nurses stated they observed the facility caregivers providing appropriate dementia care to the residents.

On 3/14/12, seven random caregivers records were reviewed. The records documented the caregivers had received dementia training.

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

Allegation #2:

An identified resident was force fed an inappropriate diet.

Findings #2:

The identified resident's closed record was reviewed on 3/14/12. The record documented the resident was admitted on a mechanical soft diet. The record further documented the resident declined and required several changes in diet from mechanical soft, to mechanical soft with pureed soup, to pureed diet, to offering small sips of fluids and small bites of food as the resident became unable to swallow food.

On 3/14/12 between 9:50 AM and 12:00 PM, six caregivers were interviewed. The caregivers denied they had ever force fed a resident and had not seen other caregivers force feed residents. Three caregivers stated, the identified resident would fall asleep during meals, but they would try to wake the resident and have the resident swallow the food. One of the caregivers stated the identified resident's diet was changed to accommodate the resident's decline in medical condition.

On 3/14/12 at 12:25 PM, a hospice nurse stated he had not witnessed the facility staff force feeding the identified resident. The nurse further stated, the resident required many diet changes, as the resident declined rapidly.

Two random residents' records were reviewed on 3/14/12. One of the residents had an order for a mechanical soft diet and required assistance with feeding.

On 3/14/12 between 9:35 AM and 12:45 PM, caregivers were observed during a morning snack and at lunch time. The residents were observed to receive their appropriate diets and caregivers were observed to appropriately assist residents with their meals.

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

Allegation #3:

Caregivers did not treat an identified resident with dignity and respect, i.e. not explaining assistance being provided to the resident.

Findings #3:

On 3/14/12 between 9:35 AM and 12:45 PM, caregivers were observed treating the residents with dignity and respect. The caregivers were observed addressing residents by their names, responding to their needs in responsive mamier and were heard explaining the level of assistance they were providing to the residents.

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On 3/14/12 between 9:45 AM and 11:55 AM, two caregivers stated that in the past, some of the caregivers had not explained cares prior to assisting residents with their cares. However, the issue had been addressed at the time the concern was raised and caregivers had been retrained and some had been let go. They stated that all caregivers currently working at the facility, would explain the cares they were providing prior to and during the assistance.

On 3/14/12 between 9:50 AM and 12:00 PM, four other caregivers were interviewed. They stated they always explained the assistance they would be providing to the residents prior to and during the assistance.

On 3/14/12 at 11:41 AM, a random resident's family member stated their loved one was treated with dignity and respect.

On 3/14/12 between 11:15 AM and 12:45 PM, two outside service agency nurses stated they had observed caregivers treating residents with dignity and respect.

Substantiated. The facility was not cited as they had implemented training and the deficient practice was no longer occurring.

Allegation #4:

The facility's former nurse did not address an identified resident's change of condition or coordinate care between the facility and outside service agency.

Findings #4:

On 3/14/12, the identified resident's closed record was reviewed. The record contained documentation by the facility and the hospice agency which addressed the resident's changes of condition.

On 3/14/12, two current residents' records were reviewed. The records documented the current facility murse had addressed residents' changes of condition in a timely manner.

On 3/14/12 at 12:25 PM, a hospice nurse stated the identified resident had a rapid decline in health, which was coordinated between the hospice agency and the facility nurse and staff.

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

Allegation #5:

The facility did not implement an identified resident's chair alarm.

Findings #5:

On 3/14/12, the identified resident's record was reviewed. The record contained documentation that on the evening of 10/17/11, the resident's alarm box was

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misplaced and was broken.

On 3/14/12 between 9:35 AM and 12:45 PM, caregivers were observed providing appropriate care and supervision to residents. There were no chair alarms observed in use at that time.

Between 9:50 AM and 12:00 PM, six caregivers were interviewed. The caregivers stated they tried to keep the residents who required extensive supervision in line of sight. Two of the caregivers stated the identified resident had a chair alarm which was supposed to be used, but on occasion had not been used by some of the caregivers. Additionally, the caregivers stated they currently did not have any residents who required chair alarms.

On 3/14/12 at 11:41 AM, a family member stated their loved one received appropriate cares and felt appropriate supervision was provided to the residents.

On 3/14/12 between 11:15 AM and 12:45 PM, two outside service agency nurses stated the caregivers provided appropriate care and supervision to the residents.

Substantiated. There were times when the identified resident's chair alarm was not used. However, there is no requirement to use chair alarms per the Idaho Assisted Living Rules. Therefore, supervision had to be investigated. During the investigation, it could not be determined the identified resident and current residents had not received appropriate supervision.

Allegation #6:

The facility did not ensure sufficient staff were available to transfer an identified resident.

Findings #6:

On 3/14/12, the facility's October 2011, November 2011 and March 2012 as worked schedules were reviewed. The schedules documented the facility always had two caregivers available to transfer residents when needed.

On 3/14/12 on 9:40 AM, the current facility nurse stated on the day shift there were always two caregivers and one medication aide in the unit. He further stated on the evening shift there was always one caregiver and one medication aide, with a set floater between 4:00 PM and 8:00 PM in the unit. The nurse also stated on the night shift there was one medication aide in the unit and a floater staff that was available to assist as needed.

On 3/14/12 between 9:35 AM and 12:40 PM, two caregivers and one medication aide were observed working in the memory care unit.

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Between 9:50 AM and 12:00 PM, six caregivers were interviewed. They all stated there were always enough caregivers to assist in transferring residents whether they be a one or two-person assist.

On 3/14/12 at 11:41 AM, a family member stated their loved one received appropriate cares and did not have concerns about the staffing level.

Between 11:15 AM and 12:45 PM, two outside service agency nurses stated the caregivers provided appropriate care to the residents and were not aware of any staffing issues.

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

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

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