



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

May 21, 2013

Amy Rackham, Administrator  
Gables Of Ammon Management, Inc  
1405 Curlew Drive  
Ammon, ID 83406

License #: RC-1013

Dear Ms. Rackham:

On March 29, 2013, a State Licensure/follow-up and Complaint Investigation survey was conducted at Gables Of Ammon Management, Inc. As a result of that survey, deficient practices were found. The deficiencies were cited at the following levels:

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

Should you have questions, please contact Donna Henscheid, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 334-6626.

Sincerely,

Donna Henscheid, LSW  
Team Leader  
Health Facility Surveyor  
Residential Assisted Living Facility Program

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



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April 15, 2013

**CERTIFIED MAIL #: 7007 3020 0001 4050 8098**

Amy Rackham  
Gables of Ammon Management, Inc.  
1405 Curlew Drive  
Ammon, ID 83406

Dear Ms. Rackham:

Based on the licensure, follow-up and complaint investigation survey conducted by Department staff at Gables of Ammon Management, Inc. between March 25, 2013 and March 29, 2013, it has been determined the facility was not providing adequate care to residents.

The failure to provide adequate care to residents is a core issue deficiency, as described in IDAPA 16.03.22.010.20. The facility specifically failed to provide appropriate assistance and monitoring of medications, including but not limited to: residents going without ordered medications for seventeen (17) days; incorrect dosages of insulin given to several residents on numerous occasions; not implementing new physician's orders; not ensuring medications were obtained for new orders; and not rectifying documentation errors or clarifying medication orders. This core issue deficiency for inadequate care substantially limits the capacity of Gables of Ammon Management, Inc. to ensure that residents' health and safety are safe-guarded. The deficiency is described on the enclosed Statement of Deficiencies.

#### BACKGROUND

Gables of Ammon Management, Inc. became licensed to assume operations of the assisted living facility located at 1405 Curlew Drive, Ammon, Idaho, on November 22, 2011. Prior to this date, the facility, which was operated as Gables Senior Living, received repeated core deficiencies for inadequate care and abuse, including: a core issue deficiency for inadequate care on February 11, 2011; core issue deficiencies for both inadequate care and abuse on April 27, 2011; and a core issue deficiency for inadequate care on August 11, 2011.

IDAPA 16.03.22.105.03 states that an entity purchasing a facility with enforcement actions acquires the enforcement action. Since new management/ownership took over in November of 2011, the facility has continued to receive repeat core issue deficiencies for similar issues found during the previous management/ownership. On September 26, 2012, the facility received core issue deficiencies for both inadequate care and neglect, and was placed on a provisional license, which expired April 9, 2013. On March 29, 2013, the facility was again issued a core issue deficiency for inadequate care. Because of the repeated nature of the core issue deficiencies and the failure of the facility to maintain substantial compliance with IC 39-3301 and IDAPA 16.03.22, the following actions are being taken:

## ENFORCEMENT ACTIONS

Because the facility failed to maintain substantial compliance through the end of the provisional license period, and as a result of the March 25-29, 2013, survey findings, a second and final provisional license is being issued, effective April 9, 2013 through September 9, 2013. The following administrative rule for Residential Care or Assisted Living Facilities in Idaho (IDAPA 16.03.22) gives the Department the authority to issue a provisional license:

***935. ENFORCEMENT REMEDY OF PROVISIONAL LICENSE.***

*A provisional license may be issued when a facility is cited with one (1) or more core issue deficiencies, or when noncore issues have not been corrected or become repeat deficiencies. The provisional license will state the conditions the facility must follow to continue to operate. See Subsections 900.04, 900.05 and 910.02 of these rules.*

The conditions of the provisional license are:

- 1. Ban on all new admissions. Readmission from the hospital will be considered after consultation between the facility, the resident/family and the Department. The ban on new admissions will remain in effect until the Department has determined that the facility has achieved full compliance with the requirements. The following administrative rules for Residential Care or Assisted Living Facilities in Idaho (IDAPA 16.03.22) give the Department the authority to impose the remedy of a limit on admissions:**

***920. Enforcement Remedy of Limit of Admissions.***

***02. Reasons for Limit on Admissions.*** *The Department may limit admissions for the following reasons: a. The facility is inadequately staffed or the staff is inadequately trained to handle more residents. b. The facility otherwise lacks the resources necessary to support the needs of more residents.*

- 2. A registered nurse consultant, with experience working for a residential care assisted living facility in Idaho as a registered nurse, will be obtained and paid for by the facility, and approved by the Department. This registered nurse consultant must have an Idaho nursing license, and may not also be employed by the facility or company that operates the facility. The registered nurse consultant must be allowed unlimited access to the facility and its systems for the provision of care to residents. The name of the consultant with the person's qualifications will be submitted to the Department for approval no later than April 19, 2013.**
- 3. The Department-approved consultant will submit a weekly written report to the Department commencing on April 26, 2013, and every Friday thereafter. The reports will address progress on correcting the core deficiency described on the Statement of Deficiencies and Non-Core Issues Punch List.**
- 4. The facility will maintain, on an ongoing basis, the deficient area in a state of compliance in accordance with the submitted Plan of Correction.**
- 5. The facility will retain a minimum of two full time nurses, who have a valid, full Idaho nursing license, to provide a minimum of eighty (80) hours per week of nursing oversight at the facility. The nurses must be employed directly by the facility, as opposed to an agency that provides rotating nursing services.**

6. When the facility nurses are not available in the building, the facility will maintain at all times, an on-call, licensed nurse available to provide consultation to facility staff and respond to the facility within one hour to respond to resident changes of condition, conduct assessments and make determinations regarding further care or emergency services.
7. The facility will retain a full-time (40 hours per week), residential care administrator, who has both a full residential care administrator's license in Idaho and at least one year previous experience serving as a residential care administrator for an Idaho facility.

When the consultant, the administrator and the facility nurses agree the facility is in full compliance, they will notify the Department and a follow-up survey will be conducted. If, during the follow-up survey, the deficiency still exists or a new core issue deficiency is identified, the Department will have no alternative but to initiate revocation of the facility license, or summarily suspend the license and transfer the residents, should the identified deficiencies place any of the residents' health or safety in danger.

Please be advised that you may contest this decision by filing a written request for administrative review pursuant to IDAPA 16.05.03.300. no later than twenty-eight (28) days after this notice was mailed. Any such request should be addressed to:

**Tamara Prisock, Administrator**  
**Division of Licensing and Certification**  
**Department of Health and Welfare**  
**3232 Elder Street**  
**P.O. Box 83720**  
**Boise, ID 83720-0009**

If you fail to file a request for administrative review within the time allowed, this decision shall become final.

#### PLAN OF CORRECTION

You have an opportunity to make corrections and thus avoid a potential enforcement action. Correction of this core issue deficiency must be achieved by **May 13, 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 **within 10 calendar days of your receipt of this letter**, and keep a copy for your records. Your license depends upon the corrections made and the evaluation of the Plan of Correction you develop.

#### INFORMAL DISPUTE RESOLUTION

In accordance with Informational IDAPA 16.03.22.003.02 Informal Dispute Resolution Meeting (IDR), you have available the opportunity to question core issue deficiencies through an informal dispute resolution process. If you disagree with the Statement of Deficiencies survey report findings, you may make a written request to the Supervisor of the Residential Assisted Living Facility 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](http://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.

#### EVIDENCE OF RESOLUTION

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 **April 28, 2013**.

Our staff is available to answer questions and to assist you in identifying appropriate corrections to avoid further enforcement actions or revocation or summary suspension of the facility license. Should you have any questions, or if we may be of assistance, please contact us at (208) 334-6626 and ask for the Residential Assisted Living Facility program.

Sincerely,

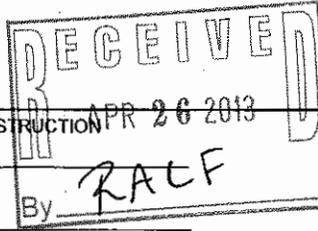


JAMIE SIMPSON, MBA, QMRP  
Program Supervisor  
Residential Assisted Living Facility Program

dph/mmc

Enclosures

cc: L&C Medicaid Notification Group



PRINTED: 04/05/2013  
FORM APPROVED

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13R1013	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED  03/29/2013
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NAME OF PROVIDER OR SUPPLIER  GABLES OF AMMON MANAGEMENT, INC	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	Initial Comments  The following deficiency was cited during the Licensure/follow-up and Complaint Investigation conducted on 03/25/13 through 03/29/13 at your residential care/assisted living facility. The surveyors conducting the survey were:  Donna Henscheid, LSW Team Leader Health Facility Surveyor  Matt Hauser, QMRP Health Facility Surveyor  Karen Anderson, RN Health Facility Surveyor  Maureen McCann, RN Health Facility Surveyor  Survey Definitions: BG = Blood Glucose LPN = licensed practical nurse MAR = Medication Assistance Record mcq = milliequivalents MD = Physician mg = milligrams ml = milliliters PO = by mouth RN = registered nurse TID = three times a day U = Units	R 000		
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.	R 008		

*[Signature]* Administrator  
TITLE 4/26/13 (X6) DATE

Bureau of Facility Standards

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

Bureau of Facility Standards

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R 008	Continued From page 1  This Rule is not met as evidenced by: According to IDAPA 16.03.22.430.05, the "following are basic services to be provided to the resident by the facility within in the basic service rate: g. assistance and monitoring of medications."  Based on observation, interview and record review it was determined the facility did not provide appropriate assistance and monitoring of medications for 5 of 10 sampled residents (#1, #4, #6, #8 and #10) whose records were reviewed. The findings include:  1. Resident #8, a 77 year-old female, was admitted to the facility on 12/28/12, with a diagnosis of Type II diabetes.  A physician's order, dated 11/27/12, documented the following Humalog sliding scale:  Less than 150 = 0 units 151-200 = 2 units 201-250 = 4 units 251-300 = 6 units 301-350 = 8 units 351- 400 = 10 units Over 400 = Call MD  A hospital discharge sheet, dated 1/29/13; a March 2013 MAR; a hospice "Episode Summary Report," dated 3/15/13; and a "Physician's Quarterly Medication Review Report," dated 3/25/13, documented Resident #8's blood glucose would be checked 4 times day and if needed, hospice would administer insulin to the resident. The forms further documented the resident's Humalog insulin sliding scale had been changed to:	R 008	RULE 008 16.03.22.520 Protect Residents from Inadequate Care  I. Insulin and Blood Sugars Resolution: 1. Resident #8- is on hospice with Aspen Home Health and Hospice. Her blood sugar and insulin is being managed by the hospice company. When the resident went to the hospital for a brief stay she came back with different orders for the insulin. She was then re-admitted to the home health company under different doctor's orders. In reviewing the orders and inquiring from her primary care physician, we found that her physician did not wish to use the orders from the hospital. New signed orders were obtained dated. Since then the resident has been admitted to hospice and her blood sugar checks and insulin have been decreased to twice daily.	

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R 008	Continued From page 2  Less than 150 = 0 units 151-250 = 2 units 251-350 = 4 units 351 and over = 8 units  The hospice agency's "Vital Signs Reports" documented the following BG's and amounts of Novolog were given by the hospice agency:  *3/1 BG was 217 - 4 units were given BG was 249 - 4 units were given  *3/2 There were only two BGs recorded for the day. There was no other documentation indicating the BGs were checked two more times as ordered.  *3/3 BG was 201 - 4 units were given BG was 248 - 4 units were given  There were only three BGs recorded for the day. There was no other documentation indicating the BG was checked one more time as ordered.  *3/4 BG was 231 - No units documented as given BG was 257 - 6 units were given  *3/6 BG was 200 - 4 units were given  *3/7 BG was 229 - 4 units were given  *3/8 BG was 278 - 6 units were given	R 008		

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R 008	Continued From page 3  *3/10 BG was 200 - 4 units were given  *3/12 BG was 211 - 4 units were given  *3/14 BG was 233 - 4 units were given BG was 249 - 4 units were given  *3/16 BG was 225 - 4 units were given  *3/17 BG was 204 - 4 units were given  *3/18 BG was 256 - 6 units were given  *3/20 BG was 159 - No units were documented as given  *3/24 BG was 168 - No units were documented as given  On 3/27/13 at 2:45 PM the administrator stated she had spoken to the hospice agency and they had been following the order from 11/27/12 "all along."  Fifteen times during the month of March, the hospice agency gave Resident #8 an incorrect dosage of Humalog. Three times the hospice agency documented BGs were taken, but failed to document how many units were given. Three times there was no documentation Resident #8's BGs were done at all.	R 008		

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R 008	<p>Continued From page 4</p> <p>The facility failed to ensure Resident #8 received the correct insulin dosage and did not ensure BG's measurements were taken as ordered.</p> <p>2. Resident #1, a 55 year-old female, was admitted to the facility on 6/1/12, with diagnoses which included diabetes.</p> <p>A "Shift Change Note," dated 12/12/12 and signed by the previous facility RN, documented, "When doing blood sugars please document the BG reading and document the amount of Novolog insulin given."</p> <p>A physician's order, dated 5/3/12, documented the following sliding scale Novolog:</p> <p>0-150 = 0 units 151-200 = 2 units 201-250 = 4 units 251-300 = 6 units 301-350 = 8 units 351-400 = 10 units Greater than 400 = 16 units - a maximum of 16 units before meals.</p> <p>The facility's "Vital Signs" report and "Test" report documented the BGs were checked at following times in March 2013:</p> <p>*3/2 1:46 PM the BG was 87 1:46 PM the BG was 192 2:19 PM the BG was 149 2:22 PM the BG was 191</p> <p>There was no documentation that units were given for the four readings as indicated. Nor was there any reason documented to explain why the</p>	R 008	<p>2. Resident #1- was discharged from the facility on April, 1, 2013 after a 30 day discharge notice was given due to wounds not healing biweekly.</p> <p>3. Resident #4- is on home health with Aspen Home Health and Hospice. His blood sugar and insulin is being managed by the home health company.</p>	

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R 008	<p>Continued From page 5</p> <p>BGs were taken within two minutes of each other or why different numbers were recorded at the same time.</p> <p>*3/3 1:08 PM the BG was 167 1:52 PM the BG was 152 9:26 PM the BG was 74 9:26 PM the BG was 426 9:38 PM the BG was 192 9:40 PM the BG was 154</p> <p>There was no documentation that units were given for six of the readings as indicated. Nor was there any reason documented to explain why BGs were taken 44 minutes apart or why different numbers were recorded at the same time.</p> <p>*3/5 9:35 AM the BG was 222 1:35 PM the BG was 107 9:12 PM the BG was 323 9:44 PM the BG was 333 9:46 PM the BG was 323 9:47 PM the BG was 333</p> <p>There was no documentation that units were given for five of the readings as indicated. Nor was there any reason documented to explain why BGs were taken 35 minutes apart.</p> <p>7:53 AM the BG was 103 1:44 PM the BG was 245 5:31 PM the BG was 524 9:20 PM the BG was 353 9:42 PM the BG was 103 9:44 PM the BG was 245 9:44 PM the BG was 524 9:45 PM the BG was 335</p>	R 008		

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R 008	<p>Continued From page 6</p> <p>There was no documentation that units were given for the six readings when indicated. Nor was there any reason documented to explain why BGs were taken 25 minutes apart or why different numbers were recorded for the same time.</p> <p>*3/18 9:46 AM the BG was 121 12:05 PM the BG was 76 1:48 PM the BG was 76 9:24 PM the BG was 356 9:24 PM the BG was 124 10:24 PM the BG was 356</p> <p>There was no documentation that units were given for the two readings when indicated. Nor was there any reason documented to explain why different numbers were recorded at the same time.</p> <p>*3/23 10:58 AM the BG was 135 11:43 AM the BG was 96 11:43 AM the BG was 135 11:44 AM the BG was 96 8:28 PM the BG was 237 - four units were given 8:28 PM the BG was 435</p> <p>There was no documentation to explain why different numbers were recorded at the same time. Nor was there any documentation to explain why different numbers were recorded at the same time.</p> <p>On 3/26/13, the administrator confirmed the facility could not ensure Resident #1 received the correct amount of insulin by looking at the current system of documenting BGs used by the facility.</p> <p>Although instructed to do so back in December</p>	R 008		

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R 008	<p>Continued From page 7</p> <p>2012, the facility staff did not consistently record the units of Novolog insulin given to the resident. There was no explanation why BGs were taken within minutes of each other. There was no way to determine what, if any amount of Novolog was given. Further, during the month of March 2013, there were no BGs recorded for Resident #1 at breakfast 5 times, lunch 3 times and supper 10 times.</p> <p>The facility failed to ensure Resident #1's BG measurements were taken and insulin given as ordered. The facility also failed to investigate and resolve abnormal BGs.</p> <p>3. Resident #4, an 85 year-old male, was admitted to the facility on 2/11/13, with diagnoses including dementia, insulin dependent diabetes mellitus and peripheral neuropathy.</p> <p>a. Insulin</p> <p>On 2/26/13, during the facility tour, a caregiver stated resident #4's blood glucose was checked and insulin administered, if needed, by home health nurses who came to the facility 4 times a day.</p> <p>A physician's order, dated 2/12/13, documented: Novolog 100 units/ml insulin. "Give units per sliding scale 4 times daily" :</p> <p>0-119 = 0 units 120 - 179 = 2 units 180 - 239 = 4 units 240 - 299 = 6 units 300 - 359 = 8 units 360 - 419 = 10 units &gt; 400 = call MD</p>	R 008	<p>A. A full range audit was conducted on all residents requiring blood sugar checks and insulin. All orders, mars and outside service notes were reviewed. All discrepancies were located in Outside Service Providers Forms, Bluestep mars, and clinical notes from the hospice/home health provider. To resolve this issue, each company was contacted to review their documentation. The companies did find clinical notes documenting the blood sugar checks and insulin given within a different report. All of those were pulled into one vital sign report.</p> <p>B. The home health and hospice agencies are delivering clinical notes through portals, which can be accessed by the Facility RNs at any time. This will ensure they are available to review weekly.</p>		

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R 008	<p>Continued From page 8</p> <p>Resident #4's February and March 2013 MAR's were reviewed and the following was documented:</p> <p>February MAR: *2/11/13 at 4:30 PM, the MAR was initialed by a facility caregiver that the medication was "done by home health." *All other scheduled doses in February, except for 4 doses, were initialed as given or held by facility caregivers.</p> <p>*The MAR was blank for 4 doses on: *2/15 at 11:30 AM *2/19 at 11:30 AM *2/20 at 8:00 PM *2/26 at 11:30 AM</p> <p>There was no documentation on the MAR to explain what the resident's blood glucose reading was or how much, if any, insulin the resident received 4 times a day in February 2013. Further, there was no explanation why the MAR was blank for the 4 doses or why the facility caregivers documented for the home health nurses.</p> <p>March MAR: *All scheduled doses in March, except for 2 doses, were initialed as given or held by facility caregivers. The other 2 doses, 3/4 at 11:30 AM and 3/18 at 11:30 AM, were blank on the MAR.</p> <p>There was no documentation on the MAR to explain what the resident's blood glucose reading was or how much, if any, insulin the resident received 4 times a day in March 2013. Further, there was no explanation why the MAR was blank for the 2 doses or why the facility caregivers documented for the home health nurses.</p>	R 008	<p>C. Weekly meetings with the home health/hospice agencies to review diabetic residents they care for will be held every Friday.</p> <p>D. Orders were clarified with physicians for all residents on insulin, and Bluestep mars were updated as needed.</p> <p>E. Insulin and blood sugar checks were changed on our Bluestep mars for all residents receiving these by home health/hospice companies to reflect that a designated person was administering them. This allows us to not clutter our mar and document any different numbers that what is being done by the agency. The documentation will be on the logs in the resident rooms.</p> <p>F. On April 5, 2013, a letter was faxed to all Home Health and Hospice agencies currently seeing residents in our facility. This letter detailed the guidelines we</p>	

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R 008	<p>Continued From page 9</p> <p>Resident #4's record also contained "Outside Service Report Form(s)."</p> <p>The forms were completed by the home health nurses when administering insulin to the resident.</p> <p>The following documentation was missing:</p> <p>*2/12. Only 3 of 4 scheduled doses documented. *2/13. 1 of the 4 doses not timed. *2/17. No documentation at all. *2/21. 1 of 4 doses not timed. *2/23, 2/24, 2/25. No documentation. *2/28. Only 3 of 4 doses documented. *3/1. Only 1 of 4 doses documented. *3/2. Only 2 of 4 doses documented. *3/3 and 3/4. No documentation. *3/5. Only 2 of 4 doses documented. *3/6. Only 3 of 4 doses documented and 1 of the 3 documented doses is not timed. *3/10. Only 2 of 4 doses documented. *3/11. Only 3 of 4 doses documented. *3/12. 2 of the 4 doses not timed. *3/14. No documentation. *3/15. 2 of the 4 doses not timed. *3/17. 2 of the 4 doses not timed. *3/20. 1 of the 4 doses not timed.</p> <p>Between 2/12/13 and 3/20/13 (37 days), Resident #4 should have had 170 documented entries of his blood glucose values and the insulin units given, if needed. Of the 170 entries, 51 or 30% of these entries were either incomplete or not found at all.</p> <p>Upon surveyors request on 3/26/13, the facility administrator produced a computerized form from the home health agency. This form documented entries of Resident #4's blood glucose values and insulin units given if needed. Several entries on</p>	R 008	<p>expect them to follow when reporting to the facility about cares they provide. This also enclosed examples of "not to do" examples of Outside Service Provider forms that are being left. It also showed "to do" examples we expect to see. A copy of the letter dated October 19, 2012, was also enclosed reminding them they had been asked to do these things earlier during our last survey.</p> <p>G. The Facility RNs are reviewing every Outside Service Form and clinical notes to make sure they are the same. They are also providing follow-up on Outside Provider Forms they leave if required.</p> <p>H. Insulin logs are in the resident rooms for all residents who are receiving insulin by agency or self-injection. Blood sugar levels and units given are recorded on these logs as well as the date and time. The logs also contain the current order for insulin to be given and</p>	

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R 008	<p>Continued From page 10</p> <p>this form were also incomplete. After comparing both the "Outside Agency Service Form(s)" found in the resident's record with the computerized forms sent by the home health agency, multiple entries still were incomplete. The following entries were still either blank or incomplete:</p> <p>*2/12 Only 3 of 4 doses documented. *3/2 Only 3 of 4 doses documented. *3/4 Only 3 of 4 doses documented. *3/13 Only 3 of 4 doses documented.</p> <p>The "Outside Service Report Form(s)" also documented on 3/13 at 8:02 PM, the resident's BG was 204 and the resident received 4 units of insulin. Then at 8:38 PM, the resident's BG was 180, and the resident received another 4 units of insulin. There was no explanation in the residents record why the BGs were taken and the resident received 2 insulin doses within 36 minutes of each other.</p> <p>The facility obtained documentation of Resident #4's insulin administration record from the home health agency on 3/26/13. After reviewing the documentation received and comparing it to the documentation maintained by the facility, facility staff were unable to explain the discrepancies and the incomplete documentation.</p> <p>b. Medications Not Available</p> <p>Resident #4's February and March 2013 MAR's were reviewed and the following documentation was noted regarding several medications not being available for the resident:</p> <p>i. Vitamin B-12, 1000 mcg/ml, give one tablet by mouth daily. The MAR was not clear whether the resident was</p>	R 008	<p>sliding scale ranges.</p> <p>I. The Facility RNs are auditing the logs in rooms weekly to ensure proper dosages, times and documentation are being done. They are also continuing to compare them with the outside service notes and clinical notes to ensure there are no discrepancies.</p> <p>J. Posters are located each resident's room, for those receiving insulin, with signs/symptoms of hypoglycemia and hyperglycemia. Staff is being trained to include observing for signs/symptoms of these issues, including when it is appropriate to contact the Facility RN, physician or 911 in necessary.</p> <p>K. Date of Compliance will be May 12, 2013.</p> <p>1. Medications not available or given</p>		

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R 008	Continued From page 11 to receive pill (one tablet) or liquid (1000mcg/ml) form of the medication.  *2/12 - 2/14 (3 days). The medication was not available. *3/15 - 3/28 (11 days). The medication was not available.  On 3/28, the medication cart was observed and Vitamin B-12 could not be found in either pill or liquid form.  ii. Prednisone 5 mg Give 1 1/2 tablet by mouth daily.  *2/17 and 2/18. The medication was not available. *3/20 - 3/26 (6 days). The medication was not available.  iii. Calcitriol 0.25mg take one tablet by mouth daily.  *2/7 and 2/8. No documentation on the MAR. *2/9. The medication was not available. *2/10 - 2/11. The medication was documented as given. *2/12. The medication was not available. *2/13. The medication was documented as given. *2/14 - 2/15. The medication was not available. *2/16. The medication was documented as given. *2/17. The medication was not available.  There was no explanation in resident #4's record why the medication was unavailable some days but given on others.  iv. Allopurinol 300 mg give one tablet by mouth daily.	R 008	Resolution:  1. Resident #4- was admitted to the facility from LifeCare on February 7, 2013. There were medications not readily available after move in and we ordered them from his pharmacy immediately. The pharmacy was unable to bill some of the medications through his insurance because his wife had picked them up earlier. It took several attempts to reach his spouse to bring in the medication due to her terminal illness. Still, we audited his medication mar to find areas where medications were missing and spoke with pharmacy to place all meds on cycle.  2. Resident #6- was released from the hospital on March 9, 2013. Staff documented a change in medication, but orders received by the facility did not state the change. During	

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R 008	Continued From page 12 *3/7 and 3/8. No documentation on the MAR. *3/9 - 3/11 (3 days). The medication was not available. v. Valsartan (Diovan) 160 mg give one tablet by mouth daily. *3/17 - 3/19 (3 days). The medication was not available. vi. Torasemide 20 mg give one tablet by mouth daily. *3/24 and 3/25. The medication was not available. vii. Pentoxifylline (Trental) 400 mg give one tablet by mouth daily. *3/7 and 3/8. No documentation on the MAR. *3/9 - 3/11 (3 days). The medication was not available. viii. Simvastatin 40 mg Take one tablet by mouth once daily. *3/8 - 3/10 (3 days). The medication was not available. ix. Chlorthalidone 25 mg Give 1/2 tablet every morning. *3/10. The medication was not available. x. Vitamin D 1000u give one tablet by mouth daily. *2/12 - 2/14 (3 days). The medication was not	R 008	survey, the Administrator called the hospital to get full orders. The digoxin order was on that discharge list on March 26, 2013. Home health delivered an order to the facility to discontinue ibuprofen on March 21, 2013. The resident continued to receive the medication for 6 days until discontinued on March 26, 2013.  3. Resident #10- was given an order to receive B12 injections twice monthly in January. She only received one injection. The order changed to every 1 1/2 weeks on February 22, 2013. The order was not implemented and the resident received one injection for February. The medication was still incorrect upon survey on March 27, 2013.  A. Medication order discrepancies discovered in the survey were reviewed, clarified with the physicians, and corrected in the Bluestep mars.	

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R 008	<p>Continued From page 13</p> <p>available.</p> <p>*3/24 - 3/25. The medication was not available.</p> <p>xi. Vitamin C 1000u give one tablet by mouth daily.</p> <p>*2/12 - 2/19 (8 days). The medication was not available.</p> <p>*3/18 - 3/25 (8 days). The medication was not available.</p> <p>On 3/28/13 at 11:30 AM, the blister pack for Resident #4's vitamin C was observed. The label documented "Vitamin C 500 mg," take 1 tablet daily. Only 1 tablet was observed in each blister. The caregiver assisting the surveyor with reviewing Resident #4's medications confirmed the resident had been receiving the wrong dose of the medication.</p> <p>In February 2013, of 85 scheduled doses of medications, Resident #4 did not receive 19 doses, or 22% of scheduled medication because the medication was not available.</p> <p>In March 2012, of 250 scheduled doses of medications, Resident #4 did not receive 44 doses, or 19% of scheduled medication because the medication was not available. Further, Resident #4 received the wrong dose of Vitamin C.</p> <p>On 3/28/13 at 10:15 AM, a medication technician stated there were times when the facility ran out of resident's medications in the medication cart. She further stated, although the medications may be in the medication room often they could not be found.</p>	R 008	<p>B. The facility secured a RN Consultant in February 20, 2013 to audit Bluestep mars, medication orders, and medications available. She was in the process of a thorough audit of all resident records during survey. Any discrepancies located were fixed immediately and medications were ordered. The RN Consultant has completed the first audit and continues to audit all medications ordered and the nursing team's response with them.</p> <p>C. We recently hired another RN to assist the nursing team and current Facility RN with managing resident care and medications. Both RNs will check new orders to ensure they are being implemented, ordered and available to give. They will review each other's implementation of medications and sign off they are correct.</p>	

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R 008	<p>Continued From page 14</p> <p>On 3/28/13 at 10:30 AM, the resident care coordinator assistant stated she was a new employee to the facility and did not know why so many medications were not available. She further stated she was not familiar with the reordering process.</p> <p>Between 2/26/13 and 2/28/13, two medication technicians and the facility LPN described different processes when asked how medications that were running out, were reordered in the facility. For example, one medication technician stated, when there were only 8 doses left, the medication was reordered. Another technician stated when the medication ran out, they filled out a form notifying the nursing office personnel. The LPN stated, the cart was being monitored for medications running out.</p> <p>Between 2/11/13 and 3/28/13, 45 days, Resident #4 missed 69 doses of various medications because the medications were not available. Further, the resident was receiving the wrong dose of Vitamin C. There was no documentation in the resident's record to explain the multiple missed medications, wrong dose or how some medications could be given one day, missing the next, then given the next day and missing the day after that. Nor was there documentation Resident #4's physician had been notified.</p> <p>4. Resident #6, an 86 year-old female, was admitted to the facility on 11/16/11, with a diagnoses including dementia and heart disease.</p> <p>a. Digoxin</p> <p>On 3/9/13, Resident #6 was discharged from the hospital with a new diagnosis of "new onset a-fib</p>	R 008	<p>D. All medications are checked into the facility through the Facility RN, or shift supervisors. They will check the medication for order accuracy and place in med carts.</p> <p>E. The nursing management team is performing weekly audits of the med carts to find medications that need to be ordered prior to them being out.</p> <p>F. Bluestep, which is the electronic mar and charting service we use for resident records, contains quality assurance reports built into the system. "Yesterday missed medications" reports are pulled daily and reviewed by the Administrator and Facility RN. All meds not signed for are noted and aides who were on the cart are called back in to review if they were given or not and why. Staff is learning from instruction and we are finding</p>	

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R 008	<p>Continued From page 15</p> <p>(atrial fibrillation)" and a physician's order for "Digoxin 0.125 mg PO daily".</p> <p>A facility "Shift Change Notes" form dated, 3/11/13, documented, "[Resident #6's name] is now on Digoxin in the mornings."</p> <p>On 3/26/13, Resident #6's March 2013 MAR did not have Digoxin documented on it.</p> <p>On 3/27/13 at 10:25 AM, the facility administrator confirmed the resident had not received the Digoxin and stated the facility was not aware of the order.</p> <p>On 3/28/13 at 12:00 PM, Resident #6's medications were reviewed. The Digoxin order had been added to the MAR and the medication had been received from the pharmacy. The label on the blister pack, dated 3/26/13, documented, Digoxin 125 mcg take once daily. The blister pack was observed with 28 pills left and 2 missing, dated 3/27 and 3/28.</p> <p>Between 3/9/13 and 3/26/13 (17 days), the resident did not receive Digoxin as ordered by her physician.</p> <p>b. Ibuprofen</p> <p>A physician's order, dated 3/21/13, documented, "Discontinue ibuprofen 600 mg TID."</p> <p>On 3/26/13, Resident #6's March 2013 MAR documented ibuprofen 600 mg TID. The MAR was annotated that the resident received the medication 3 times on 3/21, 3/22, 3/23, 3/24, 3/25, and once on 3/26/13.</p> <p>Between 3/21/13 and 3/26/13 (5 days), the</p>	R 008	<p>very few issues lately. This will continue daily as part of the routine and job description.</p> <p>G. A letter dated April 3, 2013 was sent to all residents' physicians requiring that any medication prescriptions be faxed to our facility for order and not called-in to pharmacies for delivery. It explained the rules and regulations to administer medications including that all medications, even over-the-counters, require a doctor signature for us to assist with administering them.</p> <p>H. A letter dated March 31, 2013, advised the current residents of the facility the need to use one preferred pharmacy to enable the nursing department to manage medications more accurately. This letter was followed up with an addendum/reminder letter dated April 16, 2013. 4Care pharmacy will be our preferred pharmacy to fill</p>	

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R 008	<p>Continued From page 16</p> <p>resident received ibuprofen after the physician had discontinued the medication.</p> <p>The facility failed to implement new physician's orders for Resident #6's cardiac medication for 17 days and ibuprofen for 6 days.</p> <p>5. Resident #10, an 84 year-old female, was admitted to the facility on 11/14/12 with diagnoses that included coronary artery disease and syncope episodes "passing out."</p> <p>Vitamin B-12: According to Web MD on 4/3/13, an article was written explaining what signs and symptoms a person may experience when they have been diagnosed with a deficiency of vitamin B12. The article explained the deficiency may lead to a "vitamin B12 deficiency anemia." If the anemia worsens it may cause symptoms such as; "weakness, tiredness or light-headedness, rapid heartbeat..."</p> <p>Resident #10's record contained a physician's order, dated 11/28/12, which documented the resident needed to be "seen for blood work prior to ordering B12" injections.</p> <p>A physician's order, dated 12/11/12, documented Resident #10 was to receive an injection of 1 milliliter of B12 every month.</p> <p>Resident #10's MAR for December 2012, did not document the resident received an injection of Vitamin B12 as ordered. The physician's order was transcribed on the MAR and documented, "Vitamin B12 1000 mcg/ml give 1 ml once monthly on December 20, 2012."</p> <p>A physician's order, dated 1/2/13, documented Resident #10's Vitamin B12 order had been</p>	R 008	<p>prescriptions for our residents. This will allow nursing staff to be more efficient and accurate with checking in medications as they are delivered.</p> <p>I. Staff training meeting was held on April 5, 2013, where staff was in-serviced on proper documentation. This training included a workshop with a training station for medication passing. Staff was required to match blister packs to the Bluestep mar and provide proper documentation for assisting/refusals of medications.</p> <p>J. A staff training meeting was again held on April 19. This staff training discussed medications and documenting appropriately specifically. Examples of correct medication passes were used.</p> <p>K. Stand up meetings are being held at every shift to reinforce correct</p>	

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R 008	<p>Continued From page 17</p> <p>changed and was to be given "twice a month."</p> <p>The January 2013 MAR documented the resident was given only one B12 injection on 1/21/13. However, the order on the MAR documented the B12 was to be given "twice a month."</p> <p>A physician's order, dated 2/22/13, documented Resident #10's B12 injection order was changed to be given every 1.5 weeks.</p> <p>The February 2013, MAR documented the resident was given one B12 injection on 2/18/13. The resident did not receive her B12 injection on 2/28/13, as ordered. The MAR was not congruent with the current physician's orders as the MAR directed the nurse to inject, "Vitamin B12 give 1 ml of B12 once a month on February 20, 2013."</p> <p>The March 2013, MAR documented the resident was given a B12 injection on 3/5/13 and on 3/18/13, but was not given every 1.5 weeks as ordered. The MAR was not updated to reflect the order change and directed the nurse to give, "Vitamin B12" twice a month."</p> <p>On 3/25/13 at 2:30 PM, the facility RN stated she had started working for the facility the beginning of March 2013, and confirmed medications and physician's orders were not congruent.</p> <p>On 3/27/13 at 3:10 PM, the facility RN stated she was not aware Resident #10's physician's order for B12 injections had been changed to be given every 1.5 weeks, nor was she aware the resident had not been receiving the correct dose since it was ordered on 12/11/12.</p> <p>Resident #10 was not given her Vitamin B12 injection as ordered from December 2012</p>	R 008	<p>medication passing and documentation. Any medication changes or holds are being discussed at these meetings as well as electronic documentation on the Bluestep shift change notes and mar.</p> <p>L. Medications not administered the previous day are discussed during Stand-Up meeting every morning. The nursing management team returns later in the day for a Stand-Down meeting to review if the medications are ordered, in the building, or documented incorrectly. Aides who have documented incorrectly are in-serviced immediately.</p> <p>M. The Facility RNs were in-serviced that every time a resident goes to the hospital orders need to be received immediately. If necessary, we will request they be faxed to the facility to assure we do not miss any changes.</p>	

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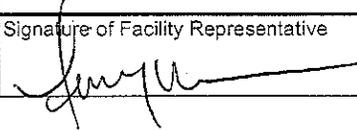
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13R1013	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____		(X3) DATE SURVEY COMPLETED  03/29/2013
NAME OF PROVIDER OR SUPPLIER  GABLES OF AMMON MANAGEMENT, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1405 CURLEW DRIVE AMMON, ID 83406		
(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 18  through March 27, 2013, due to physician orders not being followed and MARs not being congruent with current physician's orders.  The facility failed to provide appropriate assistance and monitoring of medications for Residents #1, #4, #6, #8 and #10. This failure resulted in inadequate care.	R 008	N. Any medications entered into Bluestep mars, will be reviewed by the Facility RN or the RN Consultant. The order will be reviewed and compared to the mar. This will ensure that medications are entered correctly and that medications on the order are not missed.  O. A form was developed for residents and their families to take to any doctor appointments. This form will have any situations currently presenting for the resident as well as areas for the doctor to make follow-up comments or medications orders. These forms need to be returned to the facility after the appointment by the resident. A letter dated April 24, 2013, was sent to the families and residents to make them aware of this policy change.  P. Date of Compliance will be May 12, 2013.		



**ASSISTED LIVING**  
**Non-Core Issues**  
**Punch List**

Facility Name Gables of Ammon	Physical Address 1405 Curlew	Phone Number 208-542-3400
Administrator Amy Rackham	City Ammon	Zip Code 83406
Team Leader Donna Henscheid	Survey Type Licensure, Follow-up and Complaint	Survey Date 03/29/13

**NON-CORE ISSUES**

Item #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	L&C USE
1	<del>152.05.b.iii</del>	<del>A random resident had rails attached to both sides of her bed. ***Repeat - previously cited 9/26/12***</del>		<del>mmr DH</del>
2	225.02	Residents #2 and #9 did not have behavior management plans in place.	5/21/13	DH
3	250.15	The facility's call system malfunctioned frequently.		5/21/13 DH
4	305.02	Resident #5's insulin order needed clarification. **COS**		
5	305.03	The facility RN did not document an assessment when Residents #1, 2, 4, 6, 9 and 10 had changes in their mental or physical condition.  ***Repeat - previously cited on 3/13/12***		5/21/13 DH
6	310.01.c	The facility did not maintain temperature logs on a daily basis for refrigerated medications. This includes residents' refrigerators.		5/21/13 DH
7	310.02	Previously discharged residents' medications were kept at the facility and used for current residents.		5/21/13 DH
8	310.04.a	A behavior modifying medication was requested by the facility for Resident #4 to address his behaviors prior to attempting non-medication interventions.		5/21/13 DH
9	320.08	Resident #2's NSA was not updated when the resident experienced a significant decline and required additional ADL assistance such as two person transfer, use of gait belt, and assistance with bathing. Resident #10's NSA was not updated to describe the level of assistance required for showers.		5/21/13 DH
10	350.02	The administrator did not document a complete investigation was conducted when Resident #2 had bruising of an unknown origin.  ***Repeat - previously cited on 9/26/12***		5/21/13 DH
Response Required Date 04/28/13	Signature of Facility Representative 		Date Signed 3/28/13	





# 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

Critical Violations      Noncritical Violations

Establishment Name <u>Deblee of Ammon</u>			Operator <u>Amy Ruckham</u>		
Address <u>1405 Cundw Dr</u>			City/State/Zip <u>Ammon 83406</u>		
County <u>Booneville</u>	Estab # <u>20828</u>	EHS/SUR # <u>20828</u>	Inspection time:	Travel time:	
Inspection Type:		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>3</u>	# of Retail Practice Violations <u>1</u>
# of Repeat Violations <u>3</u>	# of Repeat Violations <u>1</u>
Score <u>3</u>	Score <u>1</u>
A score greater than 3 Med or 5 High-risk = mandatory on-site reinspection	A score greater than 6 Med or 8 High-risk = mandatory on-site reinspection

**RISK FACTORS AND INTERVENTIONS (Idaho Food Code applicable sections in parentheses)**  
 The letter to the left of each item indicates that item's status at the inspection.

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

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

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
<u>meat loaf</u>	<u>165°</u>	<u>Vegetable mix</u>	<u>175.0 F</u>			<u>Beef soup</u>	<u>38°</u>
<u>Scalloped Potato</u>	<u>170°</u>	<u>Onion soup</u>	<u>120° F</u>			<u>fruit salad</u>	<u>39°</u>

**GOOD RETAIL PRACTICES (☒ = not in compliance)**

	COS	R		COS	R		COS	R
<input checked="" type="checkbox"/> 27. Use of ice and pasteurized eggs	<input type="checkbox"/>	<input type="checkbox"/>	34. Food contamination	<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"/>	35. Equipment for temp. control	<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"/>	36. Personal cleanliness	<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"/>	37. Food labeled/condition	<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"/>	38. Plant food cooking	<input type="checkbox"/>	<input type="checkbox"/>	46. Utensil & single-service storage	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 32. Sewage and waste water disposal	<input type="checkbox"/>	<input type="checkbox"/>	39. Thawing	<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"/>	40. Toilet facilities	<input type="checkbox"/>	<input type="checkbox"/>	48. Specialized processing methods	<input type="checkbox"/>	<input type="checkbox"/>
			41. Garbage and refuse disposal	<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>[Signature]</u>	Name <u>Amy Ruckham</u>	Title <u>Administrative</u>	Date <u>3/28/13</u>	Follow-up: (Circle One) Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Inspector (Signature) <u>[Signature]</u>	Name <u>KAREN Anderson</u>	Title <u>Inspector</u>	Date <u>3/28/13</u>	



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

Page 2 of 2  
Date 3/28/13

Establishment Name Cables of Ammon	Operator Tim Packham
Address 1405 Curlew Dr	
County Estab # Bonville 20828	EHS/SUR.# License Permit #

OBSERVATIONS AND CORRECTIVE ACTIONS (Continuation Sheet)

#5: On 3/25/13 through 3/28/13, observations were made in the kitchen. The staff working in the kitchen were observed touching multiple objects, and not washing their hands before donning gloves.

Effect  
OS

#6: On 3/25/13 through 3/28/13, kitchen staff were observed wearing the same gloves and touching multiple objects and not changing their gloves before handling ready to eat foods such as toast, fruit salad, meat loaf and fried eggs.

#22: The facility served eggs to order without having a consumer advisory posted regarding the potential risk of food borne illness from undercooked eggs.

COS: The dietary manager posted the consumer advisory in the dining area for residents to read.

The facility will send evidence of resolution to Licensing & Certification by April 8th 2013.

#27 The facility did not document when the ice machine was cleaned or when it should be cleaned.

Person in Charge Kurt	Date 3/21/13	Inspector Karen Anderson	Date 3/28/13
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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 15, 2013

Amy Rackham, Administrator  
Gables of Ammon Management, Inc.  
1405 Curlew Drive  
Ammon, ID 83406

Dear Ms. Rackham:

An unannounced, on-site state licensure/follow-up survey and a complaint investigation was conducted at Gables of Ammon Management, Inc. from March 25, 2013 to March 29, 2013. During that time, observations, interviews, and record reviews were conducted with the following results:

**Complaint # ID00005836**

**Allegation #1:** An identified resident was admitted to the facility on 11/14/12, and the administrator could not find a completed admission agreement, interim care plan or current care notes, in the resident's record on 11/23/12.

**Findings #1:** The identified resident's record was reviewed on 3/27/13. The record contained an admission agreement that was signed and dated on 11/15/12, by the administrator and the identified resident. Further, the record contained an interim care plan/nursing assessment, dated 11/14/12. The record also contained a State Uniform Assessment Instrument (UAI), which was completed by a Regional RN on 11/23/12. The Regional RN documented on the UAI that the facility had not completed the admission agreement, interim care plan or other necessary components required for the admission.

Between 3/25/13 and 3/29/13, eleven sampled residents' records were reviewed and all records contained the appropriate paperwork, including current care notes.

On 3/28/13 at 9:18 AM, the identified resident stated she completed admission paperwork with the administrator upon admission to the facility. She stated, the facility RN came to the hospital before she was admitted and completed an

Amy Rackham, Administrator  
April 15, 2013  
Page 2 of 2

assessment. The resident stated she had been receiving appropriate care and services since her admission.

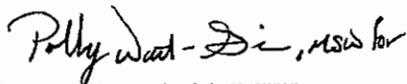
On 3/28/13 at 10:23 AM, the administrator confirmed the identified resident's admission paperwork had not been in her record when the Regional RN visited the facility. However, the administrator stated the admission paperwork had been completed and was later found in the nurse's office. The administrator stated since that incident occurred, the facility had changed the procedure on how to handle admission paperwork. She stated the office clerk was now responsible to place all the admission paperwork directly into new residents' binders (records) to ensure the information was readily available to staff.

On 3/28/13 at 1:45 PM, a friend of the identified resident stated she was with the resident the day she was admitted. The friend stated she observed the administrator and the identified resident filling out paperwork to complete the admission process.

Substantiated. However, the facility was not cited as they acted appropriately by implementing a new process for completing a residents' admission paperwork to ensure it is maintained in their records in an organized manner.

As no deficiencies were cited as a result of our investigation, no response is necessary to this report. Thank you to you and your staff for the courtesies extended to us on our visit.

Sincerely,



Donna Henscheid, LSW  
Health Facility Surveyor  
Residential Assisted Living Facility Program

dh/mmc

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



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RESIDENTIAL ASSISTED LIVING FACILITY PROGRAM  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: 208-334-6626  
FAX: 208-364-1888

April 15, 2013

Amy Rackham, Administrator  
Gables of Ammon Management, Inc.  
1405 Curlew Drive  
Ammon, ID 83406

Dear Ms. Rackham:

An unannounced, on-site state licensure/follow-up survey and a complaint investigation was conducted at Gables of Ammon Management, Inc. from March 25, 2013 to March 29, 2013. During that time, observations, interviews or record reviews were conducted with the following results:

**Complaint # ID00005956**

- Allegation #1:** An identified resident did not receive emergency medical treatment in a timely manner after she fell and sustained an injury.
- Findings #1:** Substantiated. The facility was not cited as they acted appropriately by getting the identified resident appropriate treatment after discovering the delay, re-educating all facility staff regarding proper emergency protocols and disciplining staff that were involved with the incident. However, the facility received a deficiency at IDAPA 16.03.22.305.03 for the facility nurse not assessing other residents after they had a change of condition. The facility was required to submit evidence of resolution within 30 days.
- Allegation #2:** The facility did not follow an identified resident's physician's orders for coumadin and B12 medications
- Findings #2:** Substantiated. The facility was not cited as they acted appropriately by making corrections to the resident's medications and disciplining staff for improper medication oversight. However, the facility was issued a core deficiency at IDAPA 16.03.22.520 for currently having similar problems with other residents' medications. The facility was required to submit a plan of correction within 10 days.

Amy Rackham, Administrator  
April 15, 2013  
Page 2 of 2

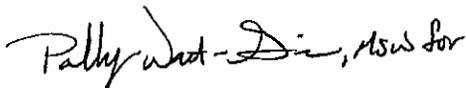
- Allegation #3: The facility did not take a an identified resident's vitals as ordered.
- Findings #3: Substantiated. The facility received a deficiency at IDAPA 16.03.22.600.05 for not providing supervision to ensure cares, such as vital signs, were provided as ordered. The facility was required to submit evidence of resolution within 30 days.
- Allegation #4: Medications were allowed to accumulate in the facility
- Findings #4: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.310.02 for allowing discharged residents' medications to accumulate at the facility and using them for other residents. The facility had to provide evidence of resolution within 30 days.

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 **03/29/2013**. 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,



Donna Henscheid, LSW  
Health Facility Surveyor  
Residential Assisted Living Facility Program

dph/mmc

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