



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

LESLIE M. CLEMENT—DEPUTY DIRECTOR
RANDY MAY —DEPUTY ADMINISTRATOR
LICENSING AND CERTIFICATION
P.O. Box 83720
Boise, Idaho 83720-0038
PHONE 208-334-6626
FAX 208-364-1888

September 15, 2011

CERTIFIED MAIL #: 7007 3020 0001 3745 7583

Tamara McCann, Administrator
Overland Court Generations Memory Care
10172 West Smoke Ranch Drive
Boise, ID 83709

Dear Ms. McCann:

Based on the licensure/follow-up survey and complaint investigation conducted by our staff at Overland Court Generations Memory Care on **September 1, 2011**, we have determined that the facility failed to provide sufficient personnel to assure residents received adequate assistance with eating.

This core issue deficiency substantially limits the capacity of Overland Court Generations Memory Care to furnish services of an adequate level or quality to ensure that residents' health and safety are safe-guarded. The deficiency is described on the enclosed Statement of Deficiencies.

You have an opportunity to make corrections and thus avoid a potential enforcement action. Correction of this deficiency must be achieved by **October 17, 2011**. **We urge you to begin correction immediately.**

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

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

Return the **signed and dated** Plan of Correction to us by **September 28, 2011**, and keep a copy for your

Tamara McCann, Administrator
September 15, 2011

records. Your license depends upon the corrections made and the evaluation of the Plan of Correction you develop.

You have available the opportunity to question cited deficiencies through an informal dispute resolution process. If you disagree with the survey report findings, you may make a written request to the Supervisor of the Residential Care Program for a Level 1 IDR meeting. The request for the meeting must be made within ten (10) business days of receipt of the statement of deficiencies (**September 28, 2011**). The specific deficiencies for which the facility asks reconsideration must be included in the written request, as well as the reason for the request for reconsideration. The facility's request must include sufficient information for Licensing & Certification to determine the basis for the provider's appeal. If your request for informal dispute resolution is received after **September 28, 2011**, your request will not be granted. Your IDR request must be made in accordance with the Informal Dispute Resolution Process. The IDR request form and the process for submitting a complete request can be found at www.assistedliving.dhw.idaho.gov under the heading of Forms and Information.

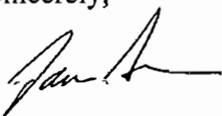
Please bear in mind that non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference. The completed punch list form and accompanying proof of resolution (e.g., receipts, pictures, policy updates, etc.) are to be submitted to this office by **October 1, 2011**.

Please bear in mind that any variance allowing the administrator to serve over other facilities is revoked as of the date of the exit conference. The facility must now employ a single, licensed administrator who is not serving as administrator over any other facilities. Failure to do so within thirty (30) days of the date of the exit conference will result in a core issue deficiency.

If, at the follow-up survey, it is found that the facility is not in compliance with the rules and standards for residential care or assisted living facilities, the Department will have no alternative but to initiate an enforcement action against the license held by Overland Court Generations Memory Care.

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

Sincerely,



JAMIE SIMPSON, MBA, QMRP
Program Supervisor
Residential Assisted Living Facility Program
Medicaid Licensing & Certification

JS/mmc

Enclosure



IDAHO DEPARTMENT OF
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FAX 208-364-1888

October 24, 2011

Tamara McCann, Administrator
Overland Court Generations Memory Care
10172 West Smoke Ranch Drive
Boise, ID 83709

License #: RC-972

Dear Ms. McCann:

On September 1, 2011, a licensure/follow-up survey and complaint investigation was conducted at Overland Court Generations Memory Care. 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.
- 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 Maureen A. McCann, RN, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 334-6626.

Sincerely,

Maureen A. McCann, RN
Team Leader
Health Facility Surveyor
Residential Assisted Living Facility Program

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R972	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/01/2011
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NAME OF PROVIDER OR SUPPLIER OVERLAND COURT GENERATIONS MEMORY	STREET ADDRESS, CITY, STATE, ZIP CODE 10172 WEST SMOKE RANCH DRIVE BOISE, ID 83709
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R 000	Initial Comments The following deficiency was cited during the licensure/follow-up survey and complaint investigation conducted on 8/30/2011 through 9/1/2011 at your residential care/assisted living facility. The surveyors conducting the survey were: Maureen A. McCann, RN Team Leader Health Facility Surveyor Gloria Keathley, LSW Health Facility Surveyor Donna Henscheid, LSW Health Facility Surveyor	R 000	September 23, 2011 Plan of correction for core citation From survey September 01, 2011 Rule # 16.03.22.520 Protect Residents from inadequate care. Rule # 16.03.22.600.06 The facility will employ and the Administrator will schedule sufficient personnel.	
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 sufficient personnel to assure residents received adequate assistance with eating. This affected 5 of 9 sampled residents (#s 2, 3, 5, 9 & 10) and 10 random residents (A, B, C, D, E, F, G, H, I, & J). The findings include: 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	R 008	1- See attachment #1 A seating arrangement has been implemented so that the Residents who require more assistance are seated together. Staff have been assigned to assist Residents at these tables and will stay at those tables until all the Residents are finished eating their meals.	

Bureau of Facility Standards

TITLE

(X6) DATE

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

STATE FORM

6899

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If continuation sheet 1 of 13

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R 008	Continued From page 1 resident's Negotiated Service Agreement, to assure residents' health, safety, comfort and supervision, ..." The facility's "Community Staffing" policy documented that "Adequate staffing is utilized to ensure outstanding care and supervision...The number of direct care staff is based upon the needs of the individual residents and is determined by appraisals and regular observation of residents as well as assessments by medical professionals." The facility was physically divided into 2 equal sides, "the north" and "the south." There were 35 residents residing in the facility. There were two caregivers on each side to assist residents with the following: eating, personal cares, toileting, laundry and supervision. On 8/30/11, the administrator stated the residents, who needed assistance with eating, dined on the north side and were assisted by three of the four caregivers. The fourth caregiver was assigned to the south side because the residents on that side did not require assistance with eating. NORTH On 8/30/11, between 4:30 PM and 5:30 PM, the supper meal was observed. There were approximately 15 residents, who required assistance or cueing with eating, sitting at four different tables. There were two caregivers present in the dining room to assist the residents. The following observations were made: *There were no place settings at the tables (glasses, napkins, silverware, etc.).	R 008	1- See Attachments # 2,3&4 A list of Residents diets has been updated and posted in the kitchen and the staff will refer to it As they serve out. We have changed the order in which the way meals are served out so that staff are available to stay in the North side dining room after the Residents have been served to start feeding while the food is warm. The South side will have staff to stay and cue Residents as needed after they are served. The activities person will assist with feeding in the North side dining room dally as well as a manager for breakfast and lunch. That will provide two extra feeders until we can reevaluate after some Residents transition to communities that provide higher levels of care. This has reduced the meal time to an hour so Residents are not sitting and waiting for long periods of time to be served their meals. Dietary will cut meat up before serving out the meal to the Residents. See Attachment #8 Scoop plates and bowls have been ordered for Residents who were identified as needing them so they do not have food falling off their plates.	

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R 008	<p>Continued From page 2</p> <p>*At 4:40 PM caregivers went from table to table offering the residents a choice between cottage cheese or peaches. Most of the residents did not have the cognitive ability to make such a choice. Some of the residents were not served either the cottage or peaches.</p> <p>*There were five residents sitting at one table; all of them required assistance or cueing with eating. A caregiver sat at the table and began feeding cottage cheese to Resident #2. While the caregiver fed Resident #2, Resident #3 repeatedly made motions as if eating with a spoon, but had no food in front of her.</p> <p>*A caregiver sat at another table between Residents #1 and #10. While the caregiver assisted Resident #1, Resident #10 stuck her fingers into the bowl of cottage cheese. The caregiver did not attempt to redirect Resident #10.</p> <p>*At another table, three residents had food placed in front of them but were not eating. There were no caregivers sitting at the table with them.</p> <p>*A caregiver stopped feeding Resident #2, went to another table and began feeding Resident #10; leaving Resident #2 with an unfinished meal. All the other residents at Resident #2's table, who required assistance, were left unsupervised.</p> <p>*At 4:55 PM, the activity director sat down to assist Resident #8 with eating. Throughout the entire meal, she did not assist or cue the four other residents at the table.</p> <p>*Resident #3 was served a bowl of soup and an uncut chicken wrap (a soft flour tortilla folded</p>	R 008	<p>See attachment 5,6&7</p> <p>In-service was conducted by a registered dietician to educate all staff on specialty diets such as the difference between mechanical soft versus puree.</p> <p>In-service was given to educate all staff on assisting residents with Dementia at meal times. Included were discussions about redirecting and approaching more than one time.</p> <p>We discussed the importance of trying different ways to encourage Resident who are resistant to eat. We asked that all Residents utensils were unwrapped at beginning of every meal. Tables will be set just before meals so Residents do not wander off with the place settings.</p>	

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R 008	<p>Continued From page 3</p> <p>around filling). The resident attempted to cut the wrap with a spoon, but was unable to cut it. The resident then, picked up the bowl of soup and spilled some of it on herself. At this point, a caregiver jumped up to take the bowl from the resident and returned to the other table. Resident #3 did not receive any further assistance with her meal.</p> <p>*Random Resident C had a plate of food in front of him with his utensils wrapped in a napkin. From 4:30 PM until until 5:09 PM, Random Resident C sat at the table making repetitive noises and staring across the table. For thirty-nine (39) minutes there were no caregivers sitting at his table to provide assistance or cueing.</p> <p>SOUTH</p> <p>On 8/30/11, between 4:30 PM and 5:30 PM, the supper meal was observed. There were 12 to 16 residents sitting at four different tables. There were no caregivers present to supervise the residents during the meal. The following observations were made:</p> <p>*Resident #5 was attempting to eat the cottage cheese from the bowl, but most of it fell on the table. Once the bowl was empty, the caregiver took the bowl from the table but did not clean the cottage cheese from the table. The resident spooned the cottage cheese off the table and into her mouth.</p> <p>*At 4:57 PM, Resident #5 was served a plate of spaghetti and bread. The utensils were wrapped in a napkin and the resident was unable to unwrap them. She picked up a piece of bread. For approximately 10 minutes, the resident attempted to eat the bread, but was unable to</p>	R 008	<p>See Attachment #8</p> <p>Scoop plates and bowls have been ordered for Residents who were identified as needing them so they do not have food falling off their plates.</p> <p>See Attachment #9</p> <p>There is a manager in the dining room for every meal in Generations.</p> <p>Residents have been reassessed and it has been determined that some Residents are ready to be transitioned to a community that provides a higher level of care. The facility nurse has met with these families and we are assisting all families at their requests with lists of facilities and a MSW or nurse from Home Health agencies that are available to speak with them as they work in many different facilities.</p>	

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R 008	<p>Continued From page 4</p> <p>chew it. The resident put the bread down and began eating the spaghetti with her hands. A caregiver intervened, handed the resident a utensil, but did not remain at the table to provide further assistance or cueing. At 5:10 PM, Resident #5 had made several attempts to take a bite of the spaghetti using her utensil, but the spaghetti slid off the utensil. The resident resumed picking up one string of spaghetti at a time with her fingers and eating it without staff intervention.</p> <p>*Random Resident A stared at the food sitting in front of him. He was served a bowl of soup and a chicken wrap. He sat for approximately 10 minutes and did not attempt to eat during this time. A caregiver approached him, cued him to eat but did not stay at the table. Random Resident A attempted to cut the wrap, but it unraveled. Instead of picking it up to eat it, he pushed it around his plate with his utensil. When last observed, the resident had pushed the contents out of the unrolled tortilla onto his plate, but had not eaten any of the wrap.</p> <p>*Random Resident D poked at the chicken wrap with a fork. As she poked at the wrap, it unraveled. When last observed, the resident picked up the unrolled tortilla with her thumb and forefinger and began licking at the contents falling into her plate. At no time did staff show the resident how to eat the wrap or provide her with any assistance.</p> <p>NORTH</p> <p>On 8/31/11, between 7:30 AM and 10:00 AM, the breakfast meal was observed. At 7:30 AM, approximately 8 residents were sitting at four different tables. During the meal, residents were</p>	R 008		

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R 008	<p>Continued From page 5</p> <p>assisted to and from the dining room. Throughout the meal there was never more than two staff, but at times there was none. The following observations were made:</p> <p>*At 7:45 AM, Resident #9 began slipping out of her wheelchair. The medication aide was preparing medications and did not see the resident slip until it was brought to her attention by the surveyors. There were no other caregivers in the room at this time.</p> <p>*At 8:45 AM the staff began serving breakfast. Approximately 8 residents had been sitting at the table since 7:30 AM without receiving food.</p> <p>At 8:45 AM, Resident #10 was asleep at the table and her food was placed in front of her beyond her reach. There were no caregivers in the dining room. At 8:56 AM, a caregiver began assisting Resident #10 with eating. Resident #10 had been in the dining room since 7:30 AM and did not receive assistance for over an hour and twenty (20) minutes.</p> <p>*At 8:50 AM, there were no caregivers present in the dining room. A women (later identified as a volunteer) assisted Resident #1 with eating. Four other residents at the table required either cueing or assistance with eating.</p> <p>*At 8:52 AM, five residents were sitting at one table. Random Resident E scooped oatmeal out of the bowl with her fingers. No staff stopped to assist Random Resident E or provide her with cueing. At 8:55 AM, Resident #2 was asleep at the table with food sitting in front of her. Resident #2 was not assisted with eating until 9:25 AM and had been sitting at the table since 7:30 AM; one hour and fifty-five (55) minutes.</p>	R 008		

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R 008	<p>Continued From page 6</p> <p>*At 9:25 AM, Random Resident C sat at the table with his food in front of him. His utensils were wrapped in a napkin. Staff did not cue or provide assistance, leaving the resident sitting for forty (40) minutes.</p> <p>SOUTH</p> <p>On 8/31/11, between 7:30 AM and 10:00 AM, the breakfast meal was observed. At 7:30 AM, approximately 11 residents sat at four different tables. There were no staff supervising the meal in the dining room. The medication aide was occasionally present as he alternated between the north and the south. Occasionally a caregiver passed through the room attending to other tasks. The following observations were made:</p> <p>*At 8:35 AM, Random Resident A was served breakfast. The resident sat and stared over the top of his plate, touching and straightening his utensils. He did not attempt to feed himself. This continued for approximately 35 minutes. A medication aide approached the table but did not offer assistance to the resident. At 9:25 AM, 50 minutes after breakfast was served, the resident sat at the table without eating. The medication aide stated, "He is very slow, but he will eat." The medication aide then cued the resident after a surveyor asked if the resident required assistance.</p> <p>*At 8:35 AM, Random Resident B pushed her full plate of food toward the middle of the table and sat staring across the table. She pushed it further away at 8:45 AM. No caregiver approached the table nor offered the resident cueing or assistance. At 8:47 AM, a surveyor asked the resident if she had eaten and she replied, "yes",</p>	R 008		

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R 008	<p>Continued From page 7</p> <p>but she had not. At 8:50 AM the medication aide stated Random Resident B "doesn't eat, but she likes sweets." At 9:25 AM, 50 minutes after the food was served and after a surveyor asked about the resident, the medication aide sat down with Random Resident B and cued the resident to eat. Initially the resident refused the meal, but was last observed biting off a piece of toast in her hand.</p> <p>*Multiple times Random Resident D picked up and put down her utensils, but did not use them to eat.</p> <p>*Random Resident F finished his meal, stacked his empty dishes on the table and stared across the table. The resident was going through the motions as if eating, but there was no food in the bowl. He then spooned liquid from his glass and into his mouth. No caregivers approached the resident to offer him more food or to remove the empty dishes.</p> <p>*Random Resident D was going through the motions as if eating, but there was no food in the bowl. This continued for approximately 7 minutes before a caregiver brought more cereal to the resident.</p> <p>*One hour after the meal was served, the medication aide and a caregiver assisted Random Residents A, B and D, who had difficulty eating. However, this assistance occurred after a surveyor identified the residents had problems. Prior to this, no caregivers were observed in the dining room supervising the residents or assisting and cueing with meals.</p> <p>NORTH</p>	R 008		

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R 008	<p>Continued From page 8</p> <p>On 8/31/11, between 11:30 AM and 12:30 PM, the lunch meal was observed. At 11:30 AM, approximately 10 residents sat at four different tables. Two caregivers, the activity director and one other staff member were in the dining room. During the meal, many residents were assisted to and from the dining room. The following observations were made:</p> <p>*At 11:50 AM, Resident #3's lap was covered with crumbs from the coffee cake served after breakfast. The resident had been sitting in the dining room since breakfast. No one assisted her to clean off her lap.</p> <p>*At 12:10 PM, caregivers were observed approaching residents and offered them a choice of a chicken breast or pork tenderloin. Most of the residents did not have the cognitive ability to make such a choice. The staff made the choice for them.</p> <p>*Between 12:10 PM and 12:30 PM, 6 residents sat at a one table. Resident #2 was assisted with eating. Only one of the residents was able to feed herself independently. The other residents slept or stared at their food. None of the meat on the plates had been cut. Random Resident E had her head down and had not eaten any of her food. The caregiver assisting Resident #2 did not cue or assist any of the other residents at the table.</p> <p>*At 12:20 PM, Resident #5 played with her food and attempted to eat the food with a knife. Most of the food was dropped on the table or floor. Ten minutes later, a caregiver cued her to use her fork. The caregiver went back to another table to assist another resident. Resident #5 continued eating with a knife. The resident later began eating the food off the floor.</p>	R 008	

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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
R 008	<p>Continued From page 9</p> <p>*Between 12:15 PM and 12:25 PM, Random Resident G had not touched her food. At 12:30 PM, a caregiver cut her meat up into large chunks. When the resident took a bite she yelled, "I want this warmed up." One caregiver said to another, "Will you help [name of random resident]." The caregiver went over to assist Random Resident G with eating, but did not heat up her food.</p> <p>*At 12:15 PM, Resident #8 received a plate of food and was assisted with eating, however after a couple bites, the caregiver left the table to assist another resident with cares. The resident sat for twenty minutes without eating until the caregiver sat back down and continued to assist the resident at 12:35 PM. The caregiver did not offer to heat up the resident's food.</p> <p>*At 12:35 PM, a caregiver said, "They (referring to surveyors) want someone at this table." A caregiver left the table she was at to assist the residents at the other table. When asked why Random Resident E's food was not cut, the caregiver responded, "[Random Resident's name] doesn't eat." The administrator then sat with the resident to assist her with eating. Later, the administrator stated the resident ate the entire piece of chicken.</p> <p>SOUTH</p> <p>On 8/31/11, between 11:30 AM and 12:30 PM, the lunch meal was observed. There were approximately 13 residents and a medication aide in the dining room. The following observations were made:</p> <p>*At 12:12 PM, Random Resident I attempted to</p>	R 008		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R972	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/01/2011
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NAME OF PROVIDER OR SUPPLIER OVERLAND COURT GENERATIONS MEMORY	STREET ADDRESS, CITY, STATE, ZIP CODE 10172 WEST SMOKE RANCH DRIVE BOISE, ID 83709
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R 008	<p>Continued From page 10</p> <p>cut her chicken breast with a spoon. A surveyor requested the medication aide to cut the resident's chicken. The medication aide picked up the plate, took it to the kitchen, cut the meat, returned to the table and placed the plate in front of the resident. When asked why the medication aide did not cut the meat at the table, a caregiver responded, "Because of 'Dine By Design', we are not allowed to cut the food at the table."</p> <p>NORTH</p> <p>*On 9/1/11, between 11:30 AM and 1:00 PM, the lunch meal was observed. There were 18 residents, who required assistance or cueing with eating, seated at four different tables. There were three caregivers, the Resident Care Coordinator (RCC) and the Activity Director in the dining room to assist residents with eating. The following observations were made:</p> <p>*At 12:15 PM, caregivers began serving the residents. Resident #5 sat at the table, but had not yet received her plate of food. The resident reached over with her fork and ate off of another resident's plate. No caregiver redirected the resident. At 12:20 PM, the RCC sat down at the table with Resident #5 to assist Resident C with eating. At 12:25 PM, Resident #5 ate cauliflower off of the arm of her chair. At 12:33 PM, Resident #5 picked food off the floor and ate it. Staff did not attempt to redirect Resident #5 from eating off the floor. At 12:45 PM, Resident #5 scraped food off the tablecloth and ate it.</p> <p>*Between, 12:20 PM and 12:28 PM, Resident #9 sat at the table with a plate full of food. The resident stared across the table. No caregiver assisted or cued the resident to eat.</p>	R 008		

Bureau of Facility Standards

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R 008	<p>Continued From page 11</p> <p>*At 12:45 PM, Random Resident E was bent over her food with her head in her plate. The resident remained like this for two minutes before the administrator woke her up.</p> <p>SOUTH</p> <p>On 9/1/11, between 11:30 AM and 1:00 PM, the lunch meal was observed. There were approximately 13 residents and one (intermittent) caregiver in the dining room. The following observations were made:</p> <p>*At 12:20 PM, "Thick-it" had been added to Random Resident F's water, however, it had all settled to the bottom of the glass. The liquid at the top of the glass was not "thickened." Caregivers did not stir the solution, so the "Thick-it" could work.</p> <p>*At 12:23 PM, Random Resident J attempted to eat some mashed potatoes, but picked up the entire serving of potatoes on the fork. She waved the pile of potatoes in the air for approximately one minute. She attempted to shake the potatoes off the fork, but was unable to do so and again waved the pile of potatoes in the air. No caregivers assisted Random Resident J.</p> <p>Between 8/30/11 and 9/1/11, four caregivers were interviewed. When asked if there was enough staff to assist the residents with eating, the caregivers responded: "There is not enough help to feed residents." "We could have used an extra person, maybe four or five." "It would be helpful if we had one extra caregiver. At times I am rushed and some days it's so crazy, I want to pull out my hair." "We need more help because we have to do the</p>	R 008		

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R 008	<p>Continued From page 12</p> <p>laundry and vacuuming."</p> <p>On 8/31/11 at 8:03 AM, the administrator stated she and the nurse had identified a problem with meals after witnessing breakfast on 8/30/11. The administrator confirmed the residents had not received the required assistance with eating.</p> <p>Over three days, four meals were observed with multiple problems noted. The tables were not set. Residents sat for extended periods of time without food or liquids. Once served, the food sat in front of the residents until it became cold. At no time did staff re-heat the food. Residents were observed sleeping, eating off the table or floor, eating with their hands, or not eating at all. While some residents were fed, the caregivers left to attend to other residents' needs before helping them finish their meal. Often the caregivers did not return to feed the residents who previously had received assistance. At one meal, eighteen (18) residents required either assistance or cueing with eating. The facility did not provide appropriate staffing to meet the residents' dining needs. This resulted in inadequate care.</p>	R 008	<p><i>Jamara McCann</i> <i>Administrator</i> <i>9/26/11</i></p>	



Facility Name Overland Court Generations Memory Care	Physical Address 10172 West Smoke Ranch Drive	Phone Number 208-322-0955
Administrator Tamara McCann	City BOISE	ZIP Code 83709
Survey Team Leader Maureen McCann, RN	Survey Type Licensure/follow-up survey and complaint investigation	Survey Date Sept. 1, 2011

NON-CORE ISSUES PAGE 1 OF 2 (3)

ITEM #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	L&C USE
1	009	One of seven staff did not have a completed criminal history background check.	10/3/11 MUC	
2	009.06.c	Three of seven staff did not have a completed state police background check.	10/24/11 MUC	
3	250.10	A) Water temperatures on the north wing were below between 105 degrees F. B) Toilets were found dirty and with rust stains.	A/B-10/3/11 MUC	
3	260.04	Ants were found in room 107.	10/3/11 MUC	
4	260.06	A) Urine odors were noted throughout the facility. B) Carpet stains/spots were noted throughout the facility.	A/B 10/3/11 MUC	
5	300.01	A) Ninety day nursing assessments were past due for resident's # 1, 2, 3 & 6. B) Three of three medication aides did not have documentation of nurse delegation.	A/B 10/3/11 MUC	
6	310.04.e	A) A six month psychotropic review was not completed for Resident #10. B) All six month psychotropic reviews did not include behavioral updates to the physician from the facility.	A/B 10/3/11 MUC	
7	320.01	Negotiated Service Agreements did not clearly reflect the residents care needs for Resident's #1, 2, 3, 5 & 6.	10/3/11 MUC	
8	320.03	Negotiated Service Agreements were not signed by the resident or the resident's representative.	10/3/11 MUC	
9	335.03	A) Not all resident rooms had paper towels available for caregivers to wash their hands after providing cares to the resident. B) A pair of used gloves were observed on the sink in room 103.	A/B 10/3/11 MUC	

Response Required Date Oct. 1, 2011	Signature of Facility Representative <i>Tamara McCann</i>	Date Signed 9-1-11
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Facility Name Overland Court Generations Memory Care	Physical Address 10172 West Smoke Ranch Drive	Phone Number 208-322-0955
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Survey Team Leader Maureen McCann, RN	Survey Type Licensure/follow-up survey and complaint investigation	Survey Date Sept. 1, 2011

NON-CORE ISSUES PAGE 2 OF 2 (3)

ITEM #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	L&C USE
10	430.04.e	There was no documentation of coordination between the facility and outside services regarding Resident #1's wound.	10/3/11 <i>mmc</i>	
11	625	Two of seven staff did not have 16 hours of orientation documentation. <i>mmc</i>	10/3/11 <i>mmc</i>	

Response Required Date Oct. 1, 2011	Signature of Facility Representative <i>Tamara McCann</i>	Date Signed 9-1-11
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IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

LESLIE M. CLEMENT – DEPUTY DIRECTOR
RANDY MAY – DEPUTY ADMINISTRATOR
LICENSING AND CERTIFICATION
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

September 15, 2011

Tamara McCann, Administrator
Overland Court Generations Memory Care
10172 West Smoke Ranch Drive
Boise, ID 83709

Dear Ms. McCann:

An unannounced, on-site complaint investigation survey was conducted at Overland Court Generations Memory Care from August 30, 2011, to September 1, 2011. During that time, observations, interviews, and record reviews were conducted with the following results:

Complaint # ID00005060

Allegation #1: The facility did not provide sufficient personnel to ensure residents received adequate assistance during meals.

Findings #1: Substantiated. The facility was issued a core deficiency at IDAPA 16.03.22.520 for not providing sufficient personnel to ensure residents received adequate assistance during meals. The facility was required to submit a plan of correction within 10 days.

Allegation #2: Two identified residents, who exhibited inappropriate behaviors, did not have behavioral management plans in place to address their behaviors.

Findings #2: On 9/1/11, the two identified residents' records were reviewed. Both residents records documented they had inappropriate behaviors which were addressed in behavioral management plans.

One of the residents no longer resided at the facility. The other resident was observed from 8/30/11 to 9/1/11. The behavior

identified (defecating in public) was not observed during the survey.

On 9/1/11 at 11:35 AM, a caregiver confirmed the resident had defecated in public but had not exhibited this behavior for months.

Unsubstantiated.

Allegation #3: The facility did not provide therapeutic diets as ordered by residents' physicians.

Findings #3: Substantiated. The facility was issued a non-core deficiency at IDAPA 16.03.22.600.05 for not providing supervision to ensure residents received therapeutic diets as ordered. The facility was required to submit evidence of resolution within 30 days.

Allegation #4: The facility did not use proper transfer techniques to ensure resident safety during transfers.

Findings #4: Between 8/30/11 and 9/1/11, multiple resident transfers were observed. Transfers were completed efficiently and competently by the caregivers without placing the resident's safety at risk.

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

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,



Maureen A. McCann, RN
Health Facility Surveyor
Residential Assisted Living Facility Program