IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DIVISION OF LICENSING & CERTIFICATION
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

October 9, 2012

Rod Johnson, Administrator
Highland Estates-Burley Operations, Llc
2050 Hiland Avenue
Burley, ID 83318

License #: RC-911

Dear Mr. Johnson:

On September 13, 2012, a Complaint Investigation survey was conducted at Highland Estates-Burley Operations, Llc. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level(s):

- Core issues, which are described on the Statement of Deficiencies, and for which you have submitted a Plan of Correction.
- 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 Rae Jean McPhillips, RN, BSN, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 334-6626.

Sincerely,

Rae Jean McPhillips RN, BSN

Rae Jean McPhillips, RN, BSN
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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DIVISION OF LICENSING & CERTIFICATION
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September 25, 2012

CERTIFIED MAIL #: 7007 3020 0001 4050 7923

Rod Johnson, Administrator
Highland Estates-Burley Operations, LLC
2050 Hiland Avenue
Burley, ID 83318

Dear Mr. Johnson:

Based on the Complaint Investigation conducted by Licensing and Certification at Highland Estates-Burley Operations, LLC on September 10 through 13, 2012, we have determined that the facility failed to protect the health of the residents.

This core issue deficiency substantially limits the capacity of Highland Estates-Burley Operations, LLC to furnish services of an adequate level or quality to ensure that residents' health and safety are safe-guarded. The deficiency is described on the enclosed Statement of Deficiencies.

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

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

Return the signed and dated Plan of Correction to us by **October 8, 2012,** and keep a copy for your records.

Your license depends upon the corrections made and the evaluation of the Plan of Correction you develop. We urge you to begin correction immediately and thus avoid further enforcement action. Correction of this deficiency must be achieved by October 28, 2012.

You have 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 I IDR meeting. The request for the meeting must be made with ten (10) business days of receipt of the statement of deficiencies (October 8, 2012). 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 October 8, 2012, 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 ten (10) non-core issue deficiencies were identified on the punch list and two (2) were identified as repeat punches. Please review the non-core issue deficiencies and correct them to ensure further enforcement actions do not arise.

One (1) of the repeat deficiencies, the facility nurse did not make recomendations regarding resident weight loss, was previously cited on three (3) consecutive surveys.

- 7/21/11
- 10/18/11
- 9/13/12

One (1) of the repeat deficiencies, the facility nurse did not document assessments after residents had changes in conditions, has been cited on four (4) consecutive surveys, as follows:

- 09/21/10
- 07/21/11
- 10/18/11
- 09/13/12

These deficiencies, which have been cited on multiple consecutive surveys, are direct violations of the following administrative rules for Residential Care or Assisted Living Facilities in Idaho:

IDAPA 16.03.22.300.REQUIREMENTS FOR NURSING SERVICES.
Nursing services must be performed in accordance with IDAPA 23.01.01, Rules of the Idaho Board of Nursing." The facility must have on staff or under contract the nursing personnel listed in Subsections 300.01 and 300.02 of these rules to provide nursing service requirements.

01. Licensed Professional Nurse (RN). A licensed professional nurse (RN) must visit the facility at least once every ninety (90) days or when there is a change in the resident's condition. The licensed professional nurse is responsible for delegation of all nursing functions, according to IDAPA 23.01.01...Idaho Board of Nursing Rules," Section 400.

IDAPA 16.03.22.305.LICENSED PROFESSIONAL NURSE RESPONSIBILITY REQUIREMENTS.
The licensed professional nurse must assess and document, including date and signature, for each resident as described in Subsections 305.01 through 305.08 of these rules.

04. Recommendations. Make recommendations to the administrator regarding any medication needs, other health needs requiring follow up, or changes needed to the Negotiated Service Agreement.

The following administrative rules for Residential Care or Assisted Living Facilities in Idaho give the Department the authority to impose a monetary penalty for these violations:

> **IDAPA 925. ENFORCEMENT REMEDY OF CIVIL MONETARY PENALTIES.**
> **01. Civil Monetary Penalties.** Civil monetary penalties are based upon one (1) or more deficiencies of noncompliance. Nothing will prevent the Department from imposing this remedy for deficiencies which existed prior to survey or complaint investigation through which they are identified. Actual harm to a resident or residents does not need to be shown. A single act, omission or incident will not give rise to imposition of multiple penalties, even though such act, omission or incident may violate more than one (1) rule.
>
> **02. Assessment Amount for Civil Monetary Penalty.** When civil monetary penalties are imposed, such penalties are assessed for each day the facility is or was out of compliance. The amounts below are multiplied by the total number of occupied licensed beds according to the records of the Department at the time noucompliance is established.
>
> **b.** Repeat deficiency is ten dollars ($10).

Based on findings that you failed to have residents assessed by the nurse after a change in their health status and failed to assess unexpected weight loss, the Department is imposing the following penalties:

For the dates of December 22, 2011 through September 13, 2012:

Penalty	Number of Deficiencies	Times number of Occupied Beds	Times Number of days of non-compliance	Amount of Penalty
$10.00	2	44	266	$ 234,080

Maximum penalty allowed in any ninety day period per IDAPA 16.03.22.925.02.c: $6,400.

Send payment of $6,400 by check or money order, made payable to:

Licensing and Certification

Mail your payment to:

Licensing and Certification - RALF
PO Box 83720
Boise, ID 83720-0009

Payment must be received in full within 30 calendar days from the date this notice is received. Interest accrues on all unpaid penalties at the legal rate of interest for judgments. Failure of a facility to pay the entire penalty, together with any interest, is cause for revocation of the license or the amount may be withheld from Medicaid payments to the facility.

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:

Debby Ransom, R.N., R.H.I.T.
Bureau Chief, 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.

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

RJM/tfp

cc: Steve Millward, Licensing & Certification

PRINTED: 09/24/2012
FORM APPROVED

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R911	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/13/2012
NAME OF PROVIDER OR SUPPLIER HIGHLAND ESTATES-BURLEY OPERATIONS, I	STREET ADDRESS, CITY, STATE, ZIP CODE 2050 HILAND AVENUE BURLEY, ID 83318		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	Initial Comments The following deficiency was cited during the complaint investigation conducted September 10, 2012 through September 13, 2012 at your residential care/assisted living facility. The surveyors conducting the survey were: Rae Jean McPhillips, RN, BSN Team Leader Health Facility Surveyor Maureen McCann, RN Health Facility Surveyor Karen Anderson, RN Health Facility Surveyor Abbreviations: & = and AM = morning B/P = blood pressure BS = blood sugar EMT = emergency medical technician ER = emergency room MAR = medication assistance record meds = medications PM = evening/night pt = patient RES = resident	R 000		
			All residents have been assessed by facility RN for changes of condition to ensure that adequate, appropriate and timely care is initiated where indicated.	10/8/12
			Resident weights have been obtained on 100%.of residents. Facility RN has reviewed all weights to identify weight variances and to implement care plan interventions to address the weight variance for those identified residents at risk.	10/8/12
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		

Bureau of Facility Standards

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

TITLE EXECUTIVE DIRECTOR (X6) DATE 10/9/12

Rob Johnson

PRINTED: 09/24/2012
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R 008	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interview, it was determined the facility did not implement timely medical care for 4 of 15 sampled residents (Resident's #1, #4, #12 and #15). Additionally, the facility did not identify significant weight loss or implement interventions to prevent further weight loss for 4 of 15 sampled residents (Resident's #2, #3, #13 and #15). These failures had the potential to effect 100% of the facility's residents. The findings include: A. Emergency and Timely Medical Care A "Twenty-four hour" book was used by staff to inform the nurse of residents' medical changes and to communicate concerns that occurred when the nurse was not available in the facility. The facility administrator stated it was the nurse's responsibility to review the book to identify health issues that required follow-up. The nurse was also responsible to document the outcome of the concerns and to provide instructions to staff. 1. Resident #1 was a 81 year old female who was admitted to the facility on 1/17/11 with diagnoses that included dementia and a history of urinary tract infections. A Quarterly Nursing Assessment, dated 3/1/12, documented Resident #1 had "increased lethargy and increased confusion." The nurse documented the resident responded "inappropriately" to questions and was "disoriented." On 9/10/12 at 4:50 PM, the nurse stated she had assessed Resident #1 on 3/1/12 because the resident had not been feeling well for approximately four days. The nurse further stated, the resident was sent to the hospital a few	R 008	**Administrator or designee will ensure that facility nurse completes a daily review of the 24-Book including the 24-Hour Report and Alert Charting Log to ensure that any notifications/communications to administrator, healthcare providers and family/guardian is completed.** **Administrator or designee will ensure that facility nurse review 24-Hour Book, including the 24-Hour Report and Alert Charting Log daily and communicate resident changes in condition on a daily basis.** **Administrator or designee will ensure that facility nurse read and understand all policies and procedures related to emergency care of residents, including those residents who may sustain head injuries from falls or other accidents.**	9/21/12 10/8/12 10/8/12

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R 008	Continued From page 2 days later but was not certain of the discharge date. Surveyor's obtained a hospital admission record which documented Resident #1 was admitted to the hospital, on 3/4/12 at 3:10 PM (three days after the nurse assessed her for a change in medical condition), for "altered mental status," a kidney infection and low sodium. On 9/11/12 at 9:40 AM, Staff A stated Resident #1 had not been feeling well for several days. He/she stated the resident continued to not feel well, was not eating and drank very little. Staff A stated the nurse was informed of the resident's change of condition, but the resident was not sent to the hospital for approximately a week. On 9/11/12 at 9:50 AM, Staff B stated Resident #1 had chronic urinary tract infections, but the last episode was different. Staff B stated, the resident was very confused and was not able to get out of bed because she was so weak. Staff B further stated the nurse had been informed the resident was not feeling well and was getting weaker. The staff stated the resident was sent to the hospital, because a family member requested the resident be sent. On 9/11/12 at 5:00 PM, Staff E stated Resident #1 had a significant change in her health. Staff E stated that he/she and other staff members left notes for the nurse, in the 24 hour communication book, concerning the resident's continuing decline. The staff member stated the nurse did not respond, nor direct staff on what should be done for the resident. She stated the resident's family came to the facility and directed staff to call 911 because of the resident's decline.	R 008	Administrator or designee will conduct an in-service for all Direct Care staff on the proper use of the 24-Hour Book including; the required documentation of resident changes in condition or changes in health status. Administrator and/or facility Nurse will audit 24-Hour Book M-F, to ensure compliance Administrator or designee will ensure that residents not capable for making health related decisions or discussions will have their designated POA/guardian notified of any health care decision needing to be made regarding resident. Administrator will ensure that Individual Service Plans for all residents will be updated to address all identified care needs; evaluation of body weight variances that will include nursing assessment, documentation of findings and a plan for addressing any identified weight loss or gain.	10/8/12 10/8/12 10/8/12

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R 008	Continued From page 3 On 9/12/12 at 11:30 AM, Staff F stated Resident #1 had increased weakness and increased confusion for about a week before being sent to the hospital. Staff F confirmed the nurse was aware of the resident's continued decline. On 9/12/12 at 2:50 PM, the administrator stated the nurse was responsible to follow-up to the concerns by assessing residents when they had changes in condition. He stated the nurse should have addressed Resident #1's continued decline. On 9/12/12 at 3:05 PM, the facility nurse stated she had not conducted any additional assessments after 3/1/12, regarding Resident #1 decline. The facility did not seek timely medical interventions for Resident #1 when the facility staff notified the nurse of the resident's continued decline in her medical condition. The resident was admitted to the hospital on 3/4/12 with "altered mental status," kidney infection and low sodium. The resident's condition continued to worsen and she passed away at the hospital on 3/20/12. 2. Resident #12 was a 93 year old female who was admitted to the facility on 8/25/09 with diagnoses that included dementia and a left arm amputation. An incident report, dated 1/5/12 at 8:47 PM, documented Resident #12 was "found on floor," after reaching for a magazine. The incident report included an anatomical picture of a human body. The body had circles on the left forehead, left hip and the back of the neck. The incident report documented the facility nurse and hospice nurse were notified of the fall, by phone, on 1/5/12.	R 008	Administrator or designee will ensure that all residents receive a monthly weight or more frequently as directed by a Physician/PA/NP. Weights will be recorded on the eMAR and the facility nurse will audit the weights to identify any variance. When a weight variance is identified, the facility nurse will complete the following: • Assess resident, including conducting a re-weigh. • If weight variance is confirmed, notify physician, administrator and family/guardian. Document findings in residents' chart. • Once Physician consultation/direction is obtained, document the action plan developed to address the weight variance in progress notes, ISP and make appropriate notifications to family/guardian, care staff, dietary staff and administration. Administration or designee will conduct random resident chart audits to ensure ISP is current and reflect identified needs.	10/8/12 10/8/12

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R 008	Continued From page 4 A resident care note, dated 1/5/12, documented the resident reported her neck was "sore." The note also documented the resident was given a narcotic pain medication for her pain. A resident care note, dated 1/6/12, documented Resident #12 continued to complain of neck pain and requested pain medication at approximately 5:00 AM, and then again around 9:50 AM. The care note further documented the resident requested to be taken to the emergency room. The note documented that an ambulance was called and "EMTs arrived & transported to ER." A hospice nursing note, dated 1/6/12 at 12:47 PM, documented a call was received on 1/5/12, regarding the resident's fall. It further documented, "Today the resident was complaining of neck pain and refusing to get out of bed." The note documented that staff stated they gave the resident a pain pill on 1/5/12, and she slept all night, but complained of pain again in the morning. The hospice nurse documented the resident requested to be evaluated for the continued neck pain. An ambulance was called for transport at the resident's request. A hospital admission record documented the resident arrived at the hospital on 1/6/12 at 10:57 AM, and was admitted. On 1/9/12, a hospice social worker documented, "...saw pt for first time after admit, following her fall, which broke her neck and expedited [Resident 12's name] decline...." On 9/12/12 at 11:00 AM, the facility nurse stated, a staff member had called her regarding Resident #12 falling out of her wheelchair. She stated the	R 008		

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R 008	Continued From page 5 staff member did not inform her the resident complained of neck pain. She further stated, "If the resident received pain medication after falling, I was not aware of it because the resident was able to request pain medications." On 9/12/12 at 11:30 AM, Staff C stated they were told by an evening staff member that Resident #12 had fallen out of her wheelchair and hit her head. Staff C stated the evening staff said the facility nurse was called, but the call went to voice mail. Staff C stated that Resident #12 continued to complain of pain throughout the night, so a narcotic pain medication was given around 5:00 AM the next morning. Staff C stated, the resident was not seen by a nurse until the next day, when a hospice nurse arrived. Staff C stated the resident requested to be taken to the emergency room and was sent by ambulance on 1/6/12. On 9/12/12 at 11:45 AM, Staff F stated, "After the resident fell out of her wheelchair, she complained of pain so I gave her a pain pill." Staff F stated, it took 3 staff members to assist her off the floor and into bed. The staff member said they tried to call the facility nurse, but the call went to voice mail. On 9/13/12 at 2:25 PM, the administrator stated the facility's policy was to send a resident to the hospital when they fell and hit their head. He confirmed their policy was not followed and the resident did not receive timely medical care. There was no documentation the resident was assessed by a medical professional for over 12 hours, after she fell striking her head, and had complaints of neck pain. The resident expired in the hospital on 1/9/12, three (3) days after she fell.	R 008		

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R 008	Continued From page 6 3. Resident #15 was a 94 year old male who was admitted to the facility on 2/8/12 with diagnoses including dementia. A quarterly nursing assessment, dated 5/2/12, documented the resident had experienced "weakness" as a change in his physical condition. The assessment further documented the resident had a non-productive cough and was on oxygen. Resident care notes documented the following: * 5/2/12 - family sent to ER, came back with pneumonia * 5/9/12 - resident still about the same, got a new order for cough medicine * 5/14/12 - the nurse documented the resident complained of coughing, continue with cough medication twice daily and that she would continue to observe him * 6/2/12 - resident not feeling well this morning * 6/5/12 - resident complained about overall body pain * 6/9/12 - fell about 10:40 PM, helped him back to bed * 6/11/12 - coughing a lot, saying he does not feel well * 6/11/12 - still coughing and looks tired, has physician appointment tomorrow * 6/12/12 - resident went to see his physician and was sent to the hospital On 9/11/12 at 3:58 PM, the facility nurse stated caregivers documented residents' changes of condition in the 24 hour book or called her. The nurse stated she would assess the resident and implement interventions as needed. No nursing assessments or interventions	R 008		

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R 008	Continued From page 7 documented in the resident's record, other than the care note dated 5/14/12. On 9/11/12 at 2:40 PM, Staff H stated that staff had written several progress notes to the nurse that Resident #15, "had a bad cough, was not sounding good but the nurse did not follow-up." On 9/12/12 at 11:30 AM, Staff M stated Resident #15 did not complain of not feeling well, but staff could tell by the sound of his cough that he was not well. He/she stated, "We kept documenting it in the 24 hour report for the nurse." On 9/12/12 at 4:30 PM, the nurse stated she remembered the resident had pain and a cough. He went to a physician's office or to the emergency room, but she could not remember if he came back. She confirmed she had not completed an assessment after the resident experienced a change of condition prior to being admitted to the hospital in June 2012. The facility did not seek medical care for Resident #15 when he continued to decline for 40 days after being diagnosed and treated for pneumonia. The resident was readmitted to the hospital on 6/12/12. 4. Resident #4 was a 72 year old female who was admitted to the facility on 10/25/11 with diagnoses including insulin dependent diabetes and depression. A "Resident Interim Service Plan," dated 12/27/11 and signed by the nurse, documented the resident had been vomiting, had appointment scheduled with her physician on 12/29/11, and wanted to wait to see her physician."Until then, encourage fluids and food that are easy on	R 008		

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R 008	Continued From page 8 stomach as requested by" the resident. Resident care notes, documented the following: * 12/22/11 - "Residents blood sugar was 51 this morning. At lunch resident got sick." * 12/23/11 - "Res blood sugar was 31 this morning...Res really depressed getting worst [sic] everyday." * 12/26/11 - "Res got sick at lunch." * 12/27/11 - "Resident got sick in bedroom, vomiting...Resident refused to go to lunch...Refused BS, meds, meal & snack. Not feeling well." * 12/28/11 - "Was spitting up brown stuff, changed sheets, not sure how she feels, she said she thinks she is fine said leave...Res not feeling well her BS was 207 this morning she refused her pills & her breakfast she ate a small orange...Resident not feeling well been up off & on throwing up." * 12/29/11 "Rang several times she still is not feeling good." * 12/30/11 "She had stroke like symptoms. Ambulance came & didn't think she had a stroke then family took her [to the hospital]." The facility did not seek medical attention for the resident for 8 days when she complained of not feeling well, experience low blood glucose levels, and vomited. A hospital progress note, dated 12/30/12, documented the resident was admitted to the	R 008		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R911	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/13/2012
NAME OF PROVIDER OR SUPPLIER HIGHLAND ESTATES-BURLEY OPERATIONS, I	STREET ADDRESS, CITY, STATE, ZIP CODE 2050 HILAND AVENUE BURLEY, ID 83318		

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R 008	Continued From page 9 hospital. A quarterly nursing assessment, dated 1/23/12, documented the resident was hospitalized between 12/30/11 and 1/2/12 for "hydration and medication management." A resident care note, dated 1/15/12, documented, "Res BG was 50, B/P 80/48 back to normal now had incident where she was non-responsive at the end of shift." Staff documented the resident recovered after about 10 minutes. There were no notes documenting the nurse had been contacted, or completed an assessment to follow-up to the resident's change of medical condition on 1/15/12. Nor did the facility seek medical attention for the resident when she had an episode of being "non-responsive." A quarterly nursing assessment which was dated eight days after the resident's "un-responsive" episode, on 1/23/12, did not address the resident's episode of being "un-responsive," or her low blood pressure and low blood glucose. The facility did not seek timely medical care for Resident #4 when she had experienced low blood glucose levels, vomiting, "spitting up brown stuff," and "not feeling well" for 8 days. The resident was hospitalized on 12/30/12. After returning from the hospital, the resident had a potentially life-threatening episode, during which she was unresponsive, had a low blood glucose level and low blood pressure. Again, the facility failed to seek timely medical care for the resident.	R 008		

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R 008	Continued From page 10 B. Not Identifying Weight Loss or Implementing Interventions Resident #2, #3, #13 and #15's records contained care plans developed by the facility. All care plans documented that staff would "monitor day-to-day health changes, review and maintain medical records, chart medical conditions and follow up on resident requests for health intervention. Health monitoring includes a records review by the facility licensed nurse..." According to an article published in the "American Family Physician," Volume 65, Number 4, February 15, 2002, titled "Evaluating and Treating Unintentional Weight Loss in the Elderly," accurate evaluation of weight loss is essential because it is associated with increased illness and death. Additionally, the article referenced a study that showed nursing home patients had a significantly higher death rate in the six months after losing 10% of their body weight. 1. Resident #15 was a 94 year old male who was admitted to the facility on 2/8/12 with a diagnosis of dementia. The resident care plan, dated 5/2/12, documented, the "Resident does not require dietary assistance." The 2012 MARs documented the following weights: * March 203 * April 205 * May 203 * June 130 Resident care notes, dated 2/8/12 through	R 008	Administrator or designee will conduct an in-service for all Direct Care staff on the proper use of the 24-Hour Book including the required documentation of resident changes in condition or changes in health status. Administrator and/or facility Nurse will audit 24-Hour Book M-F, to ensure compliance. Administrator or designee will ensure that residents not capable for making health related decisions or discussions will have their designated POA/guardian notified of any health care decision needing to be made regarding resident. Administrator will ensure that Individual Service Plans for all residents will be updated to address all identified care needs; evaluation of body weight variances that will include nursing assessment, documentation of findings and a plan for addressing any identified weight loss or gain. POLICY ENCLOSED	10/8/12 10/8/12 10/8/12

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R 008	Continued From page 11 6/12/12, did not document the resident's weight loss. However, the care notes did document the resident was diagnosed with pneumonia on 5/2/12 at the hospital emergency room. Additionally, the notes documented the resident complained of not feeling well from 5/9/12 until he was hospitalized again on 6/12/12. On 9/12/12 at 3:03 PM, the administrator stated he did not remember Resident #15 having had a weight loss. He stated Resident #15's documented weight was due to an inaccurate scale. On 9/12/12 at 3:10 PM, the facility nurse stated she did not remember Resident #15 having had a weight loss. The nurse stated the documented weight must have been due to an inaccurate scale. However, she confirmed that Resident #2's, seventy-three pound documented weight loss had not been addressed. There was no evidence the facility re-weighed the resident to determine if the resident's substantial weight loss of 73 pounds was a scale error or the result of his illness. Resident #15 had a documented 73 pound weight loss, 36% of his total body weight, between May and June 2012. There was no documentation in the resident's record that the weight loss had been identified, interventions had been implemented or that the documented loss may have been due to an inaccurate scale. Further, facility did not seek medical care for Resident #15 when he continued to cough, "look tired" and complain of "not feeling well," between 5/9/12 and 6/12/12, for forty (40) days after returning from the hospital where he was treated for pneumonia.	R 008	Administrator or designee will ensure that all residents receive a monthly weight or more frequently as directed by a Physician/PA/NP. Weights will be recorded on the eMAR and the facility nurse will audit the weights to identify any variance. When a weight variance is identified, the facility nurse will complete the following: • Assess resident, including conducting a re-weigh. • If weight variance is confirmed, notify physician, administrator and family/guardian. Document findings in residents' chart. • Once Physician consultation/direction is obtained, document the action plan developed to address the weight variance n progress notes, ISP and make appropriate notifications to family/guardian, care staff, dietary staff and administration. Administration or designee will conduct random resident chart audits to ensure ISP is current and reflect identified needs.	10/8/12 10/8/12

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R 008	Continued From page 12 2. Resident #3 was a 86 year old female who was admitted to the facility on 2/10/12 with diagnoses that included dementia. A care plan, dated 2/10/12, documented the resident could eat independently but needed standby assistance or cueing during meals. The care plan documented staff were to refer to the "parameters on the MAR's" and notify the facility nurse if the resident's weight exceeded the parameters. A nursing assessment, dated 2/10/12, documented the resident's admission weight was 110 pounds. The assessment documented the resident's appetite was fair. Additional nursing assessments, dated 5/29/12 and 7/25/12, also documented the resident's weight was 110 pounds and her appetite was fair. The resident's April, May, June, July, August and September 2012 MARs were reviewed on 9/18/12. The MARs did not contain parameters to guide staff when to report a weight loss or gain. Additionally, the MARs only documented weights in April, July, August and September, not monthly as indicated on the care plan. Staff documented the following weights: * 4/1/12 - 106 * 7/1/12 - 100 * 8/1/12 - 95 * 9/1/12 - 97 According to Resident #3's MARs, dated 2/10/12 through 8/1/12, less than 6 months, Resident #3 lost 15 pounds, or 13.6% of her total body weight. On 9/11/12 at 3:22 PM, the facility nurse stated that she was not aware that Resident #3 had lost	R 008		

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R 008	Continued From page 13 weight. On 9/12/12 at 2:25 PM, Staff K stated that about one month ago, they started to monitor residents who had weight loss. Staff K stated that when residents had weight loss they were to be weighed weekly, staff were to monitor the amount of the meal eaten and encourage the resident to have snacks. Staff K stated that currently, they were monitoring 6 or 7 residents. Additionally, Staff K stated Resident #3 was not on the list of residents who had weight loss. On 9/12/12 at 3:03 PM, the administrator stated he did not remember if Resident #3 had weight loss. He stated the facility used a software program that monitored weight abnormalities and if a resident's weight fluctuated a certain percentage, the weight would be flagged by the system. The administrator was unable to explain why the computer's software program did not identify Resident #3's fifteen pound weight loss in less than 6 months. The facility nurse documented the resident's weight had not changed since she was admitted on 2/10/12. However, staff weighed the resident on 4 separate occasions and documented the resident had lost, at one point, 15 pounds or 13.6% of her total body weight. Even though the facility weighed Resident #3 monthly, they failed to identify her significant weight loss. 3. Resident #13 was a 81 year old female who was admitted to the facility with diagnoses that included coronary artery disease. A care plan, dated 6/27/12, documented the	R 008		

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R 008	Continued From page 14 resident was able to feed herself but could only eat if staff brought food to her. A nursing assessment, dated 3/7/12, documented the resident's weight was 148 pounds and her appetite was fair. A nursing assessment, dated 6/27/12, documented the resident's weight was 142 pounds. She documented the following recommendation, "Four pound weight loss in three months noted. Family, resident, and physician notified. Encouraged resident to eat three meals plus snacks daily. Will observe for weight variance." The nurse documented the resident now had increased confusion and forgetfulness which was a change in her mental condition. According to the documented weights on the nursing assessments, the resident had lost 6 pounds, not 4 pounds as indicated on the 6/27/12 assessment. A care plan, dated 6/27/12, documented the resident's weight would be monitored and the facility would "Refer to physicians protocols." No "physician's protocols" were observed to be in the resident's record. The MARs for May, June, July, August and September 2012 documented the resident's weights were done weekly. Staff documented the following weights: * 5/2 - 146 * 5/9 - 146 * 5/16 - 145 * 5/23 - 144 * 5/30 - 143	R 008		

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R 008	Continued From page 15 * 6/6 - 142 * 6/13 - 144 * 6/20 - 139 * 6/27 - 142 * 7/4 - 142 * 7/11 - 140 * 7/19 - 140 * 7/25 - 134 * 8/1 - 128 * 8/8 - 129 * 8/15 - 128 * 8/22 - 126 * 8/29 - 125 * 9/5 - 125 On 9/12/12 at 10:04 AM, Staff H stated Resident #13 had a weight loss. Staff H also stated if a resident was on weekly weights, and had a weight loss, they would have reported that to the facility nurse. On 9/12/12 at 2:25 PM, Staff K stated that about one month ago, they started to monitor residents who had weight loss. She stated when residents had weight loss they would be weighed weekly. Staff K said staff were to monitor the amount of the meals eaten and encourage the resident to have snacks. Staff K stated currently they were monitoring 6 or 7 residents weights. Additionally, Staff K stated Resident #13 was not on the list of residents who had known weight loss. On 9/12/12 at 2:50 PM, the facility nurse stated she was aware that Resident #13 had sustained a weight loss. She confirmed that she had not implemented additional interventions other than encouragement to eat meals and for staff to offer snacks that had been started on 6/27/12. On 9/12/12 at 3:03 PM, the administrator stated	R 008		

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R 008	Continued From page 16 he did not remember Resident #13 having a weight loss. He stated the facility used a software program that monitored weight abnormalities and if a resident's weight fluctuated a certain percentage, the weight would be flagged by the system. The administrator was unable to explain why the computer's software program did not identify Resident #13's twenty-three pound weight loss in less than 6 months. According to an article published in the "American Family Physician," Volume 65, Number 4, February 15, 2002, titled "Evaluating and Treating Unintentional Weight Loss in the Elderly," involuntary weight loss can lead to muscle wasting, a decreased immune system, depression and an increased rate of disease complications. Resident #13 had an unplanned weight loss of 23 pounds, or 15.5% of her weight, in less than 6 months. The resident lost 17 additional pounds after she was assessed, on 6/27/12, and recommendations were made to encourage her to eat and to offer her snacks. There was no evidence the nurse reassessed the resident after the progressive weight loss or that she made additional recommendations to prevent further weight loss. Additionally, there was no evidence the resident's physician had been notified of the resident's continued weight loss. 4. Resident #2 was an 89 year old female who was admitted to the facility on 8/3/10. Resident #2's care plan, dated 2/27/12, documented the "Resident does not require dietary assistance."	R 008		

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R 008	Continued From page 17 The 2012 "Residential Monthly Vital Signs" forms documented the following weights: * January - 166 * February - 133 * March - 113 * April - no weight documented * May - no weight documented * June - 118 * July - 115 * August - 110 A quarterly nursing assessment, dated 8/14/12, did not document the resident's weight loss had been assessed. Resident care notes, dated 1/1/12 through 9/1/12, did not document the resident had a weight loss. On 9/12/12 at 3:03 PM, the administrator stated he did not remember if Resident #2 had experienced a weight loss. He stated the facility used a software program that monitored weight abnormalities and if a resident's weight fluctuated a certain percentage, the weight would be flagged by the system. The administrator was unable to explain why the computer's software program did not identify Resident #2's fifty-six pound (56) weight loss in 7 months. On 9/12/12 at 3:10 PM, the facility nurse stated she did not remember if Resident #2 had a weight loss. The nurse stated the facility used a software program that monitored weight abnormalities. She stated that after a resident's weight fluctuated a certain percentage, the weight would be flagged by the system. However, the nurse	R 008		

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R 008	Continued From page 18 confirmed that Resident #2's, fifty-six (56)pound documented weight loss had not been addressed. On 9/12/12 at 2:00 PM, Staff K stated Resident #2 was on a regular diet and had not received any supplements or other change in diet to prevent weight loss. Resident #2 had a documented 33 pound weight loss between January and February 2012 and a 20 pound weight loss between February and March 2012. In 7 months, Resident #2 had a total documented weight loss of 56 pounds or 34% of her total body weight. There was no documentation in the resident's record that the weight loss had been identified or interventions had been implemented. The facility did not seek timely medical interventions for Residents' #1, #4, #12 and #15 when they had changes in their medical conditions. Additionally, the facility did not identify or implement interventions when Residents' #2, #3, #13 and #15 had significant weight loss. These failures resulted in a decline in health for Residents' #1, #2, #3, #4, #12, #13 and #15 and placed 100% of the facility residents in jeopardy of inadequate care.	R 008	**Through the utilization of Continuous Quality Improvement, we will include effective mechanisms for monitoring and evaluating utilization of resident services and for the appropriate response to adverse finding. We will maximize internal and external resources as appropriate to resolve issues affecting service delivery, and to improve resident services.**	**10/8/12**

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P.O. Box 83720
Boise, ID 83720-0036
(208) 334-6626 fax: (208) 364-1888

ASSISTED LIVING
Non-Core Issues
Punch List

Facility Name	Physical Address	Phone Number
Highland Estates Burley Operations, LL	2050 Hiland Ave	208 678-4411
Administrator	**City**	**Zip Code**
Rod Johnson	Burley	83318
Team Leader	**Survey Type**	**Survey Date**
RaeJean McPhillips	Complaint and Follow-up	09/13/12

NON-CORE ISSUES

Item #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	L&C USE
1	215.01	The administrator did not assure the facility's policy was followed when Resident #12 fell and hit her head.	RM 10/9/12	
2	300.01	The facility nurse did not document assessments after residents had changes in condition. For example: Residents #2, #3, #6, #13, & #15	RM 10/9/12	
		documented weight loss. Resident #4 was not assessed when her blood glucose levels dropped as low as 31 and had an episode of		
		unresponsiveness. ***Previously cited on 9/21/10 7/21/11, 10/18/11***		
3	305.01	The facility nurse did not conduct an assessment for Resident #13's response to pain medication and nitroglycerin medication.	RM ~~10/9/12~~ 10/9/12	
4	305.04	The facility nurse did not make recommendations regarding Resident #'s 2, 3, 6, 13, & 15 weight loss. ***Previously cited on 7/21/11	RM 10/9/12	
		and 10/18/11.		
5	335.03	Paper towels were not available for caregivers use after providing personal cares to residents in the memory unit. ***Previously cited	RM 10/9/12	
		on 7/21/11.***		
6	350.02	The facility administrator did not investigate incidents and accidents or document the findings. *** Previously cited on 7/21/11.***	RM 10/9/12	
7	451.02	The facility did not routinely offer or have available snacks for residents at bedtime.	RM 10/9/12	
8	711.08.d	Calls to the physician and outcome of the calls were not documented.	RM 10/9/12	
9	711.08.e	Staff did not document notification of the nurse when residents had changes of condition.	RM 10/9/12	
10	711.14	Closed records did not include the date or location to where the resident was discharged to.	RM 10/9/12	

Response Required Date	Signature of Facility Representative	Date Signed
10/13/12		9/13/12

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DIVISION OF LICENSING & CERTIFICATION
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

September 25, 2012

Rod Johnson, Administrator
Highland Estates-Burley Operations, LLC
2050 Hiland Avenue
Burley, ID 83318

Dear Mr. Johnson:

An unannounced, on-site complaint investigation was conducted at Highland Estates-Burley Operations, LLC from September 10, 2012 to September 13, 2012. During that time, interviews and record reviews were conducted with the following results:

Complaint # ID00005386

Allegation #1: The facility did not obtain timely medical treatment for an identified resident when she fell and sustained a broken neck.

Findings #1: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.520 for not obtaining emergency medical treatment in a timely manner. The facility was required to submit a plan of correction.

Allegation #2: The facility failed to report an incident to Licensing and Certification when an identified resident fell and required medical treatment.

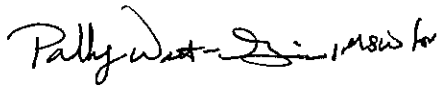
Findings #2: Unsubstantiated. During a complaint investigation survey on 9/12/12, the facility had an incident report pertaining to the resident's fall. The incident report included a time stamp that verified the report was sent to Licensing and Certification on 1/6/12.

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 ten (10) 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 . 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,



RaeJean McPhillips, RN, BSN
Health Facility Surveyor
Residential Assisted Living Facility Program

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

IDAHO DEPARTMENT OF HEALTH & WELFARE

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

DIVISION OF LICENSING & CERTIFICATION
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

September 25, 2012

Rod Johnson, Administrator
Highland Estates-Burley Operations, LLC
2050 Hiland Avenue
Burley, ID 83318

Dear Mr. Johnson:

An unannounced, on-site complaint investigation survey was conducted at Highland Estates-Burley Operations, LLC from September 10, 2012, to September 13, 2012. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00005393

Allegation #1: The facility did not seek medical interventions for residents in a timely manner.

Findings #1: Substantiated. The facility was issued a core deficiency at IDAPA 16.03.22.520 for not seeking medical treatment for residents when they experienced a change in condition. The facility was required to submit a plan of correction within ten (10) days.

Allegation #2: An identified resident, who verbally threatened another resident, did not have a documented behavioral management plan.

Findings #2: Between 9/10/12 and 9/13/12, five (5) facility staff stated the identified resident never had a behavioral management plan nor had the resident ever been observed exhibiting behaviors which would require a behavior plan.

Between 9/12/12 and 9/13/12, the identified resident was observed multiple times at meals, attending activities and walking around the facility. The resident was observed to interact appropriately with staff and other residents.

On 9/13/12 at 10:50 AM, the identified resident stated she had never had any problems with other residents and was happy living at the facility.

The identified resident's record, including progress notes, incident reports, a care plan and nursing assessments were reviewed. There was no documentation that the resident had any behaviors or had verbally threatened another resident.

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

Allegation #3: Two identified residents were moved onto the memory care unit without a valid reason.

Findings #3: On 9/10/12 through 9/13/12, during a complaint investigation survey, the following observations, interviews and record reviews were made on the memory care unit.

On 9/10/12 at 9:30 AM, two identified residents were observed being assisted by staff for meals, activities and activities of daily living. Identified Resident A stated staff were doing a good job taking care of her. Identified Resident B did not verbally reply to questions, and gazed at objects around the living/dining room. Three staff members were interviewed and stated both residents had a diagnoses of dementia and were well suited and appropriate for residing on the unit. They stated the memory unit was small, quiet and residents received more one to one attention. Staff stated Identified Resident B was non-verbal but they were able to anticipate her needs.

On 9/11/12, both identified residents' records were reviewed and included assessments to validate the rationale for them to reside on the unit. Both assessments were signed and dated by the previous administrator.

On 9/12/12 at 9:30 AM, a family member stated her loved one was liked the staff and stated the smaller unit helped decrease the resident's anxiety.

On 9/12/12 at 9:55 AM, another family member stated they felt moving their family member to the unit was a great plan because it made it possible for the resident to continue to reside at the facility.

Unsubstantiated.

Allegation #4: Three identified residents did not receive medications as ordered by their physician's.

Findings #4: Between 9/10/12 and 9/13/12, all three identified residents' records were reviewed. There was no documentation that the residents had not received their medications as ordered by their physicians.

Between 9/12/12 and 9/13/12, two of the residents who still resided at the facility, stated they had always appropriately received their medications. The third resident no longer resided in the facility and was not available for interview.

Between 9/10/12 and 9/13/12, five (5) staff stated they did not recall a time when any of the three (3) identified residents did not receive their medications as ordered by their physicians.

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

Allegation #5: An identified resident had sores on her legs and did not have physician's treatment orders.

Findings #5: The identified resident was discharged from the facility in November of 2011, and was not available for observation or interview.

The resident's September, October and November 2011's medication assistance records documented "Dressing change: Change every 3 days at office..."

On 9/11/12 at 3:50 PM, the facility nurse stated the resident was receiving treatment at her physician's office for wounds on her legs.

Unsubstantiated.

Allegation #6: Residents had frequently run out of toilet paper at night and the staff did not have extra to provide for to the residents.

Findings #6: Between 9/10/12 and 9/13/12, observations and interviews were conducted with residents and staff members. All residents' rooms were observed to have toilet paper. Six (6) staff stated at times residents' had run out of toilet paper. However, they could always get toilet paper from the storage area during the day shift. If a resident ran out of toilet paper on the night or weekend shift, and they were not able to get into the storage room, they could obtain the toilet paper from empty rooms. They stated, the facility kept an extra supply of toilet paper near the front desk. Twenty-nine (29) residents denied ever completely running out of toilet paper.

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

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 ten (10) 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 **September 13, 2012**. 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,

Pattie Watt-Dix, MSW for

Rae Jean McPhillips, RN
Health Facility Surveyor
Residential Assisted Living Facility Program

RJM/pwg

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

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Dear Mr. Johnson:

An unannounced, on-site complaint investigation was conducted at Highland Estates-Burley Operations, LLC from September 10, 2012 to September 13, 2012. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00005484

Allegation #1: The facility did not ensure timely medical care was received, when an identified resident had a change of condition.

Findings #1: Substantiated. The facility was a deficiency at IDAPA 16.03.22.520 for not ensuring timely medical care. The facility was required to submit a plan of correction.

A core issue deficiency was identified during the complaint investigation. Please review the cover letter, which outlines how to develop a Plan of Correction. The Plan of Correction must be submitted to our office within ten (10) 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 **09/13/2012**. 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,

Rae Jean McPhillips, RN
Health Facility Surveyor
Residential Assisted Living Facility Program

RJM/pwg

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

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Dear Mr. Johnson:

An unannounced, on-site complaint investigation was conducted at Highland Estates-Burley Operations, LLC from September 10, 2012 to September 13, 2012. During that time, observations, interviews, and record reviews were conducted with the following results:

Complaint # ID00005689

Allegation #1: The facility retained an identified resident's safe when he moved from the facility.

Findings #1: On 9/12/12 at 3:45 PM, the administrator stated the resident was having difficulty paying his rent and offered to "trade" his safe for a partial rent payment. The administrator stated the facility credited the resident $755.00 towards his May rent. A May invoice from the facility documented the resident was given a $755.00 credit.

A letter, dated 8/15/12, from the chief operating officer, documented, "Although we thought we were doing a good thing by giving you a credit for the safe, we are willing to simply give it back to you when you wish to get it."

An email, dated 8/17/12, from the facility's administrator to the chief operating officer documented, "I am happy to report that the safe has been returned."

On 9/12/12 at 3:45 PM, the administrator stated the safe was returned to the resident undamaged. Additionally, he stated the facility did not request the resident to repay the $755.00 he was credited towards his May rent.

Unsubstantiated.

Allegation #2: An identified resident had a private room, but was told he had to have a roommate.

Findings #2: The identified resident's record was reviewed on 9/11/12. An admission agreement, signed by the resident on 1/13/12, documented that when a resident, who was residing in a private apartment, "spends down to Medicaid will be asked to transfer to a shared apartment..."

The record documented the resident applied for Medicaid in April 2012. A June invoice from the facility documented the resident's rent had decreased to a shared apartment rate.

On 9/12/12 at 3:45 PM, the administrator stated the resident searched unsuccessfully for a roommate for approximately a year, to help share the apartment cost. He stated another gentleman was moved into the resident's room in July 2012. He stated the resident did not like his new roommate and moved from the facility on 8/2/12. He stated the resident moved prior to the facility having an opportunity to locate another roommate for him.

Substantiated. However, the facility was not cited as the practice was not in violation of state rules.

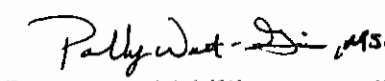
Allegation #3: The food was unpalatable.

Findings #3: From 9/10 through 9/12/12, twenty-nine, of the fifty-four residents who resided in the main portion of the building, and two family members were interviewed regarding the quality of the food. None of the residents had complaints regarding the taste, quality, or quantity of the food served at the facility. However, one family member stated they thought residents were served too much zucchini and rice. Another family member, stated the food was "good" but he/she wished the facility served "V8" more often.

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

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,



Rae Jean McPhillips, RN, BSN
Health Facility Surveyor
Residential Assisted Living Facility Program

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

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Dear Mr. Johnson:

An unannounced, on-site complaint investigation was conducted at Highland Estates-Burley Operations, LLC from September 10, 2012 to September 13, 2012. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00005690

Allegation #1: The facility did not seek medical treatment for 3 identified residents in a timely manner.

Findings #1: Substantiated. The facility was issued a core deficiency at IDAPA 16.03.22.520 for not seeking medical treatment for three identified residents when they experienced a change in condition. The facility was required to submit a plan of correction within ten (10) days.

Allegation #2: Staff did not follow the facility's protocol when at least two residents had fallen and hit their heads.

Findings #2: Substantiated. The facility was issued a none-core deficiency at IDAPA 16.03.22.215.01 for staff not following emergency protocols when two residents had fallen and hit their heads. The facility was required to submit evidence of resolution within thirty (30) days.

Allegation #3: Staff left an identified resident unattended on the toilet.

Findings #3: On 9/10/12 through 9/13/12, observations, interviews and a record reviews were conducted regarding the identified resident's care needs. During this time, staff were observed assisting the resident with care needs in a timely manner. The resident was observed to be clean and well groomed.

On 9/10/12 at 2:00 PM, the resident was observed laying on her bed resting. The resident stated she was assisted by staff with activities of daily living, including assistance with using the bathroom. The resident stated she had not fallen off the toilet, but had fallen out of her bed previously.

On 9/10/12 at 3:00 PM, two staff members stated as far as they knew the resident had not been left on the toilet unattended.

On 9/12/12 at 8:48 AM, a hospice nurse stated the identified resident's care needs were being met by facility staff. She stated she had not known of a time the resident was left on the toilet or had fallen off the toilet.

On 9/12/12 at 4:58 PM, a family member stated facility staff had been taking good care of his loved one. He stated, he was not aware of her being left on the toilet or not being assisted to use the bathroom.

An incident report dated, 6/10/12 documented the identified resident had a fall in her room.

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

Allegation #4: At times, snacks were not always offered or available to residents in the evening.

Findings #4: Substantiated. The facility was issued a non-core deficiency at IDAPA 16.03.22.451.02 for not routinely offering or having snacks available for residents in the evenings. The facility was required to submit evidence of resolution within thirty (30) days.

Allegation #5: The facility did not monitor and implement effective interventions when several resident's experienced a weight loss.

Findings #5: Substantiated. The facility was issued a core deficiency at IDAPA 16.03.22.520 for not monitoring and implementing effective interventions when residents experienced significant weight loss. The facility was required to submit a plan of correction within ten (10) days.

Allegation #6: The facility did not serve adequate food portions during meals.

Findings #6: Between 9/10/12 and 9/12/12, twenty-nine (29) residents, stated they received plenty to eat during mealtime.

On 9/10/12 at 5:07 PM, a family member stated, she often ate the food at the facility. She also stated the portion sizes she was served and had observed being served were adequate. Between 9/10/12 and 9/13/12, five (5) meals were observed and portion sizes appeared adequate and according to the menu.

On 9/11/12, the facility complaint log was reviewed. There were no complaints about food portion sizes.

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

Allegation #7: The facility nurse did not complete an assessment on an identified resident when pain medication was ineffective.

Findings #7: Substantiated. The facility was issued a non-core deficiency at IDAPA 16.03.22.305.01 for not completing a nursing assessment when an identified resident continued to complain of

pain several times after receiving pain medication. The facility was required to submit evidence of resolution within thirty (30) days.

Allegation #8: The facility administrator did not schedule an adequate number of staff to attend to residents' needs when other staff members were on their breaks.

Findings #8: Between 9/10/12 and 9/12/12, twenty-nine (29) residents, stated they felt staffing was adequate and did not feel staff breaks interfered with their cares. During the survey, staff were observed taking meal breaks at staggered times.

Between 9/10/12 and 9/13/12, eight (8) staff members stated they rotated breaks and did not feel staff breaks interfered with residents cares.

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

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 **September 13, 2012**. 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.

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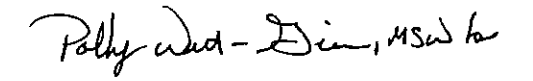

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