IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

November 19, 2012

Scott Jenkins, Administrator
Diamond View Assisted Living Community, Llc
3570 East Amity Road
Meridian, ID 83642

License #: Rc-726

Dear Mr. Jenkins:

On October 9, 2012 through October 12, 2012, a State Licensure and Complaint Investigation Survey was conducted at Diamond View Assisted Living Community, Llc. As a result of that survey, deficient practices were found. The deficiencies were cited at the following levels:

- Core issues, which are described on the Statement of Deficiencies, and for which you have submitted a Plan of Correction.
- Non-core issues, which are described on the Punch List, and for which you have submitted evidence of resolution.

This office is accepting your submitted plan of correction and evidence of resolution.

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

Sincerely,

Karen Anderson, RN

Karen Anderson, RN
Team Leader
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

October 22, 2012 **CERTIFIED MAIL #: 70073020000140507930**

Scott Jenkins
Diamond View Assisted Living Community, LLC
3570 East Amity Road
Meridian, ID 83642

Dear Mr. Jenkins:

Based on the State Licensure/follow-up survey and complaint investigation conducted by our staff at Diamond View Assisted Living Community, LLC on October 12, 2012, we have determined that the facility failed to protect residents' rights to be free from the use of physical restraints.

This core issue deficiency substantially limits the capacity of Diamond View Assisted Living Community, 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.

You have an opportunity to make corrections and thus avoid a potential enforcement action. Correction of this deficiency must be achieved by **November 26, 2012.** **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 **November 4, 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.

In accordance with Informational Letter #2002-16 INFORMAL DISPUTE RESOLUTION (IDR) PROCESS, you have available the opportunity to question cited deficiencies through an informal dispute resolution process. If you disagree with the survey report findings, you may make a written request to the Supervisor of the Residential Care Program for a Level 1 IDR meeting. The request for the meeting must be made within ten (10) business days of receipt of the statement of deficiencies. See the IDR policy and directions on our website at www.assistedliving.dhw.idaho.gov. If your request for informal dispute resolution is not received within the appropriate time-frame, your request will not be granted..

Please bear in mind that 13 non-core issue deficiencies were identified on the punch list and 7 were identified as repeat punches. As explained during the exit conference, the completed punch list form and accompanying evidence of resolution (e.g., receipts, photographs, policy updates, etc.) needs to be submitted to our office no later than November 11, 2012

If the facility fails to submit acceptable evidence of resolution within sixty (60) days from when the facility was found out of compliance, or on a subsequent survey visit, it is determined that any of these deficiencies still exist, the Department will have no alternative but to initiate the enforcement of civil monetary penalties, as described in IDAPA 16.03.22.910.02 and IDAPA 16.03.22.925.

Please ensure the facility is continually monitoring its compliance with state rules, as further repeat punches identified during future surveys could result in enforcement actions including:

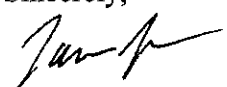
a. Issuance of a provisional license
b. Limitations of admissions to the facility
c. Hiring a consultant who submits periodic reports to the Licensing and Certification
d. Civil monetary penalties

Also, be aware 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 in Idaho, the Department will have no alternative but to initiate an enforcement action against the license held by Diamond View Assisted Living Community, LLC.

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

Sincerely,



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

ka/ka

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R726	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 10/12/2012
NAME OF PROVIDER OR SUPPLIER DIAMOND VIEW ASSISTED LIVING COMMUNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3570 EAST AMITY ROAD MERIDIAN, ID 83642		

(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 licensure survey and complaint investigation conducted October 09, 2012 through October 12, 2012 at your residential care/assisted living facility. The surveyors conducting the survey were: Karen Anderson, RN Team Leader Health Facility Surveyor Maureen McCann, RN Health Facility Surveyor Donna Henscheid, LSW Health Facility Surveyor Abbreviations: CNA = certified nurse assistant NSA = negotiated service agreement	R 000		
R 008	16.03.22.520 Protect Residents from Inadequate Care. The administrator must assure that policies and procedures are implemented to assure that all residents are free from inadequate care. This Rule is not met as evidenced by: Based on observation, interview and record review, it was determined the facility restrained 4 of 10 sampled Residents (#4, #7, #8 and #9), four (4) Random Residents (A, B, F and G) and other unidentified Random Residents by use of either a recliner, wheelchair, rocking chair, bed rail or an ottoman as measures to keep them from getting	R 008		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13R726		10/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMOND VIEW ASSISTED LIVING COMMUNIT	3570 EAST AMITY ROAD MERIDIAN, ID 83642

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 008	Continued From page 1 out of bed. The findings include: IDAPA 16.03.02.550.10 documents "Freedom from Abuse, Neglect, and Restraints. Each resident must have the right to be free from...any physical or chemical restraints." IDAPA 16.03.22.012.04 defines a Physical Restraint as "Any device or physical force that restricts the free movement of, normal functioning of, or normal access to a portion or portions of an individual's body except for treatment of a medical condition." A) Bed rail used as a restraint. 1. Resident #7 was a 77 year old male who was admitted to the facility on 11/01/10 with a diagnosis of Alzheimer's dementia. Resident #7's NSA, dated 8/20/12, documented the resident required the assistance of one caregiver for transfers. The NSA did not include the resident's use of a bed rail. Resident #7's use of a bed rail for mobility was not addressed by the nurse when she completed nursing assessments, including the most recent assessment, dated 9/20/12. On 10/09/12 at 9:40 AM, Resident #7 was observed sleeping in bed with a bed rail in the raised position. Caregiver K and Caregiver L were interviewed and stated they had been verbally instructed to keep the "bed rail up when [Resident #7's name] is in bed so he doesn't roll of of bed." On 10/09/12 at 2:50 PM, Caregiver F stated she was verbally instructed to keep the bed rail up whenever Resident #7 was in bed to prevent him	R 008	A) Bed rail used as restraint. 1. On 10/12/2012, I posted a Notice to all staff that it was brought to my attention that certain care staff is using care practices that would be defined as restraints under state regulations. The Notice directed the immediate cease of any such care practices, with additional training and guidance pending. On 10/25/2012 a formal staff meeting/in-service training took place with all community staff. One of the topics discussed was an extensive review of the facility restraint policy, with specific examples and consequences. All staff signed documentation of training. Resident #7 was recently admitted to Hospice care. A hospital bed was delivered with a half rail. The nurse did an assessment and determined the resident could utilize the side rail for mobility safely and effectively, although the assessment was not in chart at the time of survey. At no time did the licensed nurse(s) instruct care staff to use the side rail as a restraint. My follow-up interviews with care staff was they "assumed" use of the rail was for safety. In turn, the use of the side rail was passed through shift change information by caregivers. To eliminate confusion the side rail on this bed has been removed. Care staff have also been instructed and trained on acceptable alternatives (i.e. alarms, body pillows, low beds with mat next to bed) to utilize for resident safety per licensed nurse/care plan direction. To avoid confusion and inaccurate assumptions in the future, the use of bed rails in the community shall be discontinued, (unless requested by a resident to have the clear cognitive ability to use rail for mobility and can demonstrate such ability continuously). The Administrator will monitor and ensure any bed brought into the community will be without bed rails. The administrator will ensure licensed nurses provide clear care staff direction via care plans and nurse direction to eliminate care staff confusion, assumptions and/or making improper decisions relative to resident care and safety issues.	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13R726		10/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMOND VIEW ASSISTED LIVING COMMUNIT	3570 EAST AMITY ROAD MERIDIAN, ID 83642

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 008	Continued From page 2 from falling. On 10/11/12 at 10:11 AM, Caregiver A stated Resident #7 had side rails to prevent him from falling out of bed and "it's okay because he's on hospice." On 10/11/12 at 11:00 AM, Caregiver E confirmed they used a side rail while Resident #7 was in bed. The nurse would be "upset if it wasn't up." On 10/11/12 at 12:35 PM, Caregiver C stated that in Building #1, caregivers were instructed to keep Resident #7's bed rail up whenever he was in bed to prevent him from getting up alone. The facility used a bed rail, which restricted Resident #7 from getting out of bed. B) Wheelchairs, recliners, a rocking chair and an ottoman used as restraints. 1. Resident #8 was a 79 year old male who was admitted to the facility on 4/18/11 with a diagnosis of Alzheimer's dementia. Resident #8's NSA, dated 5/02/12, documented the resident required extensive assistance of one caregiver for transfers and ambulation. The NSA described the resident as someone who "wanted and needed" to be constantly walking but had a history of falls. On 10/9/12 at 3:30 PM, Resident #8 was observed being transferred to a chair with the assistance of two caregivers. Caregiver G and Caregiver H stated the resident was "constantly" wanting to walk and was at "high risk of falling." They stated when they were busy with other residents, they could not keep an eye on him.	R 008	B) Wheelchairs, recliners, a rocking chair and an ottoman used as restraints 1. On 10/12/2012, I posted a Notice to all staff that it was brought to my attention that certain care staff is using care practices that would be defined as restraints under state regulations. The Notice directed the immediate cease of any such care practices, with additional training and guidance pending. On 10/25/2012 a formal staff meeting/in-service training took place with all community staff. One of the topics discussed was an extensive review of the facility restraint policy, with specific examples and consequences. All staff signed documentation of training. Resident #8 is a "standby assist" where care staff is by his side anytime he is up and walking. He loves to walk and the small size of the building is very conducive to staff keeping him safe while he walks. Due to his frequent walking and movement, his ankles swell. He likes to rest in the common areas and he likes to sit in a recliner chair or a lounge chair with an ottoman under his feet for comfort and decrease of swelling. It is my belief care staff was never instructed by the licensed nurse(s) to position the resident in a recliner or the use of an ottoman to keep resident from "getting up". It helps with comfort and swelling and a resident preference. Care staff has been instructed not to place resident in the recliner in question due to his inability push foot rest down. When resident sits in the lounge I have personally watched the resident slide the ottoman aside and start to stand from other chairs. Licensed nurse(s) will monitor resident's ability to utilize ottoman within guidelines. The ottoman will be discontinued if resident is longer able to utilize in a safe manner or restricts his movement. In addition to the above mentioned training/in-service, care staff has been trained on the alternatives available and proper positioning to assist resident with swelling and comfort, but not restrict movement, to include any object at bedside. The resident's room is small. His large recliner is in close proximity to his bed, and there is adequate space between bed and chair for unrestricted movement of the resident.	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13R726		10/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMOND VIEW ASSISTED LIVING COMMUNIT	3570 EAST AMITY ROAD MERIDIAN, ID 83642

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 008	Continued From page 3 Caregiver G and H further stated, they assisted Resident #8 to sit in a recliner or a chair with an ottoman and put his feet up to prevent him from getting up and falling. On 10/10/12 at 2:30 PM, Resident #8 was observed sitting in a recliner with the footrest up. The resident was observed attempting to get out of the recliner but he was not be able to push the footrest down by himself. On 10/11/12 at 10:30 AM, Caregiver B stated, we were told to put Resident #8 in a chair "with the ottoman under it...so he can't get up and hurt himself." On 10/11/12 at 11:11 AM, Caregiver E stated they placed Resident #8's recliner against his bed. On 10/11/12 at 12:30 PM, Caregiver C stated when Resident #8 was in bed staff placed a recliner or locked wheelchair against his bed, "so if he's getting up....we can hear it." The facility used an ottoman, recliner or locked wheelchair to prevent Resident #8 from getting out of bed or out of a chair. 2. Resident #9 was a 92 year old female who was admitted to the facility on 4/10/10, with a diagnosis of dementia. Resident #9's NSA, dated 1/29/12, documented the resident required the assistance of one caregiver for transfers, ambulation and had extensive night needs. There was nothing documented in the resident's NSA or nursing assessment that instructed	R 008	The administrator will ensure licensed nurses provide clear care staff direction via care plans and nurse direction to eliminate care staff confusion, assumptions and/or making improper decisions relative to resident care issues. The administrator, licensed nurses and supervisory personnel shall continually perform on-the-spot observations and one-on-one in-service training to ensure proper communication/training to staff and ensure no items or situations restrict movement of a resident. B) Wheelchairs, recliners, a rocking chair and an ottoman used as restraints 1. On 10/12/2012, I posted a Notice to all staff that it was brought to my attention that certain care staff is using care practices that would be defined as restraints under state regulations. The Notice directed the immediate cease of any such care practices, with additional training and guidance pending. On 10/25/2012 a formal staff meeting/in-service training took place with all community staff. One of the topics discussed was an extensive review of the facility restraint policy, with specific examples and consequences. All staff signed documentation of training. 2. Resident #9. Any procedures stated by the caregivers interviewed as to placing items next to the resident's bed were stopped immediately per the above mentioned Notice and in-service. Administrator also had one-on-one verbal discussions with staff. In is not my conclusion based on these discussions that they were instructed by a licensed nurse to place objects next to the bed to keep resident from getting out. More of assumptions by care staff as to what they do to help prevent falls. Administrator shall ensure licensed nurse(s) prepare specific instructions and alternatives for care staff to ensure safety of fall risk residents. In addition , the licensed nurse(s) shall update care plans and assessments to indicate the same for this residents as well as all others that meet this criteria. The administrator, licensed nurses and supervisory personnel shall continually perform on-the-spot observations and one-on-one in-service training to provide proper communication/training to staff and ensure no items or situations restrict movement of a resident.	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13R726		10/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMOND VIEW ASSISTED LIVING COMMUNIT	3570 EAST AMITY ROAD MERIDIAN, ID 83642

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 008	Continued From page 4 caregivers on specific interventions to use to reduce falls at night or when the resident was in bed. On 10/9/12 at 10:30 AM, Resident #9's room was observed to have a rocking chair. Two caregivers stated the resident required assistance of one caregiver to transfer and to ambulate. They stated she was a fall risk and at times the resident tried to get up alone. On 10/11/12 at 11:08 AM, Caregiver E stated that at one time Resident #9 had a rocking chair pushed up against her bed, but "I moved it because I didn't want her falling on that." She further stated, a wheelchair was now being used to keep him from getting out of bed. The facility used a wheelchair or rocking chair to prevent Resident #9 from getting out of bed. 3. Resident #4 was a 72 year old female who was admitted to the facility on 1/21/11, with diagnoses of dementia and expressive aphasia. Resident #4's NSA, dated 4/09/12, documented the resident required the assistance of one caregiver for transfers and ambulation. There was nothing documented in the resident's NSA or nursing assessment that instructed caregivers on what fall preventions or interventions to use. On 10/9/12 at 10:45 AM, Resident #4's room was observed to have a recliner next to the side of her bed. Caregivers K and L confirmed the resident was a fall risk and would try to get up alone. On 10/11/12 at 10:05 AM, Caregiver A stated they put a recliner against the front of Resident	R 008	The administrator will ensure licensed nurses provide clear care staff direction via care plans and nurse direction to eliminate care staff confusion, assumptions and/or making improper decisions relative to resident care issues. 3. Resident #4: 1. On 10/12/2012, I posted a Notice to all staff that it was brought to my attention that certain care staff is using care practices that would be defined as restraints under state regulations. The Notice directed the immediate cease of any such care practices, with additional training and guidance pending. On 10/25/2012 a formal staff meeting/in-service training took place with all community staff. One of the topics discussed was an extensive review of the facility restraint policy, with specific examples and consequences. All staff signed documentation of training. For proper clarification, the chair in the room of Resident #4 is a lounge style chair not a recliner. The chair is positioned close to the resident's bed due to the configuration of the room and that she sits in it to watch television. It also helps the resident transferring from her chair to the bed. The normal positioning of the chair no way restricts the Resident from free movement while either in her bed or sitting in the chair. Any procedures stated by the caregivers interviewed as to placing items next to the resident's bed were stopped immediately per the above mentioned Notice and in-service. Administrator also had one-on-one verbal discussions with staff. In is not my conclusion based on these discussions that they were instructed by a licensed nurse to place objects next to the bed to keep resident from getting out. More of assumptions by care staff as to what they do to help prevent falls. Administrator shall ensure licensed nurse(s) prepare specific instructions and alternatives for care staff to ensure safety of fall risk residents. In addition , the licensed nurse(s) shall update care plans and assessments to indicate the same for this resident as well as all others that meet this criteria.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13R726		10/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMOND VIEW ASSISTED LIVING COMMUNIT	3570 EAST AMITY ROAD MERIDIAN, ID 83642

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 008	Continued From page 5 #4's bed if she was "upset" and did not want to lay down. On 10/11/12 at 11:08 AM, Caregiver E stated Resident #4's recliner was "always" against the head of the bed. The facility used a recliner to prevent Resident #4 from getting out of bed. 4. Random Residents From 10/9/12 through 10/12/12, the following interviews were conducted with caregivers from all three shifts regarding Random Residents. Caregiver B stated she was instructed by the lead CNA at night to "use locked wheelchairs" against Random Residents B and F's beds to keep them from falling out. She further stated, there was "another little lady," whose chair was turned around backwards against the bed so "she can't get up." Caregiver C stated they used a locked wheelchair against Random Resident F's bed. She further stated the nurse "told me to do it." Caregiver E stated they used the side arm of recliners pushed against the beds of Random Residents A and G. Caregiver E stated it was "common practice" at the facility to use recliners to keep residents in bed. She further stated she was taught this practice by the nurse. Caregiver E stated there were two residents that "have to have wheelchairs pushed against their beds." She stated, "It's our fault the resident fell"	R 008	The administrator, licensed nurses and supervisory personnel shall continually perform on-the-spot observations and one-on-one in-service training to provide proper communication/training to staff and ensure no items or situations restrict movement of a resident. The administrator will ensure licensed nurses provide clear care staff direction via care plans and nurse direction to eliminate care staff confusion, assumptions and/or making improper decisions relative to resident care issues. 4. Random Residents (A, B, C, D, E, F, G) On 10/12/2012, I posted a Notice to all staff that it was brought to my attention that certain care staff is using care practices that would be defined as restraints under state regulations. The Notice directed the immediate cease of any such care practices, with additional training and guidance pending. On 10/25/2012 a formal staff meeting/in-service training took place with all community staff. One of the topics discussed was an extensive review of the facility restraint policy, with specific examples and consequences. All staff signed documentation of training. As stated previously, it is my belief staff took it upon themselves with the sincere intent of keeping the residents safe. I also believe they assumed the unacceptable practices were directed by the nurse but in fact were not. Whether care staff made assumptions or felt they were nurse directed, is somewhat irrelevant to the facts at hand. The end result is unacceptable practices appear to be happening within the community and were immediately stopped. Licensed nurses responsible for developing and monitoring care plans have been counseled and instructed to give care staff the information they need in order to do their jobs effectively and within the guidelines of state regulations. The Negotiated Service Agreements for the residents highlighted in this survey as well as all other residents, shall be updated to include the specific guidance and information needed to care for the resident. Emphasis will be placed on viable options and procedures care staff may utilize for residents who are considered a fall risk. Staff training shall be an on-going process to keep care staff current on individual resident issues and acceptable care techniques.	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13R726		10/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMOND VIEW ASSISTED LIVING COMMUNIT	3570 EAST AMITY ROAD MERIDIAN, ID 83642

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 008	Continued From page 6 if a wheelchair was not against the bed. She further stated, after an incident when a resident fell, the nurse arrived the next morning and "chewed us out" because a wheelchair was not against the bed. The facility used wheelchairs or recliners to prevent Random Residents A, B, F, G and other unidentified Random Residents from getting out of bed. On 10/11/12 at 11:58 AM, the administrator stated, he was not aware of caregivers placing recliners or wheelchairs against residents' beds to prevent falls. He stated, "This is something they should not do." He further stated, Resident #7's bed rail was for positioning only, and was not to be used to keep the resident in bed. On 10/11/12 at 2:50 PM, the nurse denied she had instructed caregivers to place a recliner or wheelchair against a resident's bed to prevent residents from falling. She stated, the residents' rooms were small, and a recliner took up a lot of space, so a recliner or a wheelchair would be close to the residents' beds. The nurse stated, caregivers were trained and instructed to place a small mattress on the floor beside the bed, use a body pillow next to the resident or place a walker or a wheelchair close to the bed in case a resident wants to get up during the night. Several caregivers stated it was the facility's practice to use either a recliner, wheelchair, rocking chair, bed rail or an ottoman as measures to keep Residents #4, 7, 8 and 9, Random Residents A, B, F, G and other unidentified Random Residents from getting out of bed. By using these measures, the facility failed to protect the resident rights' to be free from physical	R 008	The Administrator will monitor staff compliance and coordinate staff in-service training. The Administrator has started a daily supervisor staff meeting each morning to discuss all issues relative to the community. Included in these daily supervisor meetings, is training to enhance supervisor awareness and understanding of state regulations and to train and guide all staff on the same. The Administrator and supervisory staff shall make unannounced site observations to ensure staff are not performing any procedure that would be against any state regulation or community policy. The Administrator has reviewed and discussed with the licensed nurse(s) preparing care plans to ensure there is sufficient detail stated for care staff to properly provide care and services. To include timely updates to care plans on any change of condition with the resident. In addition, the Administrator shall make random verbal inquiries to care staff, capable residents and family members to determine if any inappropriate verbal care instructions are given by licensed nurses, and to take immediate action if necessary. As stated, the unacceptable care practices noted during this survey ceased the day in was brought to my attention (October 12, 2012). Updates to care plans, implementing and training staff on acceptable fall prevention options and other necessary action(s) will be completed by **November 26, 2012**.	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R726	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 10/12/2012
NAME OF PROVIDER OR SUPPLIER DIAMOND VIEW ASSISTED LIVING COMMUNIT		STREET ADDRESS, CITY, STATE, ZIP CODE 3570 EAST AMITY ROAD MERIDIAN, ID 83642	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 008	Continued From page 7 restraints.	R 008		

IDAHO DEPARTMENT OF HEALTH & WELFARE

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

ASSISTED LIVING Non-Core Issues Punch List

Facility Name	Physical Address	Phone Number
Diamond View Assisted Living Community, LLC	3570 East Amity Road	208-888-7030
Administrator	**City**	**ZIP Code**
Scott Jenkins	Meridian	83642
Survey Team Leader	**Survey Type**	**Survey Date**
Karen Anderson, RN	Licensure/follow-up survey & complaint investigation	October 12, 2012

NON-CORE ISSUES **PAGE 1 OF 2**

ITEM #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	L&C USE
1	152.05.b.iii	Resident #8 and a random resident had Merry walkers.	PENDING VARIANCE	11-16-12 KA
2	300.01	A) The facility RN did not complete an assessment when Residents #1, 3, 4, 8, 9, and 10 had a change of condition. B) There was no documentation the facility nurse completed a nursing assessment every 90 days for Residents #1, 9 and 10. ***REPEAT PUNCH, PREVIOUSLY CITED ON 6/9/10***	11-16-12	11-16-12 KA
3	305.02	The facility nurse did not ensure Resident # 1's medications were available as ordered. ***REPEAT PUNCH, PREVIOUSLY CITED ON 6/9/10***	11-16-12	11-16-12 KA
4	310.01.d	Caregivers were interpreting insulin doses, dialing insulin pens and injecting residents with insulin.	10-25-12	11-16-12 KA
5	320.03	NSA's were not signed by all parties for Residents #1, 2, 3, 4, 5 and 10.	11-16-12	11-16-12 KA
6	320.08	NSA's were not updated to reflect changes in condition for Residents #1, 7 and 8. ***REPEAT PUNCH, PREVIOUSLY CITED ON 6/9/10***	11-16-12	11-16-12 KA
7	430.03	Two random residents did not have beds in their room.	PENDING VARIANCE	11-16-12 KA
8	630.03	9 of 10 staff did not have DD training.	10-25-12	11-16-12 KA
9	603.04	10 of 10 staff did not have TBI training.	10-25-12	11-16-12 KA
10	711.01 a	Behavior Management Plans did not contain documentation of the date and time behaviors were observed. ***REPEAT PUNCH, PREVIOUSLY CITED ON 6/9/10***	10-25-12	11-16-12 KA

Response Required Date	Signature of Facility Representative	Date Signed
November 11, 2012		11-16-12

RECEIVED NOV 16 2012 FACILITY STANDARDS

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

ASSISTED LIVING
Non-Core Issues
Punch List

Facility Name	Physical Address	Phone Number
Diamond View Assisted Living Community, LLC	3570 East Amity Road	208-888-7030
Administrator	**City**	**ZIP Code**
Scott Jenkins	Meridian	83642
Survey Team Leader	**Survey Type**	**Survey Date**
Karen Anderson, RN	Licensure/follow-up survey & complaint investigation	October 12, 2012

NON-CORE ISSUES **PAGE 2 OF 2**

ITEM #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	L&C USE
11	711.01.b	Behavior Management Plans did not contain documentation of what interventions were used to manage behaviors. ***REPEAT PUNCH, PREVIOUSLY CITED ON 6/9/10***	10-25-12	11-16-12 KA
12	711.01.c	Behavior Management Plans did not contain documentation of the effectiveness of interventions used to manage behaviors. ***REPEAT PUNCH, PREVIOUSLY CITED ON 6/9/10***	10-25-12	11-16-12 KA
13	711.08	Residents #2, 3, 4, 8, 9 and 10's records did not have current cares notes signed and dated by the person providing the care. ***REPEAT PUNCH, PREVIOUSLY CITED ON 6/9/10***	11-16-12	11-16-12 KA

Response Required Date	Signature of Facility Representative	Date Signed
November 11, 2012		11-16-12

Date 10/10/12 Page 1 of 2

IDAHO DEPARTMENT OF HEALTH & WELFARE

Food Establishment Inspection Report

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

Establishment Name: Diamond View		Operator: Scott Jenkins	
Address: 3570 Amity Rd			
County: ADA	Estab # / EHS/SUR.#	Inspection time:	Travel time:
Inspection Type:	Risk Category: High	Follow-Up Report: Date: ____ OR	On-Site Follow-Up: Date: ____

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

Critical Violations		Noncritical Violations	
# of Risk Factor Violations	1	# of Retail Practice Violations	0
# of Repeat Violations	0	# of Repeat Violations	0
Score	1	Score	0
A score greater than 3 Med or 5 High-risk = mandatory on-site reinspection		A score greater than 6 Med or 8 High-risk = mandatory on-site reinspection.	

RISK FACTORS AND INTERVENTIONS (*Idaho Food Code* applicable sections in parentheses)

The letter to the left of each item indicates that item's status at the inspection.

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

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

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

Item/Location	Temp	Item/Location	Temp	Item/Location	Temp	Item/Location	Temp
Chicken	168°	Turkey - cooling	130°				
Soup veg/beef	176°	in fridge after 4 hrs.					

GOOD RETAIL PRACTICES (☒ = not in compliance)

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

OBSERVATIONS AND CORRECTIVE ACTIONS (CONTINUED ON NEXT PAGE)

Mandatory facility Score MHC

Person in Charge (Signature) (Print) Title Date

Inspector (Signature) Donna Henschel (Print) Donna Henschel Date 10/10/12

Follow-up: (Circle One) Yes No

IDAHO DEPARTMENT OF HEALTH & WELFARE

Food Establishment Inspection Report

Food Protection Program, Office of Epidemiology
450 West State Street, Boise, Idaho 83702
208-334-5938

Date 10/10/12

Establishment Name Diamond View	Operator Scott Jenkins
Address 3570 Amity Rd	
County Ada Estab # EHS/SUR.#	License Permit #

OBSERVATIONS AND CORRECTIVE ACTIONS (Continuation Sheet)

#17 - Turkey breast did not reach proper cooling temperatures within the timeframe. COS - Facility disposed of turkey.

Person in Charge	Date	Inspector Donna Henderson	Date 10/10/12

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

October 24, 2012

Scott Jenkins, Administrator
Diamond View Assisted Living Community, LLC
3570 East Amity Road
Meridian, ID 83642

Dear Mr. Jenkins:

An unannounced, on-site complaint investigation survey was conducted at Diamond View Assisted Living Community, LLC from October 9, 2012, to October 12, 2012. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00005633

Allegation #1: The facility did not have sufficient staff to meet the needs of residents who required a two person assist with transfers and ambulation.

Findings #1: On 10/9/12 through 10/12/12, between 8:00 AM and 4:30 PM observations of the four separate buildings were made. Building #1 and #2 had two caregivers assisting ten residents each, Building #3 had two caregivers assistmg sixteen residents and Building #4 had four caregivers assisting sixty-five residents. Further, the administrator, three nurses, an activity director and an administrative assistant were observed assisting residents in all buildings as needed. All residents who required the assistance of two people to transfer were observed receiving that assistance.

The September and October 2012 work schedule documented the following:

*Day shift (6:00 AM - 2:00 PM)
- Building #1 - 1 caregiver + 1 float between buildings 1 &2
- Building #2 - 1 caregiver
- Building #3 - 2 caregivers
- Building #4 - 4 caregivers

*Evening Shift (2:00 PM - 10:00 PM)
- Building #1 - 1 caregiver + 1 float between buildings 1 &2
- Building #2 - 1 caregiver

- Building #3 - 2 caregivers
- Building #4 - 4 caregivers

*Night Shift (10:00 PM - 6:00 AM)
- Building #1 - 1 caregiver
- Building #2 - 1 caregiver
- Building #3 - 1 caregivers
- Building #4 - 3 caregivers

On 10/11/12 at 2:55 PM, the LPN stated there was always float staff scheduled to assist the caregivers in the buildings where only one caregiver was scheduled. The LPN stated she felt there was adequate staffing to meet the needs of the residents.

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

Allegation #2: An identified caregiver cursed, yelled at and handled residents in a rough manner.

Findings #2: Between 10/9/12 and 10/12/12, observations of various staff/resident interactions were observed. All staff were observed to interact with residents in an appropriate manner.

During a tour of the facility, on 10/9/12 between 9:40 AM and 11:00 AM, twenty-three residents were interviewed. None of the residents expressed any concerns with staff yelling or handling them in a rough manner.

Between 10/9/12 and 10/11/12, eleven staff from various positions and shifts were interviewed. Two caregivers stated they were aware of staff members being fired for speaking "gruffly" to residents but it was not the identified caregiver. All staff members denied observing or hearing that a caregiver had handled any resident in a rough manner.

On 10/10/12 at 3:22 PM, two administrative staff stated they were not aware of any incidents where a caregiver had yelled at or handled any residents in a rough manner.

On 10/11/12 at 12:11 PM, the administrator stated he was not aware of any caregivers being "rough, pulling, yanking or yelling" at residents. He stated he had fired a caregiver for being "impatient" with the residents. He further stated, they had provided additonal training to a caregiver because the caregiver's "approach was not acceptable" but not because of abuse. The administrator

denied there was ever a situation he felt it was necessary to call Adult Protection.

On 10/11/12 at 2:55 PM, the LPN stated she was not aware of any allegations of abuse towards residents. She confirmed a caregiver received additional training and was moved to another building to work because of her "approach." The LPN denied knowing of any incident where a caregiver had yelled at or handled residents roughly.

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

Allegation #3: The facility retained an identified resident who was not compatible with the other residents.

Findings #3:

Substantiated. However, the facility was not cited as they acted appropriately when they assisted the resident in being evaluated and hospitalized for a exacerbation in behavioral symptoms related to an underlying mental illness.

Allegation #4: The facility did not offer fluids to an identified resident unable to obtain fluids independently.

Findings #4: Between 10/9/12 and 10/12/12, the identified resident was observed at several meals and in-between meals being offered fluids. At times the resident was offered fluids with a straw and at other times without it. When the resident was offered fluids with a straw, she drank significantly more fluid than when she did without it. Five caregivers and the administrator stated they offered fluids through a straw to the identified resident. However, other caregivers were not aware to offer the resident fluids with a straw.

Unsubstantiated. Although the allegation may have occurred, it could not be determined during the complaint investigation. However, technical assistance was provided to the facility of the importance of training all caregivers to ensure the identified resident was offered fluids with a straw.

Allegation #5: The facility used restraints such as: recliners, wheelchairs and side rails to keep residents in bed.

Findings #5:

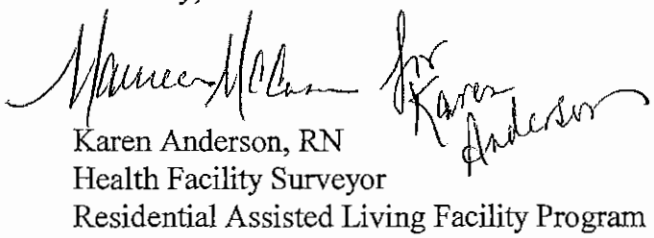
Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.550.10 for violating residents' rights when they used physical restraints to keep residents from getting out of bed. The facility was required to submit a plan of correction.

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

Please bear in mind that non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference, on **10/12/2012**. 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,



Karen Anderson, RN
Health Facility Surveyor
Residential Assisted Living Facility Program

ka/mmc

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