



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

LESLIE M. CLEMENT – DEPUTY DIRECTOR
LICENSING AND CERTIFICATION
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

November 14, 2011

CERTIFIED MAIL #: 7007 3020 0001 3745 7682

Amy Robinson, Administrator
Overland Court Generations Memory Care
10172 West Smoke Ranch Drive
Boise, ID 83709

FILE COPY

Dear Ms. Robinson:

Based on the Follow-Up survey and Complaint Investigation conducted by our staff at Overland Court Generations Memory Care on **November 3, 2011**, we have determined that the facility failed to protect the residents' right to live in a clean and sanitary environment and to be treated with dignity and respect, which resulted in inadequate care. The facility also failed to retain a licensed residential care administrator for a period of more than thirty (30) days. Additionally, the facility was issued repeat non-core issue deficiencies.

I. PROVISIONAL LICENSE

These core issue deficiencies and repeat punch list deficiencies seriously impair the capacity of Overland Court Generations Memory Care to furnish safe and effective services, and place the health and safety of the residents in jeopardy. The deficiencies are described on the enclosed Statement of Deficiencies. As a result of the survey findings, a provisional license is being issued effective **November 15, 2011**. The provisional license expires on **May 15, 2012**. Please post this license in a prominent area of the facility, and return your original license to us. The following administrative rule for Residential Care or Assisted Living Facilities in Idaho (IDAPA 16.03.22) gives the Department the authority to issue a provisional license:

935. ENFORCEMENT REMEDY OF PROVISIONAL LICENSE.

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

The conditions of the provisional license are as follows:

2011-972

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

920. ENFORCEMENT REMEDY OF LIMIT ON ADMISSIONS.

01. Notification of Limit on Admissions. *The Department will notify the facility limiting admissions or limiting admissions of residents with specific diagnosis to the facility pending correction of deficiencies. Limits of admissions to the facility remain in effect until the Department determines the facility has achieved full compliance with requirements or have received written evidence and statements from the outside consultant that the facility is in compliance.*

02. Reasons for Limit on Admissions. *The Department may limit admissions for the following reasons:*

- a. The facility is inadequately staffed or the staff is inadequately trained to handle more residents.*
- b. The facility otherwise lacks the resources necessary to support the needs of more residents.*

910. NON-CORE ISSUES DEFICIENCY.

02. First Follow-Up Survey. *When the Licensing and Survey Agency finds on the first follow-up survey that repeat non-core deficiencies exist, the Department may initiate any of the following enforcement actions: a. A provisional license may be issued; b. Admissions to the facility may be limited; or c. The facility may be required to hire a consultant who submits periodic reports to the Licensing and Survey Agency.*

2. A registered nurse or licensed administrator consultant, with experience working for a residential care or assisted living facility in Idaho, shall be obtained and paid for by the facility, and approved by the Department. This consultant must have an Idaho nursing license or an Idaho residential care administrator license, and may not also be employed by the facility or the company that operates the facility. The registered consultant must be on-site for a minimum of twenty (20) hours per week, and must not be utilized to complete routine nursing or administrative tasks for the facility. The consultant shall be allowed unlimited access to the facility and its systems for the provision of care to residents. The name of the consultant with the person's qualifications shall be submitted to the Department for approval no later than November 25, 2011.

3. The Department-approved consultant will submit a weekly written report to the Department commencing on December 2, 2011, and every Friday thereafter. The reports shall address progress on correcting the deficiencies listed on the Statements of Deficiencies and the Non-Core Issues Punch Lists.

4. The facility shall maintain, on an ongoing basis, the deficient area in a state of compliance in accordance with the submitted Plan of Correction.

5. The provisional license shall be prominently displayed in the facility.

6. When the consultant and the administrator agree that the facility is in full compliance, they shall notify the Department. The Department will conduct a follow-up survey to verify compliance.

The provisional license, which expires on May 15, 2012, shall not be extended. If the facility is unable

to meet the terms of the provisional license or come into compliance with the rules for Residential Care or Assisted Living Facilities in Idaho (IDAPA 16.03.22), a new license will not be issued. The facility will be required to transfer the residents, and cease operations as a residential care or assisted living facility.

II. PLAN OF CORRECTION AND EVIDENCE OF RESOLUTION

Correction of these deficiencies must be achieved by **December 18, 2011**. **We urge you to begin correction immediately.**

The following administrative rules for Residential Care or Assisted Living Facilities in Idaho (IDAPA 16.03.22) give the Department the authority to require plans of correction and evidence of resolution:

130.LICENSURE SURVEYS.

08. Plan of Correction for Core Issue Deficiencies. The facility must develop a plan of correction and return an acceptable plan of correction to the Licensing and Survey Agency, for all core-issue deficiencies, within ten (10) calendar days of receipt of the Statement of Deficiencies and Plan of Correction form.

After you have studied the enclosed Statement of Deficiencies, please write a Plan of Correction (POC) 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** POC within ten (10) calendar days of receiving this letter, and keep a copy for your records. Your license depends upon the corrections made and the evaluation of the POC you develop. Failure to develop and submit an acceptable POC may result in further enforcement actions, including additional civil monetary penalties and revocation of the provisional license.

09. Evidence of Resolution for Non-Core Deficiencies. The facility must provide evidence of resolution of non-core issues to the Licensing and Survey Agency, within thirty (30) calendar days of the exit conference. The facility may show evidence of resolution by providing receipts, pictures, and completed policies, training, schedules, and other records.

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 November 3, 2011. The completed Punch List form and accompanying proof of resolution (e.g., receipts, pictures, policy updates, etc.) are to be submitted to this office by **December 3, 2011**. Failure to submit acceptable evidence of resolution may result in further enforcement actions, including additional civil monetary penalties and revocation of the provisional license.

III. IDR

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.

IV. CIVIL MONETARY PENALTIES

The following administrative rule for Residential Care or Assisted Living Facilities in Idaho (IDAPA 16.03.22) gives the Department the authority to impose a monetary penalty for this violation:

910. NON-CORE ISSUES DEFICIENCY.

03. Second Follow-Up Survey. *When the Licensing and Survey Agency finds on the second follow-up survey that repeat non-core deficiencies still exist, the Department may initiate the "Enforcement Remedy of Civil Monetary Penalties," as described in Section 925 of these rules.*

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 the 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 non-compliance is established.*

b. Repeat deficiency is ten dollars (\$10).

During the follow-up, and complaint investigation survey, ten (10) non-core deficiencies were identified. Six (6) of these were repeat deficiencies from September 1, 2011, and one (1) was cited for the third time September 16, 2009, September 1, 2011 and November 3, 2011. Based on the repeat nature of these deficiencies and the facility's pattern of failure in correcting non-core deficiencies, the Department is imposing the following penalties:

For the dates of, September 1, 2011 through November 3, 2011:

Penalty	Times Number of Deficiencies	Times Number of Occupied Beds	Times Number of Days of Non-compliance	Amount of Penalty
\$10.00	1	34	63	\$21,420.00

Maximum penalty allowed in any 90-day period per IDAPA 16.03.22.925.02.c: **\$6,400.00**

Send payment of \$6,400.00 by check or money order, made payable to:

Licensing and Certification
Department of Health and Welfare
P.O. 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 these decisions 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, Bureau Chief
Division of Licensing and Certification - DHW
P.O. Box 83720
Boise, ID 83720-0009

If you fail to file a written 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

Enclosure

c: Pam Mason, Program Manager, Regional Medicaid Services, Region IV - DHW
Debby Ransom, Bureau Chief
Cathy Hart, Idaho Ombudsman for the Elderly, Idaho Commission on Aging



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HEALTH & WELFARE

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LICENSING AND CERTIFICATION
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE 208-334-6628
FAX 208-364-1888

December 9, 2011

Amy Robinson, Administrator
Overland Court Generations Memory Care
10172 West Smoke Ranch Drive
Boise, ID 83709

License #: RC-972

Dear Ms. Robinson:

On November 3, 2011, a follow-up survey and complainant investigation was conducted at Overland Court Generations Memory Care. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level(s):

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

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

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

Sincerely,

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

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R972	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 11/03/2011
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NAME OF PROVIDER OR SUPPLIER OVERLAND COURT GENERATIONS MEMORY	STREET ADDRESS, CITY, STATE, ZIP CODE 10172 WEST SMOKE RANCH DRIVE BOISE, ID 83709
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(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}	<p>Initial Comments</p> <p>The following deficiencies were cited during the follow-up survey and complaint investigation conducted on 10/31/2011 through 11/3/2011 at your residential care/assisted living facility. The surveyors conducting the survey were:</p> <p>Maureen A. McCann, RN Team Leader Health Facility Surveyor</p> <p>Gloria Keathley, LSW Health Facility Surveyor</p> <p>Donna Henscheid, LSW Health Facility Surveyor</p> <p>Abbreviations and definitions:</p> <p>+ = and ^ = increase ASAP = as soon as possible Ass = assessment BM = bowel movement/feces BMP - behavioral management plan c = with cg = caregiver cm = centimeter cont = continue dtr = daughter HH = Home Health Agency L = left MAR = Medication Assistance Record meds = medications MD = physician min = minute NSA = Negotiated Service Agreement NOC = night shift occ. = occasional pm = evening</p>	{R 000}		

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *Administrator* (X6) DATE: *11/25/11*

Bureau of Facility Standards

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{R 000}	Continued From page 1 PRN = as needed pt. = patient Qtrly = quarterly Res = resident S/SX = signs and symptoms WC = wound care wk = week	{R 000}		
R 004	16.03.22.215.03 Licensed Administrator Requirement - 30 Days The facility may not operate for more than thirty (30) days without a licensed administrator. This Rule is not met as evidenced by: Based on interview and record review, it was determined the facility failed to retain a licensed administrator responsible for the day-to-day operations of the facility for a period of more than 30 days. The findings include: A record review of the facility correspondence, on 8/26/11, documented a variance had been granted, on 8/23/11, for the licensed administrator to oversee two facilities. The variance letter documented, "Should the administrator change, or should any building receive a core issue deficiency, the variance would be revoked, and each facility would be expected to comply with 16.03.22.215 by obtaining separate, licensed administrators." A licensure survey and complaint investigation was conducted on 9/1/11. At that time, a core issue deficiency was cited and the variance was revoked. On 10/5/11, the new administrator was given a provisional administrator license.	R 004	<ol style="list-style-type: none"> 1. The provisional License was issued on 10/5/11 and the permanent licenses on 10/13/11 See attachment #1 2. N. A. 3. Should the employment of the Administrator change the Executive Director for the campus and the corporate management team will appoint an interim administrator until the position can be filled permanently. 4. The Executive Director for the campus will be responsible to notifying the state and the corporate management team of vacancies in the facility. 5. Completion date : December 18, 2011 	

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R 004	Continued From page 2	R 004		
(R 008)	<p>From the exit date of 9/1/11 until 10/5/11, the facility went 34 days without a licensed administrator.</p> <p>16.03.22.520 Protect Residents from Inadequate Care.</p> <p>The administrator must assure that policies and procedures are implemented to assure that all residents are free from inadequate care.</p> <p>This Rule is not met as evidenced by: Based on observation, record review and interview, it was determined the facility failed to provide adequate supervision for 2 of 12 sampled residents (Resident #1 and #3). The facility also failed to develop a behavior management plan for 1 of 2 (Resident #6) who had aggressive behaviors. Further, the facility did not protect 5 of 12 sampled residents (Residents #3, 6, 9, 10, 11) and multiple random residents rights to live in a safe and sanitary environment and to be treated with dignity and respect. This had the potential to affect 100% of the residents. The findings include:</p> <p>I. SUPERVISION</p> <p>1. Resident #1 was admitted to the facility in July 2011 with a diagnosis of dementia.</p> <p>A physician's order, dated 3/24/11, documented the resident had an order for Lantiseptic skin protectant to "use as needed as a skin barrier for incontinence or for reddened, excoriated skin."</p> <p>A nursing assessment, dated 8/2/11, documented the resident had a "small red spot on coccyx."</p>	(R 008)	<ol style="list-style-type: none"> 1. Resident #1 no longer resides at the facility. Resident #3 NSA and room has been reviewed to ensure directions are clear and devices are in place. 2. All residents could be affected by the same deficient practice. 3. A skin check was done, concerns were communicated to the nurse and the MD. Fall precautions/alarms were visually checked for all residents. A new skin care check sheet has been implemented that the caregivers will fill out if any problems are noted as they shower residents. (See attachment #6) The nurse has created a repositioning schedule form-see attachment #8 for any residents that show signs of redness or any kind of skin breakdown. The nurse/administrator had a meeting on 11/16/11 with all outside services to discuss the documentation and communication requirements for our facility. (See attachment #9) 	

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{R 008}	<p>Continued From page 3</p> <p>The nurse recommended to "monitor bottom for breakdown." There was no evidence the staff were instructed to utilize the Laniseptic or put other preventative measures into place to prevent further breakdown.</p> <p>A MAR, dated 8/1/11 through 8/31/11, documented the Lantiseptic had not been used for the entire month.</p> <p>An NSA, dated 8/2/11, documented the "resident has fragile skin and needs occasional skin checks."</p> <p>An "Individual Service Plan", dated 8/2/11, documented "staff will provide occasional skin checks and evaluate need for skin care."</p> <p>There was no further documentation regarding what interventions were to be used to prevent further skin breakdown.</p> <p>A nursing note, dated 8/30/11, documented the resident "has sore on coccyx and on (L) heal [sic], requesting HH order from MD to treat."</p> <p>A home health "Patient Activity" form, dated 9/3/11, documented the resident was evaluated for wound care on the buttocks and left foot. It further documented, "...examined wounds. Left ankle wound had dried scab that when removed revealed healthy tissue with no open areas. Bottom wound is better per staff, and is blanching, not a pressure ulcer. Instructed facility to continue with skin barrier cream.... Pt does have red area on right cheek that presents almost as a boil, but has no open areas, blanches, and does not require wound care at this time."</p> <p>A nursing note, dated 9/6/11, documented home</p>	{R 008}	<p>CONT...A staff meeting was held on 11/22/11 (see attachment #4) to explain the importance of communication. There is a new process in place for shift to shift report (see attachment #5) The meeting also discussed the importance of making sure a verbal report is given to the nurse with any concerns or changes.</p> <p>Every morning there will be a "stand up" meeting with the staff so that there is a verbal update on every resident to the nurse. See attachment #4 & #7 A staff meeting was held to discuss barrier cream use. The creams will be kept in all residents rooms where appropriate and the caregiver will document on the ADL sheets with each use. All staff has been delegated. Any changes in skin conditions will be discussed at standup with the nurse the NSA will reflect any skin care needs. The nurse will check all residents with skin breakdown and document any change.</p>	

Bureau of Facility Standards

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{R 008}	<p>Continued From page 4</p> <p>health had evaluated the wounds and the wounds were healed.</p> <p>A "Daily Log Note" from unlicensed staff to the facility nurse, dated 9/26/11, documented, "The sore on her back is very Bad! Open red and turning brown. We don't understand why she was taken off her cream? She really needs to have stuff to put on that sore, it keeps getting worse." There was no documentation by the facility nurse that the resident's wound was assessed at this time.</p> <p>A MAR, dated 9/1/11 through 9/30/11, documented the Lantiseptic had not been used for the entire month.</p> <p>From 9/6/11 to 9/30/11, approximately 24 days, there was no further documentation by the facility nurse regarding the status of the resident's wound.</p> <p>A nursing note, dated 10/1/11, documented the resident "has open sore on coccyx, MD notified..." There was no documentation the nurse provided education to staff regarding what interventions to put into place to prevent further skin breakdown.</p> <p>A fax from the physician, dated 10/5/11, documented an order for a home health wound care evaluation.</p> <p>A "Daily Log Note" from unlicensed staff to the facility nurse, dated 10/6/11, documented the resident was "breaking down on bottom." There was no documentation by the facility nurse that the resident's wound had been assessed. Nor was there any documentation the nurse provided education to staff regarding what interventions to put into place to prevent further skin breakdown.</p>	{R 008}	<p>CONT....A temporary care plan binder/communication binder will be implemented that we will require all staff to review and sign as the com on shift. This will include all care plans including skin breakdown, turning and falls. In-service was given about the importance of alarms and making sure they are placed correctly. The administrator will do walk rounds daily and will check alarms at this time. (See attachment #4) Forms will be made from the NSA's with a snap shot of care needed for each resident (see attachment #20) The forms will be handed out to staff and then kept on each side of the nurses station so all staff will have access. (This form will include alarms, ADL's or special needs)</p>	

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{R 008}	<p>Continued From page 5</p> <p>A "Daily Log Note" from unlicensed staff to the facility nurse, dated 10/9/11, documented the resident's "bed sore [on the buttocks] smells really, really bad. Can we get her cream? She really needs something for that sore." There was no documentation by the facility nurse that the resident's wound had been assessed. Nor was there any documentation the nurse provided education to staff regarding what interventions to put into place to prevent further skin breakdown.</p> <p>A home health "Plan of Care", dated 10/10/11, documented the resident had a Stage II pressure ulcer on her buttocks and home health services would begin on 10/13/11.</p> <p>A nursing note, dated 10/20/11, documented the resident had a Stage II wound that was being treated by home health. There was no evidence the facility nurse assessed the wound.</p> <p>A nursing note, dated 10/25/11, documented the resident's daughter was concerned the resident's wound was not improving.</p> <p>A home health note, dated 10/25/11, documented the resident had a Stage II pressure ulcer, with "foul odor" and "necrotic tissue partially covering wound bed." Further it documented, "Found dressing rolled about halfway off of wound bed. Reinforced to cg on duty that if this happens, they can remove dressing and apply barrier cream."</p> <p>Home health notes, dated 10/28/11, documented the resident had a Stage II pressure ulcer with "necrotic tissue completely covering wound bed." It further documented, "When removed diaper to do WC, pt had had a BM."</p>	{R 008}	<p>4. We have hired a Dementia coordinator to assist nursing. The coordinator will do a weekly audit on all rooms, ADL's & BMP's and will give copies of the audit to the facility nurse. See attachment # 2 & 3. The coordinator will also do a sample MED/MAR audit monthly and will give copies to the facility nurse to review. See attachment #4 The Admin/RN will review audits and address trends/concerns and create a plan of action as needed.</p> <p>5. Completion date: December 18, 2011</p>	

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{R 008}	<p>Continued From page 6</p> <p>A "Daily Log Note," dated 10/30/11, documented the resident's "bed sore is bleeding and has puss! We have put this in the daily log over and over. Who do we need to tell? I had to clean BM out of her open Band Aide tonight."</p> <p>On 10/31/11, a family member stated Resident #1 was "frequently found not groomed and in wet depends." She further stated, "The wound is not getting better, it's getting worse."</p> <p>On 11/1/11, a caregiver stated, "The sore on [Resident #1's name] back is stinky. I can't look at it."</p> <p>On 11/1/11 at 3:00 PM, Resident #1's wound was observed. The wound was located on the resident's buttocks. The actual wound appeared to be approximately the size of a quarter but was surrounded by reddened area about the size of a baseball. The home health nurse stated the wound nurse specialist explained to her the reddened area was a "road map" of where the wound would be headed if not taken care of.</p> <p>On 11/1/11 at 3:03 PM, a home health nurse stated the resident's wound was "worse" and gets "bigger and bigger every time I come." She stated the wound measured "3.4 cm by 3.4 cm" and was "covered with slough and tissue" which was "unstageable" at this time. When asked if she had ever found the resident soiled, the home health nurse responded, "I don't think there's a time she isn't." When asked if she had communicated these concerns to the facility nurse, the home health nurse stated she had only spoken to the facility nurse once.</p> <p>On 11/1/11 at 3:10 PM, a friend stated she visited the resident 2 to 3 times a week and the resident</p>	{R 008}		

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{R 008}	<p>Continued From page 7</p> <p>was "often" found wet.</p> <p>On 11/1/11 at 3:15 PM, the administrator/facility nurse stated she had last seen the resident's wound "two weeks ago." The facility nurse stated she felt the appropriate measures were put into place to prevent further breakdown. Further, she stated the resident was not on any turning/repositioning schedule because that is "something we can't do, it's more of skilled nursing need."</p> <p>On 11/3/11 at 3: 20 PM, the administrator/facility nurse stated she "inherited a mess" from the previous nurse and administrator. She stated, the sister facility hired a new nurse and she was training him, dealing with staffing issues and trying to keep up with paperwork and medical needs of residents in both buildings.</p> <p>2. Resident #3 was admitted to the facility on 1/11/07, with a diagnosis of dementia.</p> <p>On 10/31/11 at 11:25 AM, Resident #3 was observed in her room attempting to get out of her chair on her own. A tab alarm was observed hanging on a post on the right side of the bed. Her call light was observed out of her reach and her hearing aids were located in a cup on her bedside table. Surveyors handed the call light to her and she pressed the button. Within a few minutes, a voice came over the intercom asking the resident what she needed. The resident was unable to hear the person, therefore could not answer and the intercom was turned off by the caregiver. The resident continued to press the call light button until staff came into her room.</p> <p>On 10/31/11 at 11:30 AM, one caregiver entered the room and the resident told her she wanted to</p>	{R 008}		

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{R 008}	<p>Continued From page 8</p> <p>"get up." The caregiver stated she would need to get help because the resident was a two-person transfer. The caregiver was asked why the resident did not have her tab alarm attached to the chair. The caregiver was unaware the resident had a tab alarm. Further, when asked why the resident did not have her hearing aid in. The caregiver replied, "She doesn't have a battery in it." Another caregiver entered the room. When told about the hearing aid, the second caregiver opened the drawer from the bedside table and pulled out a package of hearing aid batteries.</p> <p>The facility did not provide adequate supervision to ensure Resident #1 and #3 received the appropriate care. The facility nurse did not assess Resident #1's wound for extended periods of time and did not provide direction to the staff. The barrier cream was not utilized and the resident was often left in soiled or wet attends. Because appropriate interventions were not put into place, Resident #1's wound continued to worsen. Further, Resident #3 had not been assisted with inserting her hearing aids and was unable to hear a caregiver responding to her over the intercom. She was left in a chair unable to reach her call light to ring for assistance. Also, when Resident #3 was attempting to get out of a chair unassisted, the alarm meant to alert staff of this, was not implemented, thus placing her at risk for falls.</p> <p>II. BEHAVIORAL MANAGEMENT PLAN</p> <p>According to IDAPA 16.03.22.225 Requirements for Behavior Management, "The facility must identify and evaluate behavioral symptoms that are distressing to the resident or infringe on other</p>	{R 008}		

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{R 008}	<p>Continued From page 9</p> <p>residents' rights." Further, "The facility must develop an intervention for each behavioral symptom. All staff must be aware of and consistently implement each behavioral symptom intervention and the intervention needs to be the least restrictive."</p> <p>According to IDAPA 16.03.22.310.04 Requirements for medication - Psychotropic or Behavior Modifying Medications, "a. Psychotropic or behavior modifying medication intervention must not be the first resort to address behaviors. The facility must attempt non-drug interventions to assist and redirect the resident's behavior."</p> <p>Resident #6 was admitted to the facility on 5/6/11, with a diagnosis of Alzheimer's dementia.</p> <p>Two NSA's, dated 4/26/11 and 10/19/11, documented under the "Behavior" heading, "Physically Aggressive, improving with medications routine and PRN." Instructions to staff under the "Service" heading documented, "Staff will verbally redirect and administer behavior medication when resident is verbally aggressive. Staff will keep family and supervisor apprised of ongoing verbally aggressive behavior." There were no instructions or interventions documented for caregivers when the resident became physically aggressive.</p> <p>Between 9/13/11 and 10/30/11, the following notes were documented by caregivers in the "Daily Log":</p> <p>*9/13 - "[Resident #6's name] was being violent, hitting, kicking, biting, pulling hair."</p> <p>*9/14 - "He is combative every time it is time to toilet or get ready for bed, once he is in bed he's</p>	{R 008}	<ol style="list-style-type: none"> 1. Behavior management plan has been implemented for resident #6 (see attachment #11) Information was collected from a variety of shifts and a variety of caregivers. The family was also contacted to provide input as well, a room audit was completed. 2. All residents could be affected. Each resident will have a detailed BMP to include interventions specific to that resident. 3. Caregivers will update nurse daily at stand up if there are any changes. Staff meeting is scheduled on 12/7/11 with a hospice agency to discuss redirecting and providing care to dementia patients. A staff meeting was held on 11/22/11 (see attachment #4) to discuss on-call nurse and encourage staff to notify nurse any time 24/7 of issues that may be going on. 4. Nurse will review BMP every 30 days or sooner if needed. 5. Completion date: December 18, 2011 	

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(R 008)	<p>Continued From page 10</p> <p>fine. Hitting, + cursing."</p> <p>*9/19 - "Very combative when being changed. Punching kicking very hard. This has gone on the past 2 nights it was almost impossible for [caregiver's name] and I to change him."</p> <p>*9/22 - "Mean and aggressive w/caregiver (female) when taking him to the family room after dinner."</p> <p>*9/26 - "It has been taking 3 caregivers to change him on our NOC rounds. He was soaked last round and so we had to dress him and we got hit and then I got both my knees kicked in By [sic] him. he is getting very dangerous."</p> <p>*9/27 - "Very aggressive, hitting and kicking when we changed him."</p> <p>*10/1 - "Tried hitting caregiver and even said 'I'm gonna hit you in your face.' When caregiver tried moving him away from another resident's door, he was pounding on [other resident's name] door constantly while caregivers were putting [other resident's name] to bed. Was also very aggressive when putting him down for the night. Hitting, punching, elbowing, kicking."</p> <p>*10/4 - "Combative in the morning trying to punch - 3 person assist with him. Soaked."</p> <p>*10/5 - "Became very aggressive kicking and hitting, slugging. Punched [caregiver's name] under her right arm, grabbing at us. Left red marks on our arms, verbally [sic] abusive calling foul names as he's punching at us. Let go of bar and almost fell."</p> <p>*10/10 - "Took 3 caregivers to change him during</p>	(R 008)		

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{R 008}	<p>Continued From page 11</p> <p>rounds very combative (hitting)."</p> <p>*10/18 - "Very violent. Hitting, tried to kick me in the face when I was bent over We had to change him he was soaked."</p> <p>*10/22 - "Res was aggressive when toileting him. Hitting, kicking, bling caregivers."</p> <p>*10/24 - "Very violent and verbally abusive [sic]. Biting [sic], hitting kicking it took 3 people to hold him down and took 10 min to change him."</p> <p>*10/25 - "Caregiver tried pulling him backwards out of another residents [sic] room (they had visitors). He pinned caregiver against wall with his wheelchair purposely. Couldn't push him forward because he doesn't pick up his feet. When straightened him out, he tried hitting and kicking caregiver, calling her names."</p> <p>*10/29 - "Tried to give [Resident #6's name] shower. he was violent, hitting kicking, yelling, etc. [Resident #6's name] NEEDS a behavior sheet ASAP."</p> <p>*10/29 - "Angry when we tried to bed chang [sic] him was trying to hit caregiver in stomach."</p> <p>Between 9/13/11 and 10/30/11, the following notes were documented by the facility nurse:</p> <p>*9/22 - "Res is becoming more agitated + resisting pm cares redirected staff + encouraged male caregivers will monitor."</p> <p>*10/19 - "Qtrly Ass done, Phoned [sic] MD to discuss behaviors meds altered res is resistant to care + combative will discuss with MD on Friday how meds are working also spoke with daughter</p>	{R 008}		

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{R 008}	<p>Continued From page 12</p> <p>She agrees with plan to try meds."</p> <p>A Quarterly "Nurse Assessment", dated 10/19/11, documented the resident was displaying, "agitation" and was "resistant to care." It further documented there was a behavior "Tracking Tool" in place, however the only behavior tracking tool found in the resident's record was dated 10/31/11 and was blank.</p> <p>"Psychotropic Medication Physician Review" forms, signed by the resident's physician on 9/26/11, contain the following care provider notes:</p> <ul style="list-style-type: none"> * "some irritability" * "resistive to cares" * "mood has occ. episodes of agitation" * "med (lorazepam) effective when used" <p>There was no behavior management plan in place, behavior tracking documentation or nursing assessment of the resident's aggressive behaviors to provide the physician accurate behavioral updates.</p> <p>A "Physician Phone Order" form, dated 10/19/11, documented to the physician, "Res is having ^ [increased] agitation very combative c [with] staff + pm cares, used Alivan in past not effective, spoke with dtr, ok with MD reccomedation [sic] - please advise."</p> <p>A "Physician Phone Order" form, dated 10/31/11, documented to the physician, "Res has been on meds for 1 wk + is cont to be combative + resistive to care. Very mild improvement seen. No significant s/sx of sedation seen. Alert during day hours."</p> <p>August, September and October 2011 MARs</p>	{R 008}		

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{R 008}	<p>Continued From page 13</p> <p>documented the resident received the following behavior modifying medications:</p> <ul style="list-style-type: none"> * Klonopin 0.5 milligrams every 12 hours. Increased to 0.5 milligrams in the morning and 1.0 milligram at bedtime on 10/19/11 and to 1.0 milligram twice daily on 10/31/11. * Divalproex Sodium 500 milligrams at bedtime * Seroquel 75 milligrams twice daily * Lorazepam 0.5 mg every 8 hours as needed for agitation. Discontinued on 9/21/11. <p>A behavioral management plan, dated 10/31/11, documented the resident displayed, "agitation" and was "combative, resistant to care." The attached behavior tracking tool was blank. There was no facility documentation identifying and evaluating the residents behavioral symptoms, date and time a specific behavior occurred, what interventions were used or the effectiveness of the interventions.</p> <p>Between 11/1/11 and 11/2/11, five caregivers stated the resident was violent, hit, kicked and scratched them, especially when they tried to provide incontinent care or showers. "It takes three of us to toilet or shower him when he is slugging us." They further stated the resident did not have a behavior plan in place.</p> <p>On 11/1/11 at 12:00 PM, the facility administrator/nurse stated, "I just completed a BMP for [Resident #6's name] yesterday." She did not elaborate on why a BMP was not initiated earlier.</p> <p>Resident #6 displayed significant aggressive verbal and physical behaviors. Although the resident displayed these behaviors for several months, a behavior management plan was not</p>	(R 008)		

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{R 008}	<p>Continued From page 14</p> <p>initiated until 10/31/11. The resident's NSA did not clearly identify the resident's behaviors or caregiver interventions. There was no nurse assessment of the resident's behaviors or instructions to assist the caregivers to safely attend to the residents needs. Further, the resident had been receiving behavioral modifying medications without a behavioral management plan for at least 3 months.</p> <p>III. RESIDENT RIGHTS</p> <p>A. Clean and Sanitary Environment</p> <p>According to IDAPA 16.03.22.001.02, the purpose of a residential care or assisted living facility in Idaho is to provide choice, dignity and independence to residents while maintaining a safe, humane, and home-like living arrangement for individuals needing assistance with daily activities and personal care. These rules set standards for providing services that maintain a safe and healthy environment.</p> <p>IDAPA 16.03.22.550.03.a.iii documents each resident has "The right to a safe and sanitary living environment."</p> <p>On 10/31/11, a follow up survey and complaint investigation was conducted at the facility. Upon entering the facility, on the north side of the building, an overpowering smell of urine was detected. While touring the facility, the urine odor was strong in the hallways and in several residents' rooms throughout the facility. Additionally, residents' dirty laundry was observed piled in their rooms and bathrooms.</p> <p>On 11/1/11, upon entering the facility, there was a strong urine odor detected throughout the facility.</p>	{R 008}	<ol style="list-style-type: none"> 1. Resident's # 3, 6,9,10 &11 rooms and NSA's have been addressed and corrective actions have been taken. 2. All residents could be affected. Staff completed in room audits. 3. The facility will have carpets shampooed every Friday The maintenance/ housekeeping will change the automatic airfreshners every 30 days (see attachment #12) the laundry schedule has been updated to include all residents to have laundry done twice weekly. (see attachment #13) The shower schedule has been updated to show all residents will get showered twice a week (see attachment #14) Two electric razors have been purchased for staff to use on residents (see attachment #15) At staff meeting discussed the need to use razors and perform oral care prior to bringing residents to common areas (see attachment #4) A family meeting is scheduled on 11/30/11 to discuss concerns as well as have them make a decision about clothing protectors or cloth napkins, then the facility will purchase the napkins or clothing protectors. 	

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{R 008}	<p>Continued From page 15</p> <p>On 11/2/11, the south side dining room smelled strongly of urine. Numerous residents' rooms had strong urine odors. Several residents' rooms were observed to have baskets and hampers full of dirty clothes.</p> <p>On 11/3/11, upon entering the facility, there was a strong urine odor in the south side living and dining room.</p> <p>On 10/31/11 at 2:50 PM, a caregiver stated the facility smelled good on some days but often there was a "harsh" urine smell.</p> <p>On 11/1/11 at 3:00 PM, a resident's family member stated, "Two weeks ago the towel covering the cushion on her wheelchair was wet." Further, she stated the incontinent pads were often found stained and smelled of urine.</p> <p>The facility failed to protect resident rights to a safe and sanitary living environment when the facility smelled strongly of urine and residents' soiled clothing was allowed to pile up in the residents' living space.</p> <p>B. Dignity and Respect</p> <p>During a previous survey exit conference on 9/1/2011, surveyors provided the following technical assistance to the facility. "Several residents required assistance with grooming. Monitor males being unshaven."</p> <p>IDAPA 16.03.22.550.03.d documents "Each resident has the right to be treated with dignity and respect..."</p> <p>i. Unkempt Residents</p>	{R 008}	<p>CONT....A staff meeting was held to discuss the staff needing to change soiled clothing as soon as it is soiled. (See attachment #4) See Attachment #16 is a schedule to show we have 5 ½ staff on day shift, 5 on swing shift and 2 on Noc shift for 31 residents. Staff will be provided a NSA snap shot to assist with understanding each residents needs (see attachment #10) Staff meeting held to show all residents should be served at the same time as those they sit with this was discussed at the staff meeting (see attachment #4) also discussed that the Med Techs need to check that all residents have been served.</p> <p>4. All the staff, managers and housekeeping have been instructed to monitor for urine odor. A Manager will be scheduled to monitor all meals (see attachment #17) Rounds will be done by the nurse/admin or other staff daily to monitor for odor, laundry, shaving, grooming, toileting/changing.</p> <p>5. Completion date: December 18, 2011</p>	

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{R 008}	Continued From page 16 On 10/31/11, during the tour of the facility, numerous residents were observed with uncombed hair, facial hair (women included) and wearing soiled clothing. This included Resident's #6, 9, 10 and multiple random residents. On 10/31/11 at 10:15 AM, Resident #10 was observed sleeping in a sitting position on the couch with her blouse up and her belly showing. Her pants were twisted. At 11:35 AM, the resident was still asleep with her belly exposed and pants twisted. At 11:45 AM, a caregiver approached the sleeping resident to get her up for lunch and adjusted her blouse, but not her pants. From 10:15 AM to 11:45 AM, the resident slept upright with her belly exposed to visitors coming into the north-side living room. Caregivers were observed walking by the area where the resident was sleeping. The caregivers did not attempt to pull the resident's blouse down until she was assisted off the couch at lunchtime. On 11/1/11, Resident #10 was observed in the same blouse from the day before. On 11/1/11 at 8:52 AM, Random Resident B was observed with uncombed, stringy hair, her clothing was soiled with food. On 11/1/11 at 1:33 PM, Random Resident C was observed asleep in a wheelchair wearing soiled clothing. On 11/1/11 at 3:12 PM, Resident #6 and a random male resident were sitting at a table with unshaven faces. On 11/2/11 from 2:30 PM to 4:00 PM, multiple	{R 008}		

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{R 008}	Continued From page 17 random residents were again observed with uncombed hair and soiled clothing. A "Daily Log" note, dated 9/24/11, documented the following: * "No bathes [sic] short staffed no time." * "No sheets washed short staffed no time." * "People are being left with BM crusted on them. It's very hard to get it off when its [sic] left like that." On 10/31/11 at 11:52 AM, a caregiver stated residents were often brought to breakfast with their hair uncombed and without their dentures or glasses. On 10/31/11 at 1:00 PM, a family member stated she often found her mother not groomed and sitting in wet depends. On 10/31/11 at 2:30 PM, two caregivers stated on a "typical day, residents get good care." On 11/1/11 at 9:02 AM, when asked how things were going with cares, a caregiver responded, "We just need some help." On 11/1/11 at 9:05 AM, another caregiver stated, "It is impossible at times to get everything done." On 11/1/11 at 1:40 PM, a home health nurse was asked about the care her resident was receiving from facility staff. The home health nurse responded, "I just finished writing that they need to provide more frequent peri-care." On 11/1/11 at 3:07 PM, a caregiver stated she remembered a couple of times residents did not get groomed. The caregiver was unsure of which residents needed assistance with grooming.	{R 008}		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R972	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 11/03/2011
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NAME OF PROVIDER OR SUPPLIER OVERLAND COURT GENERATIONS MEMORY	STREET ADDRESS, CITY, STATE, ZIP CODE 10172 WEST SMOKE RANCH DRIVE BOISE, ID 83709
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{R 008}	<p>Continued From page 18</p> <p>The facility failed to protect residents' right to be treated with dignity and respect when a resident sat with her belly exposed for approximately ninety minutes and several residents were observed unkempt.</p> <p>ii. Dining</p> <p>The facility campus manager stated, the facility policy was to serve mechanically altered diets after all regular diets had been served. A married couple resided at the facility. The wife (Random Resident D) received a regular diet and the husband (Resident #11) required a mechanical soft diet.</p> <p>On 10/31/11, between 12:05 PM and 12:18 PM, all of the residents seated on the south side of the facility had received their lunch plates. The wife received her plate at approximately 12:10 PM and sat without eating, waiting for her husband to be served. At 12:26 PM, a surveyor approached the administrator and asked if the kitchen had served all of the residents. The administrator went to the kitchen and brought back a plate for the husband and both residents began to eat. Staff did not offer to reheat the wife's plate.</p> <p>On 11/1/11, the wife received her breakfast plate at 8:17 AM and sat without eating, waiting for her husband to receive his plate. At 8:23 AM, the husband was observed eating off of his wife's plate. At 8:25 AM, a caregiver brought the husband's plate to the table, and both residents began to eat. Staff were observed not to notice the wife would not eat until her husband was served.</p> <p>The facility did not provide adequate supervision</p>	{R 008}		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R972	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 11/03/2011
NAME OF PROVIDER OR SUPPLIER OVERLAND COURT GENERATIONS MEMORY		STREET ADDRESS, CITY, STATE, ZIP CODE 10172 WEST SMOKE RANCH DRIVE BOISE, ID 83709		
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{R 008}	Continued From page 19 to ensure Residents #1 and #3 received appropriate care. Additionally, the facility failed to develop a behavior management plan for Resident #6 who had aggressive behaviors. Futher, the facility did not protect Residents #3, #6, #9, #10, #11 and multiple random residents rights to live in a safe and sanitary environment and to be treated with dignity and respect. These failures resulted in inadequate care. ****THIS IS A REPEAT CORE DEFICIENCY****	(R 008)		

[Signature] Administrator 11/28/11



Facility Name Overland Court Generations Memory Care	Physical Address 10172 West Smoke Ranch Dr	Phone Number 208-322-0955
Administrator Amy Robinson	City BOISE	ZIP Code 83709
Survey Team Leader Maureen McCann, RN	Survey Type Follow-up Survey and Complaint Investigation	Survey Date Nov. 3, 2011

NON-CORE ISSUES PAGE 1 OF 2

ITEM #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	L&C USE
1	009	One staff member did not have a criminal history background check completed. ****REPEAT PUNCH****	12/6/11 <i>mmc</i>	
2	009.06.c	One staff member did not have a state police background check completed. ****REPEAT PUNCH****	12/6/11 <i>mmc</i>	
3	220.02	The facility did not complete an admission agreement when Residents #1, 6 & 12 were admitted to the facility.	12/6/11 <i>mmc</i>	
4	260.06	The facility was not maintained in a clean, safe and orderly manner. The following was observed: A) A urine odor was noted throughout the facility. B) Laundry was piled in multiple resident rooms. C) A resident's door was propped open with an oxygen bottle, another with a wheelchair foot rest. D) A resident's nebulizer was lying on the floor. E) Window blinds were broken in a resident room in the SE hallway. ****REPEAT PUNCH****	12/9/11 <i>mmc</i>	
5	260.04.b	The laundry room door was propped open where toxic chemicals were stored.		
6	300.01	A) Resident #7 did not have a 90 day nursing assessment completed. ***REPEAT PUNCH X3*** B) A caregiver was assisting residents with medications before being delegated by the facility nurse. ****REPEAT PUNCH****	12/9/11 <i>mmc</i>	
7	320.01	A) The facility did not complete a Negotiated Service Agreement for Residents #1, 6 & 12 when they were admitted to the facility. B) Negotiated Service Agreements did not clearly reflect the resident's current needs for 10 of 10 sampled residents. ****REPEAT PUNCH****	12/9/11 <i>mmc</i>	

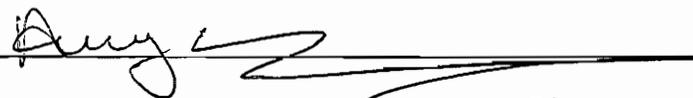
Response Required Date Dec. 3, 2011	Signature of Facility Representative 	Date Signed 11/3/11
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Facility Name Overland Court Generations Memory Care	Physical Address 10172 West Smoke Ranch Dr	Phone Number 208-322-0955
Administrator Amy Robinson	City BOISE	ZIP Code 83709
Survey Team Leader Maureen McCann, RN	Survey Type Follow-up Survey and Complaint Investigation	Survey Date Nov. 3, 2011

NON-CORE ISSUES

ITEM #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	L&C USE
8	350.02	A) The administrator did not respond in writing to complainants within 30 days. B) The administrator did not investigate bruises of unknown origin for Resident #8 and Random Resident A.	12/9/11 <i>mmc</i>	
9	430.05.i	There was no evidence of coordination between the facility and outside services regarding Resident #1's wound and Resident #8's bruising.	12/9/11 <i>mmc</i>	
10	625	The facility does not have an orientation program which meets the requirements outlined in the rule. ****REPEAT PUNCH****	12/9/11 <i>mmc</i>	

Response Required Date Dec. 3, 2011	Signature of Facility Representative 	Date Signed 11/3/11
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IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

LESLIE M. CLEMENT—DEPUTY DIRECTOR
LICENSING AND CERTIFICATION
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

November 21, 2011

Amy Robinson, Administrator
Overland Court Generations Memory Care
10172 West Smoke Ranch Drive
Boise, ID 83709

Dear Ms. Robinson:

An unannounced, on-site complaint investigation survey was conducted at Overland Court Generations Memory Care from October 31, 2011, to November 3, 2011. During that time, observations, interviews, and record reviews were conducted with the following results:

Complaint # ID00005234

Allegation #1: Ants were present in an identified resident's room.

Findings #1: On a prior survey conducted 9/1/11, the facility was issued a non-core deficiency at IDAPA 16.03.22.260.04 for ants being found in the identified resident's room. The facility was required to submit evidence of resolution within 30 days.

A follow-up survey was conducted on 10/31/11 through 11/3/11. During a tour of the facility, the identified resident's room was observed to be free of ants.

On 11/2/11, a family member of the identified resident stated, after telling staff three times about the ant problem, the resident no longer had problems with ants in her room.

Substantiated. However, not cited as the facility eradicated the ants from the identified resident's room.

Allegation #2: Water was not offered to residents on a regular basis.

Findings #2: Between 10/31/11 and 11/3/11, staff were observed offering residents fluids (juice, coffee or water) at meals and during activities. A container of water was observed on

Amy Robinson, Administrator
November 21, 2011
Page 2 of #2

a counter in each dining room. No containers of water or other liquids were observed in residents' rooms

Unsubstantiated as there is no rule that stipulates water has to be offered. However, the facility was provided technical assistance that it was a good practice to ensure residents, who are not capable of asking or who do not attend activities, are offered fluids throughout the day.

Allegation #3: The facility smelled of urine.

Findings #3: Substantiated. The facility was issued a core deficiency at IDAPA 16.03.22.550.03.a.iii, for not providing a clean and sanitary environment. The facility was required to submit plan of correction within 10 days.

Allegation #4: There were residents with behaviors and the facility did not have enough staff to supervise them.

Findings #4: Substantiated. The facility was issued a core deficiency at IDAPA 16.03.22.520 for not providing adequate supervision. The facility was required to submit a plan of correction within 10 days.

Allegation #5: An identified resident did not receive assistance with cares to prevent skin breakdown.

Findings #5: Substantiated. The facility was issued a core deficiency at IDAPA 16.03.22.520 for not providing adequate supervision to prevent skin breakdown. The facility was required to submit a plan of correction within 10 days.

If you have questions or concerns regarding our visit, please call us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,



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



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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November 21, 2011

Amy Robinson, Administrator
Overland Court Generations Memory Care
10172 West Smoke Ranch Drive
Boise, ID 83709

Dear Ms. Robinson:

An unannounced, on-site complaint investigation survey was conducted at Overland Court Generations Memory Care from October 31, 2011, to November 3, 2011. During that time, observations, interviews, and record reviews were conducted with the following results:

Complaint # ID00005293

Allegation #1: An identified resident was not assisted with toileting and was found with dried feces on her skin.

Findings #1: Substantiated. The facility was issued a core deficiency at IDAPA 16.03.22.520 for not providing supervision to ensure the resident received assistance as needed. The facility was required to submit a plan of correction within 10 days.

Allegation #2: An identified resident was not assisted with activities of daily living (ADL's) including repositioning.

Findings #2: Substantiated. The facility was issued a core deficiency at IDAPA 16.03.22.520 for not providing supervision to ensure the resident received assistance with activities of daily living (ADL's) including repositioning. The facility was required to submit a plan of correction within 10 days.

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.

Amy Robinson, Administrator

November 21, 2011

Page 2 of #2

Sincerely,

A handwritten signature in black ink that reads "Maureen McCann, RN". The signature is written in a cursive style with a large initial 'M' and a trailing flourish.

Maureen McCann, RN

Health Facility Surveyor

Residential Assisted Living Facility Program



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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November 21, 2011

Amy Robinson, Administrator
Overland Court Generations Memory Care
10172 West Smoke Ranch Drive
Boise, ID 83709

Dear Ms. Robinson:

An unannounced, on-site complaint investigation survey was conducted at Overland Court Generations Memory Care from October 31, 2011, to November 3, 2011. During that time, observations, interviews, and record reviews were conducted with the following results:

Complaint # ID00005296

Allegations #1: The facility nurse did not assess residents when they experienced a change in condition.

Findings #1: Substantiated. The facility was issued a core deficiency at IDAPA 16.03.22.520, for not providing supervision to address residents' change in condition. The facility was required to submit a plan of correction with in 10 days.

Allegation #2: The facility did not have behavioral management plans for residents exhibiting significant behaviors.

Findings #2: Substantiated. The facility was issued a core deficiency at IDAPA 16.03.22.520, for not developing a behavior management plan to address residents displaying significant behaviors. The facility was required to submit a plan of correction with in 10 days.

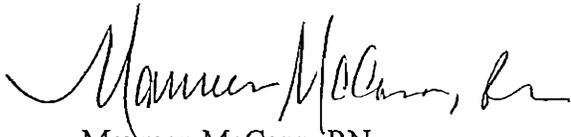
If you have questions or concerns regarding our visit, please call us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,

Amy Robinson, Administrator

November 21, 2011

Page 2 of #2

A handwritten signature in black ink, reading "Maureen McCann, RN". The signature is written in a cursive style with a large initial "M" and a long horizontal flourish at the end.

Maureen McCann, RN

Health Facility Surveyor

Residential Assisted Living Facility Program