



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

December 12, 2011

Ms. Denise Hall, Administrator  
Streamside Assisted Living  
1355 South Edgewater Circle  
Nampa, ID 83686

License #: Rc-862

Dear Ms. Hall:

On November 3, 2011, a Licensure/follow-up survey and complaint investigation was conducted at Streamside Assisted Living. 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 Polly Watt-Geier, MSW, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 334-6626.

Sincerely,

Polly Watt-Geier, MSW  
Team Leader  
Health Facility Surveyor  
Residential Assisted Living Facility Program

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



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November 15, 2011

CERTIFIED MAIL #: 7007 3020 0001 3745 7705

Ms. Denise Hall  
Streamside Assisted Living  
1355 South Edgewater Circle  
Nampa, ID 83686

Dear Ms. Hall:

Based on the stat licensure/follow-up survey and complaint investigation conducted by our staff at Streamside Assisted Living between November 1, 2011 and November 3, 2011, we have determined that the facility failed to appropriately assist and monitor medications for residents who were on insulin.

This core issue deficiency substantially limits the capacity of Streamside Assisted Living 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 **December 18, 2011**. **We urge you to begin correction immediately.**

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

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

Return the **signed** and **dated** Plan of Correction to us by **November 28, 2011**, 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](http://www.assistedliving.dhw.idaho.gov). If your request for informal dispute resolution is not received within the appropriate time-frame, your request will not be granted..

Please bear in mind that non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference. The completed punch list form and accompanying evidence of resolution (e.g., receipts, pictures, policy updates, etc.) are to be submitted to this office by **December 3, 2011**.

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 Streamside Assisted Living.

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

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13R862	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  11/03/2011
NAME OF PROVIDER OR SUPPLIER  STREAMSIDE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 1355 SOUTH EDGEWATER CIRCLE NAMPA, ID 83686		
(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/follow-up survey and complaint investigation conducted between 11/1/2011 and 11/3/2011 at your residential care/assisted living facility. The surveyors conducting the survey were:  Polly Watt-Geier, MSW Team Leader Health Facility Surveyor  Rachel Corey, RN Health Facility Surveyor  Rae Jean McPhillips, RN, BSN Health Facility Surveyor  Karen Anderson, RN Health Facility Surveyor  Survey Abbreviations:  BG = Blood Glucose MAR = Medication Assistance Record PRN = As Needed  Survey Terms:  Insulin Pen = an insulin delivery system that can be "dialed" to the correct dosage Lantus Insulin = A long acting insulin given injected daily to control blood sugars Novolog = a short acting insulin that should be injected 5 to 10 minutes before meals.	R 000	This Page left blank Intentionally  <b>RECEIVED</b> NOV 30 2011 DIV. OF MEDICAID	12/18/11
R 008	16.03.22.520 Protect Residents from Inadequate Care.  The administrator must assure that policies and	R 008		

Bureau of Facility Standards

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

STATE FORM

6899

HS0511

TITLE

(X8) DATE

If continuation sheet 1 of 15

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R 008	<p>Continued From page 1</p> <p>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, interview and record review it was determined the facility did not provide appropriate monitoring of medications, for 2 of 2 diabetic residents (#5 and #9) who received insulin. The findings include:</p> <p>1. Resident #5 was admitted to the facility on 8/3/09 with diagnoses that included diabetes.</p> <p>The resident's record did not contain an assessment by an RN, as required at IDAPA 16.03.22.305.06, to determine if Resident #5 was capable to safely self-administer her medications.</p> <p>On 11/2/11 at 10:20 AM, a medication aide stated Resident #5 did not know her standard dose of insulin and was not able to determine the amount of insulin she needed.</p> <p>On 11/2/11 at 2:20 PM, Resident #5 stated she did not know how much insulin she took. She stated, "I don't know, they just hand it to me." She also stated she did not dial her insulin pen, "they just do it and hand it to me."</p> <p>Resident #5's September and October 2011 MARs documented BG levels were to be done daily before each meal. The BG levels were scheduled to be done at 6:30 AM, 11:00 AM and 4:00 PM. Resident #5 was to receive 6 units of Novolog (a short acting insulin that should be injected 5 to 10 minutes before meals).</p> <p>The resident was also to receive additional units of Novolog insulin according to the following</p>	R 008	<p><b>16.03.22.520 Protect Residents from Inadequate Care.</b></p> <p>The administrator must assure that policies and procedures are implemented to assure that all residents are free from inadequate care.</p> <ul style="list-style-type: none"> <li>The Corrective Action that will and/or has been implement related to Resident #5 is:</li> </ul> <p>Resident #5 was assessed by the community LN on November 7, 2011 and was found to be incapable of comprehending his/her sliding scale insulin as prescribed by his/her physician due to Dementia.</p> <p>A fax was sent (See Attachment A) to his/her physician to determine if a routine amount of insulin could be obtained, which would allow him/her to continue living in the assisted living as it was felt by his/her family it would be better for the resident's overall psychosocial well being. On Friday November 11, 2011 Resident #5 returned from his/her physician appointment with an order (See Attachment B) to</p> <ol style="list-style-type: none"> <li>"stop sliding scale Novolog insulin</li> <li>Novolog 6 units at meals".</li> </ol>	12/18/11

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R 008	<p>Continued From page 2</p> <p>sliding blood glucose scale:</p> <p>under 200 = no additional insulin 200 - 250 = 2 units 251 - 300 = 4 units 301 - 350 = 6 units 351 - 400 = 10 units over 400 = 12 units and notify RN</p> <p>The MARs listed the sliding blood glucose scale insulin as a PRN medication, however there was no documentation in the PRN section of the MAR.</p> <p>The resident's BG levels were to be checked daily at 8:00 PM. She was to receive 20 units of Lantus (a long acting insulin injected once daily) at this time. There were no orders for her to receive any additional units of either insulin at 8:00 PM.</p> <p>Medication aides documented the results of the resident's BG checks and the times they assisted her with insulin in two different sections of the electronic record: vital signs or MARs. The aides were not consistent where they documented and would sometimes document in both sections.</p> <p>The September vital signs and MARs documented the resident's BG levels exceeded 200, thirty-three times and she should have received additional units of insulin, according to her sliding scale. There was no documentation in the resident's record for those 33 times as to the amount of additional insulin she was given, if any.</p> <p>Additionally, the September 2011 vital signs and MARs documented the following:</p> <p>*9/9/11: There was no documentation of the 4:00 PM or 8:00 PM BG results, however, the medication aide documented at 11:05 PM a BG</p>	R 008	<p>Cont. from page 2:</p> <p>Due to Resident #5's inability to comprehend how to dial an insulin pen the community now orders viles and/or prefilled syringes from the pharmacy to ensure that the Resident receives the 6 units of Novolg as prescribed by his/her physician. (See Attachment C).</p>	11/18/11

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R 008	Continued From page 3  level of 280. The aide did not document if the BG results of 280 was for the 4:00 PM or 8:00 PM reading. The aide documented the resident was assisted with an additional 4 units of insulin at 4:00 PM. It was unclear from the resident's record what her actual BG level at 4:00 PM was and if she was correctly assisted with the right amount of insulin.  *9/13/11: A medication aide documented the resident's BG level was 298 at 8:30 PM. The aide also documented she assisted the resident with 4 units of additional insulin. There was no documentation of the type of insulin (Novolog or Lantus) Resident #5 received. The resident was not suppose to receive any additional insulin at night unless it was ordered by a medical professional. There was no documentation the unlicensed aide contacted a medical professional prior to assisting the resident with the additional dose of insulin.  *9/20/11: There was no documentation of the resident's BG level at 11:00 AM. The medication aide documented the resident was assisted with her standard 6 units of insulin, but it was unknown if she needed or received additional units of insulin per her sliding scale.  *9/28/11: There was no documentation of the resident's BG level at 6:30 AM. The medication aide documented the resident was assisted with her standard 6 units of insulin, but it was unknown if she needed or received additional units of insulin per her sliding scale.  *9/29/11: There was no documentation of the resident's BG level at 11:00 AM. The medication aide documented the resident was assisted with her standard 6 units of insulin, but it was	R 008	This Page left blank intentionally	12/18/11

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R 008	<p>Continued From page 4</p> <p>unknown if she needed or received additional units of insulin per her sliding scale.</p> <p>Thirty-three times in September the medication aides did not document if they assisted the resident with additional Novolog insulin as per her sliding scale. One insulin error was made when an aide inappropriately assisted the resident with an unknown type of additional insulin on 9/13/11 at 8:00 PM. Additionally, there were four times where the medication aides' documentation was unclear as to whether the resident received the correct dosage of insulin.</p> <p>The October vital signs and MARs documented the resident's BG levels exceeded 200, twenty-one times and she should have received additional units of insulin according to the BG sliding scale. There was no documentation in the resident's record for those 21 times as to the amount of additional insulin she was given, if any.</p> <p>Additionally, the October 2011 vital signs and MARs documented the following:</p> <p>*10/2/11: There was no documentation of the resident's BG level at 11:00 AM. The medication aide documented the resident was assisted with her standard 6 units of insulin, but it was unknown if she needed or received additional units of insulin per her sliding scale.</p> <p>*10/3/11: There was no documentation of the resident's BG level at 6:30 AM. The medication aide documented the resident was assisted with her standard 6 units of insulin, but it was unknown if she needed or received additional units of insulin per her sliding scale.</p> <p>*10/3/11: The medication aide documented the</p>	R 008	<p>_____</p> <p><b>This Page left blank intentionally</b></p>	<p>12/18/11</p>

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R 008	<p>Continued From page 5</p> <p>resident's BG was 191 at 4:00 PM. The aide also documented she assisted the resident with her standard 6 units and an additional 4 units of insulin. According to the resident's sliding blood glucose scale she should not have received any additional insulin.</p> <p>*10/7/11: The medication aide documented in the vital signs the resident's BG level was 266, but then documented in the MARs that her BG level was 236. The aide documented she assisted with an additional 4 units of insulin which would be correct if the resident's BG level was 266. However, if the BG level was 236, the resident received 2 units of insulin too much. It was unclear from the record if the correct dose of insulin was given.</p> <p>*10/9/11: The medication aide documented, in the vital signs, the resident's BG level was 316 at 10:44 PM and 238 at 10:45 PM. There was no documentation of the resident's BG levels at 4:00 PM or 8:00 PM. The same medication aide documented in the MARs the resident's BG at 4:00 PM was 216 and at 8:00 PM was 238. The aide documented the resident was assisted with her standard doses of insulin at 4:00 PM and an additional 6 units of insulin. If the resident's BG was 216 at 4:00 PM, she was assisted with 4 units too much of insulin. It was unclear from the record if the resident received the correct dose of insulin or if an error was made and the resident received too much insulin.</p> <p>*10/17/11: There was no documentation of the resident's BG level at 11:00 AM. The medication aide documented the resident was assisted with her standard 6 units of insulin, but it was unknown if she needed or received additional units of insulin per her sliding scale.</p>	R 008	This Page left blank intentionally	12/18/11

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R 008	Continued From page 6  *10/20/11: There was no documentation of the 6:30 AM and 11:00 AM BG results. The medication aides documented the resident was assisted with her standard 6 units of insulin, but it was unknown if she needed or received additional units of insulin per her sliding scale.  *10/21/11: There was no documentation of the resident's BG level at 11:00 AM. The medication aide documented the resident was assisted with her standard 6 units of insulin, but it was unknown if she needed or received additional units of insulin per her sliding scale.  *10/26/11: The medication aide documented the resident's BG level at 4:00 PM was 289. The aide also documented she assisted the resident with her standard 6 units and an additional 2 units of insulin. According to the resident's sliding scale, she should have received an additional 4 units of insulin. According to the documentation, the resident did not receive enough insulin.  *10/28/11: There was no documentation of the resident's BG level at 6:30 AM. The medication aide documented the resident was assisted with her standard 6 units of insulin, but it was unknown if she needed or received additional units of insulin.  Twenty-one times in October, the medication aides did not document if they assisted the resident with additional Novolog insulin as per her sliding scale. Three insulin errors were made, on 10/3, 10/7 and 10/9/11, when aides inappropriately assisted the resident with too much insulin. Another error was made, on 10/26/11, when an aide did not assist the resident with additional insulin as per the sliding scale.	R 008	This Page left blank intentionally	12/18/11

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R 008	<p>Continued From page 7</p> <p>Additionally, there were six times where the medication aides' documentation was unclear, as to whether the resident received the correct dosage of insulin.</p> <p>On 11/2/11 at 10:40 AM, the facility nurse stated she was unaware of problems related to Resident #5's insulin. She confirmed that she did not review the MARs or vital signs for the accuracy of the BG readings, the types of, or the amounts of insulin given.</p> <p>On 11/2/11 at 10:20 AM, a medication aide stated she was unaware that she needed to document Resident #5's the sliding scale dose of insulin. She stated they just added the additional amount of insulin to the standard dose. She said that she checked Resident #5's BG, then checked the sliding scale and then told the resident what dose she needed to dial her insulin pen to. She stated Resident #5 did not know her standard doses of insulin and was not able to determine the amount of insulin she needed.</p> <p>On 11/2/11 at 11:05 AM, a medication aide was observed entering Resident #5's room. The medication aide was overheard assisting the resident to take her BG. The medication aide told Resident #5 what her BG was and then asked her what her dosage of insulin should be. Resident #5 told the medication aide, she did not know. The medication aide was heard to ask the resident how long she had been diabetic, then stated to the resident, "you should know." The medication aide then instructed Resident #5 to dial the insulin pen to the required dosage.</p> <p>In September and October medication aides did not document 54 times if they assisted the resident with additional insulin per her sliding</p>	R 008	This Page left blank intentionally	11/18/11

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R 008	<p>Continued From page 8</p> <p>scales. Additionally, The medication aides made 5 insulin errors and 10 times their documentation was unclear, as to whether the resident received the correct dosage of insulin.</p> <p>Resident #5 was unable to determine if she received the correct dosage of insulin when medication aides dialed her insulin pen and gave it to her to self-inject. The facility's medication aides documented the results of the resident's BG levels in two different sections of the record. Some medication aides documented the results under vital signs and others in the MARs. Additionally, at times the results of the BG levels were documented hours after the actual test was to be performed, making it difficult to determine the resident's BG level at the time it should have been checked and if any additional Novolog insulin should be given. Further, there was discrepancies in the documentation which made difficult to determine if errors were made in the amount of additional Novolog insulin given.</p> <p>2. Resident #9 was admitted to the facility on 12/28/08 with a diagnosis of insulin dependent diabetes mellitus.</p> <p>Physician orders documented the resident was to receive 8 units of Novolog insulin, three times a day before meals. Additional Novolog insulin was also to be given before meals for blood glucose over 199, based on the following sliding scale:</p> <p>BG: 200-250 = 2 units BG: 251-300 = 4 units BG: 301-350 = 6 units 351 = call MD</p> <p>Resident #9's record did not contain a nursing assessment documenting his ability to interpret</p>	R 008	<ul style="list-style-type: none"> <li>The Corrective Action that will and/or has been implemented related to Resident #9 is:</li> </ul> <p>Resident #9 has been assessed by the community RN and was found to be capable of understanding his/her sliding scale, when provided a written copy of the unit dose parameters (See Attachment D).</p> <p>Resident #9's sliding scale insulin has now been transcribed onto the MAR (Medication Administration Record) per units not just one (1) order (See Attachment F); i.e. Novolog 0 Units – if BG is below 200 = 0 units Novolog 2 units – if BG is 201-250 = 2 units Novolog 4 units – if BG is 251-300 = 4 units Novolog 6 units – if BG is 301-350 = 6 units</p> <p>Separating each order out in this manner provides the documentation to show how many units of Insulin is needed to correspond with the BG.</p>	12/18/11

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NAME OF PROVIDER OR SUPPLIER  <b>STREAMSIDE ASSISTED LIVING</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1355 SOUTH EDGEWATER CIRCLE NAMPA, ID 83686</b>		
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R 008	<p>Continued From page 9</p> <p>his sliding scale or ability to self-inject his medication based on his blood glucose levels.</p> <p>a. Assistance of Insulin:</p> <p>On 11/1/11 at 10:55 AM, an unlicensed medication aide was observed dialing Resident #9's insulin pen and handing the pen to the resident. The medication aide cued him to inject the insulin. She stated, he was capable of dialing the pen and could interpret his sliding scale if it were in front of him. However, she determined the dosage required and dialed the pen for him.</p> <p>On 11/2/11 at 10:20 AM, an unlicensed medication aide stated the resident could determine his own sliding scale insulin dose. She stated she was not aware that she needed to document what amount of insulin he received for his sliding scale. She further stated she had only documented the routine insulin dose that was scheduled three times a day.</p> <p>Unlicensed aides dialed and determined Resident #9's sliding scale insulin dose. Further, medication aides did not document consistently the resident's blood glucose level or the insulin dose that was given. This practice lead to insulin errors.</p> <p>b. Insulin Errors:</p> <p>Resident #9's September and October 2011 MARs documented sliding scale insulin was given at 7:00 AM and 4:30 PM. The MARs did not document sliding scale insulin was given before lunch.</p> <p>The September 2011 MAR and vital signs documented there were 39 instances when</p>	R 008	<p>Cont. from page 10:</p> <ul style="list-style-type: none"> <li>Corrective Action that will be accomplished for those personnel affected by the deficient practice:</li> </ul> <p>A new procedure has been implemented (See Attachment E) and each medication aide, as well as all new hires, will be in-serviced, on December 5, 2011, and required to sign the procedure which will then be placed in their employee file. The new procedure outlines that a resident must administer the insulin, although staff may provide hand over hand assistance if needed. The procedure also educates the staff regarding rapid-acting and short-acting insulin and when meals should be provided after receiving said insulin.</p> <ul style="list-style-type: none"> <li>How will you identify other residents that may be affected by the same deficient practice?</li> </ul> <p>The community LN has assessed all residents within the community who receive insulin and/or other injections to ensure that they have the ability and comprehension to self inject and/or dial insulin pens. All residents identified are able to perform said tasks with or without hand over hand assistance and/or have been changed, in the instance of insulin pens, over to prefilled insulin syringes.</p>	12/18/11

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13R862	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  11/03/2011
NAME OF PROVIDER OR SUPPLIER  STREAMSIDE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 1355 SOUTH EDGEWATER CIRCLE NAMPA, ID 83686		
(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 10</p> <p>Resident #9's blood glucose was greater than 199, and thus additional Novolog insulin was required, based on the sliding scale. Of those 39 instances, the September 2011 MAR only documented the dosage for the sliding scale Novolog insulin on 5 occasions. Furthermore, staff initiated that sliding scale insulin was given each day at 6:30 AM and 4:30 PM, even when no insulin was required.</p> <p>Additionally, the September MAR and vital signs documented the following discrepancies:</p> <p>*9/9/11: 2 units of sliding scale insulin was given at 4:30 PM; however, a BG was not documented at this time to correspond with the sliding scale insulin dosage. A BG of 240, was documented at 11:07 PM. There was no documentation additional insulin was given beyond the 4:30 PM dose.</p> <p>*9/25/11: 2 units of sliding scale insulin was given at 11:00 AM; however, a BG was not documented at this time to correspond with the sliding scale insulin dosage. On this day, two BGs were documented (185 &amp; 208), both occurring at 11:06 PM. For the BG of 208, 2 units of insulin would have been required. There was no documentation that 2 units were given after the 11:00 AM dosage.</p> <p>For the month of September, there were only three occasions when sliding scale insulin was documented appropriately; there were 34 other occasions when Resident #9 should have received sliding scale insulin, but no dosage was documented.</p> <p>The October 2011 MAR and vital signs documented there were 18 instances when</p>	R 008	<p>Cont. from page 10:</p> <ul style="list-style-type: none"> <li>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</li> </ul> <p>Each of these residents will be reassessed at a minimum of every ninety (90) days by the community LN to ensure that they can perform said tasks within compliance.</p> <p>In the event that Resident #9, who is the only sliding scale and insulin pen resident at this time, can no longer dial his/her pen the community LN will change his/her insulin pen to prefilled insulin syringes. If his/her mental capacity should change to the point he/she cannot comprehend the insulin sliding scale dosage, the community LN will request that a routine dosage be prescribed and if this is not achievable than the resident will be transferred to a higher level of care.</p> <p>Any resident who inquires about placement into the community who is on insulin either routine and/or sliding scale will be assessed prior to admission to ensure the resident meets the current guidelines related to ability to perform tasks as well as has the comprehension to understand his/her insulin units.</p>	12/18/11

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER  STREAMSIDE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 1355 SOUTH EDGEWATER CIRCLE NAMPA, ID 83686		
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R 008	<p>Continued From page 11</p> <p>Resident #9 should have received sliding scale insulin. However, there were only 11 instances when the sliding scale dosage was documented. Furthermore, staff initiated that sliding scale insulin was given for each day at 6:30 AM and 4:30 PM, even when no insulin was required.</p> <p>c. Blood Glucose Levels</p> <p>Resident #9's September and October 2011 MARs documented BG checks were to be done before each meal. They were scheduled to be taken at 5:00 AM, 10:30 AM and 3:30 PM.</p> <p>Medication aides documented the results of the resident's BG checks and the times they assisted him with insulin in two different sections of the electronic record, vital signs or MARs. The aides were not consistent where they documented and would sometimes document in both sections.</p> <p>The September 2011 MAR and "Vital Signs" sections documented the following discrepancies:</p> <p>*9/6/11: A BG at 3:30 PM was not documented, but the "Vital Signs" section documented a BG of 240 at 10:23 PM.</p> <p>*9/7/11: The 5:00 AM BG was not documented. The MAR documented a BG of 230 at 4:30 PM and the "Vital Signs" sheet documented a BG of 230 at 11:28 PM.</p> <p>*9/8/11: The 5:00 AM BG was not documented. A BG at 3:30 PM was not documented, but a BG of 240, was documented at 10:34 PM.</p> <p>*9/9/11: The 5:00 AM BG was not documented. A BG before dinner was not documented, but a BG of 236, was documented at 11:07 PM.</p>	R 008	<p>Cont. from page 11:</p> <p>An in-service will be held on December 5, 2011 with all med aides to ensure they understand how to document appropriately, that BG's must be entered immediately before moving on to the next tasks, and failure to document BG's including time obtained and the corresponding units given will result in a medication error and the employee's delegation could be pulled and/or the employee can be terminated.</p>	12/18/11

Bureau of Facility Standards

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R 008	Continued From page 12  *9/25/11: The 5:00 AM BG was not documented. "Vital Signs" section documented two BGs at 11:06 PM: a BG of 185 and 208. The MAR documented a BG of 185 at 3:30 PM.  For the month of September, 30 BGs were not documented. Of the 30 days, only 8 days had blood glucose documented three times daily at the correct scheduled times. There were 34 other occasions when Resident #9 should have received sliding scale insulin, but no dosage was documented.  The October 2011 MAR and "Vital Signs" sections documented the following discrepancies:  *10/2/11: The 5:00 AM BG was not documented. Further, the MAR documented a BG of 229 at 3:30 PM and the "Vital Signs" section documented a BG of 229 at 11:15 PM. It was unclear if the 229 BG was for the 3:30 PM or the 11:15 PM. BG check.  *10/3/11: The 5:00 AM BG was not documented. Further, the MAR documented a BG of 279 at 3:30 PM and the "Vital Signs" section documented a BG of 279 at 10:26 PM.  *10/9/11: The 5:00 AM and 10:30 AM BG were not documented. A BG at 3:30 PM was not documented, but a BG of 207, was documented at 10:46 PM. It was unclear why the BG was taken at 10:46 PM, or if 2 units of insulin was given according to the sliding scale physician's orders.  *10/15/11: The 5:00 AM and 10:30 AM BG were not documented. Further, the MAR documented a BG of 226 at 3:30 PM, but the "Vital Signs"	R 008	<ul style="list-style-type: none"> <li>How will the corrective action(s) be monitored and how often will monitoring occur to ensure that the deficient practice will not recur?</li> </ul> <p>A CQI (continuous quality improvement) form will and/or has been implemented (See Attachment G) that will show if the BG has been done at the appropriate time; number of units given; staff member responsible and the corrective action taken towards staff member if non-compliant.</p> <p>This monitor will be done every week day by the LN and/or designee and on Mondays for the weekend days. The LN and/or designee will provide monitor to the Administrator every week for review.</p> <p>The CQI monitoring form will continue until determined by the Administrator that the community is in complete compliance at which time the LN and/or designee will perform, monthly random audits to identify continued compliance and/or on going education.</p>	12/18/11

Bureau of Facility Standards

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R 008	Continued From page 13  section documented a BG of 226 at 10:28 PM. It was unclear why the BG was taken at 10:28 PM, or if insulin 2 units of insulin was given because his BG was over 200.  *10/9/11: 2 units of sliding scale insulin was given at 4:30 PM; however, a BG was not documented at this time to correspond with the sliding scale insulin dosage. A BG of 207 was documented at 10:46 PM. There was no documentation additional units of insulin was given beyond the 4:30 PM dose.  *10/21/11: 2 units of sliding scale Insulin was given at 4:30 PM. The MAR documented a BG of 235 at 3:30 PM. "Vital Signs" sheets documented a BG of 292 at 4:00 PM, which would have required 4 units of insulin.  For the month of October, 23 BGs were not documented. Of the 31 days, only 13 days had blood glucose documented three times daily at the correct scheduled times.  Medication aides had not documented 53 times for scheduled BG levels for the months of September and October 2011. Without this information, it could not be determined whether the resident required insulin or not. Additionally, the October 2011 MAR documented the following discrepancies:  Resident #9's September and October 2011 MARs documented BGs were to be taken and insulin was to be given prior to each meal. The MARs documented BGs were to be taken at 5:00 AM, 10:30 AM and 3:30 PM. However, the MARs documented the resident was to receive insulin at 6:30 AM, 11:00 AM and 4:30 PM. There was up to 90 minutes lapse between when the BG was	R 008	This Page left blank intentionally	12/18/11

Bureau of Facility Standards

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R 008	Continued From page 14  scheduled to be taken and when insulin was scheduled to be given. This did not ensure that the insulin dosage corresponded to the appropriate BG reading.  On 11/2/11 at 10:40 AM, the facility nurse stated she was unaware of problems related to Resident #9's Insulin. She confirmed that she did not review the MARs or vital signs for the accuracy of the BG readings or the amounts of insulin given.  The facility nurses did not ensure Resident #5 and Resident #9 received the correct doses of insulin when they did not monitor or track the amount of insulin residents received. Further, the facility allowed unlicensed medication aides to dial residents' insulin pens and determine the required dosage. Additionally, the facility did not have a consistent method or location for medication aides to document residents' blood glucose and insulin doses to ensure accuracy. This resulted in inadequate care.	R 008	This Page left blank intentionally	12/18/11



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

Facility Name Streamside Assisted Living	Physical Address 1355 S Edgewater Circle	Phone Number 208-442-0097
Administrator Denise Hall	City Nampa	Zip Code 83686
Team Leader Polly Watt-Geier	Survey Type Licensure, Follow-up and Complaint	Survey Date 11/03/11

**NON-CORE ISSUES**

Item #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	L&C USE
1	009.03	An employee worked unsupervised prior to having a background check clearance completed.	COS - 11/3/11	
2	009.04	Two employees did not submit their fingerprints for criminal history checks within 21 days of hire. (REPEAT)	COS - 11/3/11	
3	300.01	The facility nurses did not complete all resident nursing assessments quarterly (i.e.. Residents #6, #9 & #10)	12/3/11	12/12/11 PWS
4	305.02	The facility nurses did not verify current medication orders were consistent with medications given to residents (i.e.. Resident #3 & #10)	12/3/11	12/12/11 PWS
5	305.03	The facility nurses did not assess and document Resident #2's and #9's wounds to determine the status.	12/3/11	12/12/11 PWS
6	305.04	The facility nurses did not inform staff on the importance of providing food shortly after residents received fast acting insulin. Additionally, the facility nurses did not inform or guide staff on how to proceed when residents had weight loss or gain (i.e.. implement weight loss preventative measure or make sure weights were accurately obtained). (Resident #4, #6 & #9)	12/3/11	12/12/11 PWS
7	305.05	The facility nurses did not follow-up on the recommendations for Resident #6's foot care.	12/3/11	12/12/11 PWS
8	305.06.a	The facility nurses did not assess Resident #5 & 9's ability to self-inject insulin.	12/3/11	12/12/11 PWS
9	305.06.b	The facility nurses did not evaluate Resident #6's ability to safely self-administer medications for the next 90 days.	12/3/11	12/12/11 PWS
10	335.05	The facility did not follow proper infection control techniques when a caregiver did not wash her hands after removing her gloves that were used to apply a cream to a resident's inflamed legs. Additionally, the facility did not have liquid hand soap or paper towels available in all resident rooms for caregivers to wash their hands after providing personal cares.	12/3/11	12/12/11 PWS

*See Attached for Response*

Response Required Date

12/3/11

Signature of Facility Representative

*[Handwritten Signature]*

Date Signed

11/3/11

RECEIVED  
DEC 2 2011

FACILITY REPRESENTATIVE



IDAHO DEPARTMENT OF HEALTH & WELFARE

# Food Establishment Inspection Report

Food Protection Program, Division of Health  
450 W. State Street, Boise, Idaho 83720-0036  
208-334-5938

Establishment Name <u>Streamside Assisted Living</u>			Operator <u>Denise Hall</u>		
Address <u>1355 Edgewater Circle</u>			City <u>Nampa</u>		
County	Estab #	EHS/SUR#	Inspection time:	Travel time: <u>8:36 AM</u>	
Inspection Type:		Risk Category: <u>High</u>	Follow-Up Report: OR	On-Site Follow-Up:	
Items marked are violations of Idaho's Food Code, IDAPA 16.02.19, and require correction as noted.					

# of Risk Factor Violations	<u>0</u>	# of Retail Practice Violations	<u>0</u>
# of Repeat Violations	<u>0</u>	# of Repeat Violations	<u>0</u>
Score	<u>0</u>	Score	<u>0</u>
A score greater than 3 Med or 5 High-risk = mandatory on-site reinspection		A score greater than 6 Med or 8 High-risk = mandatory on-site reinspection	

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

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

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

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

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

Item/Location	Temp	Item/Location	Temp	Item/Location	Temp	Item/Location	Temp
<u>rice-oven</u>	<u>188</u>	<u>broccoli cook-top</u>	<u>198</u>				
<u>chicken-oven</u>	<u>168</u>	<u>chicken-cooked</u>	<u>169</u>				

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

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

OBSERVATIONS AND CORRECTIVE ACTIONS (CONTINUED ON NEXT PAGE)

Inspector (Signature) <u>Elizabeth Smith</u>	(Print) <u>Elizabeth Smith</u>	Title <u>deputy Super</u>	Date <u>11/3/11</u>	Follow-up: (Circle One) <u>Yes</u> No
Inspector (Signature) <u>[Signature]</u>	(Print) <u>[Print]</u>	Date <u>11/11/11</u>		



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 15, 2011

Ms. Denise Hall, Administrator  
Streamside Assisted Living  
1355 South Edgewater Circle  
Nampa, ID 83686

Dear Ms. Hall:

An unannounced, on-site complaint investigation survey was conducted at Streamside Assisted Living from November 1, 2011, to November 3, 2011. During that time, observations, interviews, and record reviews were conducted with the following results:

**Complaint # ID00005204**

- Allegation #1:** Two employees did not submit their fingerprints for a background check within 21 days of hire.
- Findings #1:** Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.009.04 for two employees not submitting their fingerprints for background checks within 21 days of their hire date. The facility submitted the employees fingerprints, so the deficiency was corrected on site.
- Allegation #2:** Two employees worked unsupervised prior to having a background check clearance completed.
- Findings #2:** Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.009.03 for allowing two employees to work unsupervised prior to having a background check clearance completed. The facility corrected the deficiency on-site, when they placed an employee on suspension until the background check process is completed.

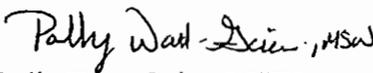
M. Denise Hall, Administrator

November 15, 2011

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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,

  
Polly Watt-Geier, MSW  
Health Facility Surveyor  
Residential Assisted Living Facility Program