IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

January 15, 2013

Tami Nichols, Administrator
Country Living
255 Blue Lakes Blvd North Pmb 710
Twin Falls, ID 83301

License #: Rc-792

Dear Ms. Nichols:

On November 9, 2012, a Complaint Investigation survey was conducted at Country Living Retirement Homes, Inc.. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level(s):

- 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 evidence of resolution.

Should you have questions, please contact Rae Jean McPhillips, RN, BSN, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 334-6626.

Sincerely,

Rae Jean McPhillips RN, BSN

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

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

IDAHO DEPARTMENT OF HEALTH & WELFARE

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

ASSISTED LIVING
Non-Core Issues Punch List

Facility Name	Physical Address	Phone Number
Country Living Retirement	1852 E 3900 North	208-326-6560
Administrator	**City**	**ZIP Code**
Tami Nichols	Buhl	83316
Survey Team Leader	**Survey Type**	**Survey Date**
Rae Jean McPhillips	Complaint	11/9/12

NON-CORE ISSUES

ITEM #	RULE #	DESCRIPTION	DATE RESOLVED
1	~~25~~ 215.04	The administrator is the legal guardian of a resident.	12/26/12 RM

Response Required Date: 12/9/12

Signature of Facility Representative: [signature] 12/9/12

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November 16, 2012

Tami Nichols
Country Living Retirement Homes
255 Blue Lakes Blvd North Pmb 710
Twin Falls, ID 83301

Dear Ms. Nichols:

An unannounced, on-site complaint investigation survey was conducted at Country Living Retirement Homes, Inc. from November 8, 2012, to November 9, 2012. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00005523

Allegation #1: The facility did not have sufficient staff to meet residents' needs.

Findings #1: Between 11/8/12 and 11/9/12, a complaint investigation survey was completed. Two staff members were observed to be on duty during the day and evening shift on these dates. Residents were observed to be clean and well groomed. The facility was clean and odor free.

On 11/8/12 between 2:00 PM and 3:00 PM, three residents stated they received the assistance they needed in a timely manner. They further stated there was always a couple of staff on duty at any given time.

On 11/8/12 at 1:30 PM, the facility administrator stated there were two staff on duty during the day, two on the evening shift and one at night. She stated if there were problems on the night shift, two staff members lived closed by and were willing to come in and assist, as needed. She additionally stated that staff were trained on how to use the hoyer lift to assist a resident up off the floor, if they fell.

Between 11/8/12 and 11/9/12, four staff members stated they had enough staff on duty to care for the residents. All four stated there were two on duty on days plus the house manger and administrator, two on evenings and one at night. Two of

the staff stated if night shift had a problem, they were only a few minutes away and would come in to

On 11/9/12 at 10:57 AM, a resident's family member stated that he was very pleased with the care being provided at the facility and had no concerns.

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

Allegation #2. Facility staff were not trained on how to respond to an identified resident's behaviors.

Findings #2: Between 11/8/12 and 11/9/12, a complaint investigation survey was completed. Staff were observed appropriately interacting with residents and redirecting residents at times.

On 11/9/12 the identified resident's record was reviewed. The record contained a behavior management plan to direct staff on how to implement interventions for the behaviors.

Between 11/8/12 and 11/9/12, four staff that provided care were interviewed about their training on behaviors. All four staff stated they had been trained on what a behavior was and how to respond to the behaviors.

On 11/9/12 at 9:30 AM, the facility nurse stated staff were trained on behaviors, however the identified resident responded more positively to some staff more than others and if the staff was off duty they would come in to help with this resident, if needed.

On 11/9/12 at 10:15 AM, the facility administrator stated staff were trained on how to respond to behaviors appropriately.

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

Allegation #3: The facility did not notify Licensing and Certification when an identified resident eloped.

Findings #3: The identified resident was interviewed on 11/8/12 at 1:45 PM. The resident stated that he just returned to live at the facility three days ago. He stated his care

needs were being met and that he had no concerns. There were no indications during the interview the resident had impaired decision making abilities.

The resident's record was reviewed on 11/9/12. The negotiated service agreement documented the resident had diagnoses that included high blood pressure, history of a stroke, chronic obstructive pulmonary disease, and depression. There was no evidence in the record the resident had an impairment, such as dementia, that affected his decision making ability.

A "Uniform Assessment Instrument," (UAI) dated 6/11/12, documented the resident had diagnoses that included depression, high blood pressure, history of two strokes, and chronic obstructive pulmonary disease. The UAI did not document the resident had dementia or was incapable of making decisions.

On 11/9/12 at 9:15 AM, the facility administrator stated the identified resident signed himself out of the facility, called a taxi and left the facility.

Unsubstantiated. There was no elopement as there was no evidence the identified resident was incapable of making the decision to sign himself out of the facility.

Allegation #4: The facility was the payee for three identified residents and they did not buy cigarettes as requested by the residents.

Findings #4: Between 11/8/12 and 11/9/12, three identified resident's records were reviewed. The records documented two of the identified residents had either a Power of Attorney or court appointed guardianship. The papers were in the record naming family members as their agent or guardian. One identified resident had the facility as payee representative.

On 11/9/12, the facility administrator furnished paperwork showing that she had purchased cigarettes with her money and the resident signed that they had received cartons of cigarettes and the price they had agreed to refund the administrator. The identified resident that the facility was payee over, owes the facility over $800.00 in purchases.

On 11/9/12 at 2:50 PM, the facility administrator stated the facility was payee for one of the identified residents and that the resident was a heavy smoker and often ran out of cigarettes and had no money left to purchase more. She stated the identified resident attempted to quit smoking by using the patch, however failed to do so. She stated when the resident ran out of money to purchase cigarettes,

she purchased cigarettes for the resident out of her own funds, as the resident would bum cigarettes from other residents. Further, the administrator stated she had purchased cigarettes for the other two residents when the families refused to buy them. One of the identified residents had quit smoking, so he no longer required cigarettes.

Between 11/8/12 and 11/9/12, four staff interviewed stated one of the identified residents had quit smoking. When he did smoke, he kept cigarettes all the time in his jacket pocket. They further stated the other two did run out, but the administrator would buy them more.

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

Allegation #5: Facility staff did not treat an identified resident with dignity and respect.

Findings #5: Between 11/8/12 and 11/9/12, staff were observed interacting with residents in a positive manner.

On 11/8/12, the identified resident's closed record was reviewed. There was documentation in the record that the resident was demanding of staff. This occurred for quite a few months when he first arrived and then it stopped.

Between 11/8/12 and 11/9/12, six residents stated they had never heard staff be disrespectful to other residents. All six residents stated staff were kind and helpful.

Between 11/8/12 and 11/9/12, four staff stated they had never heard or seen other staff treating a resident disrespectful or compromising their dignity. Staff stated there was one resident that was very demanding of staff's time and wanted staff to do everything for him, but they were not disrespectful to him.

On 11/9/12 at 9:25 AM, the facility nurse stated she had never heard staff treat residents in a disrespectful manner. She remembered the identified resident as a demanding person, but staff were always accommodating and respectful.

On 11/9/12 at 10:15 AM, the facility administrator stated the identified resident was a "tough situation" and the resident always wanted attention from staff. However, she stated she had never heard staff speak disrespectful to him. She further stated she reviewed the video tapes daily and had seen nothing out of the ordinary on the videos.

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

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

Sincerely,

Rae Jean McPhillips, RN, BSN

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

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

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November 16, 2012

Tami Nichols, Administrator
Country Living
255 Blue Lakes Blvd North Pmb 710
Twin Falls, ID 83301

Dear Ms. Nichols:

An unannounced, on-site complaint investigation survey was conducted at Country Living Retirement Homes, Inc. from November 8, 2012, to November 9, 2012. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00005794

Allegation #1: At the end of October 2012, the facility withheld an identified resident's cigarettes until he agreed to take a shower.

Findings #1: The identified resident was unable to be interviewed due to his dementia.

On 11/9/12 between 9:00 AM and 10:30 AM, four staff members were interviewed. All stated they were told around the end of October not to give the identified resident cigarettes until he agreed to take a shower. They stated they had never been asked to withhold cigarettes from a resident before or after this occasion. None of the staff interviewed knew if the cigarettes that were withheld belonged to the resident or were supplied by the facility at its expense.

On 11/9/12 at 10:50 AM, the facility owner/administrator stated the resident's sister was in control of his finances and refused to buy him cigarettes when he ran out funds. She stated that towards the middle of October 2012 the resident started to refuse to shower. She stated that she bought a pack of cigarettes from her own funds and told staff that if the resident agreed to shower he could have the pack of cigarettes. She said that residents' personal cigarettes would never be withheld from them, nor would they be used as an incentive.

The owner/administrator provided receipts of cigarettes that she bought for the

facility around the end of October.

Unsubstantiated. The identified resident's personal cigarettes were not withheld from him. The facility's owner/administrator provided cigarettes at her own expense as an incentive for the identified to shower.

Allegation #2: The administrator refused to tell an identified resident that a family member had called and did not allow the resident to talk with a family member over the phone.

Findings #2: On 11/9/12 at 10:55 AM, the owner/administrator confirmed that a family member of the identified resident did call the facility. She stated the family member called to discuss financial matters concerning the identified resident. She stated the family member did not call to talk to the resident nor did he request to talk to the resident.

On 11/9/12 at 11:05 AM, the family member of the resident was called. He stated that he did call the facility to talk to the owner/administrator regarding financial matters. He stated that he did not call to talk to the resident, it was strictly business. He stated that he or the resident's sister called the facility at least weekly and were always allowed to talk to the resident. He stated their contact with the resident was never restricted.

Unsubstantiated.

Allegation #3: The administrator had guardianship over three identified residents.

Findings #3: **Substantiated**. The records of the three identified residents were reviewed on 11/8 and 11/9/12. Two of the records contained evidence the administrator was not their legal guardian. The owner/administrator confirmed that she was the guardian of the third identified resident. The facility was issued a deficiency at IDAPA 16.03.22.215.04 for allowing the administrator to be the legal guardian of a resident. The facility was required to submit evidence of resolution within 30 days.

Allegation #4: An identified resident was assisted with medications prior to obtaining current physician's orders.

Findings #4:

On 11/9/12 between 9:00 AM and 10:30 AM, four staff members were interviewed. All four stated the identified resident was not assisted with medication prior to receiving orders from his physician.

On 11/9/12 at 8:45 AM, the facility nurse stated that she entered the physician's medication orders in the facility's computerized medication assistance record, prior to the medications being delivered to the facility. Additionally, she stated she was always very involved with residents' medications.

On 11/9/12 at 10:55 AM, the owner/administrator stated the physician's medication orders were received at the facility prior to staff assisting the resident with his medications. She provided surveyors a copy of the signed physician's orders.

Unsubstantiated.

Allegation #5:

An identified resident required a secure environment.

Findings #5:

The facility's incident and accident documentation was reviewed along with the identified resident's record on 11/9/12. There was no documentation of the resident leaving the facility.

On 11/9/12 between 9:00 AM and 10:30 AM, four staff members were interviewed. Three staff stated that as far as they knew the identified resident had never exited the facility unattended. One staff member stated the resident did leave the facility one time unattended. She stated the resident did not exit seek after that one occurrence. All stated there were alarms on the exit doors that were activated when the resident was up and ambulating within the building.

The identified resident was observed on 11/8/12 and 11/9/12. The resident was not observed to be exit seeking while she ambulated around the interior of the facility. Additionally, the alarms on the exit doors were observed to be activated when the resident was ambulating within the facility.

On 11/9/12 at 10:55 AM, the owner/administrator stated that as far as she knew the identified resident had never exited the facility unattended. She stated the first three weeks the resident was at the facility she was non-ambulatory and non-verbal. She stated the resident was now ambulatory, and would walk around the interior of the facility. She stated that all exterior doors were monitored by cameras and that she reviewed the video tapes daily. She stated, that in reviewing the video tapes she had not observed the resident leaving the facility without staff in attendance.

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

Please bear in mind that a non-core issue deficiency was identified on the punch list, a copy of which was reviewed and left with you during the exit conference, on **11/09/2012**. The completed punch list form and accompanying evidence of resolution (e.g., receipts, pictures, policy updates, etc) are to be submitted to this office within thirty (30) days from the exit date.

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

Sincerely,

Rae Jean McPhilllips, RN, BSN

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