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

February 22, 2013

Bryon Martin, Administrator
Golden Age Heritage Home
Po Box 47
Preston, ID 83263

License #: RC-467

Dear Mr. Martin:

On December 12, 2012, a Follow-Up and Complaint Investigation survey was conducted at Golden Age Heritage Home. 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 Gloria Keathley, LSW, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 334-6626.

Sincerely,

Gloria Keathley, LSW
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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December 24, 2012

CERTIFIED MAIL #: 7007 3020 0001 4050 7985

Bryon Martin, Administrator
Golden Age Heritage Home
PO Box 47
Preston, ID 83263

Dear Mr. Martin:

Based on the Complaint Investigation and Follow-Up survey conducted by Department surveyors at Golden Age Heritage Home on **December 12, 2012,** we have determined that the facility failed to protect a resident from physical and chemical restraints, which resulted in the resident's rights being violated and her suffering a broken wrist.

This core issue deficiency substantially limits the capacity of Golden Age Heritage Home 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. As a result of the survey findings, the Department is issuing the facility a provisional license, effective December 21, 2012, through May 21, 2013. The following administrative rule for Residential Care or Assisted Living Facilities in Idaho (IDAPA 16.03.22) give 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 noncore 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:

1. **A licensed, residential care administrator (RCA) consultant will be obtained and paid for by the facility, and approved by the Department. This consultant must have a current, valid, Idaho residential care administrator's license (RCA), and may not also be employed by the facility or company that operates the facility. The administrator consultant must have at least five years experience operating a residential care assisted living facility in Idaho, and must have a demonstrated, positive survey history. The administrator consultant must 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 will be submitted to the Department for approval no later than January 4, 2013.**

2. **The Department approved consultant will submit a weekly written report to the Department commencing on January 11, 2013 and every Friday thereafter. The reports will address progress on correcting the deficiencies on the Statements of Deficiencies and Non-Core Issues Punch Lists.**

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

4. **A provisional license is issued which is to be prominently displayed in the facility. Upon receipt of this provisional license, return the full license currently held by the facility.**

5. **When the consultant and the administrator agree the facility is in full compliance, they will notify the Department and a follow-up survey will be conducted.**

Please be advised that you may contest this decision by filing a written request for administrative review pursuant to IDAPA 16.05.03.300, **no later than twenty-eight (28) days after this notice was mailed.** Any such request should be addressed to:

Debby Ransom, R.N., R.H.I.T.
Bureau Chief, Licensing and Certification
Department of Health and Welfare
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009

If you fail to file a request for administrative review within the time allowed, this decision shall become final.

You have an opportunity to make corrections and thus avoid further enforcement action. Correction of this deficiency must be achieved by **January 26, 2013. 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)?
- By what date will the corrective action(s) be completed?

Return the **signed** and **dated** Plan of Correction to us within ten (10) days of receipt of this letter, and keep a copy for your records. Your license depends upon the corrections made and the evaluation of the Plan of Correction you develop.

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. The specific deficiencies for which the facility asks reconsideration must be included in the written request, as well as the reason for the request for reconsideration. The facility's request must include sufficient information for Licensing & Certification to determine the basis for the provider's appeal. If your request for informal dispute resolution is received later than ten (10) business days of your receipt of this letter, your request will not be granted. Your IDR request must me made in accordance with the Informal Dispute Resolution Process. The IDR request form and the process for submitting a complete request can be found at www.assistedliving.dhw.idaho.gov under the heading of Forms and Information.

Please bear in mind that 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 proof of resolution (e.g., receipts, pictures, policy updates, etc.) are to be submitted to this office by **January 11, 2013.**

The facility is due for a full, licensure survey, which shall be conducted in conjunction with the follow-up survey. If, at that survey, it is found that the facility is not in compliance with the rules and standards for residential care or assisted living facilities, the Department will have no alternative but to initiate further enforcement actions to include at a minimum, a ban on new admissions to the facility.

The survey staff is here to assist you. Should you or the consutlant 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

JS/tfp

Enclosure

cc: Medicaid Notification Group
Steve Millward, Licensing & Certification

364-1888

PRINTED: 12/31/2012
FORM APPROVED

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13R467	A. BUILDING _____ B. WING _____	R-C 12/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN AGE HERITAGE HOME	155 & 175 EAST 3RD NORTH PRESTON, ID 83263

(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, and complaint investigation survey conducted from 12/10/12 through 12/12/12 at your residential care/assisted living facility. The surveyors conducting the survey were: Gloria Keathley, LSW Team Leader Health Facility Surveyor Matt Hauser, QMRP Health Facility Surveyor Donna Henscheid, LSW Health Facility Surveyor Definitions: & = and ER = Emergency room IM = intramuscular lorazepam = used for the management of anxiety disorders or for short-term relief of symptoms of anxiety. The 2010 PDR Nurse's Drug Handbook "cautions its use with elderly." LPN = Licensed Practical Nurse mg = milligram NP = Nurse Practitioner NSA = Negotiated Service Agreement pt = patient (R) = right risperidone = psychotropic medication - described by the 2010 PDR Nurse's Drug Handbook as "not approved for the treatment of patients with dementia related psychosis." sundowning = A term used among professionals working with residents with Alzheimer's disease or other dementias. The term describes a pattern of increased behavior problems in late afternoon	{R 000}	Corrective action for Golden Age Heritage home regarding these rules: IDAPA 16.03.22.520) 1. Protect Residents from Inadequate Care IDAPA 16.03.22.010.16) 2. Chemical restraint IDAPA 16.03.22.550.10) 1. Freedom from abuse, neglect and restraints A. Facility hired consultant January 9, 2013. Consultant will help facility become compliant with rules and regulations for Assisted Living Facilities.	1/25/2013

Bureau of Facility Standards — TITLE — (X6) DATE

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

accepted Keathley 1/25/13

Bureau of Facility Standards

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{R 000}	Continued From page 1 and early evening where the resident becomes more confused and restless.	{R 000}		
R 008	16.03.22.520 Protect Residents from Inadequate Care. The administrator must assure that policies and procedures are implemented to assure that all residents are free from inadequate care. This Rule is not met as evidenced by: Based on record review and interview it was determined the facility did not protect 1 of 4 sampled resident's (#2) right to be free from physical and chemical restraints. Further, the facility did not protect the resident's right to refuse medication. This had the potential to effect 100% of the residents living in the facility. The findings include: IDAPA 16.03.22.010.16 - Chemical Restraint. A medication used to control behavior or to restrict freedom of movement and is not a standard treatment for the resident's condition. IDAPA 16.03.22.550.10 - Freedom from Abuse, Neglect and Restraints. Each Resident must have the right to be free from physical, mental or sexual abuse, neglect, corporal punishment, involuntary seclusion and any physical or chemical restraints. Resident #2, an 88 year old woman, was admitted to the facility, on 7/7/12, with a diagnosis of dementia. An NSA, dated 7/30/12, documented the resident's behaviors included "pacing, rummaging, anxious, disturbing, wandering into	R 008	B. Administrator and consultant updated the Policies and Procedures regarding physical and chemical restraints, behavior management and refusal of medications. Completed on January 20, 2013. C. Training for staff is being done by consultant and administrator on January 23-24th and the training to be ongoing will include: New policies and procedures on abuse neglect and restraints, How to chart behaviors and interventions, who to report to, the importance of residents' rights and the right to refuse medications. D. Furthermore, new employee training will be implemented upon hire for these exact issues and ongoing quarterly for old employees concerning behavior management.	

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R 008	Continued From page 2 other's rooms and wandering-seeking." The cause of the behaviors was documented as "confusion." A nursing assessment, dated 10/24/12 and signed by the NP, documented Resident #2 was confused and had "periods of aggitation [sic]." Further, it documented she was not sleeping well at night and had signs of sundowners.... The NP requested "extra lorazepam for periods of aggitation [sic]." The nurse instructed staff to "record when aggitation [sic] occurs to see trends." A November 2012 "Behavior Management Tracking Worksheet" documented the resident's behaviors included the following: 1."has become very combative and wont [sic] listen to what people say to her. She just gets angry & stays angry." 2. "yelling & angry with the church people & was trying to leave the building." 3. slapped another resident in the back of the head when told to leave that resident's room 4. upset with staff, combative, angry Nursing notes, dated 11/21/12 and signed by the LPN, documented the resident "slapped" another resident when asked to get out of another resident's room. The facility requested a change in the resident's medication, and the physician increased the lorazepam order from 0.5 mg to 1 mg daily. The November 2012 MAR documented the resident received a 2 mg IM injection of	R 008	E. Administrator will review all notes and behavior tracking daily. Administrator will keep the facility nurse updated to make sure no incidents go unreported and to ensure all documentation is complete. Implemented January 15, 2013. F. Facility nurse will provide training concerning behavior charting, PRN medications, chemical restraints, the use of least restrictive intervention before giving behavioral modifying medications, who to report to and how. In-service on February 1, 2013.	

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R 008	Continued From page 3 lorazepam on 11/24/12 at 9:58 PM. On 11/24/12 at 2:15 PM and 7:45 PM, the behavioral worksheet documented the resident had behaviors, but it did not clearly describe what those behaviors were. Two of the interventions used to address the behaviors included calling the nurse and giving PRN medications. Nursing notes, dated 11/24/12 at 4:45 PM and signed by the NP, documented the resident had been "very aggitated [sic] today" and had two episodes where she hit care providers. It documented, Resident #2 had not been cooperative with taking medication, had been in other residents' rooms rummaging in their things and had scratched a care provider. The nurse practitioner called the administrator to discuss increasing the psychotropic medication and later went to the facility to see the resident. The resident was asleep on another resident's bed and was "given medications without difficulty." Nursing notes, dated 11/24/12 at 9:30 PM and signed by the NP, documented the administrator called stating the resident was "very aggitated [sic]" and was "moving around... unable to calm down." The NP documented the administrator called the physician and "got order for lorazepam 2 mg IM." Nursing notes, dated 11/24/12 at 9:45 PM, documented the NP "administered 2 mg lorazepam in (R) gluteus while other care providers held pt gently as possible." This was five hours after the NP had been there and had given the resident her medications without difficulty. Nursing notes, dated 11/26/12 and signed by the	R 008	G. Administrator and the facility nurse will meet monthly to review any concerns regarding policies and procedures, discuss residents' levels of care to assure that the facility can meet resident's needs. Defining problems and solutions so that deficiencies will not reoccur. In regards to resident #2, she has deceased. For other residents the above actions will be taken to ensure the rights and no abuse will occur. Implemented January 15, 2013	

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R 008	Continued From page 4 NP, documented the administrator "made every effort" to ensure Resident #2 "would not get injured. In order to give IM medication pt needed to be in a safe position. Resident guided to bed by both [administrator's name] & care provider. Resident wrapped in blanket as easily as possible while injection given IM by myself. Noted resident fighting during time injection given." Nursing notes, dated 11/26/12 and signed by the LPN, who was not present during the injection on 11/24/12, documented the resident struck a staff member in the head with her right arm during the lorazepam injection "procedure." Further, the LPN documented bruising was noted to Resident #2's wrist on 11/26/12. The resident was sent to the ER where it was determined the resident had a broken wrist. An undated administrator's report, documented the administrator was called at 9:00 PM, on Saturday November 24, 2012, to assist the caregiver on duty because Resident #2 refused to take her evening dose of lorazepam and risperidone. The report documented the resident "was beginning to show signs of aggression." The report documented the administrator called the NP, who suggested the resident "might need injection to help calm her, and that she would be glad to assist" in giving the resident an injection. The administrator documented he contacted the ER and the physician authorized the resident be given an injection of 2 mg of lorazepam. The administrator called the NP to inform her the medication had been authorized and was available at the hospital. The administrator further documented, he "remained with resident in her room standing in front of her door to prevent her from going out in resident common area where she had been disruptive. Resident was verbally	R 008		

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R 008	Continued From page 5 frustrated that she was not able to leave her room but no physical altercation took place." The report documented the NP arrived and the administrator assisted with giving the resident the injection. The administrator further documented, when the injection took place, the "resident struck me with right arm across back of my head." On 12/11/12 at 2:07 PM, a caregiver stated, on the day the injection was given, at 4:00 PM, the resident was "unsettled and agitated" thinking the facility was her house and trying to go into the kitchen. Resident #2 was in another resident's room going through his things. That other resident was not in the room and was "not bothered" by this. The caregiver further stated, she told the resident it wasn't her room room and took her by the hand to lead her out of the room. At that time, the resident dug her nails into the caregiver's hand. The caregiver stated she called the nurse and was told to give her medications. After the resident refused to take the medications, the caregiver called the administrator to come sit with her. The caregiver further stated, when the NP arrived she attempted to pull down the resident's pants to give her the injection, but the resident resisted. On 12/11/12 at 2:25 PM, a caregiver demonstrated how she, the NP and the administrator put a blanket over Resident #2's arms, laid her back on the bed and held the sides of the blanket while the NP injected the resident with the lorazepam. She said the administrator strattled the resident's legs. While being restrained, the caregiver stated the resident was "yelling and was not very happy" and at some point got her arm free and hit the administrator in the head.	R 008		

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R 008	Continued From page 6 On 12/11/12 at 3:00 PM, the administrator stated the physician ordered the injection because they did not want her transported. When asked about her behaviors leading up to the injection, the administrator replied, "I think you have some documentation there." He was referring to the documentation he had previously given surveyors. The administrator stated the resident previously had a resident to resident "conflict" on 11/21/12, four days prior to the injection. He stated he saw the resident being aggressive, such as "rummaging through cupboards and throwing things out of the drawers." He stated he "coaxed" the resident into her room and stood by the door to prevent her from leaving because of her "history of previous" behaviors. Although Resident #2 refused the medication, the facility physically restrained her in order for the NP to inject her with a chemical restraint. While being restrained, the resident hit the administrator in the head. Two days later, the resident was sent to the hospital where it was determined she had a fractured wrist. The facility did not protect the resident's right to refuse medication or her right to be free from both physical and chemical restraints. The use of chemical restraints prevented the resident from free movement, such as wandering and rummaging and the use of physical restraints had the potential to cause injury to the resident. All of these actions resulted in inadequate care.	R 008		

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IDAHO DEPARTMENT OF HEALTH & WELFARE

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

ASSISTED LIVING
Non-Core Issues
Punch List

Facility Name	Physical Address	Phone Number
Golden Age Heritage Home	155 & 175 East 3rd ST	208-852-2273
Administrator	**City**	**Zip Code**
Bryon Martin	Preston	83263
Team Leader	**Survey Type**	**Survey Date**
Gloria Keathley	Complaint and Follow-up	12/12/12

NON-CORE ISSUES

Item #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	L&C USE
1	210	The facility did not provide an ongoing activity program.		2/11/13 gr
2	220.02	Admission agreements did not provide a complete reflection of the facility's charges, commitments agreed by each party, and the actual		2/11/13 gr
		practices that will occur in the facility.		
3	220.03.c	The facility's admission agreement did not disclose all prices, formulas and calculations used to determine the residents' basic services rate		2/11/13 gr
		including: assessment forms and charges for levels determined by the assessment.		
4	220.03.e	The admission agreement did not identify services or rates or the assessment tool, the assessor and how often the facility uses the tool		2/11/13 gr
		to determine rate changes.		
5	220.16	The admission agreement did not provide information regarding methods by which residents can contest charges or rate increases.		2/11/13 gr
6	225.01.a thru f	The facility did not document that Resident #2's behaviors were evaluated to determine if there was a change in the resident's life or	Corrected on Follow-up gr	
		routine. Or if there were environmental or medical causes triggering the behaviors.		
7	225.02.a thru c	All staff were not aware of and did not consistently implement each intervention to address Resident #1, #2,3's behaviors.	Corrected on follow-up gr	
8	305.04	The facility nurse did not document recommendations made to address Resident #3's weight loss or changes needed to the NSA.	Corrected on follow-up	
9	305.08	The facility nurse did not educate staff or document how to provide assistance with eating for Residents #1 and #3 .	Corrected on follow-up	
10	310.01.a	Medications were not secured at all times. ** COS 12/11/12		Ok gr
11	310.04.a	The facility did not document non-drug interventions prior to utilizing psychotropic medications.		

Response Required Date	Signature of Facility Representative	Date Signed
01/11/13		12-12-12

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ASSISTED LIVING Non-Core Issues Punch List

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Administrator	**City**	**Zip Code**
Bryon Martin	Preston	83263
Team Leader	**Survey Type**	**Survey Date**
Gloria Keathley	Complaint and Follow-up	12/12/12

NON-CORE ISSUES

Item #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	L&C USE
12	320.01	4 of 4 residents' NSAs did not clearly identify the resident, describe frequency of services provided and include outside		2/21/13
		services.		
13	320.03	NSAs were not signed by all parties.		2/21/13
14	320.08	NSAs were not updated when residents required different or additional services.		2/20/13
15	451.01.d	The facility did not serve the planned menu or document substitutions.		2/21/13
16	451.02	The facility did not offer snacks three times a day.		2/11/13
17	451.03.a and b	The facility did not provide the planned menu to meet the resident's specialized diet. The diet was not planned as close to the regular		2/11/13
		diet as possible.		
18	600.06.a	The administrator did not schedule sufficient staff on all shifts to provide two-person transfers to residents who require that level of		2/21/13
		assistance.		
19	711.08.c	The facility did not document when Resident #3 attempted to leave the facility through a window.		2/21/13

Response Required Date	Signature of Facility Representative	Date Signed
01/11/13		12-12-12

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ASSISTED LIVING Non-Core Issues Punch List

Facility Name	Physical Address	Phone Number
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Administrator	**City**	**Zip Code**
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Gloria Keathley	Complaint and Follow-up	12/12/12

NON-CORE ISSUES

Item #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	L&C USE
20	550.23.a	The facility did not give residents or their legal representatives a written notice within 5 days of fee changes when residents		2-21-13
		needed additional care, services and supplies.		
21	550.23.b	The facility did not allow residents or their legal representatives an opportunity to agree to an amended negotiated service agreement on		2-21-13
		proposed fee changes.		

Response Required Date	Signature of Facility Representative	Date Signed
01/11/13		

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

December 20, 2012

Bryon Martin, Administrator
Golden Age Heritage Home
Po Box 47
Preston, ID 83263

Dear Mr. Martin:

An unannounced, on-site complaint investigation survey was conducted at Golden Age Heritage Home from Invalid Datetime, to Invalid Datetime. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00005829

Allegation #1:	An identified resident was restrained both physically and chemically.
Findings #1:	Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.550.10 for physically and chemically restraining a resident. The facility was required to submit a plan of correction.
Allegation #2:	The facility did not provide a five day notice for care fee increases.
Findings #2:	Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.550.23.1 and 550.23.b for not providing residents or their legal representatives a written notice within 5 days of fee increases when additional care was needed. Additionally, the facility did not allow residents or their legal representatives an opportunity to agree to amended negotiated service agreements on fee changes. The facility was required to submit evidence of resolution within 30 days.
Allegation #3:	Food was of poor quality and quantity.
Findings #3:	Substantiated. However, the facility was not cited as they acted appropriately by having a resident council meeting to get suggestions from the residents on what they would like to have on the menu. Further, the facility was also working with a new dietician on changing the menus to meet the residents' needs and suggestions.
Allegation #4:	An identified resident had weight loss which was not documented by the facility nurse.
Findings #4:	Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.305.04 for the facility nurse not documenting recommendations made to address the identified resident's weight loss or changes needed to the NSA. The facility was required to submit evidence of resolution within 30 days.

Allegation #5:	Two identified residents did not receive assistance with eating.
Findings #5:	On 12/11/12, the two identified residents were observed at the supper meal. One of the identified residents was eating independently. The other identified resident was observed to take one bite of her food and a sip of milk. The resident then placed the cup of milk in her soup. One caregiver was observed feeding another resident and the other caregiver was dishing up food for the other residents. After approximately 20 minutes of observing the resident play in her food, the resident's daughter came and assisted her with eating. The two identified resident's negotiated service agreements documented the residents were independent with eating and only needed assistance cutting up the food. On 12/11/12 between 8:45 AM and 5:00 PM, four caregivers stated the two identified residents needed their food cut up, but were able to feed themselves. One caregiver stated, the resident usually feeds herself because she "doesn't like to be fed." Further, the caregiver stated, some days the resident eats only one big meal. All four caregivers stated both residents received a nutritional supplement if their food intake was poor. Unsubstantiated. However, the facility was issued a non-core deficiency for the facility nurse not educating staff or documenting how to provide appropriate assistance with eating to resident.
Allegation #6:	An identified resident did not receive a gluten free diet as ordered.
Findings #6:	Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.451.03.a and 16.03.22.451.03.b for not providing a planned menu to meet the resident's specialized diet and not planning the specialized diet as close to a regular diet, as possible. The facility was required to submit evidence of resolution within 30 days.
Allegation #7:	Snacks were not offered at the facility.
Findings #7:	Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.451.02 for not providing snacks three times a day. The facility was required to submit evidence of resolution within 30 days.
Allegation #8:	The facility did not provide adequate supervision when an identified resident eloped off the premises.
Findings #8:	On 12/10/12 a tour of the facility was conducted. The facility was a secured facility and needed a special code to exit the building. Observations were conducted throughout the survey process and none of the residents were observed going to the doors or windows. The identified resident was observed either walking around the facility or watching TV. An incident report dated 9/12/12, documented an identified resident had tried to crawl out a window and the screen was partially pushed out. The identified resident was redirected and the screen placed back in the normal position. On 12/12/12 at 3:00 PM, three caregivers interviewed stated they could not recall a resident eloping off the premises. However, all three caregivers recalled when an identified resident left the facility back in August or September, but only made it outside the front door. They further stated, the resident would go out in the fenced area and throw her clothes over the fence.

Additionally, the caregivers stated the same resident attempted to get out the facility by removing the screen in a bedroom, but did not get out the window. They also stated, the resident had not attempted leaving in a while.

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

Allegation #9: There was not enough staff scheduled to provide two person transfer assist.

Findings #9: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.600.06 for not scheduling sufficient staff on all shifts to provide two person transfers to residents who required that level of assistance. The facility was required to submit evidence of resolution within 30 days.

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

Please bear in mind that non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference, on December 12, 2012. The completed punch list form and accompanying evidence of resolution (e.g., receipts, pictures, policy updates, etc) are to be submitted to this office within thirty (30) days from the exit date.

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

Sincerely,

Gloria Keathley, LSW
Health Facility Surveyor
Residential Assisted Living Facility Program

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

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December 20, 2012

Bryon Martin, Administrator
Golden Age Heritage Home
Po Box 47
Preston, ID 83263

Dear Mr. Martin:

An unannounced, on-site complaint investigation survey was conducted at Golden Age Heritage Home from December 10, 2012, to December 12, 2012. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00005815

Allegation #1:	There was not enough staff scheduled to meet the residents' needs at night.
Findings #1:	Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.600.06 for not scheduling sufficient staff on all shifts to provide two person transfers to residents who required that level of assistance. The facility was required to submit evidence of resolution within 30 days.
Allegation #2:	The facility was not maintained in a clean manner.
Findings #2:	Between 12/10/12 and 12/11/12, a tour of the facility was conducted. The rooms toured were clean and odor free. Staff were observed cleaning rooms. On 12/11/12 at 9:15 AM, the facility lead caregiver stated the two staff who float building to building cleaned the residents' rooms. Between 12/10/12 and 12/13/12, sixteen residents were interviewed. All sixteen residents stated their rooms were cleaned one time a week. They further stated they had no concerns about the cleaning process. Unsubstantiated. This does not mean the incident did not take place; it only means that the allegation could not be proven.
Allegation #3:	Activities were not being offered.
Findings #3:	Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.210 for not providing an ongoing activity program. The facility was required to submit evidence of resolution within 30 days.

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

Please bear in mind that non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference, on **12/12/2012**. The completed punch list form and accompanying evidence of resolution (e.g., receipts, pictures, policy updates, etc) are to be submitted to this office within thirty (30) days from the exit date.

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

Sincerely,

Gloria Keathley, LSW
Health Facility Surveyor
Residential Assisted Living Facility Program

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Golden Age Heritage Home
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Preston, ID 83263

Dear Mr. Martin:

An unannounced, on-site complaint investigation survey was conducted at Golden Age Heritage Home from December 10, 2012, to December 12, 2012. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00005734

Allegation #1:	Residents did not receive assistance with activities of daily living such as medications, room cleaning and preparing for bed.
Findings #1:	On 12/10/12 and 12/11/12, a tour of the facility was conducted and residents were interviewed about the care they received. Sixteen residents stated they received assistance with preparing for bed, and that medications were given in a timely manner. They further stated, staff cleaned their rooms one time a week, which they felt was sufficient. Rooms were observed clean and tidy. Residents were observed clean and well groomed. On 12/11/12, three facility caregivers stated residents received their medication within the specified time frame. Further, caregivers stated they cleaned the resident's rooms one time a week or more frequently when required. Additionally, they stated residents who needed assistance to bed were assisted according to their care plan. Unsubstantiated. This does not mean the incident did not take place; it only means that the allegation could not be proven.
Allegation #2:	The facility did not follow dietician approved menu.
Findings #2:	Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.451.01.d for not following and documenting changes to the menu. The facility was required to submit evidence of resolution within 30 days.
Allegation #3:	Food was of poor quality and quantity.
Findings #3:	Substantiated. However, the facility was not cited as they acted appropriately by having a

resident council meeting to get suggestions from the residents on what they would like to have on the menu. The facility was also working with a new dietician on changing the menus to meet the residents' needs and suggestions.

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

Please bear in mind that non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference, on **12/12/2012**. The completed punch list form and accompanying evidence of resolution (e.g., receipts, pictures, policy updates, etc) are to be submitted to this office within thirty (30) days from the exit date.

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

Sincerely,

Gloria Keathley, LSW
Health Facility Surveyor
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