



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: 208-364-1962
FAX: 208-364-1888

April 22, 2014

Erika Schreiber, Administrator
Creekside Inn Assisted Living Alzheimer's Community
240 East Kathleen Avenue
Coeur d'Alene, Idaho 83814

License #: RC-954

Ms. Schreiber:

On January 9, 2014, a state licensure survey and complaint investigation were conducted at Creekside Inn Assisted Living Alzheimer's Community. 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.

Your submitted plan of correction and evidence of resolution are being accepted by this office. Please ensure the corrections you identified are implemented for all residents and situations, and implement a monitoring system to make certain the deficient practices do not recur.

Thank you for your work to correct these deficiencies. Should you have questions, please contact Karen Anderson, RN, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 364-1962.

Sincerely,

KAREN ANDERSON, RN
Team Leader
Health Facility Surveyor

KA/sc



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HEALTH & WELFARE

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RESIDENTIAL ASSISTED LIVING FACILITY PROGRAM
P.O. Box 83720
Boise, Idaho 83720-0009
EMAIL: ralf@dhw.idaho.gov
PHONE: 208-364-1962
FAX: 208-364-1888

January 27, 2014

CERTIFIED MAIL #: 7007 3020 0001 4050 8296

Erika Schreiber, Administrator
Creekside Inn Assisted Living Alzheimer's Community
240 East Kathleen Avenue
Coeur D'Alene, Idaho 83814

Provider #RC-954

Dear Ms. Schreiber:

On January 9, 2014, a state licensure/follow up survey and complaint investigation were conducted by our staff at Creekside Inn Assisted Living Alzheimer's Community. The facility was cited with a core issue deficiency for failing to protect residents' right to refuse medications, the right to be free from chemical restraints and for retaining individuals whom they did not have the capacity to safely care for.

PLAN OF CORRECTION:

1. 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?

An acceptable, **signed and dated** Plan of Correction must be submitted to the Division of Licensing and Certification within **ten (10) calendar days of your receipt of the Statement of Deficiencies**. You are encouraged to immediately develop and submit this plan so any adjustments or corrections to the plan can be completed prior to the deadline.

EVIDENCE OF RESOLUTION:

- 2. 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 following administrative rule for Residential Care or Assisted Living Facilities in Idaho (IDAPA 16.03.22) describes the requirements for submitting evidence that the non-core issue deficiencies have been resolved:

910. Non-core Issues Deficiency.

01. Evidence of Resolution. *Acceptable evidence of resolution as described in Subsection 130.09 of these rules, must be submitted by the facility to the Licensing and Survey Agency. If acceptable evidence of resolution is not submitted within sixty (60) days from when the facility was found to be out of compliance, the Department may impose enforcement actions as described in Subsection 910.02.a through 910.02.c of these rules.*

The twenty three non-core issue deficiencies must be corrected and evidence (including but not limited to receipts, pictures, completed forms, records of training) must be submitted to this office by February 8, 2014.

CIVIL MONETARY PENALTIES

- 3. Please bear in mind that twenty three non-core issue deficiencies were identified on the punch list, five of which were identified as repeat deficiencies. A deficiency for not having medications available as ordered was cited on both of the two (2) previous surveys, 1/13/2011 and 4/26/2011. Please review the non-core issue deficiencies and correct them to ensure further enforcement actions do not arise.

The following administrative rules for Residential Care or Assisted Living Facilities in Idaho give the Department the authority to impose a monetary penalty for this violation:

IDAPA 925. ENFORCEMENT REMEDY OF CIVIL MONETARY PENALTIES.

01. Civil Monetary Penalties. *Civil monetary penalties are based upon one (1) or more deficiencies of noncompliance. Nothing will prevent the Department from imposing this remedy for deficiencies which existed prior to survey or complaint investigation through which they are identified. Actual harm to a resident or residents does not need to be shown. A single act, omission or incident will not give rise to imposition of multiple penalties, even though such act, omission or incident may violate more than one (1) rule.*

02. Assessment Amount for Civil Monetary Penalty. *When civil monetary penalties are imposed, such penalties are assessed for each day the facility is or was out of compliance. The amounts below are multiplied by the total number of occupied licensed beds according to the records of the Department at the time noncompliance is established.*

b. Repeat deficiency is ten dollars (\$10). (Initial deficiency is eight dollars (\$8)).

Based on findings, you failed on three (3) consecutive surveys to have medications available as ordered, the Department is imposing the following penalties:

For the dates of 10/11/2014 through 1/9/2014

Penalty	Number of Deficiencies	Times number of Occupied Beds	Times Number of days of non-compliance	Amount of Penalty
\$10.00	1	49	90	\$44,100

Maximum penalties allowed in any ninety-day period per IDAPA 16.03.22.925.02.c:

# of Occupied Beds in Facility	Initial Deficiency	Repeat Deficiency
3-4 Beds	\$1,440	\$2,880
5-50 Beds	\$3,200	\$6,400
51-100 Beds	\$5,400	\$10,800
101-150 Beds	\$8,800	\$17,600/
151 or More Beds	\$14,600	\$29,200

Your facility had 49 occupied beds at the time of the survey. Therefore, your maximum penalty is: **\$6,400.**

Send payment of \$6,400 by check or money order, made payable to:

**Licensing and Certification - RALF
PO Box 83720
Boise, ID 83720-0009**

Payment must be received in full within 30 calendar days from the date this notice is received. Interest accrues on all unpaid penalties at the legal rate of interest for judgments. Failure of a facility to pay the entire penalty, together with any interest, is cause for revocation of the license or the amount may be withheld from Medicaid payments to the facility.

ADMINISTRATIVE REVIEW

You may contest this decision to impose a civil monetary penalty by filing a written request for administrative review pursuant to IDAPA 16.05.03.300, which states: **the request must be signed by the licensed administrator of the facility, identify the challenged decision, and state specifically the grounds for your contention that this decision is erroneous.** The request must be received **no later than twenty-eight (28) days after this notice was mailed.** Any such request should be addressed to:

**Tamara Prisock, Administrator
Division of Licensing and Certification - DHW
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036**

Upon receipt of a written request that meets the requirements specified in IDAPA 16.05.03.300, an administrative review conference will be scheduled and conducted. The purpose of the conference is to clarify and attempt to resolve the issues. A written review decision will be sent to you within thirty (30) days of the date of the conclusion of the administrative review conference.

If the facility fails to file a request for administrative review within the time period, this decision shall become final.

INFORMAL DISPUTE RESOLUTION

Pursuant to IDAPA 16.03.22.003.02, you have available the opportunity to question the core issue deficiency 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 Assisted Living Facility Program for an IDR meeting. The request for the meeting must be in writing and must be made within ten (10) business days of receipt of the Statement of Deficiencies. The facility's request must include sufficient information for Licensing and Certification to determine the basis for the provider's appeal, including reference to the specific deficiency to be reconsidered and the basis for the reconsideration request. If your request for informal dispute resolution is received more than ten (10) days after you receive the Statement of Deficiencies, your request will not be granted. Your IDR request must be 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.

FOLLOW-UP SURVEY

An on-site, follow-up survey will be conducted after 45 days from the date of exit. If at the follow-up survey, the core issue deficiency still exists, a new core issue deficiency is identified or non-core deficiencies have not been corrected, the Department will take further enforcement action against your license. Those enforcement actions will include one or more of the following:

- Revocation of the Facility License
- Summary Suspension of the Facility License
- Imposition of Temporary Management
- Ban on Admissions
- Additional Civil Monetary Penalties
- Hiring a Consultant

Division of Licensing and Certification staff is available to assist you in determining appropriate corrections and avoiding further enforcement actions. Please contact our office at (208) 364-1962 if we may be of assistance, or if you have any questions.

Sincerely,



JAMIE SIMPSON, MBA, QMRP
Program Supervisor
Residential Assisted Living Facility Program

JS/sc

cc: Medicaid Notification Group

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R954	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/09/2014
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NAME OF PROVIDER OR SUPPLIER
CREEKSIDE INN ASSISTED LIVING ALZHEIME

STREET ADDRESS, CITY, STATE, ZIP CODE
240 EAST KATHLEEN AVENUE
COEUR D'ALENE, ID 83814

(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)	(X6) COMPLETE DATE
R 000	<p>Initial Comments</p> <p>The following deflency was cited during the licensure/follow-up and complaint survey conducted between 1/6/2014 and 1/9/2014 at your residential care/assisted living facility. The surveyors conducting the survey were:</p> <p>Karen Anderson, RN Team Coordinator Health Facility Surveyor</p> <p>Rachel Corey, RN Health Facility Surveyor</p> <p>Donna Henscheld, LSW Health Facility Surveyor</p> <p>Matt Hauser, QIDP Health Facility Surveyor</p> <p>Definitions:</p> <p>ASAP = as soon as possible @ = At Creutzfeldt Jacob Disease = A degenerative neurological disorder that is incurable and invariably fatal DRS = Director of Resident Services LN = Licensed nurse MD = Medical Doctor mg = milligram PRN = As needed Res = Resident RSD = Resident Services Desk Stat = now</p>	R 000		
R 008	<p>16.03.22.520 Protect Residents from Inadequate Care.</p> <p>The administrator must assure that policies and</p>	R 008		

Bureau of Facility Standards

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

Eula Salas

TITLE

Exec. Director

(X6) DATE

2/20/14

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R954	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/09/2014
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NAME OF PROVIDER OR SUPPLIER CREEKSIDE INN ASSISTED LIVING ALZHEIME	STREET ADDRESS, CITY, STATE, ZIP CODE 240 EAST KATHLEEN AVENUE COEUR D'ALENE, ID 83814
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>Initial Comments</p> <p>The following deficiency was cited during the licensure/follow-up and complaint survey conducted between 1/6/2014 and 1/9/2014 at your residential care/assisted living facility. The surveyors conducting the survey were:</p> <p>Karen Anderson, RN Team Coordinator Health Facility Surveyor</p> <p>Rachel Corey, RN Health Facility Surveyor</p> <p>Donna Henscheid, LSW Health Facility Surveyor</p> <p>Matt Hauser, QIDP Health Facility Surveyor</p> <p>Definitions:</p> <p>ASAP = as soon as possible @ = At Creutzfeldt Jacob Disease = A degenerative neurological disorder that is incurable and invariably fatal DRS = Director of Resident Services LN = Licensed nurse MD = Medical Doctor mg = milligram PRN = As needed Res = Resident RSD = Resident Services Desk Stat = now</p>	R 000	<p>RECEIVED</p> <p>FEB 24 2014</p> <p>DIV OF LIC & CERT</p>	
R 008	<p>16.03.22.520 Protect Residents from Inadequate Care.</p> <p>The administrator must assure that policies and</p>	R 008		

Bureau of Facility Standards

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

TITLE

(X6) DATE

Bureau of Facility Standards

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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 record review and interview, it was determined the facility failed to protect 1 of 7 sampled residents (#1), right to refuse medications and to be free from chemical restraints. Additionally, the facility retained 2 of 2 sampled residents (#6 & #8) who were a danger to themselves or others. These failures resulted in inadequate care. The findings include:</p> <p>I. RESIDENT RIGHT TO REFUSE MEDICATION</p> <p>IDAPA 16.03.22.550.12 states "Each resident must have the right to control his receipt of health related services, including (d) the right to refuse medical services based on informed decision making..."</p> <p>Resident #1's record documented she was an 84 year-old female who was admitted to the facility on 6/3/11, with diagnoses including dementia, depression and anxiety. Additionally, there was no guardianship in place.</p> <p>On 1/7/14 at approximately 8:50 AM, Resident #1 was observed being assisted to take her medications in pudding. During the observation, the nurse fed the resident her pudding without telling the resident her medications were in it.</p> <p>Nurses' Notes documented the following related to Resident #1's medications:</p> <p>*5/10/13 at 1:13 PM, Resident #1 was resistive to cares and attempted to hit staff and was yelling at staff. She yelled "Go to hell." The resident's</p>	R 008	<p><u>Resident Right to Refuse Medication</u></p> <p><i>What corrective action(s) will be accomplished for those specific residents/personnel/areas found to be affected by the deficient practice?</i></p> <ul style="list-style-type: none"> Resident #1's physical and emotional status will be re-evaluated. Licensured nurse will seek to identify reason that resident refuses medications (history from family, chart review, statements from staff). Resident #1's medications will be evaluated by the Director of Resident Services and communicated to the primary care physician. Resident #1 has a legal representative in place. The resident's advanced age and dementia prevent her from being able to make sound decisions. Any changes in medication will be reviewed with the legal representative. A behavior plan will be developed for Resident #1 to guide staff when resident refuses to take medications. 	

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER CREEKSIDE INN ASSISTED LIVING ALZHEIME	STREET ADDRESS, CITY, STATE, ZIP CODE 240 EAST KATHLEEN AVENUE COEUR D'ALENE, ID 83814
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R 008	<p>Continued From page 2</p> <p>medications were placed in a cup of hot cocoa, because she refused to take them.</p> <p>*5/11/13 at 4:30 PM, the resident was very angry and confused. Her evening medications were put in a cup of cocoa.</p> <p>*5/16/13 at 4:30 PM, the resident refused all of her medications. After multiple attempts Ativan cream was applied because she refused her medications.</p> <p>*5/26/13 at 11:00 AM, the resident took all of her morning medications in her hot cocoa due to having "multiple refusals."</p> <p>*5/27/13 at 2:30 AM, the resident was awake all night "wandering around, sitting in various chairs, but never laid in bed." Resident #1 refused her medications three times. A nurse crushed her medications including a "PRN Vicodin and masked it in her hot chocolate." The pain medication was not effective, so the nurse administered two vials of "liquid Morphine masked in coffee."</p> <p>*5/28/13 at 11:00 PM, the resident was administered 2 vials of PRN Haldol. The resident expressed she did not want the medication, but the DRS placed the liquid in the resident's mouth. The nurse noted the resident's evening and night time medications were given in "Hot Cocoa Successfully."</p> <p>*5/29/13 at 11:40 PM, the resident refused dinner, but she was given her medications in pudding. Vials of Haldol were placed in her water and administered.</p> <p>*5/31/13 at 6:15 AM, the resident's morning</p>	R 008	<p><i>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?</i></p> <ul style="list-style-type: none"> • All residents could be potentially affected by the same practice. <ul style="list-style-type: none"> ○ A full census audit will be completed to identify other residents who refuse medications. ○ For the resident's identified as having similar problems, the Director of Resident Services will complete a medication evaluation and communicate with the primary care physician. ○ A behavior plan will be developed for residents who refuse medications. Interventions to encourage residents to take medications will be added. • All nurses could be potentially affected by the same practice. <ul style="list-style-type: none"> ○ All nurses on staff will receive training about Resident's Right to refuse medication ○ All nurses on staff will receive training about Assistance With and Administration of Medications and what to do when residents refuse. ○ All nurses on staff will receive training about the Behavior Management Plans and documentation expectations for residents who refuse medications. 	



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R 008	<p>Continued From page 3</p> <p>medications were crushed and were given in pudding. Haldol was given in a cup of hot cocoa.</p> <p>*7/18/13 at 10:00 AM, the resident had increased anxiety and had spit out her morning medications. The resident drank juice and had sips of hot cocoa with liquid Haldol.</p> <p>The July 2013 MAR, documented on 7/18/13, Haldol was mixed with orange juice and was taken after three attempts.</p> <p>On 1/7/14 at 9:30 AM, the administrator stated the facility nurses dealt with the medical side of the facility and she relied on them to know what was an acceptable practice.</p> <p>On 1/7/14 at 10:30 AM, the DRS stated Resident #1 did not have a plan in place to address her refusals of medications. She stated the nurses placed Resident #1's medications in her pudding, hot cocoa, coffee or water to ensure she would take them. She said if the resident was told the medications were in her food or beverages, she would refuse to take them. The DRS stated she was not aware this practice was a violation of residents' rights to refuse medications.</p> <p>On 1/7/14 at 4:15 PM, another facility nurse stated she had given Resident #1's medications in her pudding or beverages because the resident was on a pureed diet. She stated if the resident was told the medications were in her food or beverages, the resident would refuse to take them.</p> <p>On 1/7/14 at 4:30 PM, the administrator stated during the night shift, on 5/28/13, a caregiver and a nurse observed the former DRS forcing liquid Haldol into Resident #1's mouth. The</p>	R 008	<p><i>What measures will be put into practice or what systemic changes will you make to ensure that the deficient practice does not recur?</i></p> <ul style="list-style-type: none"> Documentation and communication systems will be reviewed and revised to ensure the Director of Resident Services and the Administrator are made aware of residents who are refusing medication. Director of Resident Services will follow up and reassess residents who refuse medications to identify the cause or reason for the refusal. Refusals of medication will be documented and communicated to the MD as well as decision makers. Plans to ensure residents receive necessary medications will be reviewed with the legal representative. <p><i>How will the corrective action(s) be monitored and how often will monitoring occur to ensure that the deficient practice will not recur?</i></p> <ul style="list-style-type: none"> Monthly audit of MARs will be completed by the Director of Resident Services (or designee). Refusals will be noted and communicated to MD and family or decision maker as appropriate. <p><i>By what date will the corrective action be accomplished?</i></p> <ul style="list-style-type: none"> The above corrections will be made and new processes will be implemented by March 31, 2014. 	



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R 008	<p>Continued From page 4</p> <p>administrator stated, this was a violation of the resident's right to refuse her medication. The administrator stated, the former DRS was terminated and an in-service was provided to staff regarding medication administration.</p> <p>On 1/8/14 at 11:15 AM, a caregiver stated, the resident had behaviors related to pain and anxiety. The nurses put her medication in pudding and hot cocoa so she would take them.</p> <p>On 1/8/14 at 2:45 PM, another caregiver stated that she had witnessed facility nurses put medications in Resident #1's hot chocolate and they would not tell the resident. The caregiver stated, "If the resident was told, she would not have drank it."</p> <p>An in-service was provided on 5/30/13, regarding proper administration of medications. However, the practice was observed on 1/7/14, when Resident #1 was fed pudding without being told her medications were in it. Even though there was no documentation after July 2013, the observations and interviews confirmed the practice was continuing.</p> <p>The facility failed to protect Resident #1's right to refuse her medications when they disguised her medications in pudding and beverages to ensure she would take them.</p> <p>II. RESIDENT RIGHT TO BE FREE OF CHEMICAL RESTRAINT</p> <p>According to IDAPA 16.03.22.550.10, each resident must have the right to be free from any physical or chemical restraints.</p> <p>According to IDAPA 16.03.22.16, a chemical</p>	R 008		



Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R954	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/09/2014
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R 008	<p>Continued From page 5</p> <p>restraint is defined as: A medication used to control behavior or to restrict freedom of movement and is not a standard treatment for the resident's condition.</p> <p>According to the Nursing 2014 Drug Handbook, Haldol is used to treat chronic psychosis. A "Black Box Warning" for elderly patients documented it was not an approved treatment of dementia related psychosis. The Handbook also documented there were multiple severe side effects including death, associated with the medication.</p> <p>Morphine is used to treat moderate to severe pain. Additionally, side effects to Morphine are anxiety, dizziness, irritability, restlessness, sedation and tremor (Nursing 2014 Drug Handbook).</p> <p>Resident #1's record documented she was an 84 year-old who was admitted to the facility on 6/3/11, with diagnoses which included dementia, depression and anxiety.</p> <p>On 1/7/14 through 1/8/14, observations were made of Resident #1 requiring total assistance for all activities of daily living. The resident had a tilt-back wheelchair. She was observed to require staff to push her wheelchair.</p> <p>There was no documentation the facility had evaluated potential medical, physical or environmental causes for Resident #1's behaviors.</p> <p>Nurses' Notes documented the following regarding Resident #1:</p> <p>*6/20/13 at 1:30 PM, Resident #1 scratched and</p>	R 008	<p><u>Resident's Right to be Free of Chemical Restraint</u></p> <p><i>What corrective action(s) will be accomplished for those specific residents/personnel/areas found to be affected by the deficient practice?</i></p> <ul style="list-style-type: none"> • Resident #1's physical and emotional status will be re-evaluated. Evaluation will include causes of behaviors. This information will be communicated to the MD and the resident's hospice provider. • Resident #1's medications will be evaluated by the Director of Resident Services. Concerns will be communicated to the MD. • Use of Tilt back chair for Resident #1 has been evaluated by a physical therapist, ordered by an MD and consent has been given by the legal representative. • Resident #1's behavior plan will include NON-drug interventions to be used prior to medication. 	



Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER CREEKSIDE INN ASSISTED LIVING ALZHEIME	STREET ADDRESS, CITY, STATE, ZIP CODE 240 EAST KATHLEEN AVENUE COEUR D'ALENE, ID 83814
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R 008	<p>Continued From page 6</p> <p>pinched a caregiver on the arm and caused a bruise and the skin to break open. A "vial of Morphine was given to try to alleviate combativeness." At 2:40 PM, the resident had extreme anxiety, agitation and was combative. She was given 1 mg Haldol and 1 vial of Morphine. The medications had "minimal effectiveness and the resident only slept for an hour."</p> <p>*6/21/13 at 1:45 PM, the resident received Morphine due to increased agitation, before she was assisted with a shower.</p> <p>*6/22/13 at 9:30 AM, Resident #1 had increased confusion, unsteady gait, and would only eat a small amount of food. Orders were received to give 2 vials of Haldol 1 mg "stat."</p> <p>*7/4/13 at 2:00 AM, Resident #1 was up out of bed, wandering around the facility and was unsteady while walking. The resident was given 2 vials of morphine and 2 vials of Haldol. The resident eventually went back to bed and was asleep at 3:30 AM.</p> <p>*7/6/13 at 12:43 AM, the resident began "crying hysterically." The resident received 2 vials of morphine because Haldol had already been administered.</p> <p>*7/7/13 at 10:10 PM, Resident #1 was very agitated and was given PRN morphine and Haldol. The note documented the medications were effective and the resident was "resting and quickly calmed down."</p> <p>*7/19/13 at 11:00 AM, Resident #1 refused her meal, threw it all over the dining room and spit out bites of food. The resident was given a PRN</p>	R 008	<p><i>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?</i></p> <ul style="list-style-type: none"> • All other residents could potentially be affected by the same practice. <ul style="list-style-type: none"> ○ All residents are assessed for physical and emotional status changes at least quarterly and with change of condition. Evaluation will include causes of behaviors. ○ All resident's medications will be evaluated by the Director of Resident Services and communicated with the MD. ○ Behavior plans will include NON-drug interventions to be used prior to medication. • All nurses could be potentially be affected by the same practice. <ul style="list-style-type: none"> ○ All nurses on staff will receive training about Resident's Right to refuse medication. ○ All nurses on staff will receive training about Assistance With and Administration of Medications and the use of Chemical Restraints. ○ All nurses on staff will receive training about the Behavior Management Plans and documentation expectations. 	



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R 008	Continued From page 7 Haldol. *7/19/13 at 1:40 PM, the resident was very agitated, yelling curse words and was unsteady on her feet. The resident was given 2 vials of Morphine. *7/20/13 at 10:00 PM, Resident #1 was sitting in her tilt-back wheelchair with her feet up. She continuously tried to climb out of her chair. The resident was yelling out "Go to hell, I will pour duck poop on your head, assholes." The resident was given PRN Morphine and Haldol without "effectiveness." *7/21/13 at 10:30 PM, the resident was yelling off and on during the night shift, "go to hell" and "kiss my ass." The resident was given PRN Haldol and Morphine. *7/24/13 at 2:00 PM, Resident #1 was given 2 vials of Haldol due to increased agitation and yelling "help." *7/25/13 at 11:00 AM, the resident had increased anxiety and was yelling "help." The resident was given 2 vials of PRN Haldol. *7/26/13 at 10:00 AM, Resident #1 received 2 vials of PRN Haldol and was cooperative with her care needs. *8/14/13 at 4:00 AM, the resident was up ambulating the hallways, exhibiting increased anxiety and agitation. Resident #1 stated, "this place is a joke..." The resident was given 5 mg of Haldol PRN for anxiety. *8/21/13 at 4:00 AM, Resident #1 was given 5 mg of Haldol PRN as she "continued to pace in the	R 008	<p><i>What measures will be put into practice or what systemic changes will you make to ensure that the deficient practice does not recur?</i></p> <ul style="list-style-type: none"> Behavior Management Plans will include tips for encouraging residents to take their medications, as applicable. <p><i>How will the corrective action(s) be monitored and how often will monitoring occur to ensure that the deficient practice will not recur?</i></p> <ul style="list-style-type: none"> Monthly MAR reviews for chemical restraint use will be completed by the Director of Resident Services. A letter will be sent to Home Health/ Hospice agencies working with residents at the facility, as well as physicians, to inform them about the Assisted Living Rules related to Chemical Restraints. <p><i>By what date will the corrective action be accomplished?</i></p> <ul style="list-style-type: none"> The above corrections will be made and new processes will be implemented by March 31, 2014. 	



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R 008	<p>Continued From page 8</p> <p>hallways and was standing and sitting in chairs."</p> <p>*8/26/13 at 6:10 PM, the resident was given 5 mg of Haldol PRN for increased agitation with minimal effectiveness. Another dose of PRN Haldol was given at 11:30 PM, with minimal effects. The resident continued to yell "help."</p> <p>*8/27/13 at 2:30 PM, the resident was given two vials of PRN Haldol at 3:45 PM with minimal effect two hours after.</p> <p>*8/29/13 at 10:00 PM, the resident was given two vials of PRN Haldol for agitation, yelling help and "screaming excuse me."</p> <p>*8/31/13 at 2:25 PM, the resident was given one vial of PRN Haldol for shouting "help" and not being able to state what she needed.</p> <p>*9/10/13 at 9:30 PM, the resident was given two vials of PRN Haldol for yelling out help from her room. After determining there was nothing wrong, the Haldol was given.</p> <p>*9/12/13 at 1:45 PM, the resident was given PRN Haldol due to "anxiety for shower."</p> <p>*9/15/13 at 9:30 PM, the resident was given PRN Haldol for anxiety and yelling.</p> <p>*9/17/13 at 9:30 PM, the resident received PRN Haldol prior to hospice providing a shower. Resident #1's son expressed concern with the use of Haldol as he felt it had the opposite effect on the resident.</p> <p>*9/19/13 at 7:00 PM, the resident was given PRN Haldol with no effect and again at 7:20 PM for restlessness.</p>	R 008		



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R 008	<p>Continued From page 9</p> <p>*9/25/13 at 10:30 AM, the resident was given PRN Haldol for restlessness and showing increased agitation.</p> <p>*9/26/13 at 11:25 AM, the resident was given PRN Morphine and PRN Haldol for extreme agitation and restlessness. The resident yelled help "non-stop." The staff was unable to redirect the resident so she was placed in a reclining wheelchair for safety.</p> <p>*9/26/13 at 11:00 PM, the resident received 2 vials of PRN Haldol for increased anxiety.</p> <p>*10/1/13 at 12:45 PM, Resident #1 had increased anxiety at breakfast, was yelling and wanted to get out of her wheelchair. The resident received PRN Haldol.</p> <p>*1/3/14 at 2:10 AM, the resident was awake and yelling. Two vials of PRN Haldol were administered without "effectiveness." Resident #1 continued to be awake and yelling at 3:35 AM.</p> <p>1/4/14 at 4:00 AM, Resident #1 was awake and yelling at 2:00 AM. Two vials of PRN Haldol was administered at 2:35 AM. The resident remained yelling until 3:45 AM.</p> <p>On 1/6/14 at 4:00 PM, a hospice nurse and a hospice caregiver stated Resident #1's health had significantly declined around November.</p> <p>On 1/7/14 at 4:15 PM, the director of nursing and another nurse stated they were not sure about how to develop a behavior management program to train caregivers regarding each residents' specific behaviors. They stated all care staff were provided a general education program related to</p>	R 008		

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R 008	<p>Continued From page 10</p> <p>residents with behaviors, but they had not provided specific training on each resident's behaviors. Both nurses stated, they had used Haldol for Resident #1's behaviors and it "seemed to calm her down."</p> <p>The facility did not evaluate potential causes for Resident #1's behaviors. As a result, non-drug interventions were not developed and were not consistently implemented. The facility administered anti-psychotic and sedating pain medications in an attempt to reduce Resident #1's yelling, hitting, refusal of cares, staying in bed or wandering the hallways.</p> <p>The facility failed to protect Resident #1's right to be free of chemical restraints.</p> <p>III. ADMISSION/RETENTION</p> <p>The facility was observed to have the capacity to house 70 residents, with rooms spread out amongst multiple hallways. The nurses' station (RSD) was observed at the front of the building. From the nurses' station three hallways were visible and three were not. The common areas consisted of two dining rooms, two living rooms, an activity room and a sunroom. At the time of the survey, 49 residents were present with varying levels of dementia.</p> <p>According to IDAPA 16.03.22.152.05.e, a resident will not be admitted or retained who is violent or a danger to himself or others.</p> <p>1. According to his records, Resident #6, a 74 year old male, was admitted to the facility on 12/2/13 with diagnoses including Creutzfeldt Jacob Disease, history of alcoholism, dementia</p>	R 008	<p>Admission and Retention</p> <p><i>What corrective action(s) will be accomplished for those specific residents/personnel/areas found to be affected by the deficient practice?</i></p> <ul style="list-style-type: none"> Resident # 6 was discharged from the community, prior to survey, on January 1, 2014. Resident #8 was re-evaluated using the Admission/Retention Criteria. Recent physical and verbal altercations have made it necessary to give discharge notice. Thirty day notice was given, move out will occur on or before March 7, 2014. 	
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R 008	<p>Continued From page 11</p> <p>and agitation/aggression. The resident was discharged to a hospital on 1/1/14.</p> <p>A "Resident Assessment," dated 12/2/13, documented the resident had a history of verbal aggression when exit seeking.</p> <p>A care plan, dated 12/3/13, documented the resident had a history of being verbally and physically aggressive and staff were to redirect as needed.</p> <p>A behavior management plan was not developed to evaluate Resident #6's behaviors. Further, the facility did not develop a behavior plan to direct staff regarding appropriate interventions.</p> <p>A fax to the physician, dated 12/13/13, documented the resident was very aggressive throughout the evening. While a caregiver was trying to redirect him, he grabbed her around the neck and pushed her into the wall. Prior to this, he chased a caregiver and a resident into a room with a handful of hangers. He also picked up a large table and shoved it at the staff while yelling at them.</p> <p>Nurses notes documented the following:</p> <p>*12/3/13 - Resident #6 had increased "agitation/anxiety" after dinner. He was checking all doors and opening fire extinguisher doors, sounding alarms then cursing at them (the alarms). "Unable to redirect for long. PRN Zyprexa given at 5:30 PM for behaviors. Resident then attempted and did crawl over the RSD."</p> <p>*12/8/13 - Resident #6 was extremely agitated, pacing around the caregivers when they were "attempting" to do rounds. The resident was</p>	R 008	<p><i>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?</i></p> <ul style="list-style-type: none"> • All residents could potentially be affected by this same practice. ○ All residents are routinely evaluated using the Admission/Retention Criteria. Any residents deemed to be a danger to themselves or others will be considered for discharge to an appropriate level of care. <p><i>What measures will be put into practice or what systemic changes will you make to ensure that the deficient practice does not recur?</i></p> <ul style="list-style-type: none"> • All residents will be assessed using the Admission/Retention Criteria prior to admission, with change of condition and with routine Level of Care assessments. All assessments will be completed by a nurse on staff and/or the Director of Resident Services. Recommendations will be made to the Administrator regarding the resident's condition and ability to remain in the facility. • All staff will receive in-service training on Behavior Management; with attention given to both redirection techniques and appropriate documentation. 	



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R 008	<p>Continued From page 12</p> <p>cussing and saying, "Call the police, you want me to burn down this shit?" The resident pushed over a cart, threatened and cussed at a caregiver.</p> <p>*12/12/13 - At 10:00 PM, the resident began to "escalate into full blown agitation." The resident wanted to get to his car and when told he had to stay at the facility, he ran down the hall and pushed on the hall door until it beeped. The resident continued to pace throughout the facility "off and on the majority of the night."</p> <p>*12/13/13 - At 11:55 PM, the resident was "very aggressive" throughout the evening. The resident grabbed a caregiver around her neck and slapped her on the side of her face.</p> <p>*12/17/13 - The resident had "some mild agitation noted" at dinner regarding refusing to take the 5:00 PM dose of Seroquel and "getting irritated" with his tablemates.</p> <p>*12/19/13 - After striking another resident on the head, the resident continued walking throughout the halls swearing and attempting to hit or kick other residents.</p> <p>*12/20/13 - Resident was "verbally agitated" and exit seeking. PRN Zyprexa was given at 9:05 AM and the resident was no longer exit seeking.</p> <p>*12/20/13 - At 10:30 PM, the resident was "getting agitated" and was climbing under the gate at the front desk throwing markers.</p> <p>*12/20/13 - The resident was wandering in and out of open bedrooms throughout the morning.</p> <p>*12/21/13 - The resident exhibited "exit seeking behaviors, opening all unlocked doors. At one</p>	R 008	<p><i>How will the corrective action(s) be monitored and how often will monitoring occur to ensure that the deficient practice will not recur?</i></p> <ul style="list-style-type: none"> Potential Admits will be reviewed by the Director or Resident Services, the Director of Community Relations and the Administrator as a team. The Admission/Retention Criteria will be reviewed prior to making an admission offer to a resident or family. Residents and family members will be informed at the time of admission about the Admission/Retention criteria and the need to relocate resident should these conditions arise. The Director of Resident Services and Administrator will review the assessments and documentation completed each month, or as condition changes, in order to confirm the residents continues to meet appropriate Admission/Retention criteria. <p><i>By what date will the corrective action be accomplished?</i></p> <ul style="list-style-type: none"> The above corrections will be made and new processes will be implemented by March 31, 2014. 	

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R 008	<p>Continued From page 13</p> <p>point standing on furniture attempting to unscrew door hinges to exit doors." Resident #6 pushed a female resident when she tried to get him out of her room. The resident pulled a picture off the wall and yelled at staff.</p> <p>*12/25/13 - The resident got up on a table and tore off the exit sign in the front dayroom. The nurse attempted to give him Xanax, but the resident refused. He continued to try to take off light fixtures, pictures and name signs from the walls. At 10:32 PM, the resident had an "extremely busy" night. The resident moved furniture and climbed on top of it. He removed ceiling tiles and while holding onto ceiling pipes, kicked his feet at staff and yelled "Get the hell away from me."</p> <p>*12/26/13 - The resident opened the fire extinguisher and discharged it outside the room of another resident.</p> <p>12/29/13 - The resident became verbally aggressive and "verbally abusive" with his roommate.</p> <p>*12/30/13 - The resident was "very agitated and anxious." He was going into other residents' rooms and removing their belongings. When staff attempted to redirect him, he began "swatting" at staff and attempted to "urinate on a caregiver."</p> <p>*1/1/14 - The resident was sent to the hospital for a psychiatric evaluation after "choking and slapping a caregiver."</p> <p>Incident and accident reports documented the following:</p> <p>*12/8/13 - The resident used another resident's</p>	R 008		

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R 008	<p>Continued From page 14</p> <p>walker to climb over the front desk stating he had to get his clothes. A nurse asked him to get down and the resident jumped off, tumbled forward and landed on his knees. He refused to let the nurse assess him for injuries. The "Plan of Action" was to encourage the resident to "stay off of the RSD."</p> <p>*12/11/13 - The resident was "very agitated" and climbed over the front desk "attempting to elope." The resident yelled at staff and then walked quickly down the hall and "forcefully" shoved another resident to the ground. The resident continued to be "angry" and was walking towards the exit. The other resident sustained an abrasion. The "Plan of Action" was to monitor for increased behaviors.</p> <p>*12/13/13 - The resident was very agitated. A caregiver was attempting to redirect him when he grabbed her by the neck and pushed her. Law enforcement was called and the resident was provided 1 to 1 care for 20 minutes. The "Plan of Action" was to monitor him for increased agitation.</p> <p>*12/19/13 - The resident was agitated and when a caregiver attempted to redirect him, he "struck" the caregiver on the head. The "Plan for Action" was to monitor him for aggressive behaviors.</p> <p>*12/21/13 - The resident entered another resident's room. When the other resident "attempted" to escort him out, Resident #6 pushed the resident. The other resident "screamed" and Resident #6 ran down the hall. The "Plan for Action" was to redirect ASAP due to the history of aggression.</p> <p>*12/28/13 - Resident #6 walked behind another resident and "shoved" the other resident in the</p>	R 008		

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R 008	<p>Continued From page 15</p> <p>back of the head and neck. Resident #6 then kicked the glass in the doors trying to break it, screaming, "I want to get out of here." The "Plan for Action" was to provide redirection and notify the physician.</p> <p>*1/1/14 - The resident had increased agitation and "attacked" a caregiver when the caregiver was conducting room checks.</p> <p>On 1/8/14 at 2:02 PM, a nurse stated Resident #6 exhibited behaviors that occurred more often in the evening and were often a result of staff trying to redirect him. She stated, she remembered one instance when the resident was going through others' rooms and when a caregiver tried to redirect him, he peed on the caregiver. She further stated, "at one point he was hanging from the ceiling grid."</p> <p>On 1/8/14 at 2:10 PM, a caregiver stated Resident #6 was "really busy" and would want to turn the lights off, take pictures off of the wall and climb over the counters. She stated, when Resident #6 became angry, it happened suddenly. The caregiver recalled Resident #6 cornering another caregiver with a hanger. When she tried to intervene, the resident threw her into the closet. She further stated, another incident occurred when the resident grabbed her by the neck and punched her in the head. The caregiver stated, other residents witnessed the incident and were afraid of Resident #6. The other residents would yell at him, "stay away." The caregiver further stated, after the second incident she was afraid to provide cares to Resident #6. She stated, not only was he a danger to others, but to himself, "based on the things he did, like ripping things off the wall and climbing over the counter."</p>	R 008		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R954	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/09/2014
NAME OF PROVIDER OR SUPPLIER CREEKSIDE INN ASSISTED LIVING ALZHEIME		STREET ADDRESS, CITY, STATE, ZIP CODE 240 EAST KATHLEEN AVENUE COEUR D'ALENE, ID 83814		
(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 16</p> <p>On 1/8/14 at 2:25 PM, a caregiver stated she had not provided many cares to Resident #6, but she had seen the resident get angry and knew he had a "temper." She further stated, she heard other caregivers state that they were unable to provide cares to the resident due to his behaviors.</p> <p>On 1/8/14 at 2:45 PM, a caregiver stated she would see Resident #6 stand on chairs and break handles off doors. She further stated, the resident walked around cussing and she was worried about what he would do if another resident approached him. She stated she worried about the other residents' safety.</p> <p>The facility did not evaluate Resident #6's behaviors to determine if they could retain him and keep other residents safe. Further, the facility failed to provide support, direction and training to staff on safe, effective, interventions. The facility retained Resident #6 for 30 days while he was physically aggressive towards other residents and staff. The facility did not have the capacity to deal with his behaviors. This placed Resident #6, other residents and staff members in danger.</p> <p>2. Resident #8's record documented he was an 87 year-old male admitted to the facility on 5/24/13 with a diagnosis of dementia.</p> <p>Between 1/7/14 and 1/8/14, observations were made of Resident #8 ambulating the hallways independently.</p> <p>A care plan, dated 5/28/13, documented Resident #8's thought processes were impaired related to dementia and he "may get verbally aggressive and refuse cares."</p> <p>A nursing assessment, dated 7/15/13,</p>	R 008		



Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R954	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/09/2014
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NAME OF PROVIDER OR SUPPLIER CREEKSIDE INN ASSISTED LIVING ALZHEIME	STREET ADDRESS, CITY, STATE, ZIP CODE 240 EAST KATHLEEN AVENUE COEUR D'ALENE, ID 83814
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R 008	<p>Continued From page 17</p> <p>documented staff were unable to reason with Resident #8 or redirect him, as he would become more agitated and angry.</p> <p>A nursing assessment, dated 11/20/13, documented Resident #8 had poor memory, was easily confused, and had a lot of verbal and physically aggressive behaviors.</p> <p>The following documentation was found in incident reports, faxes and nurse's notes contained in Resident #8's record:</p> <p>*6/30/13: Resident #8 was agitated with staff entering his room to check on him.</p> <p>*7/29/13: A female resident entered Resident #8's room. Resident #8 came after the resident and placed his hands on her neck and stated, "I am going to kill you." The resident was reminded not to put his hands on people and Resident #8 showed "remorse".</p> <p>*8/10/13: A female resident (Resident A) was in Resident #8's "personal space." Resident #8 shoved the Resident A and she kicked him. Resident #8 then pushed her and attempted to hit her. He then grabbed her by the arm and pulled her down the hall yelling, "I will kill this bitch next time." Staff were instructed to lock his door to prevent further occurrences and the resident was reminded that he was stronger than the female resident.</p> <p>*8/11/13: Resident #8 continued to be agitated with Resident A, who had entered his room the day before. Resident #8 stated repeatedly that he would kill her if she bothered him again. Resident #8 went from room to room, increasing other residents' agitation by speaking about the incident</p>	R 008		

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER CREEKSIDE INN ASSISTED LIVING ALZHEIME	STREET ADDRESS, CITY, STATE, ZIP CODE 240 EAST KATHLEEN AVENUE COEUR D'ALENE, ID 83814
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R 008	<p>Continued From page 18</p> <p>the day before.</p> <p>*8/12/13: Resident #8 exhibited increased aggression towards Resident A. The female resident walked by Resident #8, causing Resident #8 to raise his hand at her and begin cursing. A facility nurse intervened.</p> <p>*8/20/13: Resident #8 was heard yelling in the hallway. A facility nurse witnessed Resident #8 pushing another resident, causing that resident to "stumble into furniture." The "plan of action" was to keep both residents separated for 72 hours.</p> <p>*8/28/13: Resident #8 pushed another resident in a common area, because the other resident was "invading personal space."</p> <p>*10/1/13: Resident #8 was agitated due to another resident continuing to enter his room. Resident #8 was asked to lock his room, but he refused.</p> <p>*11/1/13: Another resident entered Resident #8's room. Resident #8 pushed him into the hallway and "kneed" the other resident's buttocks. The "plan of action" was to monitor for aggressive behaviors.</p> <p>*11/2/13: Resident #8 told a facility nurse "that guy came into my room last night and I beat him out of there, I won of course."</p> <p>*11/6/13: Resident #8 was agitated with other residents and scolding them for pacing the hallways.</p> <p>*11/9/13: Another resident entered Resident #8's room. Resident #8 put his hands on the other resident and pulled him out into the hallway. Staff</p>	R 008		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R954	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/09/2014
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NAME OF PROVIDER OR SUPPLIER CREEKSIDE INN ASSISTED LIVING ALZHEIME	STREET ADDRESS, CITY, STATE, ZIP CODE 240 EAST KATHLEEN AVENUE COEUR D'ALENE, ID 83814
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R 008	<p>Continued From page 19</p> <p>were to encourage the resident to keep his door locked.</p> <p>*11/10/13: "Res verbally aggressive with other res, who was involved in recent altercation. Other res was sitting in common area, minding own business when this res walked up and began raising voice." The nurse separated the residents on two occasions that morning.</p> <p>*11/11/13: Resident #8 stated another resident was an "asshole and he hates him."</p> <p>*11/16/13: Resident #8 walked towards another resident, yelled at the resident and shoved the resident down causing the resident to fall to the floor. The other resident experienced a "slight injury" to his shoulder area. The "plan of action" was to provide education to the resident and family regarding behavior issues, and keep the two residents separated. A licensed nurse documented "educated this resident about no matter how upset he gets with some residents, he may not physically touch them and to ask staff for help."</p> <p>*11/18/13: Resident #8 "continued with irritation" this evening.</p> <p>*11/19/13: Resident #8 became upset with another resident during breakfast and voiced his dislike to him. Staff were to "attempt to keep residents separated."</p> <p>*11/20/13: Resident #8 "continues to be easily agitated, talking rudely to other residents."</p> <p>*12/13/13: Resident #8 was observed with wet pants. Staff attempted to assist the resident, but the resident shoved the caregiver across the hall.</p>	R 008		

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER CREEKSIDE INN ASSISTED LIVING ALZHEIME	STREET ADDRESS, CITY, STATE, ZIP CODE 240 EAST KATHLEEN AVENUE COEUR D'ALENE, ID 83814
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R 008	<p>Continued From page 20</p> <p>At a later time, Resident #8 was "exit seeking and very agitated" when staff attempted to redirect.</p> <p>Resident #8's record did not contain documentation that a behavior management plan had been developed after he exhibited physical altercations with residents, putting other residents at risk for harm.</p> <p>On 1/8/14 at 11:05 AM, a caregiver stated Resident #8 would get "annoyed" with other residents, but she did not think he had any behaviors.</p> <p>On 1/8/14 at 2:00 PM, a facility nurse stated Resident #8 was frequently irritable with other residents, because his disease was not as progressed as many of the residents. She stated, he would frequently shout or push other residents and had the potential to "hurt someone."</p> <p>On 1/8/14 at 2:14 PM, a caregiver stated, "He gets loud sometimes. He does not like people in his space." She stated she had not witnessed any physical altercations, but had heard he had pushed other residents.</p> <p>On 1/8/14 at 2:25 PM, a caregiver stated Resident #8 would frequently raise his voice to make other residents back off.</p> <p>On 1/8/14 at 2:56 PM, a caregiver stated one minute Resident #8 would be happy and the next minute he would be very angry. She further stated, she had frequently witnessed him yelling at other residents.</p> <p>On 1/8/14 at 3:15 PM, the administrator stated Resident #8 was served meals in a smaller dining room to prevent his behaviors and sometimes it</p>	R 008		

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER: CREEKSIDE INN ASSISTED LIVING ALZHEIME
STREET ADDRESS, CITY, STATE, ZIP CODE: 240 EAST KATHLEEN AVENUE COEUR D'ALENE, ID 83814

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R 008	<p>Continued From page 21</p> <p>was necessary to keep Resident #8 separated from certain residents who agitated him. She further stated, Resident #8 would get "defensive" if other residents came in his room.</p> <p>The facility was a 70 bed facility, with 49 residents diagnosed with dementia, which increased the likelihood that residents would wander into Resident #8's bedroom frequently, causing him to escalate and possibly harm other residents. In less than 8 months, Resident #8 had 7 physical altercations with other residents. The facility's "plan of action" was to remind the resident to lock his door, or remind the resident not to physically touch other residents. This intervention was not effective as the resident continued to verbally and physically assault other residents. The facility retained Resident #8 while he was physically and verbally aggressive towards other residents. The facility did not have the capacity to deal with his behaviors. This placed other residents in danger.</p> <p>The facility failed to protect residents #1's right to refuse her medications and to be free of chemical restraints. Additionally, the facility retained Residents' #6 and #8 who were a danger to themselves or others. These failures resulted in inadequate care and had the potential to affect 100% of the residents at the facility.</p>	R 008		

Gulistan E.D.
2/20/14



Facility Creekside Inn Assisted Living Alzheimer's Community	License # RC-954	Physical Address 240 E Kathleen Ave	Phone Number (208) 665-2444
Administrator Erika Schreiber <i>Erika Schreiber</i> 1/9/14	City Coeur d' Alene	ZIP Code 83815	Survey Date January 9, 2013
Survey Team Leader Karen Anderson	Survey Type Licensure, Follow-up and Complaint Investigation	RESPONSE DUE: February 8, 2013	
Administrator Signature	Date Signed		

NON-CORE ISSUES

Item #	IDAPA Rule #	Description	Department Use Only	
			EOR Accepted	Initials
1	153.07	The facility did not have procedures to ensure the least restrictive intervention was used to address behaviors. **previously cited on 2/25/11**	2/27/14	KA
2	220.03.c.iii	The admission agreement did not include the assessment form to determine rates.	2/27/14	KA
3	220.09	The admission agreement did not describe all conditions under rule 152 for which emergency transfers would be necessary.	2/27/14	KA
4	225.01.a-g	The facility did not evaluate behaviors for all residents with behavioral symptoms.	2/27/14	KA
5	225.02.a-c	The facility did not develop written interventions for any residents with behaviors.	2/27/14	KA
6	225.03	The facility did not ensure that psychotropic medications were at the lowest dose and were necessary. Additionally, behavioral updates were not provided to residents' physicians.	2/27/14	KA
7	300.02	The facility did not ensure orders were implemented. For example: Resident #4's and a random resident's oxygen, Resident #9's foot soaks and Resident #10's heel protectors.	2/27/14	KA
8	305.02	Prednisone was not available for Resident #4 for 20 days in December. Additionally, there were no orders for Resident #4's hospice medications and not all PRN were available as ordered. **Previously cited 1/13/11 and 4/26/11**	2/27/14	KA
9	305.03	The facility nurse did not assess residents' wounds biweekly to determine the progression of the wound. Additionally, the facility nurse did not stage pressure wounds to determine if the wounds were appropriate for assisted living.	2/27/14	KA
10	305.04	The facility nurse did not make recommendations when Resident #2 experienced weight loss.	2/27/14	KA
11	310.01.c	The facility did not document daily temperatures of the medication refrigerator.	2/27/14	KA
12	310.04.a	The facility did not ensure non-drug interventions were attempted prior to utilizing psychotropic or behavioral modifying medications.	2/27/14	KA



Facility Creekside Inn Assisted Living Alzheimer's Community	License # RC-954	Physical Address 240 E Kathleen Ave	Phone Number (208) 665-2444
Administrator Erika Schreiber <i>Erika Schreiber 1/9/14</i>	City Coeur d' Alene	ZIP Code 83815	Survey Date January 9, 2013
Survey Team Leader Karen Anderson	Survey Type Licensure, Follow-up and Complaint Investigation	RESPONSE DUE: February 8, 2013	
Administrator Signature	Date Signed		

NON-CORE ISSUES

Item #	IDAPA Rule # 16.03.22.	Description	Department Use Only	
			EOR Accepted	Initials
13	320.01	Negotiated Service Agreements were not developed for 10 sampled residents. Resident #2 was not toileted according to the care plan.	2/26/14	KA
14	330.02	Caregivers' documentation was shredded and not maintained for 3 years.	2/27/14	KA
15	350.01	The administrator was not notified of all complaints.	2/27/14	KA
16	350.02	The administrator did not investigate all complaints, incidents and accidents. **Previously cited 1/13/11**	2/27/14	KA
17	350.04	The administrator did not provide a written response to complainants within 30 days. **Previously cited 1/13/11**	2/27/14	KA
18	451.03	The planned mechanical soft diet was not consistent with the Idaho Diet Manual.	2/26/14	KA
19	550.23.b	The admission agreements documented rate changes would be effective immediately without providing a 5 day written notice.	2/27/14	KA
20	600.06.a	The administrator did not schedule sufficient staff to provide supervision in the dining room, assistance with eating in a dignified manner, and to monitor residents with behaviors.	2/27/14	KA
21	711.01.a-c	The facility did not have a method to track behaviors for all residents with behaviors.	2/27/14	KA
22	711.08	Care notes were not documented by caregivers. **Previously cited 1/13/11**	2/27/14	KA
23	711.11	There was no documentation of why medications or treatments were not implemented as ordered.	2/27/14	KA
24				
25				
26				
27				
28				



IDAHO DEPARTMENT OF

HEALTH & WELFARE Food Establishment Inspection Report

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

Critical Violations Noncritical Violations

Establishment Name <u>Creekside Inn</u>		Operator <u>Erika Schreiber</u>	
Address <u>240 E. Kathleen Ave</u>		Inspection time: <u>10:00</u> Travel time:	
County <u>Kootenai</u>	Estab # <u>1000000000</u>	EHS/SUR.#	Inspection time: <u>10:00</u> Travel time:
Inspection Type: <u>Standard</u>	Risk Category: <u>High</u>	Follow-Up Report: OR On-Site Follow-Up: Date: _____ Date: _____	
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>1 MA</u>
# of Repeat Violations <u>0</u>	# of Repeat Violations <u>0</u>
Score <u>0</u>	Score <u>1 MA</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"/>
	Employee Health (2-201)		
<u>Y</u> N	2. Exclusion, restriction and reporting	<input type="checkbox"/>	<input type="checkbox"/>
	Good Hygienic Practices		
<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"/>
	Control of Hands as a Vehicle of Contamination		
<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"/>
	Approved Source		
<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 <u>N/A</u>	10. Records: shellstock tags, parasite destruction, required HACCP plan (3-202 & 3-203)	<input type="checkbox"/>	<input type="checkbox"/>
	Protection from Contamination		
<u>Y</u> N <u>N/A</u>	11. Food segregated, separated and protected (3-302)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N <u>N/A</u>	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 <u>N/O</u> <u>N/A</u>	15. Proper cooking, time and temperature (3-401)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N <u>N/O</u> <u>N/A</u>	16. Reheating for hot holding (3-403)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N <u>N/O</u> <u>N/A</u>	17. Cooling (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N <u>N/O</u> <u>N/A</u>	18. Hot holding (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N <u>N/O</u> <u>N/A</u>	19. Cold Holding (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N <u>N/O</u> <u>N/A</u>	20. Date marking and disposition (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N <u>N/O</u> <u>N/A</u>	21. Time as a public health control (procedures/records) (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
	Consumer Advisory		
<u>Y</u> N <u>N/A</u>	22. Consumer advisory for raw or undercooked food (3-603)	<input type="checkbox"/>	<input type="checkbox"/>
	Highly Susceptible Populations		
<u>Y</u> N <u>N/O</u> <u>N/A</u>	23. Pasteurized foods used, avoidance of prohibited foods (3-801)	<input type="checkbox"/>	<input type="checkbox"/>
	Chemical		
<u>Y</u> N <u>N/A</u>	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"/>
	Conformance with Approved Procedures		
<u>Y</u> N <u>N/A</u>	26. Compliance with variance and HACCP plan (8-201)	<input type="checkbox"/>	<input type="checkbox"/>

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

Item/Location	Temp	Item/Location	Temp	Item/Location	Temp	Item/Location	Temp
<u>Chicken</u>	<u>165</u>	<u>Pudding</u>	<u>38</u>				
<u>Ground Meat</u>	<u>51</u>						

GOOD RETAIL PRACTICES (X = 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 label 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)

Person in Charge (Signature) Erika Schreiber (Print) Erika Schreiber Title Admin Date 1/9/14

Inspector (Signature) Mark Hauer (Print) Mark Hauer Date 1/9/14

Follow-up: (Circle One) Yes No



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

Page 2 of 2
Date 1/9/14

Establishment Name <i>Creekside INN</i>	Operator <i>Erika Schreiber</i>
Address <i>240 F Kuthloval</i>	
County Estab # <i>Kootenai</i>	EHS/SUR.# License Permit #

OBSERVATIONS AND CORRECTIVE ACTIONS (Continuation Sheet)

Ground chicken was refrigerated at 51°

→ C.O.S. = Facility threw away chicken on 1/8/14

Person in Charge <i>[Signature]</i>	Date <i>1/9/14</i>	Inspector <i>[Signature]</i>	Date <i>1/9/14</i>
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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: 208-364-1962
FAX: 208-364-1888

January 27, 2014

Erika Schreiber, Administrator
Creekside Inn Assisted Living Alzheimer's Community
240 East Kathleen Avenue
Coeur d'Alene, Idaho 83814

Dear Ms. Schreiber:

An unannounced, on-site complaint investigation survey was conducted at Creekside Inn Assisted Living Alzheimer's Community between January 6 and January 9, 2014. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00006138

Allegation #1: The facility did not consistently implement precautions to reduce further skin breakdown after residents sustained pressure ulcers.

Findings #1: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.300.02 for not ensuring physician orders were implemented. The facility was required to submit evidence of resolution within 30 days.

Allegation #2: The facility did not provide timely medical intervention when residents had a change in condition.

Findings #2: On 1/8/14, the identified resident's record was reviewed. Nursing notes, dated 4/10/13, documented the resident was not showing any increased edema or shortness of breath. On 4/11/13, at 2:00 PM, a nurse documented the resident refused to eat, appeared fatigued and was communicating with "quiet, mumbling speech." The resident's vitals were taken and the resident's physician was contacted. The physician ordered an immediate EKG and vitals to be taken every hour until the physician came to assess the resident. A nurse practitioner (NP) came to assess the resident at the facility and the resident was transferred to the hospital at 6:10 PM.

A vitals sheet, documented that vitals were started at 2:00 PM as ordered by the physician and continued until the resident was transferred.

Erika Schreiber, Administrator

January 27, 2014

Page 2 of 3

On 1/7/14, a caregiver stated she remembered the identified resident stayed in bed that day because she was not feeling well. She stated at times the resident did refuse to get up and they would let her sleep.

None of the nurses working during the survey, were on duty in April when this resident was transferred.

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

Allegation #3: The administrator did not investigate all complaints regarding residents' preferences and missing belongings.

Findings #3: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.350.01 and .350.04 for the staff not notifying the administrator of all complaints and the administrator not providing a written response to complaints. The facility was required to submit evidence of resolution within 30 days.

Allegation #4. The facility did not assist residents with their care needs.

Findings #4: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.320.01 for not developing NSAs to describe residents' care needs. The facility was required to submit evidence of resolution within 30 days.

Allegation #5: The facility did not provide activities to residents.

Findings #5: Between 1/6/14 and 1/8/14, a variety of activities such as bingo, music and exercise were observed being conducted at various times throughout the survey.

An activity calendar was observed and documented that van rides, current events, chair exercises, bingo, music and memory games were provided throughout the month.

On 1/6/14 at 3:00 PM, outside agency staff were interviewed. They both stated they had seen activities such as music, bowling, and current events being provided to the residents. The nurse stated whenever she had been at the facility, there was always something going on. Further, the nurse stated the facility had a full time activity director.

On 1/7/14 at 3:15 PM, a family member stated, the facility provided many different activities and the facility made sure her loved one got to those activities.

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

Allegation #6: The administrator did not schedule sufficient staff to supervise residents' behaviors.

Findings #6: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.600.06.a for the administrator not scheduling sufficient staff to provide supervision in the dining room, assistance with

Erika Schreiber, Administrator
January 27, 2014
Page 3 of 3

eating and to monitor residents with behaviors.

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 **January 9, 2014**. 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) 364-1962. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,

A handwritten signature in cursive script, appearing to read "Karen Anderson".

KAREN ANDERSON, RN
Health Facility Surveyor
Residential Assisted Living Facility Program

KA/sc



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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January 27, 2014.

Erika Schreiber, Administrator
Creekside Inn Assisted Living Alzheimer's Community
240 East Kathleen Avenue
Coeur d'Alene, Idaho 83814

Dear Ms. Schreiber:

An unannounced, on-site complaint investigation survey was conducted at Creekside Inn Assisted Living Alzheimer's Community between January 6 and January 9, 2014. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00006063

Allegation #1: A resident's right to refuse medication was violated when the resident was held down and forced to take the medication.

Findings #1: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.550 for the facility not protecting residents' rights to refuse medications. The facility was required to submit a plan of correction.

Allegation #2: The facility did not respond appropriately when an allegation of abuse occurred.

Findings #2: On 1/8/14, an incident report documented on 5/29/13 at 6:30 PM, a licensed nurse witnessed another nurse "forcefully" administer a medication after the resident refused to take the medication. The facility administrator documented the nurse was terminated immediately, staff were interviewed, and an inservice was provided to staff.

An in-service record, dated 5/30/13, documented staff were in-serviced regarding residents' rights.

On 1/8/14 at 2:45 PM, a caregiver stated she recalled attending the in-serviced, regarding abuse procedures and residents' rights after the incident occurred.

On 1/8/14 at 3:07 PM, the administrator stated she received a call from one of the facility's nurses regarding the director of nursing (DNS) forcing a resident to take a medication. The administrator stated

Erika Schreiber, Administrator

January 27, 2014

Page 2 of 2

she came in immediately and suspended the DNS. She called in another nurse to cover for the DNS, called and left a voice message with adult protection and the ombudsman, and collected statements from staff. She further stated, an in-service was provided to staff to re-educate them regarding the facility's policy on abuse and residents' rights.

On 1/9/14 at 9:45 AM, an adult protection investigator confirmed the allegation had been phoned in by the facility. The investigator stated he felt the facility handled the situation appropriately.

Unsubstantiated. However, the facility was given technical assistance regarding ensuring their abuse policy was consistent with Idaho statutes.

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 **January 9, 2014**. 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) 364-1962. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,



KAREN ANDERSON, RN
Health Facility Surveyor
Residential Assisted Living Facility Program

KA/sc