



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

March 18, 2014

Duke Rodgers, Administrator
Brookstone Village
921 Corporate Lane
Nampa, Idaho 83651

License #: RC-896

Mr. Rodgers:

On February 3, 2014, a state licensure survey and complaint investigation were conducted at Brookstone Village. 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 Donna Henscheid, LSW, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 364-1962.

Sincerely,

DONNA HENSCHIED, LSW
Team Leader
Health Facility Surveyor

DH/sc

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



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February 19, 2014

CERTIFIED MAIL #: 7007 3020 0001 4050 8302

Duke Rodgers, Administrator
Brookstone Village - Brookstone Village LLC
921 Corporate Lane
Nampa, Idaho 83651

Mr. Rodgers:

Based on the complaint investigation and state licensure survey conducted by Department staff at Brookstone Village-Brookstone Village, LLC between January 27, 2014 and February 3, 2014, it has been determined that the facility failed to protect residents from abuse. Additionally, the facility failed to protect residents who received narcotic medications from exploitation when their narcotic medications were missing. The facility also failed to protect residents from inadequate care when the administrator failed to ensure residents lived in a safe living environment or that their needs were met.

These core issue deficiencies substantially limit the capacity of Brookstone Village-Brookstone Village, LLC to furnish services of an adequate level or quality to ensure that residents' health and safety are protected. The deficiency is described on the enclosed Statement of Deficiencies.

You have an opportunity to make corrections and thus avoid a potential enforcement action. Correction of this deficiency must be achieved by **March 20, 2014**. **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?

Duke Rodgers
February 19, 2014
Page 2 of 2

Return the **signed** and **dated** Plan of Correction to us by **March 4, 2014**, and keep a copy for your records. Your license depends upon the corrections made and the evaluation of the Plan of Correction you develop. In accordance with IDAPA 16.03.22.003.02, you have available the opportunity to question cited deficiencies through an informal dispute resolution process. If you disagree with the survey report findings, you may make a written request to the Supervisor of the Residential Care Program for a Level 1 IDR meeting. The request for the meeting must be made within ten (10) business days of receipt of the Statement of Deficiencies. See the IDR policy and directions on our website at www.assistedliving.dhw.idaho.gov. If your request for informal dispute resolution is not received within the appropriate time-frame, your request will not be granted.

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. Your evidence of resolution (e.g., receipts, pictures, policy updates, etc.) for each of the non-core issue deficiencies is to be submitted to this office by **March 5, 2014**.

Four of the thirty non-core deficiencies cited were identified as repeat punches. Please be aware, any non-core deficiency which is identified on three consecutive surveys will result in a civil monetary penalty.

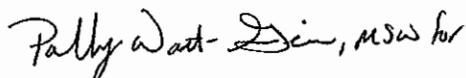
If, at the follow-up survey, the core deficiency still exists or a new core deficiency is identified, or if any of the repeat non-core punches are identified as still out of compliance, the Department will have no alternative but to initiate an enforcement action against the license held by Brookstone Village-Brookstone Village, LLC.

Enforcement actions may include:

- Imposition of civil monetary penalties;
- Issuance of a provisional license;
- Limitation on admission to the facility;
- Requirement that the facility hire a consultant who submits periodic reports to Licensing and Certification.

Our staff is available to answer questions and to assist you in identifying appropriate corrections to avoid further enforcement actions. Should you have any questions, or if we may be of assistance, please contact us at (208) 364-1962 and ask for the Residential Assisted Living Facility program. Thank you for your continued participation in the Idaho Residential Care Assisted Living Facility program.

Sincerely,



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

DH/sc

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R896	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/03/2014
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NAME OF PROVIDER OR SUPPLIER BROOKSTONE VILLAGE - BROOKSTONE VILL	STREET ADDRESS, CITY, STATE, ZIP CODE 921 CORPORATE LANE NAMPA, ID 83651
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R 000	<p>Initial Comments</p> <p>The following deficiencies were cited during the Licensure survey and complaint investigation conducted between 1/27/14 and 2/3/14 at your residential care/assisted living facility. The surveyors conducting the survey were:</p> <p>Donna Henscheid, LSW Team Coordinator Health Facility Surveyor</p> <p>Polly Watt-Geier, MSW Health Facility Surveyor</p> <p>Abbreviations:</p> <p>dc'd = discontinued MAR(s) = Medication Assistance Record(s) MD = physician MED = Medications narc/narcs = narcotics RN = Registered Nurse UA = Urine Analysis</p>	R 000		
R 006	<p>16.03.22.510 Protect Residents from Abuse.</p> <p>The administrator must assure that policies and procedures are implemented to assure that all residents are free from abuse.</p> <p>This Rule is not met as evidenced by: Based on observation, record review and interview, it was determined the facility failed to develop and implement policies and procedures to protect 1 of 4 sampled residents (Resident #3), Random Resident A and potentially 100% of the residents from abuse. The findings include:</p>	R 006		

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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R 006	<p>Continued From page 1</p> <p>According to IDAPA 16.03.22.153.01, "The facility must develop policies and procedures to assure that allegations of abuse, neglect and exploitation are identified, reported, investigated, followed-up with interventions to prevent reoccurrence and assure protection, and documented."</p> <p>1. Resident #3, a 102 year old male, was admitted to the facility on 11/2/13 with diagnoses including cerebrovascular accident and dementia.</p> <p>A nursing assessment, dated 11/2/13, documented the resident had "fragile skin and bruises." The nurse did not document where the bruises were located, nor did she describe what the bruises looked like. There was no further documentation found in the resident's record regarding the bruising.</p> <p>On 1/27/14 at 10:46 AM, Resident #3 was observed in his room laying on his back in his bed. Bruising was observed on both of his forearms.</p> <p>On 1/28/14 at 10:35 AM, Resident #3 was observed in his room sitting in a wheelchair next to his bed. The resident was observed to be wearing a long-sleeved shirt and bruising was noted below the sleeves on his left wrist. The resident stated he was unsure how he obtained the bruising.</p> <p>On 1/28/14 at 4:16 PM, the facility RN was asked to look at Resident #3 with the surveyors. The following bruising was observed on Resident #3:</p> <p>*approximately a four inch bruise on and above the left wrist and outer forearm. *a 2 by 2 inch bruise on the inner left arm, which the RN referred to as a "slide" bruise</p>	R 006		

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R 006	<p>Continued From page 2</p> <p>*one round dark purple bruise on the inner left arm *two round dark purple bruises on his right outer lower arm. *a large bruise on the left shoulder *one bruise on the right upper bicep.</p> <p>The RN stated the shoulder bruises were probably from "hug" transfers. She demonstrated how the caregivers were possibly putting their arms around the resident in a hugging fashion and moving him. The RN further stated, the round dark purple bruises appeared to be "thumbprint" bruising. The RN stated that no one had reported Resident #3's bruising to her.</p> <p>An incident report, dated 1/28/14, documented Resident #3 "has had bruising since moving in (on 11/2/13) that mimicked the same as now. When asked, resident states he doesn't know." It was signed by the house manager and the facility RN at 4:30 PM. There was no description of Resident #3's bruising, nor was there any documentation that other staff were interviewed about when they first noticed the bruising.</p> <p>Interviews were conducted with family, residents, and caregivers between 1/27/14 and 2/3/14. The following statements were made regarding Resident #3's bruising or staff treatment of all residents:</p> <p>*A family member stated, some of the caregivers were not patient with residents. The family member further stated, "Some staff don't have these qualities."</p> <p>*A caregiver stated, Resident #3 did not like Caregiver B because she transferred him on her own and she "hurts him." She stated Resident #3</p>	R 006		

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R 006	<p>Continued From page 3</p> <p>was "... 103, can't just toss him around." She also stated Caregiver B had been "rude" to another resident. "I don't know if she means to be rough, but she likes to do it on her own." No one tells the house manager "anything."</p> <p>*A caregiver stated, Resident #3 had a "giant bruise" on his left upper arm. The caregiver stated, Resident #3 complained about the caregiver being "aggressive" with him. She had not personally reported this to the manager, but believed someone on another shift had reported it.</p> <p>*A caregiver stated, Resident #3 had more bruising than when he moved into the facility. The caregiver also stated, the bruising "looked worse" on Resident #3's upper arms.</p> <p>*A caregiver stated, the resident had the bruises when he was admitted to the facility, but the bruising was "getting worse."</p> <p>*A caregiver stated, "I saw bruising" on Resident #3's shoulders a "couple weeks ago" and saw bruises on his legs "here and there...last week I noticed the round one (bruise) and I talked to the house manager about it earlier in the week." She stated the house manager told her Resident #3 "had been like that" due to his age he had "frail skin."</p> <p>*A caregiver stated, she had heard Caregiver B "speak harshly to residents." The caregiver further, stated Caregiver B "put a lot of bruises on" another resident's arms.</p> <p>*A caregiver stated, "I don't recall" the bruising to be "as bad as now."</p>	R 006		

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R 006	<p>Continued From page 4</p> <p>*A caregiver stated, Resident #3's bruising "looked worse" and she had not "seen it that bruised before."</p> <p>*A caregiver stated Caregiver B was "aggressive" with Resident #3.</p> <p>On 1/28/14 at 4:55 PM, the house manger stated Resident #3 had bruising "since he came in."</p> <p>On 1/29/14 at 9:15 AM, the house manager stated the facility RN told her they did not have to do an investigation of Resident #3's bruises because he came in with them. A few minutes later, the house manager stated she had just reviewed the state requirements regarding when finger-print bruising and severe bruising of an unknown origin needed to be reported to adult protection. The house manager said, "I will report that now."</p> <p>On 1/30/14 at 3:30 PM, the facility RN stated there was "no way" all the bruises were there when Resident #3 was admitted because "they're a nice deep purple."</p> <p>The facility failed to protect Resident #3 from possible abuse when they failed to document suspicious bruising, investigate, report and take steps to prevent further injury.</p> <p>2. Random Resident A</p> <p>On 1/29/14 at 11:48 AM, a family member stated she witnessed Caregiver D being "rough" with Random Resident A. The caregiver "jerked" the resident around and "slammed" her down in a chair. She stated she reported it to the house manager, but the caregiver was never taken off the shift. She stated the house manager told her</p>	R 006		

Bureau of Facility Standards

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R 006	<p>Continued From page 5</p> <p>"it was taken care of." The family member could not recall the time of the incident.</p> <p>On 1/30/14 at 3:15 PM, the house manager stated she was not aware of any complaint regarding a caregiver being rough with Random Resident A.</p> <p>The next morning, on 1/31/14 at 10:45 AM, the house manager stated she had forgotten that she received a complaint about Caregiver D being rough with Random Resident A. She stated two caregivers made an allegation that Random Resident A was treated roughly. The house manager stated she had not obtained statements from them, but had found the following document regarding the incident:</p> <p>An undated care note documented two family members (rather than 2 caregivers as the house manager previously mentioned) told the house manager that Caregiver D had been "rough" and "was making" Random Resident A walk. The note documented the house manager told the family members, that she "appreciated" their "concern and would look into it." The note further documented the family had demanded Caregiver D be "fired." The note documented the house manager told the family she "would address the issue," but could not "discuss" the situation with them. The note documented the house manager had interviewed Caregiver D about "how she would do a transfer," but there was no documentation as to whether the house manager specifically questioned Caregiver D about the incident that had been reported to her. Additionally, the note documented one other caregiver was interviewed and he denied seeing Caregiver D being rough with Random Resident A. There was no documentation that other</p>	R 006		

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R 006	<p>Continued From page 6</p> <p>caregivers or family members were interviewed. The note further documented, after the house manager interviewed Caregiver D and another caregiver, she concluded the investigation as she had never seen Caregiver D being rough with Random Resident A.</p> <p>There was no documentation as to how Random Resident A was protected from Caregiver D after an allegation of abuse was reported. The facility also failed to complete a thorough investigation or notify Adult Protection after the allegation of abuse.</p> <p>The facility failed to protect Resident #3, Random Resident A and potentially 100% of the residents from abuse, when there were bruises of unknown origin and allegations of rough treatment that were not reported to Adult Protection nor investigated.</p>	R 006		
R 007	<p>16.03.22.515 Protect Residents from Exploitation</p> <p>The administrator must assure that policies and procedures are implemented to assure that all residents are free from exploitation.</p> <p>This Rule is not met as evidenced by: Based on interview and record review it was determined the facility did not protect 4 of 4 residents (Residents A, B, C and D), who received narcotic medications, from exploitation when their narcotic medications were missing. This practice had the potential to effect 100% of the residents who received narcotic medications. The findings include:</p> <p>IDAPA 16.03.22.010.29 defines exploitation as:</p>	R 007		

Bureau of Facility Standards

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R 007	<p>Continued From page 7</p> <p>"The misuse of a resident's funds, property, resources, identity or person for profit or advantage..."</p> <p>IDAPA 16.03.22.350.06 documents, "When an allegation of abuse, neglect or exploitation is known by the facility, corrective action must be immediately taken and monitored to assure the problem does not recur."</p> <p>Between 1/27/14 and 2/3/14, caregivers were interviewed and stated the following:</p> <p>*A caregiver stated, there had been "a lot" going on with the medication cart. She stated a couple of weeks ago two bubble packs of methadone went missing. She stated she was aware of three incidents in January (2014), where methadone went "missing." She further stated on one occasion, methadone had been "popped out," and not given to Random Resident B and C. The caregiver further stated, she had found pill cups sitting on top of the medication cart when she was working with another caregiver. When she returned the pill cups were gone.</p> <p>*A caregiver stated, she knew there had been 3 or 4 times when methadone went missing and on one occasion lorazepam went missing. She stated she reported the issue once to the nurse, but did not believe the police were called or that anything had been done about it. The caregiver stated she felt like everything was "just covered up" and residents were not being protected.</p> <p>*A caregiver stated, there was an incident on 1/24/14 where someone forged another caregiver's signature on the narcotic count sheets.</p>	R 007		

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R 007	<p>Continued From page 8</p> <p>*A caregiver stated, if they were aware of missing medications, they "would not feel comfortable" telling the house manager. The caregiver stated, "No one wants to work the cart, they get into trouble with missing meds. The caregiver further stated, when the missing methadone incident took place on 1/24/14, they were never interviewed about the incident by the police, nurse or house manager.</p> <p>*A caregiver stated, "I was warned about passing medications when I first started working" at the facility. She stated awhile ago, there were 2 packs of methadone missing and she thought a caregiver was terminated. However, that caregiver returned to work at the facility. The caregiver further stated methadone was missing again, but no one was interviewed and nothing was done. She also stated all the caregivers "are trying to cover ourselves." The caregiver stated when "anything was reported, nothing got done" or "we'll be fired for saying something."</p> <p>*A caregiver stated, "For as long as I remember" stolen narcotics have always been an issue at the facility.</p> <p>*A caregiver stated, one month ago was the first time she knew that medications were missing. She stated it was "always the same medication, methadone." The caregiver stated, "I don't trust anyone I work with here."</p> <p>*A caregiver stated, Caregiver A would "pop a pill out and put it in her pocket." Caregiver A person was taken off the medication cart when the former administrator was here, but then was put back on by the current house manager. She stated she felt the residents were in pain, but they could not vocalize it. Further, she felt like</p>	R 007		

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R 007	<p>Continued From page 9</p> <p>everything was "just covered up" and residents were not being protected.</p> <p>*A caregiver stated, she had witnessed Caregiver A take out pills and not give them to the residents. She stated, the medications were "sometimes" not locked and there would be a medication "cup full of meds" sitting on the top of the medication cart. The caregiver stated, "I would go to give" a resident a pain medication and was told by Caregiver A, the pills were given earlier. She stated "about three months ago around October or November," someone took pictures of the medications sitting on top of the counter and showed them to the house manager. Additionally, the caregiver stated a "while ago" syringes of lorazepam "went missing."</p> <p>A note on the front of the medication book was observed on 1/27/14. The note was written by the facility nurse and documented, "It is everyone's responsibility to complete 'the narcotic log' when meds come in and when they are dc'd or empty. Everyone is also responsible for signing the 'Narcotic Count Log' each shift. If this doesn't get done I will need to start taking away Med Delegations...."</p> <p>During the survey, it was determined that residents' narcotic medications were missing or possibly diverted. The following examples include, but are not limited to:</p> <p>1. August 21, 2013 - lorazepam incident</p> <p>Random Resident A received 5 syringes of sublingual lorazepam on 7/26/13. The July and August 2013 MARs documented the lorazepam had not been given. On 8/21/13, only two syringes of lorazepam were found in the</p>	R 007		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R896	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/03/2014
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NAME OF PROVIDER OR SUPPLIER BROOKSTONE VILLAGE - BROOKSTONE VILL	STREET ADDRESS, CITY, STATE, ZIP CODE 921 CORPORATE LANE NAMPA, ID 83651
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R 007	<p>Continued From page 10</p> <p>medication refrigerator and there should have been five.</p> <p>Between 1/27/14 and 2/3/14, caregivers were interviewed. Two caregivers stated they were aware of a time when Random Resident A had missing liquid lorazepam.</p> <p>On 1/29/14 at 3:21 PM, the house manager and RN were interviewed regarding the missing lorazepam. The house manager stated staff were signing and saying they counted the lorazepam, but they had not been counting the medications in the refrigerator. When asked if the lorazepam syringes were unaccounted for or missing, the RN replied, "missing."</p> <p>Random Resident A's lorazepam medication arrived at the facility on 7/26/13. Sometime between then and 8/21/13, three syringes went missing.</p> <p>2. December 20, 2014 - methadone incident:</p> <p>Random Resident C received 10 morning doses of methadone on 12/12/13 from the pharmacy. Random Resident C's morning narcotic count sheet documented she received two doses of the methadone on 12/20/13. However, the December MAR documented she was assisted with only one dose of methadone that morning. There was one dose of methadone that was not accounted for.</p> <p>3. December 21, 2013 through December 22, 2013 - methadone incident</p> <p>A. Random Resident C's AM narcotic sheets (#434 & #444) documented 1 methadone pill was taken out of each medication card, for a total of 2 methadone pills. The December 2013 MAR</p>	R 007		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R896	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/03/2014
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NAME OF PROVIDER OR SUPPLIER BROOKSTONE VILLAGE - BROOKSTONE VILL	STREET ADDRESS, CITY, STATE, ZIP CODE 921 CORPORATE LANE NAMPA, ID 83651
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R 007	<p>Continued From page 11</p> <p>documented the resident received 1 dose of her AM methadone, leaving 1 methadone pill unaccounted for.</p> <p>B. Random Resident C's 2:00 PM narcotic sheets (#435 & #445) documented 1 pill was taken out of each medication card on 12/21 & 12/22/13, for a total of 4 pills. The December 2013 MAR documented Random Resident C received 1 dose of her 2 PM methadone on 12/21 and 12/22/13, leaving 2 methadone pills unaccounted for.</p> <p>4. Around December 25, 2013 - methadone incident</p> <p>* Random Resident B's bedtime methadone narcotic count sheet (#440) documented one pill was popped out and given to the resident from 12/19 through 12/21/13. The dates of the next 4 doses were illegible, as they had been written over, so it could not be determined when the pills had been popped out. The next legible date a pill was popped out was on 12/25/13, which meant 4 pills were popped out of the medication card over a 3 day period (12/22 through 12/24/13). This left one pill unaccounted for.</p> <p>* Random Resident C's narcotic count sheet #446 for the bedtime dose of methadone documented one pill was given out of the card on 12/21 and 12/22/13. The dates of the next 4 doses were illegible, as they had been written over, so it could not be determined when the pills had been popped out. The next legible date a pill was popped out was on 12/25/13, which meant 4 pills were popped out of the medication card over a 2 day period (12/23 and 12/24/13). This left two pills unaccounted for.</p>	R 007		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R896	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/03/2014
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NAME OF PROVIDER OR SUPPLIER BROOKSTONE VILLAGE - BROOKSTONE VILL	STREET ADDRESS, CITY, STATE, ZIP CODE 921 CORPORATE LANE NAMPA, ID 83651
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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 007	<p>Continued From page 12</p> <p>Random Resident B and C's December 2013 MARs documented both residents received their bedtime methadone, as well as all of their other bedtime medications, for the entire month of December. The MARS did not document any medication errors occurred in December.</p> <p>Two incident reports, dated 12/25/13, documented that during a cart audit, it had been found that Random Resident B and C had received two doses of methadone on 12/25/13. However, according to the narcotic count sheets, only one pill was given on 12/25/13.</p> <p>Around December 25, 2013, Random Resident B had one methadone pill that was unaccounted for and Random Resident C had 2 methadone pills unaccounted for. The December MARs and narcotics sheets did not document either resident had received "double doses" of methadone on 12/25/13.</p> <p>5. December 25, 2013 through December 31, 2013 - methadone incident</p> <p>Random Resident C's December 2013 MAR documented she was to receive methadone in the morning, at 2 PM and at bedtime (three times a day). Each scheduled methadone dose, had its own card (1 for AM, 1 for 2 PM and 1 for bedtime doses). The MAR documented the resident was assisted with methadone as ordered.</p> <p>Random Resident C's narcotic count sheet #444 for the AM dose of methadone documented 15 pills arrived at the facility on 12/20/13 and the first pill was given on 12/21/13. The sheet further documented one pill was popped out and given to the resident on each day between 12/22 and 12/26. The dates of the next 4 doses were</p>	R 007		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R896	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/03/2014
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NAME OF PROVIDER OR SUPPLIER BROOKSTONE VILLAGE - BROOKSTONE VILL	STREET ADDRESS, CITY, STATE, ZIP CODE 921 CORPORATE LANE NAMPA, ID 83651
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R 007	<p>Continued From page 13</p> <p>illegible, as they had been written over, so it could not be determined when the pills had been popped out. This meant 4 pills were popped out of the medication card over an unknown period of time. Additionally, the last 5 pills on the narcotic count were never signed out or dated as being popped out or given to the resident, leaving 5 pills unaccounted for. In conclusion, after 12/26/13, it could not be determined what happened to 9 pills of Random Resident C's AM methadone.</p> <p>Random Resident C's narcotic count sheet #445 for the 2 PM dose of methadone documented 15 pills arrived at the facility on 12/20/13 and the first pill was given on 12/21/13. The sheet further documented one pill was popped out and give to the resident on each day between 12/22 and 12/28/13. The dates of the next 2 doses were illegible, as they had been written over, so it could not be determined when the pills had been popped out. This meant 2 pills were popped out of the medication card over an unknown period of time. Additionally, the last 5 pills on the narcotic count were never signed out or dated as being popped out or given to the resident, leaving 5 pills unaccounted for. In conclusion, after 12/28/13, it could not be determined what happened to 7 pills of Random Resident C's 2 PM methadone.</p> <p>Narcotic count sheet #446 for the bedtime dose of methadone documented 15 doses of methadone arrived at the facility on 12/20/13. The narcotic count sheet documented the last 5 pills on the narcotic count were never signed or dated as being given to the resident, leaving 5 pills unaccounted for. In conclusion, after 12/28/13, it could not be determined what happened to 5 pills of Random Resident C's bedtime methadone.</p> <p>After 12/26/13, a total of 21 methadone pills were</p>	R 007		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R896	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/03/2014
NAME OF PROVIDER OR SUPPLIER BROOKSTONE VILLAGE - BROOKSTONE VILL		STREET ADDRESS, CITY, STATE, ZIP CODE 921 CORPORATE LANE NAMPA, ID 83651		
(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 007	<p>Continued From page 14</p> <p>unaccounted for; however, an investigation was not conducted to determine what had happened to those narcotic medications.</p> <p>6. January 10, 2014 - methadone incident</p> <p>The facility RN documented, on 1/10/14, that she was called in by the house manager and notified two of Random Resident B's methadone medication cards were missing. The RN documented she searched the garbage and found the 2 PM card "ripped in two" and the pills were missing. She stated she could never locate the 8 AM card.</p> <p>The house manager documented, on 1/10/14, she came into the facility and found that Random Resident B's 8 AM and 2 PM bubble packs were missing. The house manager also documented, she found the two associated narcotic sheets for the 8 AM and 2 PM methadone were also missing.</p> <p>On 1/29/14 at 3:21 PM, the house manager and the facility RN confirmed two bubble packs and their corresponding narcotic count sheets had been taken. The RN stated she had found one of the bubble packs ripped in half in the trash, without any medications in the card. She stated they never found the other bubble pack or the narcotic count sheets. The house manager stated she had not known who to report the incident to, but was advised four days later to call the police and adult protection, which she did. She stated the nurse and herself had searched the caregiver's purse who was on duty at the time the methadone came up missing. She stated, she also had suspended Caregiver A for two days, but had not suspended any other staff member. The house manager confirmed she had not</p>	R 007		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R896	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/03/2014
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NAME OF PROVIDER OR SUPPLIER BROOKSTONE VILLAGE - BROOKSTONE VILL	STREET ADDRESS, CITY, STATE, ZIP CODE 921 CORPORATE LANE NAMPA, ID 83651
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R 007	<p>Continued From page 15</p> <p>interviewed all of the employees. Additionally, she stated the facility RN or herself would be doing daily narcotic audits.</p> <p>Random Resident B's 8 AM and 2 PM medication cards of methadone were stolen on 1/10/14. The number of missing methadone pills could not be confirmed because the narcotic count sheets and medication cards were missing.</p> <p>7. January 24, 2014 - methadone incident</p> <p>An untitled typed document, dated 1/22 through 1/24/14, documented, on 1/24/14, the house manager and a hospice agency were counting Random Resident D's narcotics and noticed 4 pills of methadone were missing. The note documented the facility nurse was notified.</p> <p>On 1/29/14 at 3:21 PM, the house manager and the facility nurse stated they found Random Resident D had 4 missing 5 mg methadone pills on 1/24/14. They stated there were three caregivers on three different shifts that denied the count was off when they counted at the end of their shift. Additionally, they reported a caregiver stated her signature had been forged on one of the narcotic count sheets.</p> <p>Despite the interventions that had previously implemented, five doses of Random Resident D's methadone went missing on 1/24/14 and no further interventions were put into place.</p> <p>8. January 31, 2014 - methadone incident</p> <p>On 2/3/14 at 10:13 AM, the facility nurse stated one of Random Resident C's methadone pills "went missing" on Friday night (1/31/14).</p>	R 007		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R896	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/03/2014
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NAME OF PROVIDER OR SUPPLIER BROOKSTONE VILLAGE - BROOKSTONE VILL	STREET ADDRESS, CITY, STATE, ZIP CODE 921 CORPORATE LANE NAMPA, ID 83651
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R 007	<p>Continued From page 16</p> <p>On 2/3/14 at 2:17 PM, the house manager stated sometime after the medication cart lock was changed, one of Random Resident C's methadone was taken from medication card.</p> <p>9. February 1, 2014 - methadone incident</p> <p>On 2/3/14 at 10:13 AM, the facility nurse stated Random Resident B's morning and bedtime methadone cards were ripped open at the bottom and methadone pills were taken.</p> <p>On 2/3/14 at 2:17 PM, the house manager stated five of Random Resident B's bedtime methadone pills and 6 of the morning methadone pills were missing.</p> <p>On 2/6/14 at 9:48 AM, the facility nurse confirmed five of Random Resident B's bedtime methadone pills and 6 of the morning methadone pills were missing.</p> <p>The facility did not protect Random Residents A, B, C and D from exploitation when their narcotic medications went missing, ten times between 8/1/13 and 2/3/14. Corrective actions were not immediately put in place nor did the interventions that were implemented correct the diversion of narcotic medications. This resulted in Exploitation.</p>	R 007		
R 008	<p>16.03.22.520 Protect Residents from Inadequate Care.</p> <p>The administrator must assure that policies and procedures are implemented to assure that all residents are free from inadequate care.</p>	R 008		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R896	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/03/2014
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NAME OF PROVIDER OR SUPPLIER BROOKSTONE VILLAGE - BROOKSTONE VILL	STREET ADDRESS, CITY, STATE, ZIP CODE 921 CORPORATE LANE NAMPA, ID 83651
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R 008	<p>Continued From page 17</p> <p>This Rule is not met as evidenced by: Based on observation, record review and interview it was determined the administrator failed to provide a safe living environment for 100% of the residents and failed to ensure residents' needs were met for 3 of 4 sampled residents (Residents #1, #3 and #4), two Random Residents (E and A), and two unidentified residents. The findings include:</p> <p>Supervision as defined in IDAPA 16.03.22.012.25 is: "a critical watching and directing activity which provides protection, guidance, knowledge of the resident's general whereabouts and assistance with activities of daily living. The administrator is responsible for providing appropriate supervision based on each resident's Negotiated Service Agreement or other legal requirements."</p> <p>On 1/29/14 a review of the facility's administrator history was conducted. This information was obtained from data provided to Licensing and Certification with the following findings:</p> <ul style="list-style-type: none"> *Administrator left on 3/11/13 *New administrator hired on 4/7/13 *Administrator left on 8/9/13 *House manager had provisional administrator's license from 8/29/13 to 11/29/13 *Previous administrator returned on 12/29/13 *No administrator after 1/5/14 <p>Between 1/27/14 and 2/3/14, caregivers, family members, outside agency employees, the facility RN and residents were interviewed and stated the following regarding the management of the facility:</p> <ul style="list-style-type: none"> * The communication "sucks." 	R 008		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R896	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/03/2014
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NAME OF PROVIDER OR SUPPLIER BROOKSTONE VILLAGE - BROOKSTONE VILL	STREET ADDRESS, CITY, STATE, ZIP CODE 921 CORPORATE LANE NAMPA, ID 83651
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R 008	<p>Continued From page 18</p> <p>*"There is no follow-up on anything."</p> <p>*When you bring something in, it becomes "community property...I do not bring up issues for fear of retaliation."</p> <p>*There was "not a lot of communication around here...communication log is pointless...residents look a mess...it's crazy out there...staff are not following rules" and the house manager "gets frustrated."</p> <p>From 1/1/13 to 2/3/14, the facility did not have a licensed administrator for an accumulative total of 106 days.</p> <p>The following are examples of lack of administrative oversight and supervision:</p> <p>I. Background Check</p> <p>According to IDAPA 16.03.22.009.01, "A residential care or assisted living facility must complete a criminal history and background check on employees and contractors hired or contracted with after October 1, 2007, who have direct patient access to residents..."</p> <p>According to IDAPA 16.03.22.009.03, "Any direct patient access individual hired or contracted with on or after October 1, 2007, must self-disclose all arrests and convictions before having access to residents....If a disqualifying crime as described in IDAPA 16.05.06, 'Criminal History and Background Checks,' is disclosed, the individual cannot have access to any resident."</p> <p>On 1/29/14, Caregiver A's employee record was reviewed and documented she had previously been hired at the facility on 6/2/09 and quit</p>	R 008		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R896	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/03/2014
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NAME OF PROVIDER OR SUPPLIER BROOKSTONE VILLAGE - BROOKSTONE VILL	STREET ADDRESS, CITY, STATE, ZIP CODE 921 CORPORATE LANE NAMPA, ID 83651
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R 008	<p>Continued From page 19</p> <p>working at the facility on 9/16/10. The employee's record further documented, Caregiver A was rehired on 11/6/12. There was no documentation in Caregiver A's record that a Department Criminal history background check had been completed when she was rehired by the facility in 2012. Additionally, there was no self-disclosure form found in the employee's record.</p> <p>On 1/29/14 at 11:52 AM, a representative from the Criminal History Unit stated Caregiver A had not completed a background check since 2008. He stated the caregiver failed to show up for fingerprints on 5 separate occasions and currently had two potentially disqualifying crimes.</p> <p>A letter to the surveyors from the Criminal History Unit, dated 1/29/14 at 1:49 PM, documented Caregiver A had two potentially disqualifying convictions.</p> <p>The December 2013 and January 2014, as worked schedules, documented Caregiver A worked the day shift (38 days) with one other caregiver.</p> <p>During the survey, Caregiver A was observed at the facility providing cares alone in resident rooms on the following days:</p> <ul style="list-style-type: none"> *1/27/14 *1/28/14 *1/30/14 *1/31/14 * 2/3/14 <p>Between 1/27/14 to 1/30/14, current and former caregivers, the Ombudsman and outside agency staff members were interviewed and they confirmed Caregiver A was the sister of the house</p>	R 008		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R896	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/03/2014
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NAME OF PROVIDER OR SUPPLIER BROOKSTONE VILLAGE - BROOKSTONE VILL	STREET ADDRESS, CITY, STATE, ZIP CODE 921 CORPORATE LANE NAMPA, ID 83651
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R 008	<p>Continued From page 20</p> <p>manager. They also stated, Caregiver A had a "felony" conviction "for stealing drugs."</p> <p>On 1/30/14 at 11:05 AM, when the facility RN was asked if she was aware of anyone working with disqualifying crimes, she responded, "Hell no!"</p> <p>On 1/31/14 at 11:35 AM, when the facility house manager was asked if she was aware an employee was working with two disqualifying crimes, she shook her head "no" and asked, "Wouldn't that come out in their background check?"</p> <p>The facility failed to provide appropriate supervision to protect 100% of all residents, when they rehired Caregiver A and allowed her to work with residents without a background check and with disqualifying crimes.</p> <p>II. Assistance with cares</p> <p>The facility was a 16 bed facility which currently had 14 residents residing in it. Of the fourteen residents, nine of them required extensive to total assistance with cares. Five of the nine residents required two-person or Hoyer assistance with transfers.</p> <p>Between 1/27/14 and 2/3/14, caregivers, family members, outside agency employees and residents were interviewed and stated the following regarding the management of the facility:</p> <p>*"Residents look a mess...it's crazy out there...."</p> <p>*Residents are often wearing other residents' clothes. She also stated the residents were often left unsupervised during meals.</p>	R 008		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R896	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/03/2014
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NAME OF PROVIDER OR SUPPLIER BROOKSTONE VILLAGE - BROOKSTONE VILL	STREET ADDRESS, CITY, STATE, ZIP CODE 921 CORPORATE LANE NAMPA, ID 83651
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R 008	<p>Continued From page 21</p> <p>*A resident was often found wearing other residents' clothes. She also stated the resident had been found sitting in her chair the entire day and smelled of urine. She stated the resident's face was often dirty because the staff did not take the time to clean it.</p> <p>An undated memo, signed by staff on various days in November 2013, documented "Residents that are unable to toilet self, is [sic] to be changed every 2 hours. We have had outside agencies that have made several concerns about people getting the proper care in changing."</p> <p>A night shift note, dated 12/16/13, documented one caregiver told another caregiver, "You change her and walked out of the facility." It further documented, Random Resident E "was really wet" when she was finally changed.</p> <p>A swing shift note, dated 12/21/13, documented Random Resident A had sat "in BM awhile [sic], changed after diner [sic] and wouldn't come off."</p> <p>Staff communication notes, dated 12/22/13, documented the following regarding 5 different random residents:</p> <p>*Resident #1 "didn't look changed all day - so full it was coming apart." *A former unidentified resident "didn't look changed all day." *Resident #4 and an unidentified resident "didn't look changed." *Resident #3 "looked like not changed all day."</p> <p>On 1/29/14 at 3:35 PM, the house manager and RN were interviewed about the incident that occurred on 12/22/13 when five residents were</p>	R 008		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R896	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/03/2014
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NAME OF PROVIDER OR SUPPLIER BROOKSTONE VILLAGE - BROOKSTONE VILL	STREET ADDRESS, CITY, STATE, ZIP CODE 921 CORPORATE LANE NAMPA, ID 83651
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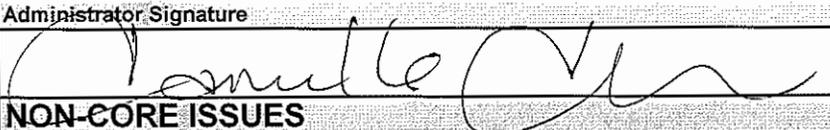
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 008	<p>Continued From page 22</p> <p>not changed. They stated a family came in and distracted the staff.</p> <p>During December, the facility did not have a licensed administrator. There was no documentation that an investigation was conducted for any of the three incidents where residents were not assisted with their care needs. There was no plan put into place after the first incident, nor was there administrative oversight to ensure residents were toileted appropriately.</p> <p>Between 3/11/13 and 2/3/14, the facility did not have a licensed administrator for an accumulative total of 106 days (approximately 3 months) to provide a critical watching and directing of activity to ensure:</p> <p>*100% of the residents were provided a safe living environment when an individual worked without a background check and with potentially disqualifying crimes.</p> <p>*Residents #1, #3 and #4, Random Residents A and E, and two unidentified residents were assisted with activities of daily living.</p> <p>This resulted in inadequate care.</p>	R 008		



Facility Brookstone Village	License # RC-896	Physical Address 921 Corporate Ln	Phone Number (208) 468-7714
Administrator No administrator at time of survey	City Nampa	ZIP Code 83651	Survey Date February 3, 2014
Survey Team Leader Donna Henscheid	Survey Type Licensure, Follow-up and Complaint Investigation	RESPONSE DUE: March 5, 2014	
Administrator Signature 	Date Signed 2/3/14		

NON-CORE ISSUES

Item #	IDAPA Rule #	Description	Department Use Only	
			EOR Accepted	Initials
1	009.01	One caregiver did not have a completed criminal history and background check after being rehired in 2012. **Previously cited on 3/24/11**	3/17/14	DH
2	009.06.c	One caregiver did not have the required state police background check.	3/17/14	DH
3	150	The facility's policies did not include procedures.	3/17/14	DH
4	210	The facility did not have an on-going activities program.	3/17/14	DH
5	215	The facility did not have a licensed administrator for 29 days. **Previously cited on 8/20/13**	3/17/14	DH
6	220.02	The facility admission agreements did not provide a complete reflection of the facility charges. For example: The pricing outline did not match what the residents were charged. It documented that nursing and medications were included, but residents were charged for those services. The assessments being used had different point values for the levels which did not match the current pricing outline.	3/17/14	DH
7	220.03.e	The facility's admission agreements did not include the frequency of when the level of care determination were to be done, nor who was going to complete those assessments.	3/17/14	DH
8	220.04	The facility's admission agreements did not include the staffing patterns or the qualifications of the staff on duty.	3/17/14	DH
9	220.09	The facility's admission agreements did not clearly describe conditions under which residents would be transferred. See section 152.	3/17/14	DH
10	220.10.c	The facility's admission agreement did not allow for a 15 day prorated rent upon a resident's emergency discharge.	3/17/14	DH
11	220.16	The facility's admission agreement did not describe how a resident could contest charges or rate increases.	3/17/14	DH
12	220.17	The facility's admission agreement did not disclose what happens when a resident transitions to Medicaid.	3/17/14	DH
13	225.01	The facility did not evaluate Resident #1 and 2's behaviors.	3/17/14	DH
14	225.02	The facility did not develop interventions for Resident #1 and 2's behaviors.	3/17/14	DH
15	260.06	The facility did not have the equipment (working vacuum and rug cleaner) available to maintain the interior of the facility in a clean and safe manner.	3/17/14	DH

Facility Brookstone Village	License # RC-896	Physical Address 921 Corporate Ln	Phone Number (208) 468-7714
Administrator No administrator at time of survey	City Nampa	ZIP Code 83651	Survey Date February 3, 2014
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Administrator Signature 	Date Signed 2/3/14		

NON-CORE ISSUES

Item #	IDAPA Rule # 16.03.22.	Description	Department Use Only	
			EOR Accepted	Initials
16	305.03	The facility nurse did not assess Residents #1, 2 and 4 when they had changes of condition. For example: Resident #1 and 4's wound conditions and Resident #2's fever and diarrhea.	3/17/14	DH
17	305.08	The facility nurse did not provide training to staff regarding dressing Resident #4's skin tears or specific transferring methods for each resident.	3/17/14	DH
18	310.01.d	Unlicensed staff dialed insulin pens.	3/17/14	DH
19	320.01	Residents #1, 2, 3 and 4's NSAs were not updated to reflect their current needs.	3/17/14	DH
20	335.02	Facility staff were allowed to work in the kitchen when the exhibited symptoms of an infectious disease.	3/17/14	DH
21	350.02	Accidents and incidents were not investigated.	3/17/14	DH
22	350.04	The facility did not respond to complainants in writing. **Previously cited 3/24/11**	3/17/14	DH
23	451.01.d	The facility did not document substitutions made to the menu.	3/17/14	DH
24	451.02	The facility did not provide snacks between meals and at bedtime.	3/17/14	DH
25	600.06.a	The facility did not schedule staff to provide supervision to residents during meals and in common areas when both caregivers were assisting other residents.	3/17/14	DH
26	711.01.a-c	The facility did not track residents' behaviors including the time, intervention used and effectiveness of the intervention.	3/17/14	DH
27	711.08	Care notes were not signed and dated by the person providing the cares.	3/17/14	DH
28	711.08.c	The facility did not document all unusual events.	3/17/14	DH
29	711.11	The facility did not document the reasons why medications were not given. For example there were several times there were no signatures on the MAR.	3/17/14	DH
30	310.01.c	The facility was not monitoring daily temperatures of the refrigerator where medications were stored. **Previously cited 3/24/11**	3/17/14	DH



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

February 19, 2014

Duke Rodgers, Administrator
Brookstone Village
921 Corporate Lane
Nampa, Idaho 83651

Mr. Rodgers:

An unannounced, on-site complaint investigation and state licensure survey were conducted at Brookstone Village between January 27, 2014 and February 3, 2014. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00006328

Allegation #1: An employee worked without a criminal history and background check.

Findings #1: Substantiated. The facility was issued a core deficiency at IDAPA 16.03.22.510 for allowing an employee to work without completing a criminal history and background check. The facility was required to submit a plan of correction within 10 days.

Allegation #2: The facility did not protect residents' narcotic medications from theft.

Findings #2: Substantiated. The facility was issued a core deficiency at IDAPA 16.03.22.515 for not ensuring residents' narcotic medications were protected. The facility was required to submit a plan of correction within 10 days.

Allegation #3: The facility did not have a current licensed administrator.

Findings #3: Substantiated. The facility was issued a non-core deficiency at IDAPA 16.03.22.215 for not having a current licensed administrator for 29 days. The facility was required to submit evidence of resolution within 30 days.

Allegation #4: The facility was not maintained in a clean and orderly manner.

Findings #4: Between 1/27/14 and 2/3/14, observations of the facility were made. On 1/27/14 two of the

Duke Rodgers, Administrator

February 19, 2014

Page 2 of 2

resident's rooms were observed with crumbs on the carpeting, but overall the rooms and common areas were clean and tidy. However, one resident's room had a strong urine odor.

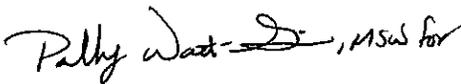
On 1/28/14, caregivers and the house manager confirmed the facility did not have a working vacuum or a carpet cleaner. The house manager stated the vacuum had been malfunctioning for a few weeks. Further, she stated the owner had purchased a carpet cleaner, but wanted to learn how to use it prior to bringing it in for staff to use. The house manager confirmed the one room with the urine odor required deep-cleaning.

On 1/30/14, the owner of the facility was observed at the facility working on the vacuum and later vacuuming the residents' rooms.

Unsubstantiated. However, the facility received a non-core deficiency at IDAPA 16.03.22.260.06 for not having the equipment available to maintain the interior of the facility in a clean and safe manner. Additionally, the facility was provided technical assistance to ensure the room with the urine odor was deep-cleaned.

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,



DONNA HENSCHIED, LSW

Health Facility Surveyor

Residential Assisted Living Facility Program

DH/sc

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



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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February 19, 2014

Duke Rodgers, Administrator
Brookstone Village - Brookstone Village LLC
921 Corporate Lane
Nampa, Idaho 83651

Provider ID: RC-896

Mr. Rodgers:

An unannounced, on-site complaint investigation and state licensure survey were conducted at Brookstone Village-Brookstone Village, LLC between January 27, 2014 and February 3, 2014. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00006336

Allegation #1: The facility did not put a plan in place to ensure residents narcotics were protected.

Findings #1: Substantiated. The facility was issued a core deficiency at IDAPA 16.03.22.515 for not ensuring residents' narcotic medications were protected. The facility was required to submit a plan of correction within 10 days.

Allegation #2: The facility did not have a licensed administrator.

Findings #2: Substantiated. The facility was issued a non-core deficiency at IDAPA 16.03.22.215 for not having a current licensed administrator for 29 days. The facility was required to submit evidence of resolution within 30 days.

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 black ink that reads "Donna Henscheid, LSW". The signature is written in a cursive, flowing style.

DONNA HENSCHIED, LSW
Health Facility Surveyor
Residential Assisted Living Facility Program

DH/sc



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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February 19, 2014

Duke Rodgers, Administrator
Brookstone Village
921 Corporate Lane
Nampa, Idaho 83651

Provider ID: RC-896

Mr. Rodgers:

An unannounced, on-site complaint investigation and state licensure survey was conducted at Brookstone Village between January 27, 2014 and February 3, 2014. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00006342

Allegation #1: The facility did not protect residents' narcotic medications.

Findings #1: Substantiated. The facility was issued a core deficiency at IDAPA 16.03.22.515 for not ensuring residents' narcotic medications were protected. The facility was required to submit a plan of correction within 10 days.

If you have questions or concerns regarding our visit, please call us at (208) 364-1962. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,

DONNA HENSCHIED, LSW
Health Facility Surveyor
Residential Assisted Living Facility Program

DH/sc