



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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RESIDENTIAL ASSISTED LIVING FACILITY PROGRAM
P.O. Box 83720
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PHONE: 208-334-6626
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October 7, 2013

Janel Davis, Administrator
Evergreen - Idaho Health Care Sandpoint LLC
624 South Division Avenue
Sandpoint, ID 83864

License #: RC-511

Dear Ms. Davis:

On September 10, 2013, a Complaint Investigation survey was conducted at Evergreen - Idaho Health Care Sandpoint LLC. As a result of that survey, deficient practices were found. The deficiency cited was at the following level:

- Non-core issues, which are described on the Punch List, and for which you have submitted evidence of resolution.

Your submitted evidence of resolution is 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 Maureen McCann, RN, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 364-1962.

Sincerely,

Maureen McCann, RN
Team Leader
Health Facility Surveyor

MM/TFP

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



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September 24, 2013

Janel Davis, Administrator
Evergreen - Idaho Health Care Sandpoint LLC
624 South Division Avenue
Sandpoint, ID 83864

Dear Ms. Davis:

An unannounced, on-site complaint investigation survey was conducted at Evergreen - Idaho Health Care Sandpoint LLC between September 9 and September 10, 2013. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00006112

Allegation #1: Caregivers assisted residents with the wrong dose of insulin.

Findings #1: A letter dated 11/15/12, documented a caregiver had assisted a resident with the wrong dose of insulin. The facility nurse was contacted and instructed the caregiver to call 911, and offer food and drink to the resident. Paramedics responded to the facility, but did not need to transport the resident to the emergency department. The caregiver was disciplined and received 1 to 1 retraining with the facility nurse regarding assisting residents with medications.

Substantiated. However, the facility was not cited as they acted appropriately by identifying the mistake, providing the needed medical care for the resident and retraining the caregiver on the proper techniques when assisting residents with their medications.

Allegation #2: Facility caregivers were not properly trained on how to respond if a resident had a low blood glucose reading.

Findings #2: Between 9/9/13 and 9/10/13, three caregivers stated they had been trained on what to do if a resident had a low blood glucose reading. They all stated they would offer the resident juice/food and call the nurse.

On 9/10/13 at 10:40 AM, the facility nurse stated she had trained all caregivers to notify her if a resident had a low glucose reading and to offer the resident juice/food.

Between 9/9/13 and 9/10/13, three diabetic residents' records were reviewed. The record documented if a resident had a low blood glucose, the caregivers offered the resident juice/food and contacted the nurse.

Unsubstantiated. Although the allegation may have occurred, it could not be determined during the complaint investigation.

Allegation #3: Caregivers did not properly assist residents with their medications when they touched the medications with their bare hands and did not observe residents take their medications.

Findings #3: On 9/10/13 at 1135 AM, the administrator stated, she had overheard a conversation that a caregiver was popping medications into his hand and not observing residents take their medications. She stated, she then observed the caregiver assisting with medications and found the allegations to be true. At that time, she discussed the problem with the nurse and the caregiver received retraining on the proper procedure when assisting residents with their medications.

Between 9/9/13 and 9/10/13, caregivers were observed assisting residents with their medications. The caregivers were observed watching the residents take their medications. Further, caregivers were observed popping medications into medication cups and handing them to the residents without touching the pills.

Substantiated. However, the facility was not cited as they acted appropriately by identifying and correcting the deficiency before the survey was conducted.

Allegation #4: Assistance with medications did not comply with Board of Nursing Rules.

Findings #4: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.310.01.d, for unlicensed staff dialing insulin pens and injecting a resident with insulin. The facility was required to submit evidence of resolution within 30 days.

Allegation #5: Staff did not complete bed checks on residents every two hours, but documented they had.

Findings #5: Insufficient evidence was available in records reviewed and through observations made at the time of the investigation to substantiate this allegation.

Unsubstantiated. Although the allegation may have occurred, it could not be determined during the complaint investigation.

Allegation #6: Night shift staff slept while on duty, leaving residents unsupervised.

Findings #6: Between 9/9/13 and 9/10/13, three caregivers and the administrator stated the overnight shift was staffed with two caregivers. They further stated, caregivers were allowed to sleep on their break as long as the other caregiver was awake.

The facility's August and September's 2013 "as worked" caregiver schedules were reviewed. Two caregivers worked each night shift.

Between 9/9/13 and 9/10/13, eight residents stated they did not have concerns about staff being available on night shift, as staff came quickly when they called for assistance during the night. Four residents, who were frequently up at night, stated there was at least one caregiver up at night.

Substantiated. However, the facility was not cited as one caregiver was up and awake at all times.

Allegation #7: Night shift staff took their break outside of the building at the same time, leaving residents unsupervised.

Findings #7: On 9/10/13 at 11:40 AM, the administrator confirmed two night shift caregivers had taken their break together outside of the building, leaving the residents unsupervised. The administrator further stated, when she heard of this practice, she disciplined the caregivers.

On 9/10/13, caregiver records were reviewed. The records documented the caregivers had been disciplined for leaving the residents unsupervised.

Substantiated. However, the facility was not cited as they acted appropriately by identifying and correcting the deficiency prior to the survey.

Allegation #8: Incontinent residents urinated on the furniture in the common area.

Findings #8: Substantiated. However, the facility was not cited as they acted appropriately by identifying the problem and having a process in place for when the problem occurred.

Allegation #9: Caregivers spoke to residents in a abusive tone of voice.

Findings #9: On 9/9/13 at 11:40 AM, the administrator stated she had noticed a caregiver's manner of speaking was "at" people rather than "to" people. The administrator further stated, she did not see this behavior as abusive and worked with the caregiver. "I spoke with her, trying to teach her to not speak 'at' people, but 'to' them."

Between 9/9/13 and 9/10/13, four staff, eight residents and the facility nurse, stated they had not heard of a caregiver speaking in an abusive tone of voice.

Staff records were reviewed. A caregiver had been disciplined for speaking "cold" toward residents. The records also documented all staff had received training on verbal abuse.

Between 9/9/13 and 9/10/13, staff interactions with the residents were observed. There were no interactions observed of staff speaking abusively toward residents.

Unsubstantiated. Although the allegation may have occurred, it could not be determined during the complaint investigation.

Allegation #10: Residents did not receive therapeutic diets ordered by their physicians.

Findings #10: Insufficient evidence was available in records reviewed and through observations made at the time of the investigation to substantiate this allegation.

Janel Davis
September 24, 2013
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Unsubstantiated. Though the allegation may have occurred, it could not be determined during the complaint investigation due to conflicting information. However, currently the identified resident stated he was satisfied with the current diet he was served.

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 **September 10, 2013**. 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,



Maureen McCann, RN
Health Facility Surveyor
Residential Assisted Living Facility Program

MM/TFP

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

