



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – GOVERNOR
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P.O. Box 83720
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PHONE: 208-364-1962
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December 2, 2013

Timothy Pape, Administrator
Beehive Homes - Kenmere
2321 N Kenmere Dr
Meridian, ID 83646

License #: Rc-987

Dear Mr. Pape:

On September 27, 2013, a Complaint Investigation survey was conducted at Beehive Homes - Kenmere / Golden Years, Inc.. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level(s):

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

Your submitted 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 Rachel Corey, RN, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 364-1962.

Sincerely,

Rachel Corey, RN
Team Leader
Health Facility Surveyor

rc/rc

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



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October 7, 2013

Gary Andrew
Beehive Homes - Kenmere
225 S. Winthrop Place
Boise, ID 83709

Dear Mr. Andrew:

An unannounced, on-site complaint investigation survey was conducted at Beehive Homes - Kenmere / Golden Years, Inc. between September 26 and September 27, 2013. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00006038

Allegation #1: The facility did not schedule sufficient staff to meet the needs of the residents.

Findings #1: On 9/26/13, eight residents resided at the facility. Between 9:00 AM and 3:15 PM, all residents were interviewed and observations were conducted. Residents stated staff members met their needs in a timely manner. Two residents stated staff had "busy" periods, and sometimes they would have to wait 5 to 10 minutes for their call lights to be answered, but staff were generally very responsive. During this time, all residents were observed to be well-groomed. The facility was observed to be clean and no odors were detected. Lunch was observed being served on time, call lights were observed being answered multiple times in less than three minutes, and residents were observed being assisted with cares in an appropriate manner. The eight residents at the facility were observed to be high functioning and able to make their needs known. The one caregiver on duty, was observed to prioritize tasks effectively.

On 9/26/13 at 8:25 AM, the ombudsman stated she had observed that residents were well-groomed and being supervised appropriately during her visits. She had not received complaints regarding insufficient staffing levels.

During the survey, two family members and three outside service providers were interviewed. All stated they observed residents receiving assistance with cares when

required. They did not express a dissatisfaction with the staffing levels. Additionally, four caregivers, and the facility nurse stated they felt staffing was sufficient to meet the needs of the residents. Two caregivers stated the facility was currently hiring additional staff to provide extra coverage during emergencies.

On 9/27/13, at 10:55 AM, a staff member was observed training a new staff member and the facility nurse was observed providing additional supervision to residents.

Three sampled records were reviewed. There was no documentation indicating cares were not provided or that incidents had occurred due to insufficient staffing levels.

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

Allegation #2: An identified employee did not treat residents with dignity and respect.

Findings #2: On 9/26/13, all of the eight residents were interviewed. They all stated current employees treated them well. Three residents acknowledged that at one time, an employee spoke in a demeaning way to one resident, but that employee no longer worked there.

During the time of the survey, an administrator was not employed. On 9/26/13 at 2:16 PM, the facility RN stated she had informed the former administrator of concerns she had with an identified caregiver. She stated, the caregiver spoke to a resident like he/she were a child. After she spoke with the administrator, the employee did not show up for work. The facility RN stated she was unaware if an investigation had been done, or what action the administrator had taken.

Substantiated. The facility received a deficiency at IDAPA 16.03.22.350.02 for not investigating all complaints and at IDAPA 16.03.22.215 for not having a licensed administrator to oversee the day to day operations of the facility. The facility was required to submit evidence of resolution within 30 days.

Allegation #3: Complainants did not receive a written response to their concerns.

Findings #3: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.350.04 for not providing a written response to all complainants. The facility was required to submit evidence of resolution within 30 days.

Allegation #4: Residents did not receive medications as ordered by their physicians.

Findings #4: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.300.02 for residents not receiving medications as ordered by their physicians. The facility also received deficiencies at IDAPA 16.03.22.300.01 and 310.01.e for the facility nurse not delegating to medication aides and for medication aides not observing residents

take their medications. The facility was required to submit evidence of resolution within 30 days.

Allegation #5: Residents' rights to confidentiality was not protected when caregivers spoke about residents' issues in common areas.

Findings #5: On 9/26/13 and 9/27/13, caregivers were not observed violating residents' rights to privacy. During the survey, four caregivers and the facility nurse stated it was the policy to speak of residents' issues in a private area, such as an empty room, the back of the hallway or on the porch with the door cracked, so residents could be observed. Three outside service providers were interviewed and stated they had not observed staff speak of residents' issues in front of other residents. Two family members stated they had not observed staff violate resident's right to confidentiality when they had visited.

On 9/26/13 at 8:25 AM, the ombudsman stated that due to the size of the facility, she could see how it would be easy to speak of residents' concerns in front of other residents; however, she had not observed it occurring while visiting the facility.

Unsubstantiated. However, the facility was given technical assistance that confidentiality issues should be closely monitored due to the layout of the facility.

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 27, 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,



Rachel Corey, RN
Health Facility Surveyor
Residential Assisted Living Facility Program

RC/TFP

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