



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 23, 2014

Jenna Gordon, Administrator
Aarenbrooke Place - Cory Lane, Ashley Manor LLC
9327 Cory Lane
Boise, Idaho 83704

License #: RC-718

Dear Ms. Gordon:

On November 1, 2013, a follow-up survey and a complaint investigation survey were conducted at Aarenbrooke Place-Cory Lane, Ashley Manor LLC. 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 Polly Watt-Geier, MSW, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 364-1962.

Sincerely,

POLLY WATT-GEIER, MSW
Team Leader
Health Facility Surveyor

PWG/sc

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



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P.O. Box 83720
Boise, Idaho 83720-0009
EMAIL: ralf@dhw.idaho.gov
PHONE: 208-334-6626
FAX: 208-364-1888

November 18, 2013

CERTIFIED MAIL #: 7007 3020 001 4050 8180

Sharla Wilson, Administrator
Aarenbrooke Place - Cory Lane, Ashley Manor LLC
9327 Cory Lane
Boise, ID 83704

Dear Ms. Wilson:

On November 1, 2013, a follow-up and complaint investigation survey was conducted by Department staff at Aarenbrooke Place-Cory Lane, Ashley Manor LLC. The facility was cited with a core issue deficiency for: failing to coordinate care with outside service providers, failing to assist and monitor residents' medications, and failing to assist with bathing and laundry.

This core issue deficiency substantially limits the capacity of Aarenbrooke Place-Cory Lane, Ashley Manor LLC to provide for residents' basic health and safety needs. The deficiency is described on the enclosed Statement of Deficiencies.

BACKGROUND:

On May 21, 2013, the facility was issued core level deficiencies for failure to protect residents from inadequate care. This included failing to provide appropriate assistance and monitoring of medications and failing to provide appropriate bathing assistance.

PROVISIONAL LICENSE:

As a result of the repeat core deficiency findings, a provisional license is being issued effective November 18, 2013. The following administrative rule for Residential Care or Assisted Living Facilities in Idaho (IDAPA 16.03.22) gives the Department the authority to issue a provisional license:

935. ENFORCEMENT REMEDY OF PROVISIONAL LICENSE.

A provisional license may be issued when a facility is cited with one (1) or more core issue deficiencies, or when non-core issues have not been corrected or become repeat deficiencies. The provisional license will state the conditions the facility must follow to continue to operate. See Subsections 900.04, 900.05 and 910.02 of these rules.

The conditions of the provisional license are as follows:

1. A licensed residential care administrator or Registered Nurse (RN) consultant, with at least three years' experience working as an administrator or as the facility nurse for a residential care or assisted living facility in Idaho, shall be obtained and paid for by the facility, and approved by the Department. This consultant must have a current, valid, Idaho Residential Care Administrator's license or a current, valid, Idaho nursing license, and may not also be employed by the facility or the company that operates the facility, or any of that company's affiliates. The purpose of the consultant is to assist the facility in identifying and implementing appropriate corrections for the deficiencies. Please provide a copy of the enclosed consultant report content requirements to the consultant. The consultant shall be allowed unlimited access to the facility's administrative, business and resident records and to the facility staff, residents, their families and representatives. The name of the consultant with the person's qualifications shall be submitted to the Department for approval no later than November 25, 2013.

2. A weekly written report must be submitted by the Department-approved consultant to the Department commencing on November 29, 2013. The reports will address progress on correcting the core deficiency identified on the Statement of Deficiencies as well as the non-core deficiencies identified on the punch list. When the consultant and the administrator agree the facility is in full compliance, they will notify the Department and request a follow-up survey be scheduled.

3. The facility will correct all core and non-core deficiencies and pass the follow-up survey with no repeat deficiencies and no new core deficiencies.

4. The facility will maintain adequate staffing at all times. This includes at a minimum, adequate housekeeping, laundry and direct care staffing to meet the needs of all residents and to maintain the facility in a clean and organized fashion, a full-time, licensed residential care administrator, and a full-time facility nurse.

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

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

PLAN OF CORRECTION:

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:

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 eighteen (18) 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 12/1/13.

ADMINISTRATIVE REVIEW:

You may contest this decision to issue a provisional license and impose enforcement action of requiring a consultant 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 scheduled after the administrator and consultant submit a letter stating that all deficiencies have been corrected and systems are in place to assure the deficient practices remain corrected. If at the follow-up survey, the core issue deficiency still exists, a new core issue deficiency is identified, non-core deficiencies have not been corrected, or the facility has failed to abide by the conditions of the provisional license, including achieving full compliance with IDAPA 16.03.22, the Department will take further enforcement action against the license held by Aarenbrooke Place - Cory Lane, Ashley Manor LLC. 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 to the facility
- Civil Monetary Penalties

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/pwg

Enclosure

cc: Medicaid Notification Group
Steve Millward, Division of Licensing and Certification

PRINTED: 11/14/2013
FORM APPROVED

Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R718	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 11/01/2013
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NAME OF PROVIDER OR SUPPLIER AARENBROOKE PLACE - CORY LANE, ASHLE	STREET ADDRESS, CITY, STATE, ZIP CODE 9327 CORY LANE BOISE, ID 83704
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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
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{R 000}	<p>Initial Comments</p> <p>The following deficiency was cited during the follow-up survey and complaint investigation survey conducted on October 28, 2013 through November 1, 2013 at your residential care/assisted living facility. The surveyors conducting the survey were:</p> <p>Polly Watt-Geier, MSW Team Leader Health Facility Surveyor</p> <p>Maureen McCann, RN Health Facility Surveyor</p> <p>Rachel Corey, RN Health Facility Surveyor</p> <p>Survey Definitions: + = and % = percentage ADL = Activities of Daily Living BG/BGs = blood glucose BID = twice daily BM = bowel movement cm = centimeter COPD = chronic obstructive pulmonary disease e-mar = electronic medication assistance record ER = Emergency room f/u = follow-up hypoxia = low oxygen levels in the bloodstream L = left LG = large MAR = Medication Assistance Record mcg = micrograms med = medication meq = milliequivalents mg = milligrams NSA = Negotiated Service Agreement PRN = as needed</p>	{R 000}		
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Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Stacy Tennant* TITLE *Admin* (X6) DATE *1-10-14*

Residential Care/Assisted Living

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{R 008}	<p>Continued From page 2 outside services."</p> <p>1. Based on record review and interview, it was determined the facility did not coordinate care when Resident #6 had a change of condition.</p> <p>Resident #6's record documented she was a 60 year-old female, who was admitted to the facility on 10/18/12, with diagnoses including rheumatoid arthritis and osteoporosis. Her record documented she had right foot surgery on 10/17/13.</p> <p>A surgery center's discharge instructions, dated 10/17/13, documented "call your doctor's office...if you experience severe headache...or pain increases...swelling and or pain of the calf muscle..."</p> <p>On 10/30/13 at 8:35 AM, Resident #6 stated, "I have been really sick." She stated, she received the flu shot, then on Saturday (the 26th), she woke up "disoriented, numb, confused and with sinus problems." She further stated that on Sunday morning, the top of her head "felt like it was going to come off" and she could not breath and was not herself. She stated, she went in the hall "crying for help." She stated, the paramedics were called and when they came to assess her, they thought it was a reaction to the flu shot. She stated, "the nurse never looked at me, only evaluated me on the day of the foot surgery." She further stated she had not been feeling well all week and was "not up to par."</p> <p>On 10/30/13 at 10:40 AM, a caregiver stated she had heard Resident #6 had been lightheaded and not feeling well. She further stated she had heard it was a reaction from the flu shot, but she could not confirm it.</p>	{R 008}	<p>Staff has been in serviced that whenever EMTs are called they are required to fill out an incident/accident report. The appropriate entities will be informed of the incident/accident (i.e. physician, nurse, administrator, family, etc). This form will be reviewed by management staff.</p> <p>Once a skin issue is identified, a facility RN will be assigned to monitor the status of the wound, treatment and interventions needed. The facility RN will coordinate the care with any outside agency being utilized by the resident, if applicable.</p> <p>A complete audit of all resident charts will be completed to ensure that we have care plans from all outside agencies. Upon admission, a care conference will be coordinated with any outside agency at which time the outside agency care plan will be placed in resident chart.</p>	
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Residential Care/Assisted Living

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{R 008}	<p>Continued From page 3</p> <p>On 10/30/13 at 10:45 AM, the operations director stated she was unaware that Resident #6 experienced a change of condition and that paramedics were called. She further stated, "she should have been on alert charting to monitor her."</p> <p>On 10/30/13 at 10:54 AM, the facility RN stated she was not aware that paramedics were called over the weekend or that Resident #6 had not been feeling well.</p> <p>On 10/30/13 at 11:15 AM, a caregiver stated, "I heard she was not feeling well. I just did not know why."</p> <p>On 10/30/13 at 11:25 AM, the operations director stated she had investigated Resident #6's change of condition and stated, "supposedly she had a panic attack." She confirmed she had not read the paramedics report, but stated the information was reported to her by the assistant administrator.</p> <p>On 10/30/13 at 11:27 AM, the assistant administrator stated, "I don't know what happened." She stated it was reported to her by the night shift, that the resident was "hyperventilating." "By the time I got here she was okay."</p> <p>On 10/30/13 at 12:00 PM, a caregiver stated she worked Saturday night (the 26th). When she took the resident dinner, the resident stated she felt "weird and miserable. She appeared groggy and looked uncomfortable." She further stated, she tried to make the resident comfortable, but confirmed she had not called the facility nurse. She stated, she had heard the night shift had</p>	{R 008}	<p>Once an order is received for an outside agency for a resident, a care conference will be set up with the agency within 72 hours. Again, the outside agency's care plan will be obtained from the agency and placed in the resident chart.</p> <p>Resident #8 has had a complete change of condition completed by facility nurse.</p> <p>Resident #5 has had a complete skin assessment which was completed by company nurse.</p> <p>Resident #7 no longer resides at facility.</p> <p>Resident #4 has had a skin assessment completed by outside company nurse and interventions were put in place.</p>	
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Residential Care/Assisted Living

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{R 008}	<p>Continued From page 4</p> <p>called the paramedics, but she was unaware what the paramedics' findings were.</p> <p>On 10/30/13 at 12:10 PM, a night shift caregiver, stated, the resident "called me at 5:30 AM and said she could not breath. I called 911. They came in and gave her oxygen, then she was fine." He further stated, she had looked "panicky," but paramedics thought she was fine and thought she had allergies to a nasal spray. He stated, he had never seen her "in that mode." He confirmed he had not reported the resident's change of condition to the facility RN.</p> <p>On 10/31/13 at 11:00 AM, a caregiver stated Resident #6 "got sent out this AM for back pain. She has not been feeling well for awhile."</p> <p>On 10/31/13 at 3:56 PM, the facility RN stated Resident #6 had been admitted to the hospital for an infection. She further stated, the resident had complained about back pain on the night of the 30th. The nurse stated, she went and assessed her. Her vital signs were normal. A urinalysis was done and it was "clear." She looked at the resident's foot and did not see any abnormalities; she stated she had not looked under the dressing or boot. Additionally, she stated, the 30th was the first time she had heard from the resident regarding her shortness of breath incident over the prior weekend.</p> <p>On 11/1/13 at 9:38 AM, the administrator stated she heard Resident #6 had a panic attack over the weekend, but refused to go to the hospital. She further stated, to her knowledge, the resident did not have a history of panic attacks, and her symptoms were unusual for her. She confirmed, the resident had not been evaluated further.</p>	{R 008}		

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{R 008}	<p>Continued From page 5</p> <p>A "24 hour report" documented on 10/26/13, that Resident #6 was "overly tired feeling faint" and caregivers were "pushing fluid, encouraging rest." It also documented, "lots of pain in right (foot) due to being on it so much." There was no further documentation regarding Resident #6's change of condition.</p> <p>Resident #6's record contained an RN assessment dated 10/17/13. There were no further RN assessments in the record. There was no documentation indicating the resident's physician was notified of her changes of condition or that paramedics had to be called. Without further physician involvement, the resident was not provided appropriate follow-up care. Additionally, the paramedics report was not in the record to confirm their assessment findings.</p> <p>A hospital report, dated 10/31/13 through 11/1/13, documented the resident was "presenting with pain over the area of her R great toe, fevers and vomiting x 1 day...Over the last 3-4 days, she has felt more lethargic, has had pain over the area and had abdominal pain. Over the last day, she had fever and vomiting and was brought into the ER for further evaluation. She also complains...of some L flank tenderness...In the ER, she was found to be febrile (fever)..." The report further documented, erythema (redness) was observed extending from the toe to the resident's mid-calf and the resident was diagnosed with cellulitis.</p> <p>Resident #6 experienced unusual symptoms on 10/26/13 and paramedics were called on 10/27/13. The resident continued to not feel well. The facility did not coordinate care to ensure her symptoms were followed up on, as her symptoms may have been indicative of an underlying condition or infection. The resident was not</p>	{R 008}		

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{R 008}	<p>Continued From page 6</p> <p>medically evaluated until the hospital visit on 10/31/13, in which the resident was admitted for cellulitis.</p> <p>2. Based on record review and interview, it was determined the facility did not coordinate wound care for Resident #11. Additionally, they retained her when her wounds were not improving bi-weekly.</p> <p>IDAPA rule 16.03.22.152.05.b states that "No resident will be admitted or retained who requires ongoing skilled nursing care not within the legally licensed authority of the facility. Such residents include:</p> <p>x. A resident with any type of pressure ulcer or open wound that is not improving bi-weekly."</p> <p>Resident #11's closed record, documented she was a 72 year-old female, admitted to the facility on 11/11/10 and discharged to another assisted living on 9/5/13. The resident had diagnosis of COPD. Her record documented she received hospice services beginning on 2/1/13.</p> <p>Resident #11's closed record reviewed on 10/31/13, contained the following:</p> <p>A hospice RN note, dated 8/6/13, documented Resident #11 had some redness and skin breakdown to her coccyx area and she reported the findings to the facility RN, instructing her to monitor for further breakdown.</p> <p>A temporary care plan written by the facility RN, dated 8/9/13, documented Resident #11 had a Stage II pressure ulcer on her buttocks measuring 1.5 cm. The temporary care plan documented, "Hospice covered with transparent</p>	{R 008}		

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{R 008}	<p>Continued From page 7</p> <p>dressing + foam. Offer cushion for sitting" and turn resident every two hours when sitting. The care plan was created 3 days after the initial breakdown was discovered; it did not contain instructions on what staff were to monitor for, or what to do if the dressing came off.</p> <p>A progress note by the facility RN, dated 8/12/13, documented, "We assessed the resident's buttocks together, to find a small reddened area on her right gluteal fold...This area is approximately 1 cm round. The Hospice nurse covered this area with Therahoney and optifoam with a transparent dressing...hospice nurse to obtain new orders" for dressing changes.</p> <p>A hospice RN note, dated 8/12/13, documented, "Assessed pressure ulcer with [facility RN's name]. Dressed w\ therahoney and optifoam. Next to stage 2 is a small...stage 1...Supplies given to facility. Therahoney and optifoam to be applied daily."</p> <p>A physician order, dated 8/13/13, documented staff were to do daily dressing changes and apply Therahoney to the Stage II pressure ulcer.</p> <p>There was no documentation from the facility RN, indicating she monitored the daily dressing changes or had provided instructions to staff on the daily dressing changes.</p> <p>The resident's August 2013 MAR, documented "Apply Therahoney, cover with PolyMem pad and suresite daily to buttocks." The MAR documented the order was implemented on 8/15/13 (two days after it was ordered and three days after the hospice nurse provided wound care). Staff documented they did the dressing change on the 15th, 16th and 19th, but not on the 17th or the</p>	{R 008}		
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{R 008}	<p>Continued From page 8</p> <p>18th. The MAR documented the order was discontinued on the 20th. The facility failed to do four dressing changes.</p> <p>A hospice RN note, dated 8/15/13, documented "Pt was very wet in urine, so I changed attends and linens. I assessed buttocks at this time. Existing stage 2 has not changed. Stage 1 is now a 2. On the R side there is a new stage 2 and a stage 1." The note further documented, the 4 ulcers were discussed with the facility RN, including the two new ulcers observed, that the Stage I had progressed to a Stage II and that there was no progress with the existing Stage II.</p> <p>A fax to the physician by the hospice RN on 8/15/13, documented the RN requested the daily dressing changes were to be discontinued and that hospice "will do dressing changes 3 x week." The fax was signed by the physician (but not dated).</p> <p>There was no documentation the facility RN evaluated Resident #11's wound care after the hospice RN reported the following on 8/15/13: two new wounds, lack of progress with one wound, and the progression of one wound from a Stage I to a Stage II.</p> <p>A hospice RN note, dated 8/16/13, documented she had spoken with the facility RN and informed her, "buttocks wounds have not gotten better." The note was signed by the facility RN.</p> <p>A hospice RN note, dated 8/19/13, documented "...change dressings on buttocks. No progress noted. 1 dressing was missing." The note documented, there were three Stage II wounds and one Stage I. The note further documented, the lack of progress on the wounds was reported</p>	{R 008}		

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{R 008}	<p>Continued From page 9</p> <p>to facility RN. The note was signed by the facility RN.</p> <p>A hospice RN note, dated 8/21/13, documented "New area of concern...blister on coccyx ...opened today. There was no blister on Monday...This is a 2.8 x 2.6 cm stage II...2 more stage II wounds right next to coccyx stage II." The note further documented the information was reported to the facility RN.</p> <p>When comparing the hospice RN notes from 8/19/13 to 8/21/13, the "new area of concern" had increased in size by 1.3 cm x 1.6 cm, as the "new area of concern" measured 1.5 cm and 1 cm on 8/19/13 and had increased to 2.8 x 2.6 cm. Additionally, the other two pressure ulcers had also increased in size from the 8/19/13 measurements.</p> <p>A progress note from the facility RN, dated 8/21/13, documented the hospice nurse, the director of nursing from hospice and the facility's corporate nurse re-evaluated the resident's skin issues.</p> <p>A progress note from the facility's corporate nurse, dated 8/21/13, documented the resident was observed to be thin and emaciated. "RN from hospice to do dressing change for stage III ulcer."</p> <p>A facility RN "Nursing Assessment" dated 8/21/13, documented the resident had a change of condition, with the "reason" listed as "stage III ulcer on coccyx." The note further documented, "hospice to change dressing 3 x weekly."</p> <p>A progress note from the facility's corporate nurse, dated 8/23/13, documented "...facility RN stated stage III ulcer on coccyx stable - no</p>	{R 008}		

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{R 008}	<p>Continued From page 10 worsening or improvement."</p> <p>A hospice RN note, dated 8/23/13, documented the largest pressure ulcer had "first layer or 2 of skin missing." The facility RN was informed of "no observable progress to wounds...waiting for new wound care products."</p> <p>A hospice RN note, dated 8/26/13, documented "LG. stage II healing, others have minimal progress."</p> <p>A hospice RN progress note, dated 9/3/13, documented, "...Changed very wet pull-ups...Dressed wounds on buttocks..." The note further documented, the facility RN was informed "Need to keep her pull-ups dry. Buttocks looks slightly worse."</p> <p>A note from a hospice caregiver, dated 9/4/13, documented "had very wet pull ups/BM. Had to change pants and bedding." The note further documented, a facility representative was informed of the caregiver's findings.</p> <p>A hospice RN noted, dated 9/4/13, documented a facility representative was informed that "Buttocks still the same, 5 openings."</p> <p>After the facility RN identified Resident #11 had a Stage III pressure ulcer on 8/21/13, there was no further documentation from her through the resident's discharge 9/5/13.</p> <p>On 10/31/13 at 10:45 AM, the administrator stated Resident #11 was discharged to a smaller sister assisted living facility, due to her being at "end of life" and needing more care. The administrator stated she was unaware that their corporate and facility nurses had staged one of</p>	{R 008}		
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{R 008}	<p>Continued From page 11</p> <p>Resident #11's wounds as a Stage III. She further stated, the corporate nurse was brought in to consult with the facility nurse, who was newly hired at that time.</p> <p>On 10/31/13 at 11:00 AM, the facility RN stated "I remember checking on the pressure ulcers two or three times." She further stated, hospice did most dressing changes and she recalled the wounds being a Stage II, but she could not say for sure. She stated the resident was moved to a smaller assisted living facility, because the resident became combative and confused and "we could not monitor her."</p> <p>On 11/5/13 at 2:05 PM, the hospice RN, who had cared for the resident's wounds, stated her wounds were "borderline Stage II" approaching a Stage III. She stated, hospice took over wound care, doing dressing changes three times weekly, as staff neglected to do daily dressing changes as ordered. "I would go in and there would be no dressing and no one could tell me who had changed the last dressing." She further stated, she frequently found the resident wet during her visits. Her concerns were reported to the facility RN and administrator, but "it did not help the situation."</p> <p>On 8/6/13, Resident #11 began to have skin breakdown. On 8/13/13, daily dressing changes were ordered for a Stage II wound, which the facility failed to implement. On 8/15/13, three pressure ulcers were present, as a new one had developed and a Stage I had progressed to a Stage II. On 8/21/13, all pressure ulcers had increased in size and the facility RN and corporate RN documented a Stage III pressure ulcer. A day before the resident was discharged to a sister facility, the resident had five pressure</p>	{R 008}		

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{R 008}	<p>Continued From page 12</p> <p>ulcers. The facility did not coordinate care, to ensure Resident #11's wounds were healing bi-weekly, and were appropriate for the level of care an assisted living facility could provide. Further, the facility transferred the resident to a sister assisted living facility, although the status of the resident's wounds were not appropriate for any assisted living facility.</p> <p>3. Based on record review, interview and observation, it was determined the facility did not coordinate care with Resident #8's physician when she had shortness of breath and an eye infection.</p> <p>Resident #8's record documented she was an 53 year-old female, who was admitted to the facility on 9/11/13, with diagnoses including schizophrenia, diabetes and arthritis.</p> <p>A. Failure to address Resident #8's shortness of breath (SOB)</p> <p>On 10/30/13 at 10:22 AM, Resident #8 was observed sitting at a table in the dining room. She requested a surveyor ask for a caregiver to assist her, as she was having shortness of breath. Resident #8 was observed to take numerous shallow breaths while asking for assistance.</p> <p>On 10/30/13 at 10:24 AM, the facility RN stated Resident #8's shortness of breath was related to an attention seeking behavior. The RN asked the caregiver when the resident last was assisted with her inhaler. The caregiver stated she had assisted with the inhaler 5 to 10 minutes earlier. The RN asked the caregiver to go talk with the resident about how she was feeling. The RN was not observed to assess the resident at this time.</p>	{R 008}		
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{R 008}	<p>Continued From page 13</p> <p>Resident #8's record was reviewed between 10/30/13 and 10/31/13. It contained following documents:</p> <p>A nursing progress note, dated 10/30/13 at 11:30 AM, documented "Resident requested the nurse. This behavior occurs daily and numerous times throughout the day. She reports this morning that she thinks she can't catch her breath. When asked if something had happened, she reports that her room is hot. However, she is sitting in the dining room....I listen to her lungs and she breathes very shallowly. Her respirations are 20 at rest and she does not appear to be laboring and she is not in visible distress. Her heart rate is 82 and her murmur can be heard on auscultation...Offered emotional support and assured her again that she might find it helpful if she makes a list that she can talk to her doctor about at her next visit. She reports that she did that for her last visit, but she can start a new one."</p> <p>A physician's clinic note, dated 10/22/13, documented the following concerns and treatments related to her shortness of breath:</p> <p>Physician's Concerns:</p> <ul style="list-style-type: none"> * Resident #8 complained of having "difficulty in breathing" and was experiencing shortness of breath (SOB). * Resident #8 had a history of asthma and there was a concern the resident was experiencing "obesity hypoventilation vs sleep apnea." * Resident #8 was "hypoxic today in the clinic to 88% while sitting; when asked to take deep breath she increased to 92%." The clinic note documented "gave albuterol tx that did not help 	{R 008}		

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{R 008}	<p>Continued From page 14</p> <p>with hypoxia."</p> <p>Physician's Treatments:</p> <ul style="list-style-type: none"> * "go to ER if chest pain, increased SOB, or syncope." * "f/u in 1 week with any provider to evaluate for any improvement in hypoxia." <p>There was no documentation in Resident #8's record that the facility monitored or observed for changes of shortness of breath, after she had visited the physician on 10/22/13. Additionally, there was no record of a follow-up appointment being scheduled.</p> <p>On 10/30/13 at 2:19 PM, the facility RN and operations director were interviewed regarding Resident #8's follow-up appointment. At that time, the facility RN was not aware of a follow-up appointment. The operations director stated the resident had been seen by the physician on 10/28/13. She stated she would request the clinic note, as it was not in the facility.</p> <p>On 10/31/13 at 8:49 AM (3 days after the physician visited the resident), the facility received the physician's clinic notes which were signed and dated by physician on 10/29/13.</p> <p>The physician's clinic note, dated 10/29/13, documented the following concerns, recommendations and treatments for Resident #8's shortness of breath:</p> <p>Physician's Concerns:</p> <ul style="list-style-type: none"> * "Still some SOB. Now coughing up phlegm, whitish, not brown or green." <p>Physician's Recommendations:</p>	{R 008}		

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{R 008}	<p>Continued From page 15</p> <p>* Resident "complains of limited duration of physical activity and also is denied the chance to use her inhaler as often as she needs for SOB."</p> <p>* "Use inhaler prior to hallway exercise walks and going out of the facility shopping."</p> <p>* "Increase duration of exercise minutes as breathing permits, taking deeper breaths and posturing with back straight when feeling dizzy or SOB while at rest allow better air exchange...."</p> <p>Physician's New Treatments: * "Use albuterol inhaler and attempt to sit more upright to take deeper breaths and enable better oxygen levels. Attempt to go for walks after using albuterol inhaler properly for 10-15 minutes at first, then increasing time for daily exercise twice a day."</p> <p>There was no documentation in the 24 hour log book, temporary care plan, progress notes or NSA to instruct caregivers on how to encourage Resident #8 to increase her physical activity or how to improve her posture while sitting.</p> <p>On 10/31/13 at 2:48 PM, the facility RN and operations director stated they had not had time to read the entire physician's clinic note and were not aware of the instructions related to decreasing Resident #8's shortness of breath. This resulted in Resident #8 experiencing continued symptoms without treatments.</p> <p>B. Failure to implement Physician's Orders:</p> <p>Resident #8's record was reviewed between 10/30/13 and 10/31/13. The record contained a physician's clinic note, dated 10/22/13. The clinic note documented the following treatments and</p>	{R 008}		

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{R 008}	<p>Continued From page 16</p> <p>medications were ordered for Resident #8's shortness of breath:</p> <p>Physician's Treatments:</p> <ul style="list-style-type: none"> * 5 days of oral steroids * albuterol inhaler every 4 to 6 hours scheduled for next 7 days * start inhaled steroid after 5 day course of oral steroid <p>Physician's orders:</p> <ul style="list-style-type: none"> * prednisone 50 mg tabs take one tablet by mouth four 4 days. * Flovent Diskus 100 mcg 1 to 2 puffs inhaled BID <p>Resident #8's October 2013 MAR, did not include the prednisone or Flovent inhaler that had been ordered on 10/22/13.</p> <p>On 10/31/13 at 3:50 PM, a bubble pack of prednisone was observed with four doses; none of the medication had been popped out and given to Resident #8. Additionally, the Flovent diskus was not observed in the facility.</p> <p>A physician's clinic note, dated 10/29/13, documented Resident #8 "complains of limited duration of physical activity and also is denied the chance to use her inhaler as often as she needs for SOB. Will check with nursing staff at her home facility to verify access to the rescue inhaler as well as...Flovent, that she was prescribed at last visit."</p> <p>On 10/31/13 at 3:56 PM, the facility RN stated she had been out sick the previous week and did not come back to the facility until 10/28/13. She</p>	{R 008}		

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{R 008}	<p>Continued From page 17</p> <p>stated she was unaware the medications had been ordered. The operations director or the administrator designee would have had to process the orders to ensure they were implemented. The facility nurse confirmed, the resident did not receive the prednisone and Flovent inhaler as ordered.</p> <p>As of 10/31/13, the facility did not ensure Resident #8 received medications for shortness of breath after they were ordered by the physician on 10/22/13. Additionally, there was no documentation the physician was notified that Resident #8 had not received her medications as ordered.</p> <p>C. Coordination of care of Resident #8's eye infection</p> <p>On 10/30/13 at 2:19 PM, the operations director stated Resident #8 had been seen by the physician for a follow-up appointment on 10/28/13, and she would request the notes.</p> <p>On 10/31/13 at 8:49 AM (3 days after the physician visited the resident), the facility received a physician's clinic note, which was signed and dated by physician on 10/29/13.</p> <p>There was no documentation in Resident #8's record the facility had been aware of 10/28/13, physician's findings, prior to obtaining the clinic note on 10/31/13.</p> <p>The physician's clinic note, dated 10/29/13, documented the following concerns, recommendations and treatments for Resident #8's eye infection (Conjunctivitis/Pink eye):</p> <p>Physician's Concerns:</p>	{R 008}		
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{R 008}	<p>Continued From page 18</p> <p>* "Eye discharge and redness; worse on R) side, present for a few days on left side. Has used eye drops to molsten but this isn't helping." The physician documented Resident #8 had a conjunctivitis infection (pink eye) in both eyes.</p> <p>Physician's Recommendations: * "Resident "has had redness in her eyes for weeks, as of recently has had thicker discharge and discomfort worsening with only using clear eye drops. Today, she has signs of bacterial conjunctivitis and should start an antibiotic eye drop...."</p> <p>Physician's Treatments: * "Eye infection: patient needs 1-2 drops of polymyxin antibiotic in each eye for a minimum of 5 days, or longer until redness and discharge are gone for a full 2 days."</p> <p>Physician's Order: * 10/28/13 - "Polymyxin B-Trimethoprim 1000-0.1 Unit/ML-% Soln apply 1 drop to each eye 4 times daily for at least 5 days, including another 2 days after symptoms resolve."</p> <p>Resident #8's October 2013 MAR, did not include Polymyxin B-Trimethoprim drops for her contagious eye infection.</p> <p>Resident #8's Polymyxin B-Trimethromprim drops were not observed in the medication cart on 10/31/13.</p> <p>On 10/31/13 at 11:24 AM, Resident #8 was resting in her room. She stated that her eyes had been bothering her for "seven weeks."</p> <p>There were no progress notes documenting the nurse had assessed Resident #8's eye at</p>	{R 008}		
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{R 008}	<p>Continued From page 19</p> <p>anytime. Nor was there documentation that she had provided infection control instructions to Resident #8 on how to prevent spreading of a contagious eye infection.</p> <p>A temporary care plan, dated 10/31/13 (3 days after diagnosis), documented Resident #8 had "Conjunctivitis (eye infection)" and required an antibiotic eye drop. The care plan also documented caregivers were to "encourage hand washing before meals, and after bathroom use." The care plan also documented the resident should not be sharing "towels (or) washcloths" with other residents. The temporary care plan was not signed by any of the caregivers, acknowledging they had read the information.</p> <p>On 10/31/13 at 12:27 PM, Resident #8 stated, "my eyes are red and stuff is coming out of them." The resident stated, she was not aware that she had an eye infection. The resident also stated she was unaware she would be receiving eye drops for her eyes. She also confirmed she had not received any infection control education on how to prevent the spread of infection to others.</p> <p>On 10/31/13 at 3:54 PM, a caregiver stated Resident #8 had complained about her eyes burning the previous evening and was given her PRN saline eye drops. She stated she was not aware the resident had an eye infection.</p> <p>On 10/31/13 at 4:06 PM, a caregiver stated Resident #8 had gotten shampoo in her eyes the previous evening during her shower, so she was assisted with her PRN saline eye drops. The caregiver further stated, she "had no idea" that Resident #8 had pink eye. She further stated, "it would have been nice to know."</p>	{R 008}		

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{R 008}	<p>Continued From page 20</p> <p>On 11/1/13 at 1:56 PM, the operations director stated, Resident #8's eye drops had not been implemented as she was allergic to the eye drops that had been ordered. She stated the pharmacy was working with the physician to get different eye drops ordered.</p> <p>The facility failed to coordinate care with Resident #8's physician, failed to provide appropriate follow-up care and failed to educate the resident and staff regarding her conditions. The facility did not implement medication orders and treatments when Resident #8 experienced shortness of breath and a contagious eye infection (pink eye). This resulted in Resident #8 experiencing continued symptoms without treatments, as well as the potential spread of an infectious eye condition.</p> <p>4. Based on record review and interview, it was determined the facility did not coordinate wound care for Resident #5, when the facility nurse did not assess his skin breakdown.</p> <p>Resident #5's record documented he was a 76 year old male, who was admitted to the facility on 2/7/13, with diagnoses including diabetes, weakness of the lower limbs, dementia and urinary incontinence.</p> <p>A hospice nurse note, dated 10/16/13, documented Resident #5 had "Un-blanching redness on buttocks - larger area this week." There was no other documentation in the resident's record, prior to 10/16/13, regarding redness on the resident's buttocks.</p> <p>An "Alert Charting" form, dated between 10/17 and 10/30/13, directed "...cream q shift only on left buttox [sic] rash." A night shift note, dated</p>	{R 008}		

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{R 008}	<p>Continued From page 21</p> <p>10/17/13, documented "Cream applied @ 12:30 when he got up for restroom." Between 10/18/13 and 10/30/13, seventeen notes were documented, but none regarding the rash on the resident's buttock, or the cream that was to be applied to the rash.</p> <p>A physician's order dated 10/21/13, documented, "Clamoseptic [sic]...apply topically to buttocks BID."</p> <p>On 10/30/13 at 3:40 PM, a family member stated, Resident #5's skin had begun to break down "a couple weeks ago." She stated, the hospice staff were good at applying the medication to the resident's buttocks, but the facility staff were not, until hospice intervened. "Hospice is great (at) keeping me informed of what is going on. The facility is not...They want hospice do everything, but the facility should be doing more." The family member further stated, she had just spoken to the facility nurse on the phone and asked if she had assessed the resident's skin breakdown and the facility nurse stated she had not.</p> <p>On 10/31/13 at 9:30 AM, a hospice nurse stated the resident had skin breakdown on his buttocks. "It's technically a Stage II, but just barely." She stated, that when she assessed residents at the facility she "always reports" her assessment findings to the facility nurse, in person, or by "leaving a note on her desk." The hospice nurse stated the facility "was not good at addressing all of the issues" she brought to their attention.</p> <p>On 10/31/13 at 10:00 AM, the facility RN stated, she had not assessed Resident #5's buttock. She stated, the hospice nurse made her aware Resident #5 had breakdown on his buttock "two days ago." She further stated, "It's been red, but</p>	{R 008}		
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{R 008}	<p>Continued From page 22</p> <p>nothing to be worried about."</p> <p>On 10/31/13 at 3:35 PM, a caregiver stated, Resident #5 "had a bedsore on his bottom that started about 3 weeks ago." She stated any instructions she had received about caring for the resident's bedsore, she received from hospice staff. "Hospice wants him to lie on his side and wants his [catheter] bag emptied every 2 hours, if not more." The only instructions she had received from the facility was by reading the MAR, which documented to put Calmoseptic ointment on his buttocks.</p> <p>On 11/1/13 at 9:50 AM, the administrator stated she had just returned from vacation on 10/28/13, and was not aware Resident #5 had a "rash" on his buttocks.</p> <p>Resident #5 was a diabetic with limited mobility and urinary incontinence who had a reddened area on his buttock for at least 15 days. During these 15 days, there was no documentation the facility nurse had assessed the resident's change in condition or the facility had coordinated the resident's care with the hospice agency. This lack of coordination increased the potential for Resident #5 to have further skin breakdown.</p> <p>5. Based on record review and interview, it was determined the facility did not coordinate orthopedic care for Resident #7's fractured arm.</p> <p>Resident #7's record documented he was a 46 year old male, who was admitted to the facility on 8/15/13, with diagnoses including traumatic brain injury, diabetes, a history of a cardiovascular accident and a history of falls.</p> <p>An incident report, dated 9/27/13 at 1:30 AM,</p>	{R 008}		

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{R 008}	<p>Continued From page 23</p> <p>documented the resident had fallen in his bathroom and complained of pain in his left arm. The report further documented, paramedics arrived, instructed the staff and resident to "ice" the area and did not transport the resident to a hospital.</p> <p>An emergency room form, dated 9/27/13, documented the resident arrived to the ER at 7:15 AM, by paramedics. The form documented the resident had fractured his left lower arm after an unwitnessed fall in his bathroom. The report also documented, the resident was to follow-up with an orthopedist, one week after the emergency room visit.</p> <p>An "Alert Charting" form, documented the resident had a left arm fracture. The only notes on the form were dated 10/29, AM and PM shifts and 10/30, AM shift (approximately one month after the resident fell). There was no other documentation found in the resident's record, including progress notes or notes documented by the facility nurse, regarding the resident's fractured arm.</p> <p>On 10/28/13 at 10:55 AM, the resident stated the nurse had not assessed his arm.</p> <p>On 10/29/13 at 2:55 PM, a family member stated the resident missed a follow-up appointment with his orthopedist because the facility did not remind him to wait for the transportation bus in the front lobby. She called the facility from the physician's office when the resident did not show up and was told by a caregiver, "He was in his room, not waiting in the lobby, so he missed the bus." The family member stated, when she tried to follow-up with his appointments, "it's difficult. There is no good organization here... The lady at the front</p>	{R 008}		

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{R 008}	<p>Continued From page 24</p> <p>desk did not know he had an appointment...One of the reasons that he is here, is because he has short term memory loss. He doesn't get the help he needs remembering things."</p> <p>Resident #7 fell and fractured his arm on 9/17/13. For 41 days, there was no documentation the facility nurse had assessed the resident's change in condition or the facility had coordinated care with the resident's orthopedist. This resulted in Resident #5 missing an appointment with his orthopedic physician and the facility nurse not providing instruction to staff on how to meet the resident's increased care needs.</p> <p>6. Based on record review and interview, it was determined the facility did not coordinate care for Resident #4's reddend toes.</p> <p>Resident #4's record documented he was an 86 year old male, who was admitted to the facility on 10/15/08, with diagnoses including atrial fibrillation, dementia and diabetes.</p> <p>A nurse assessment, dated 9/29/13, documented the facility RN had identified there was a problem with the resident's toes. There was no other facility documentation found in the resident's record regarding his reddened toes.</p> <p>A physician's "follow-up" visit report, dated 10/22/13, documented, "I will have him soak tid in warm salt water. If not substantially resolved in 7-10 days, I will refer to podiatry."</p> <p>On 10/28/13 at 10:15 AM, Resident #4 was observed to pull off his left sock and stuck his foot into the air. He stated, "Are you here to look at my toes? Someone needs to look at them." The resident stated the facility nurse had not looked at</p>	{R 008}		
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{R 008}	<p>Continued From page 25</p> <p>his toes. "I went to my doctor and I'm soaking them, but this one is not getting better." The resident pointed to his great toe which was reddened. "I'm supposed to go back (to the doctor) if it is not getting better, but no one will look at it." At this time, the resident was encouraged to ask the facility nurse to look at his toes.</p> <p>On 10/30/13 at 3:20 PM, Resident #4 stated, "Are you going to look at my toes?" He further stated, the facility nurse still had not seen his toes although he had requested that she look at them.</p> <p>Resident #4, a diabetic, experienced a change in condition involving redness and soreness of his left toes. The facility nurse documented this change, on 9/29/13. However, a month later on 10/30/13, the resident still complained his great toe remained red and sore. For 31 days, there was no documentation the facility nurse had re-assessed the resident's change in condition or the facility had coordinated care with the resident's physician.</p> <p>The facility did not coordinate care after Residents #4, #5, #6, #7, #8 and #11, experienced physical changes of conditions.</p> <p>II. Assistance and Monitoring of Medications</p> <p>IDAPA 16.03.22.011.08, states inadequate care is "When a facility fails to provide...assistance and monitoring of medications."</p> <p>1. Resident #3's record documented she was a 47 year-old female, who was admitted to the facility on 12/5/12, with a diagnosis of Type I diabetes.</p>	{R 008}	<p>II. <u>16.03.22.011.08 Assistance and Monitoring of Medications</u></p> <p>The staff was educated about the proper procedure to assist a resident with blood sugar checks and insulin injection. A sliding scale matrix was created for each resident. The matrix is stored along with the injection pen. The staff has been instructed that they can show a resident their sliding scale matrix and ask them how much they need, but cannot inform the resident of how much to take. Staff has been instructed when they must notify</p>	
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{R 008}	<p>Continued From page 26</p> <p>Resident #3's September 2013 MAR, documented she was to receive Novolog insulin at breakfast according the the following sliding scale:</p> <p>0-150 = 0 units 151-200 = 2 units 201-250 = 4 units 251-300 = 6 units 301-350 = 8 units greater than 350 = 10 units</p> <p>Resident #3's September 2013 MAR documented the following, regarding Novolog insulin at breakfast:</p> <p>*9/1: 2 units was given for a BG of 235; Resident #3 refused the additional 2 units.</p> <p>*9/7: 1 unit was given for a BG of 234; Resident #3 refused the additional 3 units.</p> <p>*9/15: 1 unit was given for a BG of 269; (6 units was ordered)</p> <p>*9/17: 1 unit was given for a BG of 290; Resident #3 refused the additional 5 units.</p> <p>*9/19: 1 unit was given before the meal and 3 units after the meal, for a BG of 161. (Resident should have received 2 units prior to the meal).</p> <p>*9/25: 1 unit was given for a BG of 197; Resident #3 refused the additional unit.</p> <p>Resident #3's September 2013 MAR, documented she was to receive Novolog insulin at lunch and dinner, according to the following sliding scale:</p>	{R 008}	<p>the facility RN and physician of refusals.</p> <p>The insulin sliding scales have been audited to ensure that the correct dosages have been injected by residents.</p> <p>The licensed nurse will monitor those residents that are admitting with insulin orders. New admissions will be observed and assessed the day of admission for their ability to self administer insulin.</p> <p>Management will educate staff on satellite medications to ensure antibiotics are started within 24 hours of prescription receipt.</p> <p>Management will pull medication report daily to ensure that all orders have been posted and have assigned times.</p> <p>Please see prior paragraph for fix in regards to resident #4.</p> <p>Resident #2 admitted with only two weeks' worth of medications and the remainder of the month's medications was not requested from the pharmacy. Upon admission, resident's medications will be reconciled with the facility's cycle fill to ensure that resident has enough meds to last until the cycle fill meds are</p>	<p>11/9/14</p>
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{R 008}	<p>Continued From page 27</p> <p>0-90 = 0 units 91-150 = 2 units 151-200 = 4 units 201-250 = 6 units 251-300 = 8 units 301-350 = 10 units 351-400 = 12 units</p> <p>Resident #3's September 2013 MAR documented the following regarding Novolog insulin at lunch:</p> <p>(BGs were documented as being taken at 11:00 AM)</p> <p>*9/2: Resident #3 refused insulin for a BG of 183; (4 units was ordered).</p> <p>*9/7: 2 units of insulin was given for a BG of 226; Resident #3 refused the additional 4 units.</p> <p>*9/8: 2 units of insulin was given for a BG of 155; (4 units was ordered)</p> <p>*9/10: 3 units of insulin was given for a BG of 325; (10 units was ordered)</p> <p>*9/11: 3 units of insulin was given for a BG of 315; (10 units was ordered)</p> <p>*9/12: 2 units of insulin was given for a BG of 201;(6 units was ordered)</p> <p>*9/13: 3 units of insulin was given for a BG of 276; (8 units was ordered)</p> <p>*9/15: 2 units of insulin was given for a BG of 270; (8 units was ordered)</p> <p>*9/16: 1 unit of insulin was given for a BG of 169;</p>	{R 008}		

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{R 008}	<p>Continued From page 28</p> <p>Resident #3 refused the additional 3 units.</p> <p>*9/26: 2 units of insulin was given for a BG of 297; Resident #3 refused the additional 6 units.</p> <p>Resident #3's September 2013 MAR documented the following regarding Novolog insulin at supper:</p> <p>(BGs were documented as taken at 4:00 PM)</p> <p>*9/5: 3 units was given for a BG of 389; (12 units was ordered)</p> <p>*9/7: 1 unit was given for a BG of 207; (6 units was ordered)</p> <p>*9/8: 3 units was given for a BG of 350; Resident #3 refused the additional 4 units</p> <p>*9/9: 1 unit was given for a BG of 206; (6 units was ordered)</p> <p>*9/18: 1 unit was given for a BG of 99; (2 units was ordered)</p> <p>*9/27: 2 units was given for a BG of 269; (8 units was ordered)</p> <p>There were at least 22 instances in September 2013, when Resident #3 was assisted with the wrong dose of insulin.</p> <p>There was no documentation in the record indicating the physician was notified that the resident was not assisted with insulin as ordered in the month of September.</p> <p>Resident #3's record contained a physician order, dated 10/2/13, documenting the resident was to receive Lantus (long acting insulin) 9 units in the</p>	{R 008}		

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{R 008}	<p>Continued From page 29</p> <p>morning and 9 units at 9:00 PM. Staff were to log all Novolog (short acting insulin) according to the sliding scale.</p> <p>Resident #3's October 2013 MAR, documented she was to receive Novolog insulin, at breakfast, according the the following sliding scale:</p> <p>0-150 = 0 units 151-200 = 2 units 201-250 = 4 units 251-300 = 6 units 301-350 = 8 units greater than 350 = 10 units</p> <p>According to the October 2013 MAR, the resident should have received Novolog insulin on 12 occasions at Breakfast, based on her 7:00 AM blood glucose levels. However, the MAR documented the resident only received Novolog insulin on five occasions. On four of those occasions, the resident received the incorrect amount of insulin. On three of those occasions, it was documented the resident refused additional insulin.</p> <p>Resident #3's October 2013 MAR, documented she was to receive Novolog insulin at lunch and dinner, according to the following sliding scale:</p> <p>0-90 = 0 units 91-150 = 2 units 151-200 = 4 units 201-250 = 6 units 251-300 = 8 units 301 -350 = 10 units 351-400 = 12 units</p> <p>According to the October 2013 MAR, the resident should have received Novolog insulin on 24</p>	{R 008}		

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{R 008}	<p>Continued From page 30</p> <p>occasions at lunch, based on the 12:00 PM blood glucose levels. However, the MAR documented the resident only received Novolog insulin on 10 occasions. Nine of the 10 occasions, the resident was assisted with the incorrect amount of insulin. On three of those occasions, it was documented the resident refused the additional units of insulin.</p> <p>A chart hand-written by Resident #3, was observed in her room. The chart included blood sugar levels recorded from 10/17/13 until 10/28/13 for each meal and the amount of insulin taken. According to the chart, the resident should have taken Novolog on six occasions at breakfast, but none was taken. At lunch, the resident required insulin on every day recorded, but it was documented the resident took insulin on two occasions, and the correct amount was not taken according to the sliding scale. At dinner, the resident required insulin each day, but she only took insulin on two occasions. On these two occasions the insulin dosage taken was not correct according to the sliding scale. Additionally, on 13 occasions, the blood sugars were incongruent with what staff documented on the MAR.</p> <p>The facility RN documented in the progress notes the following:</p> <p>*10/2/13,"Discussed new orders with the resident...Resident reports that she will track her BGs from her room on the form the doctor requested. She also acknowledged understanding of her new Lantus and BG testing orders." It was not documented if the resident was observed to have demonstrated her ability to interpret the new orders or if staff had been instructed on how to monitor the resident's usage of insulin.</p>	{R 008}		

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{R 008}	<p>Continued From page 31</p> <p>*10/14/13, "...Staff reports that this resident adamantly controls her use of insulin + monitoring of BGs. Advised using assertion with resident..." It was not documented that the physician was notified of the resident not receiving insulin as ordered or if the facility RN had evaluated Resident #3's knowledge of her sliding scale orders.</p> <p>On 10/28/13 at 3:20 PM, a medication aide stated, "She tells me her BG and I ask if she wants insulin. She refused it a lot."</p> <p>On 10/28/13 at 3:35 PM, the operations director stated she was unaware that Resident #3 was not taking insulin as ordered.</p> <p>On 10/28/13 at 3:27 PM, the facility RN stated the physician had not been notified of Resident #3 not receiving insulin as ordered, but stated, "he will now."</p> <p>On 10/29/13 at 1:55 PM, Resident #3 stated, "I check my blood sugar up to six times a day. Unless it is 200 or above, I won't take insulin." She further stated, she would take 2 units of insulin if her blood sugar was above 200 and "I may take 4 units if it is 400. If my machine says it is 'too high' I may take 10 units." The resident stated she did not like to take Novolog in the morning, as she took Lantus during that time. She further stated, the facility RN had not observed her take insulin or provided her instruction regarding her insulin. "She has not asked me about my insulin."</p> <p>On 11/1/13 at 9:45 AM, the administrator stated it was Resident #3's right to refuse insulin and she thought the resident's physician had been notified</p>	{R 008}		

Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R718	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 11/01/2013
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NAME OF PROVIDER OR SUPPLIER AARENBROOKE PLACE - CORY LANE, ASHLE	STREET ADDRESS, CITY, STATE, ZIP CODE 9327 CORY LANE BOISE, ID 83704
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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 32 regarding her refusals.</p> <p>The facility did not provide appropriate monitoring and assistance of Resident #3's insulin. The facility RN did not evaluate and monitor Resident #3's insulin usage. There were many instances when the resident required insulin, but did not take it, or did not take the correct amount, as ordered. Additionally, Resident #3's physician was not informed of her misuse of insulin, so that an informed decision could be made regarding her medical care.</p> <p>2. Resident #5's record documented he was a 76 year old male, who was admitted to the facility on 2/7/13, with diagnoses including diabetes, weakness of the lower limbs, dementia and urinary incontinence.</p> <p>a) INSULIN</p> <p>Resident #5's August, September and October's 2013 MARS, documented he was to receive Novolog insulin before meals according the following sliding scale:</p> <p>0-150 = 2 units 151-200 = 4 units 201-250 = 6 units 251-300 = 8 units 301-350 = 10 units 351-400 = 12 units 401-450 = 14 units 451-500 = 16 units ****Notify MD if BG is above 350</p> <p>Several discrepancies between the physician's order, the resident's blood glucose readings, the amount of insulin the resident received and the amount of insulin the resident should have</p>	{R 008}		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R718	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 11/01/2013
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NAME OF PROVIDER OR SUPPLIER AAREN BROOKE PLACE - CORY LANE, ASHLE	STREET ADDRESS, CITY, STATE, ZIP CODE 9327 CORY LANE BOISE, ID 83704
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{R 008}	<p>Continued From page 33</p> <p>received, were documented on Resident #5's MARs.</p> <p>August 2013 MAR:</p> <p>* At breakfast on 8/7, 8/8, 8/9, 8/12, 8/14, 8/15, 8/16, 8/24 and at lunch on 8/5, 8/16, 8/17, 8/23 and at dinner on 8/7, 8/15, 8/16 and 8/25, no blood glucose readings or amount of insulin received was documented, although insulin was required at each of these times. There also was no documentation found in the resident's record why these dates were left blank.</p> <p>* At breakfast on 8/13 and at lunch on 8/2, 8/12, 8/24, 8/26, 8/30, and at dinner on 8/1, 8/2, 8/3, 8/5, 8/6, 8/8, 8/11, 8/13, 8/14, 8/24 and 8/29, the resident's blood glucose readings were above 350. There was no documentation found in the resident's record that the physician was notified, as directed in the orders.</p> <p>September 2013 MAR:</p> <p>* At breakfast on 9/6, 9/13, 9/18, 9/19, 9/26 and at lunch on 9/6, 9/10, 9/22, 9/28 and at dinner on 9/4, there were blood glucose readings documented. However, no amount of insulin was documented, although insulin was required at each of these times. There was no documentation found in the resident's record why these dates were left blank.</p> <p>* At lunch on 9/14, 9/18 and 9/26, no blood glucose readings or amount of insulin received was documented. There was no documentation found in the resident's record why these dates were left blank.</p> <p>* At lunch on 9/30 and at dinner on 9/25, the</p>	{R 008}		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R718	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 11/01/2013
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NAME OF PROVIDER OR SUPPLIER AARENBROOKE PLACE - CORY LANE, ASHLE	STREET ADDRESS, CITY, STATE, ZIP CODE 9327 CORY LANE BOISE, ID 83704
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{R 008}	<p>Continued From page 34</p> <p>resident's blood glucose was above 350. There was no documentation in the resident's record why the physician was not called as directed in the physician's orders.</p> <p>* At lunch on 9/27, the resident's blood glucose was 155 and the resident should have received 4 units of insulin. The MAR documented the resident received only 2 units.</p> <p>* At dinner on 9/29, the resident's blood glucose was 272 and the resident should have received 8 units of insulin. The MAR documented the resident received 10 units.</p> <p>* At dinner on 9/1, 9/2 and 9/7, the MAR documented the resident was "out of the facility," yet blood glucose readings were documented. There was no documentation found in the resident's record explaining this.</p> <p>October 2013 MAR:</p> <p>* At breakfast on 10/6, 10/13, 10/21, 10/24, 10/27, 10/28, at lunch on 10/23, 10/28 and at dinner on 10/17 and 10/20, there were blood glucose readings documented. However, no amount of insulin was documented, although insulin was required at each of these times. There was no documentation found in the resident's record why these dates were left blank.</p> <p>* At lunch on 10/6, 10/9 and 10/18, no blood glucose readings or amount of insulin received was documented. There was no documentation found in the resident's record why these dates were left blank.</p> <p>* At lunch on 10/28, and dinner on 10/19 and 10/27, the resident's blood glucose was above</p>	{R 008}		

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NAME OF PROVIDER OR SUPPLIER AARENBROOKE PLACE - CORY LANE, ASHLE	STREET ADDRESS, CITY, STATE, ZIP CODE 9327 CORY LANE BOISE, ID 83704
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{R 008}	<p>Continued From page 35</p> <p>350. There was no documentation found in the resident's record why the physician was not called as directed in the physician's orders.</p> <p>* At dinner on 10/3, 10/22 and 10/23, the MAR documented the resident was "out of the facility," yet blood glucose readings were documented. There was no documentation found in the resident's record explaining this.</p> <p>On 10/30/13 at 10:15 AM, the facility RN stated she could not explain the discrepancies. She stated explanations should be documented in the "e-mar." However, at 10:30 AM, when the e-mar was reviewed online, no documentation for the discrepancies could be found.</p> <p>On 10/31/13 at 3:40 PM, the facility RN confirmed there was no facility system in place to monitor the medication assistance program to identify and correct such discrepancies.</p> <p>On 10/31/13 at 12:35 PM, Resident #5 was observed checking his blood glucose and taking his insulin. After the resident checked his blood glucose, the caregiver handed him his insulin pen. The caregiver stated, "Your blood sugar was 258, so you get 8 units of insulin." The resident stated, he did not have his insulin sliding scale memorized and took whatever the caregiver told him to take. He said, if the caregiver did not tell him how many units of insulin to take, "I would not know how much to take then."</p> <p>Resident #5, a diabetic with dementia, was not accurately assisted with his blood glucose testing and subsequent insulin doses multiple times in August, September and October of 2013. This included unlicensed assistive personnel, operating outside of their scope of practice, by</p>	{R 008}		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R718	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 11/01/2013
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NAME OF PROVIDER OR SUPPLIER AARENBROOKE PLACE - CORY LANE, ASHLE	STREET ADDRESS, CITY, STATE, ZIP CODE 9327 CORY LANE BOISE, ID 83704
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{R 008}	<p>Continued From page 36</p> <p>determining the amount of insulin to be given to the resident. Further, the resident was not familiar with his sliding scale doses to be able to question any discrepancies made by the unlicensed personnel. Additionally, the facility failed to have a system in place to monitor for and correct insulin discrepancies which increased the potential for Resident #5 to experience hypoglycemic or hyperglycemic events which could be life-threatening.</p> <p>b) CIPROFLOXACIN (oral antibiotic)</p> <p>A lab report, dated 9/27/13, documented Resident #5 had a urinary tract infection (UTI).</p> <p>A physician's order, dated 9/27/13, documented the resident was to receive Ciprofloxacin 500 mg po twice daily for 7 days for a UTI.</p> <p>Resident #5's September 2013 MAR, documented he did not receive the medication until 9:00 PM on 9/30/13, three days after the order was written.</p> <p>Resident #5 did not begin to receive Ciprofloxacin for three days after the physician's order was written, which resulted in a delay in antibiotic treatment.</p> <p>c) NITROFURANTOIN</p> <p>A physician's order, dated 10/25/12, documented Resident #5 was to receive nitrofurantoin 100 mg daily for UTI prevention.</p> <p>The medication was not documented on the October 2013 MAR.</p> <p>On 10/28/13 at 3:00 PM, the blister pack in the</p>	{R 008}		
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{R 008}	<p>Continued From page 37</p> <p>medication cart was observed. None of the blisters had been broken. The first dose to be given was marked, 10/28/13 at 5:00 PM.</p> <p>A physician's order was dated 10/25/13. As of 3:00 PM on 10/28/13, Resident #5 had not received the nitrofurantoin, three days after the order was written.</p> <p>This resulted in a delay in treatment to prevent another UTI which Resident #5 had just recovered from.</p> <p>The facility failed to have a system in place to monitor for and correct medication discrepancies. This failure increased the potential for Resident #5 to experience life threatening insulin related events. Further, this failure created a delay in treatment, which may have prolonged the signs and symptoms of a urinary tract infection.</p> <p>3. Resident #4's record documented he was an 86 year old male, who was admitted to the facility on 10/15/08, with diagnoses including atrial fibrillation, dementia and diabetes.</p> <p>The following were physician's orders and the corresponding documentation on Resident #4's August, September and October 2013 MAR's:</p> <p>* Physician's Order, 8/21/13: Coumadin 8 mg Monday, Wednesday and Friday and 7 mg on Tuesday, Thursday, Saturday and Sunday.</p> <p>* MAR 8/22/13: medication not given.</p> <p>* MAR 8/24/13: blank</p> <p>Resident #4 should have received 7 mg on both</p>	{R 008}		

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{R 008}	<p>Continued From page 38</p> <p>days. There was no documented explanation why the medication was not given on either day.</p> <p>* Physician's Order, 9/19/13: Hold Coumadin for 1 day, then resume Coumadin 8 mg Monday, Wednesday and Friday and 7.5 mg on Tuesday, Thursday, Saturday and Sunday.</p> <p>* MAR 9/21, 9/22, 9/24, 9/26, 9/28, 9/29, 10/1 and 10/3/13: 7.0 mg of Coumadin was given. The resident should have received 7.5 mg on each of these 8 days. There was no documented explanation why the resident received the wrong dose of medication.</p> <p>* Physician's Order, 10/3/13: Hold Coumadin for 2 days. Then reduce dose to Coumadin 7 mg Monday, Wednesday and Friday and 7.5 mg on Tuesday, Thursday, Saturday and Sunday.</p> <p>* MAR 10/6/13: blank</p> <p>Resident #4 should have received 7.5 mg on 10/6/13. There was no documented explanation why the medication was not given.</p> <p>On 10/31/13 at 3:40 PM, the facility RN stated, "I don't understand" when shown the Coumadin discrepancies. The facility nurse confirmed there was no facility system in place to monitor the medication assistance program to identify such discrepancies.</p> <p>Resident #4 did not receive the correct dose of Coumadin, a blood thinner, eleven times in three months. This increased the potential of the resident having excessive clotting or bleeding.</p> <p>4. Resident #2's record documented she was an</p>	{R 008}		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R71B	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 11/01/2013
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{R 008}	<p>Continued From page 39</p> <p>72 year-old female, who was admitted to the facility on 10/14/13, with diagnoses including hypertension and diabetes.</p> <p>On 10/28/13 at 10:28 AM, Resident #2 stated the facility had run out of her medications. The resident also stated the facility was going to call "today" about the medications.</p> <p>Resident #2's October 2013 MAR, documented the resident was to receive the following medications as ordered by the physician on 10/10/13; however, the resident did not receive the following medications as ordered:</p> <ul style="list-style-type: none"> * aspirin 325 mg 1 tab at bedtime <ul style="list-style-type: none"> - 10/27/13, "not in cart" - 10/28/13, "waiting on pharmacy" * carvedilol (cardiac med) 3.125 mg 1 tab BID <ul style="list-style-type: none"> - 10/26/13 AM dose, "drug not found" - 10/27/13 PM dose, "not in cart" - 10/28/13 AM dose, called pharmacy to have medication delivered. * furosemide (Lasix) 20 mg one tab daily <ul style="list-style-type: none"> - 10/24/13 dose, "not in cart" * levothyroxine 88 mcg 1 tab daily <ul style="list-style-type: none"> - 10/28/13 dose, the reason was not documented * lovastatin 40 mg daily at bedtime <ul style="list-style-type: none"> - 10/27/13 dose, "not in cart" * loratadine 40 mg 1 tab daily <ul style="list-style-type: none"> - 10/28/13 dose, "not in cart" * metformin HCL (diabetes med) 1000 mg one tab BID <ul style="list-style-type: none"> - 10/26/13 AM dose, "drug not found" 	{R 008}		
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{R 008}	<p>Continued From page 40</p> <ul style="list-style-type: none"> - 10/27/13 PM dose, "not in cart" - 10/28/13 AM dose, called pharmacy to have medication delivered. <p>*potassium chloride 10 meq 1 tab daily</p> <ul style="list-style-type: none"> - 10/23/13 dose, "med not in bubblepack" - 10/24/13 dose, "med not in bubble pack" <p>On 10/30/13 at 10:58 AM, a caregiver stated when Resident #2 moved into the facility, she had arrived with medication from the former facility. The caregiver stated the facility was under the assumption that the former facility supplied medications for the entire month, but they had not. The caregiver stated she had noticed the medications were getting low, but had not had time to request a refill, so she passed on the reorder request to the next shift. The caregiver stated the next shift must have gotten busy and was not able to order the medications. The caregiver further stated, when she came onto shift, on 10/28/13, Resident #2 only had eye drops and creams available, but none of her oral medications were available. The caregiver stated she ordered them right away on 10/28/13 and they arrived the next day (10/29/13).</p> <p>There was no documentation Resident #2's physician was notified when medications were not given.</p> <p>Resident #2 went without medications, as the facility failed to reorder them in a timely manner.</p> <p>The facility was cited for not providing appropriate monitoring and assistance with medications during a complaint investigation on 5/21/13. During this follow-up survey, which was conducted on 10/28 through 11/1/13, it was determined the facility did not provide the</p>	{R 008}		

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{R 008}	<p>Continued From page 41</p> <p>necessary oversight to ensure the medication system was corrected. Resident #3 and #5 were not assisted with insulin and Resident #5 was not assisted with three urinary tract infection medications, as ordered. Additionally, Resident #4 was not assisted with Coumadin, as ordered. Further, the facility ran out of Resident #2's medications for several days.</p> <p>REPEAT DEFICIENCY</p> <p>III. Assistance with bathing</p> <p>IDAPA 16.03.22.011.08, states inadequate care is "When a facility fails to provide...activities of daily living."</p> <p>The facility was previously cited on 5/21/13, for not providing supervision to ensure activities of daily living were met, including assistance with bathing. The facility submitted a plan of correction on 6/18/13. The plan of correction documented a shower schedule had been developed to ensure that all residents were "scheduled for the showers identified in each of their individualized NSA's." The plan of correction also documented that "when residents refuse showers the Facility staff will re-approach with a different caregiver. If the resident continues to refuse the shower they will be put onto the next shift shower schedule until the resident agrees to shower...." The facility's alleged date of compliance was 7/5/13.</p> <p>On 10/28/13 from 9:55 to 11:30 AM, four random residents stated:</p> <p>* If they refused a shower, staff did not reapproach them until their next shower date. "They are happy if someone refuses so they don't</p>	{R 008}	<p>III. <u>16.03.22.011.08 Assistance with bathing.</u></p> <p>Resident #6 no longer a resident.</p> <p>Resident #2 was showered and added to the shower schedule.</p> <p>The shower system entails offering a resident a shower three times per shift (if refused). If refused all three times, a second employee must offer a shower. If still refused,</p>	
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{R 008}	<p>Continued From page 42</p> <p>have to do it...they are too busy."</p> <p>* "I am supposed to receive a shower twice a week. I'm lucky if I get a shower one to two times a month."</p> <p>* "I went a whole month without a shower."</p> <p>* A random resident stated she had requested to receive a shower twice a week. She stated, she only received a shower once a week. She stated, "there are not enough caregivers to go around."</p> <p>On 10/28/13 at 12:05 PM, a caregiver stated, keeping up with showers and the laundry was identified as a problem in a staff meeting last week. We are supposed to be getting more help. "A lot of residents forget there are only two people working the floor."</p> <p>1. Resident #6's record documented she was a 60 year-old female, who was admitted to the facility on 10/18/12, with diagnoses including Rheumatoid Arthritis and osteoporosis. Her record documented she had right foot surgery on 10/17/13.</p> <p>On 10/30/13 at 8:30 AM, the resident was observed sitting on the edge of her bed, in her pajamas with a brace on her right foot. She stated, she had foot surgery on 10/17/13 and had not taken a shower since then. She stated, she was independent with showering prior to her surgery and took a shower the morning of the surgery. After her surgery, she had not been feeling well, and needed assistance to wrap her brace prior to showering. She stated, staff had not checked to see if she needed help with showering.</p>	{R 008}	<p>the administrator or designee must be notified, sign off and the resident will go onto the next shifts shower schedule excluding graveyard shift. The facility will evaluate the need for a bath aid.</p> <p>There is a master shower schedule that will be reviewed by the Administrator upon admission to add to NSA and add to the shower schedules.</p> <p>A new form is being utilized that will require residents to sign off completion of shower or refusal of shower. All refusals must be signed off by the facility administrator or assistant administrator. This form is reviewed daily by management staff.</p> <p>Refer to response for number two above in regards to the coordination of care for bathing.</p> <p>The Administrator or designee will monitor shower schedule daily for one month if no issues will monitor weekly for one month, if no issues, will monitor monthly and prn with oversight from V. P. of Operations.</p> <p>Compliance 1-7-14</p>	

Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R718	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 11/01/2013
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NAME OF PROVIDER OR SUPPLIER AARENBROOKE PLACE - CORY LANE, ASHLE	STREET ADDRESS, CITY, STATE, ZIP CODE 9327 CORY LANE BOISE, ID 83704
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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 43</p> <p>On 10/30/13 at 8:42 AM, a caregiver was observed to enter Resident #6's room to assist her with medications. The caregiver asked the resident if she needed help with dressing. The resident was observed to decline the help, informing the caregiver that she wanted to shower first, prior to changing into clean clothing. The caregiver then told Resident #6 she would attempt to return later in the day to assist her with the shower.</p> <p>On 10/30/13 at 2:10 PM, Resident #6 was observed in her room in her pajamas. She stated, the caregiver told her she got busy, but would return at 2:30 PM to assist her with a shower.</p> <p>A "Temporary Plan of Care," dated 10/17/13, documented staff were to leave the brace on until 10/24/13. Attached to the care plan, were physician's instructions documenting the brace was to remain clean and dry.</p> <p>An October 2013 ADL sheet, documented Resident #6 was independent with showers. It documented Resident #6 took a shower on the 24th and refused a shower on the 27th.</p> <p>A shower schedule, documented on the 10/24/13, that Resident #6 was independent with showers and the log was initialed by a caregiver. The caregiver who initialed the shower log was interviewed on 10/30/13 at 10:35 AM. She stated, "I believe she is taking a shower by herself." She stated she had not assisted the resident with a shower. She stated, if she initialed that the resident had showered, it meant she had "checked" that the resident had showered; the resident was "independent," so she had not physically assisted her with a shower. She stated, "she has not said to me that she has not</p>	{R 008}		

Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R718	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 11/01/2013
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{R 008}	<p>Continued From page 44</p> <p>showered." She further stated, she did not know if the resident's brace was to come off prior to her shower.</p> <p>On 10/30/13 at 10:40 AM, a caregiver stated she thought the resident's brace was to be wrapped when she showered, but stated she had not been instructed on how to assist the resident, and the resident was listed as being independent with showers on the shower log.</p> <p>On 10/30/13 at 10:52 AM, the facility RN stated, "I wrote on the care plan that they are to keep the boot dry, but I did not specifically state how they were to assist her with showers."</p> <p>On 10/30/13 at 10:55 AM, Resident #6 stated, "They never ever asked me if I have showered or needed help...If I ask for help, they just think I am wanting attention."</p> <p>On 10/30/13 at 11:15 AM, a caregiver stated, she was instructed to assist Resident #6 to elevate her foot, but "I apologize, I have no clue about how to assist her with a shower. I don't know if we are to wrap it or not."</p> <p>On 10/31/13 at 8:15 AM, a caregiver was interviewed by phone. She stated, "If a resident refuses a shower we are supposed to check with them again each shift and each day; it is not happening." She further stated, some caregivers were documenting that residents were refusing showers when in fact, they had not been offered the assistance.</p> <p>On 11/1/13 at 10:00 AM, the administrator stated she was aware there was a temporary care plan in place for Resident #6 after her foot surgery, but she was unaware that she had not been assisted</p>	{R 008}		

Residential Care/Assisted Living

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{R 008}	<p>Continued From page 45</p> <p>with a shower, or that staff had not been informed on how to assist her with showering.</p> <p>As of 10/30/13, Resident #6 was not assisted with a shower for 13 days.</p> <p>2. Resident #2's record documented she was a 72 year-old female, who was admitted to the facility on 10/14/13, with diagnoses including hypertension and diabetes.</p> <p>On 10/28/13 at 10:28 AM, Resident #2 stated she had resided at the facility for approximately two weeks. She stated she needed assistance with bathing, but had not received a shower since she was admitted to the facility.</p> <p>Resident #2's "Functional Assessment," dated 10/7/13, documented the resident required hands on assistance with bathing one to two times a week.</p> <p>Resident #2's NSA, dated 10/14/13, documented she required total assistance with bathing one to two times a week.</p> <p>The shower book was reviewed on 10/29/13. On the top of the shower book was a list of typed residents names under their shower day(s). The list included Resident #2's handwritten name under Wednesdays and Saturdays.</p> <p>The shower book documented Resident #2 had refused a shower on 10/23/13 (Wednesday) and wanted a shower the next morning. The 10/24/13 (Thursday) shower log was observed to include Resident #2's name, but there was no signature, indicating she had been given a shower, nor was there documentation she had refused a shower.</p>	{R 008}		

Residential Care/Assisted Living

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{R 008}	<p>Continued From page 46</p> <p>On 10/30/13 at 11:41 AM, Resident #2 stated she did not recall being offered a shower nor had she refused a shower the previous week.</p> <p>In 10/30/13 at 11:59 AM, a caregiver stated they would be giving Resident #2 a shower after lunch. The caregiver stated she was not sure why the resident had not received a bath, but thought it had taken awhile to figure out that she required assistance with bathing.</p> <p>On 10/30/13 at 12:03 PM, Resident #2's family member was interviewed. The family member confirmed Resident #2 had not been assisted with a bath/shower since being admitted. The family member further stated, that missing one to two days was understandable, but the issue needed to be "fixed."</p> <p>On 10/30/13 at 12:30 PM, a caregiver stated other caregivers would document residents refused showers, when they had not. She stated some of the caregivers were "lazy," so it was easier to document a refusal than actually provide assistance with bathing.</p> <p>On 10/31/13 at 10:47 AM, a caregiver stated when residents were admitted to the facility, their information on what they needed assistance with was added to their NSAs. The caregiver stated, if they needed assistance with bathing the assistant administrator added their name to the shower list. The caregiver further stated, they did not know why Resident #2's name had not been added to the list or why she had not received a shower.</p> <p>On 10/31/13 at 10:50 AM, a caregiver stated usually assistance with bathing was on the NSA and the assistant administrator would add those who required assistance to the shower list. The</p>	{R 008}		

Residential Care/Assisted Living

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{R 008}	<p>Continued From page 47</p> <p>caregiver had "no idea" why Resident #2 had not received a shower.</p> <p>Resident #2 was not assisted with bathing until two and a half weeks after being admitted to the facility. Additionally, the facility had documented the resident refused a shower, when she had not.</p> <p>On 5/21/13, the facility was cited with a core deficiency for not assisting residents with their bathing needs. During the follow-up survey, on 10/28 through 11/1/13, the facility was still not providing appropriate bathing assistance to Resident #2 and Resident #6.</p> <p>REPEAT DEFICIENCY</p> <p>IV. Assistance with laundry</p> <p>IDAPA 16.03.22.011.08, states inadequate care is "When a facility fails to provide the services required to meet the terms of the Negotiated Service Agreement..."</p> <p>On 10/28/13 between 10:00 AM and 11:30 AM, dirty laundry was observed piled up in multiple residents' rooms and several rooms had strong urine odors.</p> <p>On 10/30/13 at 12:30 PM, the laundry room was observed to be located behind two locked doors. When the door to the laundry room was opened, a strong urine odor was noted. There were three bags of "dirty" clothes located behind the door. Three washing machines were observed not to be in use. A table was observed across from the washing machines, haphazardly piled approximately 2 feet high with dirty blankets, towels, pillows, bags and hampers of dirty</p>	{R 008}	<p>IV. <u>16.03.22.011.08 Assistance with Laundry.</u></p> <p>Every resident has an assigned laundry day, which the staff have received a copy of such schedule. The housekeeping staff have been allotted additional hours to now be responsible for the laundry process. Housekeeping will pull all the dirty laundry when cleaning resident rooms. They will then wash, dry and fold the laundry. An internal form has been created to walk staff through the laundry process which must be signed off after completion.</p> <p>This process will be reviewed by the administrator or the assistant administrator.</p>	
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Residential Care/Assisted Living

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{R 008}	<p>Continued From page 48</p> <p>clothing. Hampers and bags full of dirty clothing were observed in front and under the table. Several hampers and bags full of dirty clothing were observed on a counter as well. Three dryers were observed and only one dryer was in use. Two stacks of folded clean clothes were observed on the top of the middle dryer. Another dryer was observed to have a pile of clean laundry that had not been folded.</p> <p>On 10/28/13 (Monday) from 9:55 AM to 11:30 AM, five random residents stated:</p> <ul style="list-style-type: none"> * "Laundry isn't getting done or on time. They were supposed to pick up my laundry on Friday and it is still here." The resident's basket was observed full of dirty laundry. * "They take your laundry, but you don't see it for a long time. You have to ask for it." * "They mix up my laundry or I don't get it back." * "My laundry has been sitting here since Friday." * "Laundry is never done. There are never any towels or washcloths available. My laundry is never returned to me and I see my clothing and towels in the other areas of the facility." <p>On 10/28/13 at 12:05 PM, a caregiver stated, keeping up with showers and the laundry was identified as a problem in a staff meeting last week. We are supposed to be getting more help. "A lot of residents forget there are only two people working the floor."</p> <p>On 10/28/13 at 3:10 PM, a family member stated the facility had lost three pairs of resident's pants. The family member further stated, "They don't</p>	{R 008}		
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Residential Care/Assisted Living

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{R 008}	<p>Continued From page 49</p> <p>keep track of people here and don't take care of their clothes. I don't think they have enough staff."</p> <p>On 10/30/13 at 8:20 AM, a caregiver stated residents had scheduled days for laundry, but "we get so busy it is hard to get it done. We need one person just to do laundry."</p> <p>On 10/30/13 at 10:16 AM, a hospice caregiver stated that when she assisted residents with showers at the facility, she was told to bag the dirty clothes and put them into the laundry room. She stated within the last year, the appearance of the laundry room went from orderly to having piles of dirty clothes. She stated currently there was always "a big o' pile" of clothes in the laundry room. The hospice caregiver stated one resident at the facility had been assisted 3-5 times within the last 3 months with showering by hospice. On those occasions, they did not have any clean laundry available for him to change into after showering. The caregiver stated the resident's roommate had just gotten a new package of underwear. The roommate gave a pair of underwear to the resident, because he did not have any clean underwear available. Additionally, she stated on some occasions, they had to redress the resident with dirty clothes, because there was no other option.</p> <p>On 10/30/13 at 3:40 PM, the family member of a male resident stated, "not too long ago" she brought in 6 pairs of pants marked with the resident's name and now they were all missing. When she asked a caregiver about the missing pants, she was told everything was marked, so after a resident's laundry was washed, it was brought back to the correct resident's room. The caregiver further stated, "We don't mess their stuff up." At which point, the family member held</p>	{R 008}		

Residential Care/Assisted Living

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{R 008}	<p>Continued From page 50</p> <p>up a pair of "women's" jeans, several sizes too small for either of the men living in the room and asked, "Which one of these men do these belong to?" The caregiver did not respond to the question. On 10/28/13 at 10:20 AM, 10/30/13 at 9:30 AM and 10/30/13 at 12:40 PM, the resident was observed wearing pants with stains and dried food on them.</p> <p>On 11/1/13 at 10:15 AM, the administrator stated, she knew that laundry and showers were an issue. She stated the facility developed a "newly designed policy."</p> <p>A complaint survey was completed on 5/21/13. At that time, the facility received a non-core deficiency for not assisting residents with their laundry according to their NSAs. During a follow-up survey on 10/28 through 11/1/13, the facility was still not providing appropriate laundry services to residents in a timely manner, as described in their NSAs.</p> <p>The facility failed to coordinate care for Residents #4, #5, #6, #7, #8 and #11, after they experienced physical changes of conditions. The facility also failed to assist and monitor medications for Residents #2, #3, #4 and #5, who currently resided at the facility. Additionally, the facility failed to provide assistance with bathing for Residents #2 and #6, who could not independently bathe. The facility also failed to provide appropriate and timely laundry services to residents. These failures resulted in inadequate care.</p>	{R 008}		
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Facility AARENBROOKE PLACE - CORY LANE	License # RC-718	Physical Address 9327 CORY LANE	Phone Number (208) 376-1300
Administrator Sharfa Wilson	City BOISE	ZIP Code 83704	Survey Date November 1, 2013
Survey Team Leader Polly Watt-Gaier	Survey Type Follow-up and Complaint Investigation		RESPONSE DUE: December 1, 2013
Administrator Signature	Date Signed		

NON-CORE ISSUES			
Item #	IDAPA Rule #	Description	Department-Use Only
			ECR Accepted Initials
1	159.01	The facility's record procedures did not ensure records were accurate, for example: staff documented residents received medications, when they had not. The staff also documented residents refused medications and bathing, when they had not. **Previously cited on 5/21/13**	1/10/14 PWS
2	215.07	The administrator did not ensure the notification of adult protection was documented at the facility, after an allegation of abuse.	1/10/14 PWS
3	260.05.f	The laundry room was not maintained in a sanitary manner.	1/8/14 PWS
4	260.05.h	Staff used the same laundry baskets for both dirty and clean clothes.	1/8/14 PWS
5	260.06	The facility's interior was not maintained in a clean, safe and orderly manner. For example: strong persistent odors were observed throughout the facility, including residents' rooms. Several residents' bathrooms were observed to be dirty and the floor were observed to be sticky. Several residents' rooms had garbage and laundry that had accumulated. Dining room floors were observed to be sticky. The salt, pepper and sugar containers were observed to be dirty. The vents in the living room area were bent and buckled.	1/8/14 PWS
6	300.01	The facility nurse did not complete an initial nursing assessment for Resident #7 until eight days after admission. **Previously cited on 5/21/13**	1/8/14 PWS
7	300.02	The facility nurse did not assess Residents #4, 5, 6, 7 and 8 when they had changes of conditions. Additionally, the facility nurse did not ensure physicians' orders were implemented. For example: Resident #3's and #7's blood sugar checks. **Previously cited 5/21/13**	1/8/14 PWS
8	305.02	Resident #3, #4 and #8's medication orders were not congruent with their MARS. Also, the facility did not have Resident #3's Aspirin available as ordered. Additionally, not all PRN medications were available as ordered. **Previously cited on 5/21/13**	1/20/14 PWS
9	305.06.a	The facility nurse did not assess Resident #3 and #5's ability to interpret their sliding scale insulin or Resident #6's ability to self-administer Fiorase. **Previously cited on 5/21/13**	1/10/14 PWS
10	310.01.c	A temperature log was not maintained for a medication refrigerator. **Previously cited on 5/21/13**	1/8/14 PWS
11	310.01.d	The facility staff assisted a resident with PRN medications, which required instructions from a nurse.	1/8/14 PWS
12	320.01	Resident #6's NSA did not describe how to assist her with bathing after having foot surgery. Resident #2's NSA was not implemented regarding her bathing needs. Additionally, several residents' NSAs were not implemented to ensure laundry was completed. **Previously cited on 5/21/13**	1/8/14 PWS

*Wilson 11-01-13
administration*

NO. VJ20
NOV. 1, 2013 1:54PM

NDU-07-2013 12:37 From: 208389909 Page: 5/10



NOV 1 2013 1:55 PM

Facility AARENBROOKE PLACE - CORY LANE	License # RC-718	Physical Address 9327 CORY LANE	Phone Number (208) 376-1300
Administrator Sharia Wilson	City BOISE	ZIP Code 83704	Survey Date November 1, 2013
Survey Team Leader Polly Watt-Geier	Survey Type Follow-up and Complaint Investigation	RESPONSE DUE: December 1, 2013	
Administrator Signature	Date Signed		

NON-CORE ISSUES

Item #	IDAPA Rule #	Description	Department Use Only	
			EOR Accepted	Initials
13	711.04	The facility did not notify a physician when Resident #3 refused insulin. **Previously cited on 5/21/13**	1/1/14	PSh
14	711.07	The facility did not have Resident #7's PSR care plan.	COS 11/1/13 PWG	
15	711.08.c	The facility did not document all unusual events, such as: when Resident #6 was treated by paramedics or when Resident #3 went to the hospital.	1/2/14	PSh
16	711.08.d	The facility did not document each time the physician was notified, for example: refusals, medications not available and changes of conditions.	1/3/14	PSh
17	711.08.e	Medication aides did not notify the nurse when random residents had abnormal blood glucose levels. **Previously cited on	1/2/14	PSh
18	711.11	The reason why medications were not given was not documented. **Previously cited on 5/21/13**		
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*Wilson 11-01-13
administrator*



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK – ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
JAMIE SIMPSON – PROGRAM SUPERVISOR
RESIDENTIAL ASSISTED LIVING FACILITY PROGRAM
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: 208-334-6626
FAX: 208-364-1888

November 18, 2013

Sharla Wilson, Administrator
Aarenbrooke Place - Cory Lane, Ashley Manor LLC
9327 Cory Lane
Boise, ID 83704

Dear Ms. Wilson:

An unannounced, on-site complaint investigation survey was conducted at Aarenbrooke Place-Cory Lane, Ashley Manor LLC between October 28, 2013 and November 1, 2013. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00006153

Allegation #1: The facility did not report an allegation of abuse to the appropriate authorities.

Findings #1: Unsubstantiated. Due to conflicting information it could not be confirmed that adult protection was not notified when there was an allegation of abuse. However, the facility was issued a deficiency at IDAPA 16.03.22.215.07 for not ensuring the facility's notification of adult protection was documented. The facility was required to submit evidence of resolution within 30 days.

Allegation #2: The facility used PRN (as needed) medications to control residents' behaviors.

Findings #2: Unsubstantiated. This does not mean the incident did not take place; it only means that the allegation could not be proven. However, the facility was issued a deficiency at IDAPA 16.03.22.310.01.d for medication aides assisting with PRN medications without notifying and receiving instructions from an RN. The facility was required to submit evidence of resolution within 30 days.

Allegation #3: The facility restrained residents, because they did not want to lift them out of bed.

Findings #3: Unsubstantiated. It could not be determined during the complaint investigation whether the resident was left on the lower mattress due to behaviors or whether it

Sharla Wilson, Administrator

November 18, 2013

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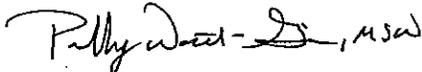
was from staff not wanting to lift the identified resident due to conflicting information. However, the facility did not have documentation of a behavior management plan or tracking of when the behaviors occurred and the interventions staff used at those times. Both of these issues had been previously cited during a complaint investigation that was completed on 5/21/13.

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 **November 1, 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) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,



Polly Watt-Geier, MSW
Health Facility Surveyor
Residential Assisted Living Facility Program

PWG/

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



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK – ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
JAMIE SIMPSON – PROGRAM SUPERVISOR
RESIDENTIAL ASSISTED LIVING FACILITY PROGRAM
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: 208-334-6626
FAX: 208-364-1888

November 18, 2013

Sharla Wilson, Administrator
Aarenbrooke Place - Cory Lane, Ashley Manor LLC
9327 Cory Lane
Boise, ID 83704

Dear Ms. Wilson:

An unannounced, on-site complaint investigation survey was conducted at Aarenbrooke Place-Cory Lane, Ashley Manor LLC between October 28, 2013 and November 1, 2013. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00006235

- Allegation #1:** Residents' catheter bags were not changed between bedside and leg bags in the morning and at bedtime. Further, the catheter bags were not rinsed and dried in a sanitary manner.
- Findings #1:** Substantiated. It was determined, when the catheter was first placed, the facility had not changed, rinsed and dried the identified resident's catheter bags in a sanitary manner. However, since the time of the complaint, the facility staff had received an in-service on how to care for the bags and had been assisting the resident appropriately. Therefore, the facility was not cited at the time of the survey.
- Allegation #2:** Residents' catheter bags were not emptied often enough.
- Findings #2:** Unsubstantiated. Due to conflicting information, the allegation may have occurred, but it could not be determined during the complaint investigation.
- Allegation #3:** Residents were moved from the facility without notifying their families.
- Findings #3:** Substantiated. However, the facility was not cited as the resident was his own guardian. Further, there is not a state rule which requires a facility to notify a resident's family when the resident is discharged from a facility.

Sharla Wilson, Administrator
November 18, 2013
Page 2 of 2

Allegation #4: The facility did not provide appropriate assistance and monitoring of residents' medications.

Findings #4: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.520 for not providing appropriate assistance and monitoring of residents' medications. The facility was required to submit a plan of correction.

Allegation #5: The facility did not coordinate appropriate wound care for residents.

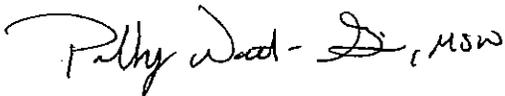
Findings #5: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.520 for failing to coordinate wound care for residents. The facility was required to submit a plan of correction.

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 **November 1, 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) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,



Polly Watt-Geier, MSW
Health Facility Surveyor
Residential Assisted Living Facility Program

PWG/

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



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P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: 208-334-6626
FAX: 208-364-1888

November 18, 2013

Sharla Wilson, Administrator
Aarenbrooke Place - Cory Lane, Ashley Manor LLC
9327 Cory Lane
Boise, ID 83704

Dear Ms. Wilson:

An unannounced, on-site complaint investigation survey was conducted at Aarenbrooke Place-Cory Lane, Ashley Manor LLC between October 28, 2013 and November 1, 2013. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00006263

Allegation #1: Residents did not receive assistance with bathing.

Findings #1: Substantiated. The facility was issued a core deficiency at IDAPA 16.03.22.520, as the facility did not ensure residents' bathing needs were met. The facility was required to submit a plan of correction.

Allegation #2: The facility did not provide appropriate assistance and monitoring of medications.

Findings #2: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.520, as the facility did not provide appropriate assistance and monitoring of residents' medications. The facility was required to submit a plan of correction.

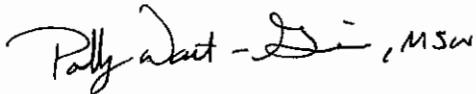
A core issue deficiency was identified during the complaint investigation. Please review the cover letter, which outlines how to develop a Plan of Correction. The Plan of Correction must be submitted to our office within 10 (ten) calendar days of receiving the Statement of Deficiencies.

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 **November 1, 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.

Sharla Wilson, Administrator
November 18, 2013
Page 2 of 2

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

Sincerely,

A handwritten signature in black ink that reads "Polly Watt-Geier, MSW". The signature is written in a cursive style.

Polly Watt-Geier, MSW
Health Facility Surveyor
Residential Assisted Living Facility Program

PWG/

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