



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 29, 2015

Linda Vestal, Administrator
Guardian Angel Homes Lewiston I
2421 Vineyard Avenue
Lewiston, Idaho 83501

Provider ID: RD-679

Ms. Vestal:

On December 17, 2014, a state licensure/follow-up survey was conducted at Guardian Angel Homes Lewiston I, 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 Donna Henscheid, LSW, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 364-1962.

Sincerely,

Donna Henscheid, LSW
for

DONNA HENSCHIED, LSW
Team Leader
Health Facility Surveyor

DH/sc

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



IDAHO DEPARTMENT OF
HEALTH & WELFARE

G.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

December 29, 2014

CERTIFIED MAIL #: 7007 3020 0001 4050 8708

Linda Vestal
Guardian Angel Homes Lewiston I
2421 Vineyard Avenue
Lewiston, Idaho 83501

Provider ID: RC-679

Ms. Vestal:

Based on the state licensure/follow-up survey conducted by Department staff at Guardian Angel Homes Lewiston I, LLC between December 15, 2014 and December 17, 2014, it has been determined that the facility retained 3 resident who had pressure ulcers which exceeded a stage II. Additionally, the facility failed to assess 2 sampled residents who had wounds or skin breakdown to ensure they did not exceed the level of care the facility was licensed to provide.

This core issue deficiency substantially limits the capacity of Guardian Angel Homes Lewiston I, LLC to furnish services of an adequate level or quality to ensure that residents' health and safety are protected. The deficiency is described on the enclosed Statement of Deficiencies.

You have an opportunity to make corrections and thus avoid a potential enforcement action. Correction of this deficiency must be achieved by **January 31, 2015**. **We urge you to begin correction immediately.**

After you have studied the enclosed Statement of Deficiencies, please write a Plan of Correction by answering **each** of the following questions for **each** deficient practice:

- ♦ What corrective action(s) will be accomplished for those specific residents/personnel/areas found to have been affected by the deficient practice?
- ♦ How will you identify other residents/personnel/areas that may be affected by the same deficient practice and what corrective action(s) will be taken?
- ♦ What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?
- ♦ How will the corrective action(s) be monitored and how often will monitoring occur to ensure

that the deficient practice will not recur (i.e., what quality assurance program will be put into place)?

- By what date will the corrective action(s) be completed?

Return the **signed** and **dated** Plan of Correction to us by **January 11, 2015**, and keep a copy for your records. Your license depends upon the corrections made and the evaluation of the Plan of Correction you develop.

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.

Please bear in mind that non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference. Your evidence of resolution (e.g., receipts, pictures, policy updates, etc.) for each of the non-core issue deficiencies is to be submitted to this office by **January 16, 2015**.

Three (3) of the eleven (11) non-core deficiencies cited were identified as repeat punches. Please be aware, any non-core deficiency which is identified on three consecutive surveys will result in a civil monetary penalty.

Also, be aware that any variance allowing the administrator to serve over other facilities is revoked as of the date of the exit conference. The facility must now employ a single, licensed administrator who is not serving as administrator over any other facilities. Failure to do so within thirty (30) days of the date of the exit conference will result in a core issue deficiency.

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

Enforcement actions may include:

- imposition of civil monetary penalties;
- issuance of a provisional license;
- limitation on admission to the facility;

Linda Vestal
December 29, 2014
Page 3 of 2

- requirement that the facility hire a consultant who submits periodic reports to Licensing and Certification.

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

Sincerely,



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

JS/sc

Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/17/2014
--	---	---	---

NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGEL HOMES LEWISTON I	STREET ADDRESS, CITY, STATE, ZIP CODE 2421 VINEYARD AVENUE LEWISTON, ID 83501
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>Initial Comments</p> <p>The following deficiency was cited during the licensure survey conducted between 12/15/14 and 12/17/14 at your residential care/assisted living facility. The surveyors conducting the survey were:</p> <p>Donna Henscheid, LSW Team Coordinator Health Facility Surveyor</p> <p>Karen Anderson, RN Health Facility Surveyor</p> <p>Rea Jean McPhillips, RN Health Facility Surveyor</p> <p>Maureen McCann, RN Health Facility Surveyor</p> <p>Survey Definitions: " = inches appx or approx = approximately Cellerate = medication used for tissue building during wound healing cm = centimeter BMP = Behavior Management Plan LPN = Licensed Practical Nurse Lt or It = left MAR = Medication Assistance Record Melgisorb Ag = a highly absorbant, antimicrobial wound dressing mg = milligrams NSA = Negotiated Service Agreement R = right Rec'd = received RN = Registered nurse Silversorb = a antimicrobial medication used in wounds s/s = signs and symptoms</p>	R 000		

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

TITLE

(X6) DATE

Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R879	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/17/2014	
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGEL HOMES LEWISTON I		STREET ADDRESS, CITY, STATE, ZIP CODE 2421 VINEYARD AVENUE LEWISTON, ID 83501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	Continued From page 1 UAI = Uniform Assessment Instrument Vancomycin hydrochloride powder = a medication used for treating a wound infection X = times	R 000		
R 008	16.03.22.620 Protect Residents from Inadequate Care. The administrator must assure that policies and procedures are implemented to assure that all residents are free from inadequate care. This Rule is not met as evidenced by: Based on observation, record review and interview it was determined the facility retained 3 of 4 sampled residents (Residents #2, #4 and #6) who had pressure ulcers which exceeded a Stage II. Additionally, the facility failed to assess 2 of 2 sampled residents (Residents #2, and #9) who had wounds or skin breakdown to ensure they did not exceed the level of care the facility was licensed to provide. Further, the facility retained 1 of 1 sampled resident (Resident #8) who had Methicillin-resistant Staphylococcus aureus (MRSA). The findings include: I. PRESSURE ULCERS: 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: ix. A resident with Stage III or IV pressure ulcer." The National Pressure Ulcer Advisory Panel defines Stage II, III, IV and unstageable pressure	R 008	R008: ix. I. Administrator has given 30 days notice to the 2 identified residents who had greater than a stage II pressure ulcer. Health Service Director obtained and trained herself the RN and LPN on staging pressure ulcers and the need to identify immediately identify greater than a stage II to the administrator in order for her to give notice to the resident's family.	1-9-15

Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/17/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER
GUARDIAN ANGEL HOMES LEWISTON I

STREET ADDRESS, CITY, STATE, ZIP CODE
2421 VINEYARD AVENUE
LEWISTON, ID 83501

(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 2</p> <p>ulcers as the following:</p> <p>*Stage II: "Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough...Presents as a shiny or dry shallow ulcer without slough or bruising...Bruising indicates suspected deep tissue injury."</p> <p>*Stage III: "Full thickness tissue loss...Slough may be present..."</p> <p>*Stage IV: "Full thickness tissue loss...Slough or eschar may be present on some parts of the wound bed."</p> <p>*Unstageable: "Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed." Until eschar is removed, the true depth can not be determined; but it will either be a Stage III or IV.</p> <p>1. According to her record, Resident #6 was an 87 year-old female who was admitted on 7/29/13, with diagnoses including dementia and urinary incontinence. On 12/16/14, the resident was observed in a recliner in her room. She was animated and conversing with the surveyor, however, her responses were non-sensical. When asked simple questions such as where she lived, the resident answered, "She is down at the road, just sitting."</p> <p>On 12/16/14 between 10:30 AM and 3:00 PM, the LPN stated "We don't stage pressure ulcers." She further stated, she was not sure if the wound was a pressure ulcer. She stated "It started as bruise and she (the resident) clawed at it, ripped it open."</p>	R 008		

Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/17/2014
--	--	---	--

NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGEL HOMES LEWISTON I	STREET ADDRESS, CITY, STATE, ZIP CODE 2421 VINEYARD AVENUE LEWISTON, ID 83501
---	---

(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 3</p> <p>On 12/16/14 at 2:35 PM, Caregiver A stated Resident #6 had a wound on her hip. She further stated, "The nurse covers it so I don't get to look at it...It was there, it didn't heal, it got worst, got infected...Now they are treating it."</p> <p>On 12/16/14 at 3:30 PM, the administrator stated she did not understand wound staging, "I'm not a nurse."</p> <p>On 12/17/14 at 9:53 AM, Caregiver B stated Resident #6 had the wound on her right hip, "maybe 1 to 3 months." She stated "it started as a red spot. The nurse said to keep her off of it so we don't have a bedsore." She further stated, "there was a dressing on it...it was getting deeper and deeper. The hole was deep and we knew it was infected when it had a smell."</p> <p>On 12/17/14 at 9:45 AM, Caregiver C stated the wound was a brown scab when she started working with Resident #6 approximately 2 months ago. She further stated, the nurses covered it with a bandage.</p> <p>The following documentation was found in "Progress Notes" in Resident #6's record:</p> <p>*10/13/2014 1:56 PM - "1" X 2" sore reported on resident's right hip. Saw and assessed wound to have scab in middle. Redness extending .5" around wound. Resident picks at wound. Applied mixture of Cellerate and Silversorb on wound. Covered with foam pad and clear bandage."</p> <p>*10/16/14 2:19 PM - "Wound is also starting to smell bad."</p> <p>*10/20/14 2:35 PM - "...packed with gauze. Clear</p>	R 008		
-------	--	-------	--	--

Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/17/2014
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGEL HOMES LEWISTON I		STREET ADDRESS, CITY, STATE, ZIP CODE 2421 VINEYARD AVENUE LEWISTON, ID 83501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETE DATE
R 008	<p>Continued From page 4</p> <p>dressing over packing."</p> <p>*10/22/14 12:00 PM - "Explored wound with sterile swabs. Vancomycin Hydrochloride powder, Celerate and Silversorb applied with Melgisorb Ag placed over that."</p> <p>*10/24/14 2:13 PM - "Green puss but the odor has decreased from Wednesday (10/22/14)."</p> <p>*11/07/14 12:00 PM - "Debrided, cleaned and dressed wound."</p> <p>A "Health Care Provider Fax", completed by the facility LPN, documented Resident #6 "Has wound on R hip approx 1 X 2" open with sloughing." The form was signed by Resident #6's provider on 11/4/14. The provider also ordered an "air mattress".</p> <p>A medical supply company request form, completed by the facility RN on 11/4/14, documented Resident #6 required a "hospital bed with alternating pressure mattress" for a "R-hip pressure area."</p> <p>There was no documentation found in Resident #6's record that the pressure ulcer had been staged. Staff interviews and facility documentation described Resident #6's pressure ulcer as greater than a Stage II.</p> <p>2. According to her record, Resident #2 was an 85 year-old woman admitted on 8/12/09 with diagnoses including dementia and a history of a left hip fracture. On 12/16/14, the resident was observed in bed in her room. The resident's eyes were open. Although the resident made eye contact when greeted, she did not respond verbally, but rather stared straight ahead with a</p>	R 008	<p>ix. II. Administrator counseled the nursing staff on the need to assess all wounds and document as well as treatment for the wound. Nurses will meet with the Administrator weekly to discuss any wounds present within the facility.</p>	1-9-15

Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/17/2014
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGEL HOMES LEWISTON I		STREET ADDRESS, CITY, STATE, ZIP CODE 2421 VINEYARD AVENUE LEWISTON, ID 83501	
(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)
R 008	<p>Continued From page 5</p> <p>flail affect.</p> <p>On 11/16/14 at 11:50 AM, Caregivers D and E stated Resident #2 had a wound on her hip and left heel which had dressings on them. Caregiver D stated the nurses changed Resident #2's dressings. She stated she covered the resident's heel wound "in plastic" when she showered the resident. Caregiver E stated, the resident had a "Duoderm" dressing on her hip wound.</p> <p>On 12/17/14 at 9:30 AM, Caregiver B stated she first was aware of Resident #2's wound "right before Thanksgiving." She further stated, she did not know what the wound looked like because the nurse came in and dressed it daily.</p> <p>A quarterly nurse assessment, dated 7/14 - 9/30/14, documented Resident #2 had "developed sore area on hip/lt heel. Not walking as she used to." The note was signed on 10/8/14 by the LPN and on 10/10/14 by the RN.</p> <p>A. Left Hip:</p> <p>The following documentation was found in "Progress Notes" in Resident #2's record:</p> <p>*9/16/2014 4:10 PM - "Area below LT hip noted by staff, dark/red surrounding appx 3 X 5 cm."</p> <p>*10/20/2014 1:00 PM - "Rec'd order for collerate/silvasorb with MepiPLEX dressing to Lt hip area. Area open-no s/s infection."</p> <p>*10/21/2014 11:22 AM - "...packed with gauze and covered with clear bandage."</p> <p>*11/07/2014 12:00 PM - "Cleansed and redressed wound on left hip."</p>	R 008	

Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/17/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGEL HOMES LEWISTON I	STREET ADDRESS, CITY, STATE, ZIP CODE 2421 VINEYARD AVENUE LEWISTON, ID 83501
---	---

(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 6</p> <p>*12/12/2014 12:13 PM - "Dressings done 2-3 X week on hip/heel...Area on hip healing well."</p> <p>B. Left Heel:</p> <p>The following documentation was found in "Progress Notes" in Resident #2's record:</p> <p>*10/31/2014 3:05 PM - "Area on Lt heel pink in color, no black, almost healed."</p> <p>*11/07/2014 12:00 PM - "Cleansed and redressed black spot on left heel."</p> <p>*11/10/2014 2:21 PM - Resident #2's "left heel no longer has a black spot, but there is still a healing wound there."</p> <p>*12/12/2014 12:13 PM - "Dressings done 2-3 X week on hip/heel. Area on heel almost healed."</p> <p>On 12/16/14 at 10:30 AM the LPN stated "We don't stage pressure ulcers."</p> <p>On 12/16/14 at 3:00 PM, the RN stated Resident #2's hip "wound was never packed." She stated she was not aware another facility nurse documented that she had packed the wound. The facility RN stated the nurse who charted she had packed the wound was on vacation and was not available for interview.</p> <p>There was no documentation found in Resident #2's record that her the pressure ulcer on her hip or heel had been staged. Observations of the wound reported during staff interviews and contained in the facility documentation, which included "slough" and "eschar", described Resident #2's pressure ulcers as greater than a</p>	R 008		

Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/17/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGEL HOMES LEWISTON I	STREET ADDRESS, CITY, STATE, ZIP CODE 2421 VINEYARD AVENUE LEWISTON, ID 83501
---	---

(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 7</p> <p>Stage II.</p> <p>3. According to his record, Resident #4 was a 90 year old male admitted to the facility on 12/21/10 with a diagnosis of Alzheimer's disease.</p> <p>Resident #4's NSA, dated 8/26/14, documented staff were to report any skin issues to nursing immediately. There was no further documentation regarding skin breakdown preventative measures.</p> <p>On 12/16/14 between 8:30 AM and 11:55 AM, Resident #4 was observed in a recliner without heel protectors (padded boots) on his feet.</p> <p>"Shift Change Notes," dated 9/26/14, documented Resident #4 has a red spot on left heel and the RN was notified. There was no documentation the facility RN had assessed the "red spot" on the resident's heel on this date.</p> <p>Nursing "Progress Notes" documented the following:</p> <p>*10/27/14 - Resident #4 had a "small black spot on his left heel. The spot was about the size of a pencil eraser. The resident was given "padded boots" to wear.</p> <p>*10/30/14 - Resident #4's dressing on the left heel came off in the shower. "Small dark spot is still there." The resident has "not kept the padded boots on."</p> <p>*11/04/14 - The resident has a "pon head black area on R heel, might be a mole."</p> <p>There was no further documentation by the facility RN regarding the status of the "black area"</p>	R 008		

Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/17/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGEL HOMES LEWISTON I	STREET ADDRESS, CITY, STATE, ZIP CODE 2421 VINEYARD AVENUE LEWISTON, ID 83501
---	---

(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 8</p> <p>on Resident #4's heel.</p> <p>On 12/16/14 at approximately 10:00 AM, Caregiver F stated Resident #4 had breakdown on his heel which had healed, but was again "starting to get red." The caregiver stated, "We try to catch it before it gets worse."</p> <p>On 12/16/14 at 10:45 AM, the LPN stated, "We don't really stage" wounds. "If they're real bad" we send the residents to the wound clinic.</p> <p>On 12/16/14 at 10:50 AM, the RN stated the spot on Resident #4's heel was very small and that she thought it was a mole.</p> <p>On 12/16/14 at 2:45 PM, the RN was observed looking at Resident #4's heel. The pressure ulcer had healed to a Stage I and no eschar (black spot or mole) was noted. The resident was observed sitting in a recliner and was not wearing heel protectors. The RN stated the resident "probably" had necrotic (eschar) tissue that had fallen off the left heel. When explained the definition of an unstageable wound, the RN replied, "What do you want me to do? I've had these people for a long time."</p> <p>There was no documentation found in Resident #4's record that the pressure ulcer on his heel had been staged. Staff interviews and facility documentation described Resident #4's pressure ulcers as greater than a Stage II.</p> <p>The facility retained Residents #2, #4 and #6 with pressure ulcers which had not been staged. Staff interviews and facility documentation described all four pressure ulcers as greater than a Stage II which was beyond the level the facility was licensed to provide.</p>	R 008		

Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/17/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER
GUARDIAN ANGEL HOMES LEWISTON I

STREET ADDRESS, CITY, STATE, ZIP CODE
**2421 VINEYARD AVENUE
LEWISTON, ID 83501**

(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 9</p> <p>II. OTHER WOUNDS NOT ASSESSED OR TREATED BY THE FACILITY</p> <p>1. According to her record, Resident #9 was a seventy year-old woman admitted to the facility on 7/28/11 with a diagnosis of dementia.</p> <p>On 12/16/14 at approximately 3:15 PM, Resident #9 was observed laying in her bed with a large bandage on her right hip.</p> <p>Resident #9's NSA, dated 11/12/14, documented the staff were to apply "tiger balm" to her skin. There were no further interventions documented regarding skin breakdown preventions.</p> <p>A nursing assessment, dated 9/12/14, documented Resident #9 was "medically stable." There was no further documentation regarding any skin breakdown on the resident's hip.</p> <p>On 12/16/14, at 9:30 AM, Caregiver G stated Resident #9 had the spot on her hip for at least three days. She stated she noticed the red mark was <i>not going away and she asked another caregiver to tell the RN. She stated the staff were instructed to keep the resident off her hip.</i></p> <p>On 12/16/14 at 9:40 AM, Resident #9 was observed laying in her bed with an uncovered reddened area on her right hip.</p> <p>On 12/16/14 at 4:22 PM, a family member stated he felt the spot on the resident's hip was from "sitting in a chair and not moving."</p> <p>On 12/17/14 at 9:35 AM, Caregiver A stated, the red spot on Resident #9's hip was "noticed" last week, at least 6 days ago. She stated she told</p>	R 008	<p>xi. III. Nursing staff will be alert to physicians stating that resident has an active stage of MRSA, any antibiotic orders consistent with the treatment of MRSA, as well as any other infective bacteria or virus. Administrator will be notified immediately and resident will be discharged.</p>	1-9-15

Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R879	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/17/2014	
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGEL HOMES LEWISTON I		STREET ADDRESS, CITY, STATE, ZIP CODE 2421 VINEYARD AVENUE LEWISTON, ID 83501		
(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 10</p> <p>Caregiver C who then called the RN.</p> <p>On 12/17/14 at 9:45 AM, the facility RN stated staff had not reported anything to her about the resident having a "red spot." The RN looked through the notes on the computer and stated, "I don't see anything about being notified. It doesn't look like there are caregiver notes for December." When told about the dressing on Resident #9's hip yesterday, the RN had no explanation.</p> <p>The facility RN did not assess the status of Resident #9's wound to determine what treatment was required or if the resident could be legally retained by the facility.</p> <p>2. According to her record, Resident #2 was a 85 year-old woman admitted on 8/12/09 with diagnoses including dementia and a history of a left hip fracture. On 12/16/14, the resident was observed in bed in her room. The resident's eyes were open. Although the resident made eye contact when greeted, she did not respond verbally, but rather stared straight ahead with a flat affect. Resident #2 currently had a pressure ulcer on her left hip and left heel.</p> <p>The following documentation was found in "Progress Notes" in Resident #2's record:</p> <p>*1/26/2014 11:28 AM - "Her right hip is starting with redness in two spots."</p> <p>*12/12/2014 12:13 PM - "Has raised area on coccyx, not red or open."</p> <p>There was no further documentation in Resident #2's record regarding the redness on the resident's right hip or raised area on her coccyx.</p>	R 008		

Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R879	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGEL HOMES LEWISTON I	STREET ADDRESS, CITY, STATE, ZIP CODE 2421 VINEYARD AVENUE LEWISTON, ID 83501
--	---

(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 11</p> <p>The facility did not assess Resident #2's and #9's wounds or skin breakdown to determine what treatment was required or if the residents could be legally retained by the facility.</p> <p>III. MRSA</p> <p>IDAPA 16.03.22.152.05.b documents "No resident will be admitted or retained who requires ongoing skilled nursing or care not within the legally licensed authority of the facility. Such residents include: xi. A resident who has MRSA in an active stage (infective stage)."</p> <p>According to the resident's record, Resident #8 was an 89 year-old male, admitted on 12/13/13 with diagnoses including dementia and diabetes mellitus II. The resident also experienced chronic venous hypertension and lymphedema with bilateral lower extremity ulceration, blistering and cellulitis.</p> <p>A physician's office visit notes documented the following:</p> <p>* 6/5/14 - "The patient has had a new ulceration noted by [the name of a home health agency] nursing staff on the right fifth lateral toe. This looks inflamed...Tissue culture and sensitivity right fifth toe."</p> <p>* 6/26/14 - The resident had a "large, inflamed, and deep right fifth lateral toe ulceration. This ended up being positive for Methicillin-resistant Staph aureus, heavy growth. The patient has taken two weeks of minocycline 100 mg twice weekly."</p> <p>A physician's order dated 6/8/14, documented Resident #8 was to receive the antibiotic</p>	R 008		

Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/17/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGEL HOMES LEWISTON I	STREET ADDRESS, CITY, STATE, ZIP CODE 2421 VINEYARD AVENUE LEWISTON, ID 83501
---	---

(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 12</p> <p>minocycline 100 mg by mouth twice daily.</p> <p>Resident #8's June MAR documented the resident received the antibiotic minocycline twice daily between 6/7/14 and 6/24/14.</p> <p>There was no documentation found in Resident #8's "Progress Notes" regarding the MRSA infection. However, the facility assisted the resident with an antibiotic, twice daily for two weeks, to treat the infection.</p> <p>On 12/16/14 at 9:15 AM, the RN stated she had "no idea" Resident #8 had infective MRSA. "I try to read the reports" from the physician's office regarding wounds, but stated the clinic is not "always timely getting them to us."</p> <p>On 12/16/14 at 4:25 PM, the LPN stated she was not aware Resident #8's wound was infected with MRSA.</p> <p>The facility retained Resident #8 with infective MRSA, although it was not licensed to do so.</p> <p>The facility retained Residents #2, #4 and #6 with Stage III or IV pressure ulcers. Also, the facility did not assess or monitor Residents #2's and #8's wounds or skin breakdown to determine what treatment was required or to determine if the residents could be legally retained by the facility. Finally, the facility retained a resident with active MRSA. This resulted in inadequate care.</p>	R 008		



Facility GUARDIAN ANGEL HOMES LEWISTON I, LLC	License # RC-679	Physical Address 2421 Vineyard Avenue	Phone Number (208) 743-6500
Administrator Linda Vestal	City LEWISTON	ZIP Code 83501	Survey Date December 17, 2014
Survey Team Leader Donna Henscheid	Survey Type Licensure and Follow-up	RESPONSE DUE: January 16, 2015	
Administrator Signature 	Date Signed 12-17-14		

NON-CORE ISSUES

Item #	IDAPA Rule #	Description	Department Use Only	
			EOR Accepted	Initials
1	009.01	Three of ten employees did not have evidence of criminal history background checks.	1/20/15	DH
2	009.06.c	Three of ten employees did not have evidence of state police background checks.	1/20/15	DH
3	210	The facility did not provide an activity program in all buildings as outlined in rule 151.	1/20/15	DH
4	225	The facility did not evaluate and develop behavior management plans for Residents #3, #4 and #5. Further, behavioral triggers were not identified and interventions were not reassessed for effectiveness. **Previously cited 7/29/10**	1/23/15	DH
5	300.01	The facility nurse did not complete a 90 day assessment for Residents #6 and #9. Further, the facility RN did not assess the following: Resident #1 after hospitalization and surgery, Resident #5's possible dislocated hip, and several residents wound status and other health conditions. Additionally, the facility RN did not assess Resident #7's shingles/rash until 5 days after it was first identified by caregivers.	1/23/15	DH
6	350.02	There was no investigation of all accidents and incidents; including bruising of an unknown origin.	1/23/15	DH
7	350.07	Not all required accidents and incidents were reported to Licensing and Certification. **Previously cited 7/29/10**	1/20/15	DH
8	625.01	Eight of ten employees did not have evidence of 16 hours of orientation.	1/20/15	DH
9	630.02	Five of ten employees did not have evidence of mental illness training.	1/20/15	DH
10	630.04	Nine of ten employees did not have evidence of traumatic brain injury training.	1/20/15	DH
11	250.10	Water temperatures exceeded 120 degrees. In the Craftsman building it temped at 129 degrees and in the Tudor building it temped at 132.8 degrees. **Previously cited 7/29/10**	1/20/15	DH
12				
13				
14				
15				
16				