



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

April 22, 2015

Diana Ray, Administrator
Streamside Alzheimer Care
1333 South Edgewater Circle
Nampa, Idaho 83686

Provider ID: RC-925

Ms. Ray:

On January 21, 2015, a state licensure/follow-up survey was conducted at Streamside Alzheimer Care-Streamside Alzheimers, 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 Maureen McCann, RN, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 364-1962.

Sincerely,

Maureen McCann RN
for

MAUREEN MCCANN, RN
Team Leader
Health Facility Surveyor

MM/sc

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



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February 9, 2015

CERTIFIED MAIL #: 7007 3020 0001 4050 8760

Diana Ray
Streamside Alzheimer Care
1333 South Edgewater Circle
Nampa, Idaho 83686

Ms. Ray:

Based on the state licensure/follow-up survey conducted by Department staff at Streamside Alzheimer Care between January 14, 2015 and January 21, 2015, it has been determined that the facility failed to protect residents from inadequate care.

This core issue deficiency substantially limits the capacity of Streamside Alzheimer Care to furnish services of an adequate level or quality to ensure that residents' health and safety are protected. The deficiency is described on the enclosed Statement of Deficiencies.

You have an opportunity to make corrections and thus avoid a potential enforcement action. Correction of this deficiency must be achieved by **March 7, 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 **February 22, 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 **February 20, 2015**.

Five (5) of the twenty-five (25) 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 Streamside Alzheimer Care.

Enforcement actions may include:

- imposition of civil monetary penalties;
- issuance of a provisional license;
- limitation on admission to the facility;
- requirement that the facility hire a consultant who submits periodic reports to Licensing and Certification.

Our staff is available to answer questions and to assist you in identifying appropriate corrections to avoid further enforcement actions. Should you have any questions, or if we may be of assistance, please

Diana Ray
February 9, 2015
Page 3 of 3

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: 13R925	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/21/2015
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NAME OF PROVIDER OR SUPPLIER STREAMSIDE ALZHEIMER CARE - STREAMSII	STREET ADDRESS, CITY, STATE, ZIP CODE 1333 SOUTH EDGEWATER CIRCLE NAMPA, ID 83686
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R 000	<p>Initial Comments</p> <p>The following deficiencies were cited during the licensure/follow-up survey conducted between 1/14/15 and 1/21/15 at your residential care/assisted living facility. The surveyors conducting the survey were:</p> <p>Maureen McCann, RN Team Coordinator Health Facility Surveyor</p> <p>Karen Anderson, RN Health Facility Surveyor</p> <p>Abbreviations used in this report:</p> <p>% = percent > = greater than ADL = activity of daily living ALF = assisted living facility ALZ = Alzheimer's disease BID = twice a day cath - catheter FYI = for your information Lab = laboratory LPN = licensed practical nurse MAR = medication assistance record med = medication ml = milliliters mg = milligram NSA = negotiated service agreement (care plan) O2 = oxygen po = by mouth PRN/prn = as needed q = every or each RN = registered nurse tab = tablet temp = temperature UAI = uniform assessment instrument UTI = urinary tract infection</p>	R 000		

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Ray 2/20/15

Residential Care/Assisted Living

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R 008	<p>16.03.22.520 Protect Residents from Inadequate Care.</p> <p>The administrator must assure that policies and procedures are implemented to assure that all residents are free from inadequate care.</p> <p>This Rule is not met as evidenced by: Based on observation, interview and record review, it was determined the facility administrator did not provide adequate supervision of staff and of day to day facility operation of the facility which led to the following:</p> <ul style="list-style-type: none"> * Staff on duty did not know how many residents were residing in the facility when the survey team arrived. * Staff were not aware who the facility administrator was between 11/25/14 and 1/13/15. * The facility did not complete a pre-admission assesment to determine if 1 of 4 sampled residents (Resident #3), was appropriate for admission. * The facility did not complete the required admission paperwork or negotiated service agreement to direct staff on how to care for 1 of 4 sampled residents (Resident #3). * The facility retained 1 of 4 sampled residents (Resident #1), who was violent and a danger to others. * The administrator did not schedule sufficient staff to meet all of the required needs of the residents. * Ineffective communication between caregivers, the nurses and the administrator led to changes in residents' conditions and multiple medication problems not being addressed. * The facility did not ensure a registered nurse completed the required nursing assessment on 1 of 1 sampled resident (Resident #3), who had 	R 008	<p>6.03.22.530 Protect Resident from inadequate care.</p> <p>PLAN OF CORRECTION:</p> <p>Census is posted daily on white board. Administrator or designee will update board daily. Daily roster is being kept by Administrator. Staff was in serviced on how to run census on blue step</p> <p>Current Administrator's Licenso has been placed in public place for staff and visitors awareness. New employees will have orientation. Durning orientation the Chain of Command will be addressed. All Department Heads will meet with new employees. A Chain of Command Chart has been placed for easy access for staff. Current Administrator is in the facility at minimum 40 hour per wee. This was corrected 1/15/2015</p> <p>A Policy is now in place for transfer of residents within sister facilities which includes full nursing assessment and pre-admission paperwork and admission agreement which was the case with resident #3(Exhibit A this was corrected 2/17/2015</p>	

Residential Care/Assisted Living

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R 008	<p>Continued From page 2</p> <p>recently been admitted to the facility. * The facility did not ensure a registered nurse completed the required nursing assessments for 1 of 1 sampled residents (Resident #2), who experienced weight loss and multiple illnesses. Additionally, the facility did not ensure 1 of 2 sampled residents (Resident #2), was free from chemical restraints.</p> <p>The facility record maintained at Licensing and Certification documented:</p> <p>* Ione Springer was the facility administrator between 9/15/14 - 11/24/14. "Previous Administrator"</p> <p>* Nancy Hines, the current facility administrator had started on 11/25/14. "Current Administrator"</p> <p>Upon entering the facility on 1/14/13, the survey team was told:</p> <p>* Diana Ray became the new facility administrator "yesterday" on 1/13/14. "New Administrator"</p> <p>* Deldre Kemp was the licensed administrator from a "sister" facility, located next door. "Sister Facility Administrator"</p> <p>The findings include:</p> <p>I. SUPERVISION</p> <p>IDAPA 16.03.22.012.25, defines supervision as, "A critical watching and directing activity which provides protection, guidance, knowledge of the resident's general whereabouts, and assistance with activities of daily living. The administrator is responsible for providing the appropriate supervision based on each resident's Negotiated</p>	R 008	<p>The records maintained at Licensing and Certification are correct, however hire date for Diana Ray was 1/13/2015</p> <p>Ione Springer 9/15/2014 - 11/24/2014</p> <p>Brandi King, Lpm Training to become Administrator 11/18/14-1/12/2015</p> <p>Nancy Hines 11/25/2014-1/13/15</p> <p>Diana Ray 1/13/2015- Present</p> <p>Current Administrator mailed letter to families and to staff to notify her acceptance of her position at Streamside Alzheimer Care</p> <p>IDAPA 16.03.22.012.25</p> <p>SUPERVISION</p> <p>*Survey team entered facility on 1/14/2015 at a critical juncture for Streamside Alzheimer's Care Facility. A change of leadership</p>	

Residential Care/Assisted Living

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R 008	<p>Continued From page 3</p> <p>Service Agreement or other legal requirements."</p> <p>A. STAFF NOT AWARE OF THE CENSUS:</p> <p>On 1/14/15 at 8:05 AM, when the survey team arrived unannounced at the facility, the facility was observed to be a 24 licensed bed, secured unit.</p> <p>The following observations and interviews occurred on 1/14/15:</p> <p>*8:10 AM, A caregiver told surveyors there were 15 or 16 residents currently residing in the facility.</p> <p>*9:20 AM, Diana Ray, the new facility administrator who started "yesterday," told the surveyors, 13 residents currently resided in the facility.</p> <p>*9:25 AM, the facility LPN provided the surveyor team a facility roster. The roster had 13 residents' names on it. The names and room numbers did not match with the names and room numbers the surveyors observed during the facility tour.</p> <p>*9:30 AM, Diana Ray, the LPN and Caregiver A were observed going from room to room counting residents and updating the facility roster.</p> <p>*9:50 AM, surveyors received the edited roster and compared it to the roster they developed during the facility tour.</p> <p>One and a half hours after arriving at the facility, the surveyors were able to determine there were actually 14 residents residing in the facility.</p> <p>B. STAFF NOT AWARE OF WHO THE ADMINISTRATOR WAS:</p>	R 008	<p>under a licensed Administrator had occurred within the previous 24 hours of survey.</p> <p>Brandi King, LPN, interviewed for and was given opportunity to work toward Licensure as an Administrator. (See attached letter application.) Nancy Hines, Owner and Licensed Administrator, put her license over the building to give Brandi King time to study and test for License. Brandi King trained under Ione Springer, Administrator, for a week before Ione Springer moved on to other employment.</p> <p>Nancy Hines, Administrator had her license hanging on the wall of the Administrator's office. She visited the site often and at different times of the day. Administrator was in daily communication with Brandi King.</p>	<p>Exhibit B</p>
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Residential Care/Assisted Living

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R 008	<p>Continued From page 4</p> <p>IDAPA 16.03.22.215 documents, "Each facility must be organized and administered under one (1) licensed administrator assigned as the person responsible for the operation of the facility."</p> <p>IDAPA 16.03.22.215.02 documents, "The facility's administrator must be on site sufficiently to provide for safe and adequate care of the residents..."</p> <p>A letter to Licensing and Certification from the facility owner, dated 11/25/14, documented the owner, Nancy Hines was the "administrator of record" effective immediately.</p> <p>The following interviews occurred on 1/14/15:</p> <p>*8:10 AM, a caregiver stated the LPN was the current facility administrator.</p> <p>*8:35 AM, the facility LPN stated she started in November of 2014 and "was hired to manage the building" until a new administrator was hired. She stated she was not a licensed administrator. She stated Nancy Hines had "her license on this building." The LPN further stated, Nancy Hines was out of the country on vacation.</p> <p>*9:10 AM, Diana Ray stated she was hired as the new facility administrator. She stated her first day was "yesterday," 1/13/15, which she spent in the office where "there was paperwork laying on the floor and in stacks all over the office."</p> <p>*10:05 AM, a social worker from a hospice agency stated she just met Diana Ray "who started yesterday." She stated the previous administrator was Lone Springer. She further stated the LPN, who she thought was the</p>	R 008	<p>When it became evident that change was necessary, Nancy Hines, Administrator, acted swiftly and appropriately to secure a new Licensed Administrator. This was accomplished 1/13/2015</p> <p>PLAN OF CORRECTION;</p> <p>Census is posted daily on white board. Administrator or designee will update board daily. Daily roster is being kept by Administrator. Staff was in serviced on how to run and check the census on blue step. Residents names are posted outside of resident's room. This was corrected 1/26/2015</p> <p>B. Current Administrator's License has been placed in a public place for staff and visitors awareness. Letter from current Administrator sent out to family to introduce herself and in service for staff. Orientation has a segment where all department heads will go and introduce themselves and give a back ground of there experience and their current job at Streamside.</p>	
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R 008	<p>Continued From page 5</p> <p>administrator, had been covering since lone Springer left in November. She was not aware Nancy Hines was the facility administrator.</p> <p>*10:45 AM, Caregiver A stated she never saw Nancy Hines and was not aware she was the facility administrator. She stated she went to the LPN, who she thought was the current administrator, when she needed guidance.</p> <p>*3:50 PM, Caregiver B stated she called the LPN, who she thought was the current administrator, when she "had issues." She was not aware Nancy Hines was the facility administrator.</p> <p>The following interviews occurred on 1/15/15:</p> <p>*10:10 AM, Caregiver B stated if there was a problem with a resident, she would call the "on-call person in charge" who was either the LPN or Deirdre Kemp.</p> <p>*11:05 AM, Caregiver D stated she did not know who the licensed administrator was, "I was told different people were in charge." She stated, "Everything was up in the air after lone [Springer] left." She stated, "I just met the new administrator today." She was not aware Nancy Hines was the facility administrator.</p> <p>*11:20 AM, a hospice nurse stated she was not aware Nancy Hines was the facility administrator. She further stated she coordinated residents' care with the LPN.</p> <p>*1:45 PM, Caregiver E stated the LPN was the current facility administrator and took over for lone Springer when she left in November 2014. She was not aware Nancy Hines was the facility administrator.</p>	R 008		
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Dray 2/20/15

Residential Care/Assisted Living

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R 008	<p>Continued From page 6</p> <p>*2:55 PM, Caregiver C stated the LPN was the facility administrator who took over for lone Springer when she left in November 2014. She stated the LPN had not been available for "about a month now" and the current administrator was Deirdre Kemp. She further stated if there was a problem after 8:00 PM, she would call the "on-call person in charge" who was either the LPN or Deirdre Kemp.</p> <p>*3:00 PM, Caregiver F stated the LPN was the current facility administrator and took over for lone Springer when she left in November 2014. She stated lone Springer and the LPN, "came in and let us know" the LPN would taking over when lone Springer left.</p> <p>Six caregivers, a hospice social worker and a hospice nurse who frequented the facility, did not know who the licensed administrator was after lone Springer left in November 2014.</p> <p>The facility administrator failed to provide supervision of the day to day operation of the facility from 11/25/14 through 1/13/15.</p> <p>C. ADMINISTRATOR RESPONSIBILITY FOR ACCEPTABLE ADMISSIONS:</p> <p>IDAPA 16.03.22.152.05.a, documents, "A resident will be admitted or retained only when the facility has the capability, capacity and services to provide appropriate care."</p> <p>1. ADMISSION ASSESSMENT AND OTHER REQUIREMENTS NOT COMPLETED IDAPA 16.03.22.220.01 documents, "Prior to or on the day of admission....the resident must be assessed by the facility to ensure the resident is</p>	R 008	<p>IDAPA 16.03.22.220.01</p> <p>C. Administrator Responsibility for Acceptable Admissions:</p> <p>Resident #3 was moved from a sister facility after a hospital stay.</p> <p>Resident had been in sister facility for approximately 3 weeks and all records were transferred to new facility via electronic transfer and</p>	
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2/20/15 *Olney*

Residential Care/Assisted Living

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R 008	<p>Continued From page 7</p> <p>appropriate for placement in their residential care or assisted living facility."</p> <p>IDAPA 16.03.22.220.02 documents, "Prior to or on the day of admission, the facility and each resident...must enter into a written admission agreement."</p> <p>Resident #3's record documented, she was an 82 year-old female, who arrived at the facility on 12/18/14, from a hospital with a diagnosis of Alzheimer's dementia.</p> <p>A hospital note, dated 12/18/14, documented Resident #3 had resided in the "sister" facility and was admitted to the hospital on 12/15/14.</p> <p>A hospital "History and Physical Report," dated 12/17/14, documented Resident #3 was admitted to the hospital with severe dementia, a UTI, constipation and hypokalemia. The report further documented the resident had been without medications for approximately two weeks prior to her hospital admission because "she had run out" while residing at the "sister" assisted living facility.</p> <p>A hospital discharge "Clinical Summary" report for Resident #3, dated 12/18/14, documented a physician's order to "bladder scan with each home health visit for two weeks, straight cath if > 550 ml and call provider."</p> <p>Resident #3's record was reviewed. There was no pre-admission assessment, admission agreement, interim care plan or a negotiated service agreement contained in the resident's record.</p> <p>A progress note, dated 12/18/14 and signed by the administrator from the "sister" facility,</p>	R 008	<p>the resident's binder and medications were physically brought to ALZ building by nursing staff.</p> <p>An incorrect assumption was made between sister facilities that the original admission paperwork and assessments would suffice for transfer.</p> <p>PLAN OF CORRECTION:</p> <p>A Policy is now in place for transfer of residents within sister facilities which includes a full pre-admission nursing assessment, an admission agreement for new facility, and a new NSA or Interim Care Plan. (Exhibit A) This was corrected 2/17/2015</p> <p>In Addition, documentation alerts on all new Admits will be added to electronic MARS and a paper copy of NSA/Interim Care Plan will be available to all staff. Staff will sign copy in binder to acknowledge that it was read and understood. This was corrected 2/19/15</p>	
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Deery 2/20/15

Residential Care/Assisted Living

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NAME OF PROVIDER OR SUPPLIER STREAMSIDE ALZHEIMER CARE - STREAMSII	STREET ADDRESS, CITY, STATE, ZIP CODE 1333 SOUTH EDGEWATER CIRCLE NAMPA, ID 83686
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R 008	<p>Continued From page 8</p> <p>documented "Resident was moved from ALF to ALZ after a brief hospital stay due to a kidney infection. Family and staff believed this to be the best move for resident's well being."</p> <p>There was no documentation found in the resident's record to alert staff the resident may have difficulty emptying her bladder.</p> <p>On 1/15/15 at 8:45 AM, the new administrator stated Resident #3 was admitted to the facility on 12/18/14 and there was no interim care plan, NSA, admission agreement or initial RN assessment done.</p> <p>Resident #3's record did not contain a pre-admission assessment or evaluation to determine if the resident was acceptable for admission to the facility. Further, the resident resided in the facility for 27 days without the completion of an admission agreement, RN assessment or a negotiated service agreement to direct staff how to assist Resident #3 with her care needs.</p> <p>2. A RESIDENT INAPPROPRIATE FOR RETENTION - DANGER TO OTHERS:</p> <p>According to IDAPA 16.03.22.152.05.e, a resident will not be admitted or retained who is violent or a danger to himself or others.</p> <p>Resident #1's record documented, she was an 82 year-old female, who was admitted to the facility, on 6/30/14 with a diagnosis of dementia.</p> <p>The following observations occurred on 1/14/15:</p> <p>*8:10 AM, Resident #1 was sitting in her wheelchair when Resident #6 walked by.</p>	R 008	<p>IDAPA 16.03.22.152.05</p> <p>2. A Resident Inappropriate For Retention – Danger to Others (Pages 9-15)</p> <p>Resident # 1 was assessed as appropriate for placement to Alzheimer's Assisted Living by nursing staff employed by company at the time of admission 7/1/2014.</p>	
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Residential Care/Assisted Living

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R 008	<p>Continued From page 9</p> <p>Resident #1 was observed to try and run over Resident #6's stocking feet with her wheelchair, two times. All staff were assisting other residents and did not observe this interaction.</p> <p>*8:30 AM, Resident #1 was observed sitting at a dining room table. When approached by a surveyor and told she had a lovely vest, the resident stated in an angry tone, "I do not have a vest." The resident repeated this statement several times, each time tugging firmly on the lapels of her vest to accent the statement. The resident then reached out and swatted the surveyor's hand that was on the dining room table.</p> <p>A UAI, dated 9/9/14 and a NSA, dated 9/27/14, signed by previous and current administrators and the facility RN, documented Resident #1 was "Sometimes disruptive/ aggressive/ socially inappropriate, Sometimes verbally/ physically threatening, Sometimes agitated/ anxious Sometimes assaultive."</p> <p>A Behavioral Management Plan, dated 11/18/14, documented Resident #1 exhibited "mood swings, aggression and crying episodes. Striking at staff or other residents."</p> <p>Resident #1's behavior tracking documentation was reviewed. The following includes a sample of some of the documentation:</p> <p>"7/2/14 at 4:00 PM, when another resident asked staff for help, Resident #1 went to the other resident and began to "yell at her." A caregiver stepped between the two residents and tried to redirect Resident #1 who "shouted, stormed down the hall knocking things off tables...banged on wall pictures, threw cups off of the medication</p>	R 008	<p>The VP of Operations and Quality Control, Ione Springer, wrote a Behavior Plan on 7/7/2014 and again on 11/18/2014 when she was Administrator of the Facility. Documented evidence proves that discussions were had between Ione Springer, Administrator, and family members regarding resident's move to a local Nursing Home. However, action to pursue the move was not documented. Resident is no longer in the facility.</p> <p>PLAN OF CORRECTION;</p> <p>*A registered Nurse has been employed at facility to ensure that pre-admission, change of condition; and routine assessments are performed on each resident as required by State Regulations.</p> <p>Resident who are prescribed psychotropic medications and have behaviors will be assessed on a quarterly bases and PRN this will include interventions and follow up to try and identify triggers and to track the behaviors.</p> <p>Staff in services on Behavior Management Strategies.</p>	
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R 008	<p>Continued From page 10</p> <p>cart," then attempted to go in other residents' rooms.</p> <p>*7/5/14 at 1:37 PM, the resident "was upset, throwing tables, chairs."</p> <p>*7/7/14 at 8:46 AM, Resident #1 started pushing chairs and tables in the dining room, "then walked out the back door and knocked the patio set table over and threw the chairs."</p> <p>*7/21/14 at 4:00 PM, "After I told her she had a place mat she got extremely aggressive and started screaming and shouting in front of all of the residents, pounding on her table, then out of nowhere she cocked her head back and hit me in the stomach with a clenched fist."</p> <p>*7/29/14 at 2:10 PM, the "resident threw a cup of water at another resident."</p> <p>*7/31/14 at 1:50 PM, the resident tried to "stab" staff with a fork.</p> <p>*7/31/14 at 9:40 PM, while getting ready for dinner, Resident #1 "began to scream, throw silverware, cups," and hit and kicked staff.</p> <p>*8/29/14 at 7:00 AM, Resident #1 "all of a sudden" started yelling to "shut the hell up I know you slept with my husband." Resident #1 then pointed to a resident and accused the resident of sleeping with her husband. She also yelled they could "all go to hell" and "banged her hand several times on the table and on the bookshelves as she walked to her room."</p> <p>*9/7/14 at 7:40 PM, staff entered the dining room and witnessed Resident #1 as she "jumped up and begin shouting at" another resident and "tried</p>	R 008	<p>Behavior Plan will be implemented prior to admission and monitored by facility nurse. Appropriate redirections will be performed before any PRN medications are given to residents. It is mandated that PRN psychotropic medications be authorized by a nurse after all redirection approaches have been implemented and failed. This direction is given to staff on EMAR. Any resident who is violent or a danger to self or other will not be retained and will be issued an emergency discharge per State Regulations and the Administrator will assist family in finding appropriate housing for said resident. The resident at that time will have a one on one while awake. This will be updated and corrected by March 7th 2015</p>	
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R 008	<p>Continued From page 11</p> <p>to smack" the resident in the back of her left arm.</p> <p>*9/12/14 at 3:18 PM, the administrator documented, "This is the first time she (Resident #1) has tried to do damage to another person." The note did not identify which incident the administrator was referring to.</p> <p>*10/30/14 at 5:47 PM, the administrator documented, Resident #1 was sitting at the dining room table when another resident reached for utensils. Resident #1 started "screaming at the other resident." When the other resident turned her back, Resident #1 slapped the other resident and the administrator.</p> <p>*11/1/14 at 8:00 AM, Resident #1 "got mad" because another resident "did not eat her breakfast...Resident #1 "hit the other resident" and started calling her names and "using bad words."</p> <p>*11/15/14 at 12:27 PM, the resident was "screaming" at staff "1..2..3...I'm going to kill you."</p> <p>*11/16/14 at 8:21 AM, the resident was "yelling at anyone who said anything in the dining room" and "threw a cup at staff."</p> <p>*11/18/14 at 12:17 PM, the administrator documented, Resident #1 was sitting in the dining room and "Without any warning...became upset" and was "yelling at anyone in the dining room."</p> <p>*11/30/14 at 11:05 AM, "Resident was being rude towards staff and told staff they "only had a couple nights 'to live'."</p> <p>*11/30/14 at 12:41 PM, Resident #1 "threatened staff," slammed her fist on a table and yelled at</p>	R 008		

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R 008	<p>Continued From page 12</p> <p>any resident that came to her table.</p> <p>*12/7/14 at 2:45 PM, Resident #1 "hit staff" in the stomach and "yelled for her to get away and that she did not give a damn."</p> <p>Progress notes, signed by the administrator, included the following documentation:</p> <p>*9/12/14 at 3:30 PM, "Have spoken with the family regarding [Resident #1's name] unpredictable behaviors. Due to not knowing what triggers are that causes her behaviors I have recommended that she be moved to a facility that is more equipped to handle her outbursts. They have agreed to call [name of a long term-care facility]."</p> <p>*10/31/14 at 8:40 AM, Resident #1 had struck another resident. "I have explained to [Resident #1's name] daughter that this is not behaviors that I can allow to happen in the facility. I have given the family options for (alternative) placement."</p> <p>*11/2/14 at 6:14 PM, Resident #1 "slapped" another resident and "is on the waiting list to go to" a long-term care facility.</p> <p>Despite Resident #1's continued verbal and physical aggressive outbursts, the resident continued to reside at the facility.</p> <p>Nurse assessments, dated 7/1/14, 9/29/14 and 1/3/15 were reviewed. There was no documentation regarding Resident #1's mental status, behaviors or the effectiveness from the behavioral modifying medications the resident was receiving for her behaviors.</p>	R 008		

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R 008	<p>Continued From page 13</p> <p>On 1/15/15 at 3:10 PM, Caregiver C stated the resident had many verbal and physical aggressive outbursts. "They had told us when [the previous administrator's name] was here, she needed a higher level of care and reported she was going to get moved out" but she never left. "Her behaviors are getting worse...swears, yells, throws things and at times hits other residents."</p> <p>On 1/15/15 at 10:10 AM, Caregiver B stated Resident #1's behaviors had increased after she returned from the hospital. She stated "When the resident gets upset she will hit." She stated Resident #1 had "slapped" her and another resident's hand.</p> <p>On 1/15/15 at 11:05 AM, Caregiver D stated Resident #1's behaviors were "pretty bad...I contacted the nurse and now she is on hospice." She stated the resident would "hit other residents."</p> <p>On 1/15/15 at 1:55 PM, Caregiver E stated, Resident #1's behaviors were "bad." She had hit other residents, "tried to stab" a caregiver in the eye, "you never know when she is going to go off...Now she screams loudly and this affects other residents." The caregiver stated the previous administrator "kept saying I need to remove her," but did not.</p> <p>On 1/15/15 at 3:00 PM, Caregiver F stated Resident #1's behaviors consisted of "cursing, aggression and crying episodes." She stated the resident's behaviors were "worse" before she was hospitalized.</p> <p>Ten weeks after the resident was admitted to the facility, the administrator documented the facility did not have the capacity to manage Resident</p>	R 008		

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R 008	<p>Continued From page 14</p> <p>#1's behaviors. However, the facility retained Resident #1 for six more months while she continued to yell and strike out at other residents and staff. By retaining a resident who was both violent and a danger to others, the facility violated IDAPA 16.03.22.152.05.e. This violated the rights of the rest of the residents' to be free from verbal and physical abuse.</p> <p>D. INSUFFICIENT STAFFING:</p> <p>IDAPA 16.03.22.600.06 documents, "The facility will employ and the administrator will schedule sufficient personnel to: a. Provide care, during all hours...to assure residents' health, safety, comfort and supervision..."</p> <p>The following observations occurred on 1/14/15:</p> <p>*8:05 AM, upon entering the facility, the survey team observed Resident #5 walking around the dining room in bare feet. Resident #6 was observed walking between the living room and the dining room with socks, but no shoes. One caregiver was assisting residents with medications and an orientee was observing. A second caregiver was busy clearing the breakfast dishes from the dining room tables, assisting residents in wheelchairs from the tables and re-directing residents who were wandering around the facility.</p> <p>*8:08 AM, Resident #2 and #4 were observed sleeping in their bedrooms not wearing oxygen. Their oxygen tubing was observed lying on the floor with oxygen flowing into their rugs.</p> <p>*8:10 AM, Resident #1 was sitting in her wheelchair when Resident #6 walked by. Resident #1 was observed to try and run over</p>	R 008	<p>IDAPA 16.03.22.600.06</p> <p>D. Insufficient Staffing</p> <p>(Pages 15-19)</p> <p>A typical staffing ratio is 1 staff to 8 residents plus Administrator during normal business hours. There is always a minimum of 2 Caregiver/Med-Tech staff members on shift who are up and awake 24/7 to care for the needs of our residents. At the time of survey there were 14 residents on our census.</p> <p>Food preparation for Lunch and Dinner is done by a separate staff 7 days per week. Clean-up of dishes is performed in commercial dishwasher at sister facility on same campus.</p>	
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R 008 Continued From page 15

Resident #6's stocking feet with her wheelchair, two times. All staff were assisting other residents and did not observe this interaction.

*8:30 AM, a housekeeper from the "sister" facility stated the administrator from the sister facility told her to come to the facility to "help out." Surveyors asked the new administrator and the LPN to have the housekeeper return to the sister facility, so surveyors could observe residents' cares being accomplished by the actual scheduled staff.

*9:15 AM, the same housekeeper was observed assisting a resident in a wheelchair from a dining room table.

*Between 9:15 AM and 11:45 PM, Resident #8 was observed sitting at the dining room table staring into space, occasionally uttering un-intelligible sounds. Staff did not interact with the resident for two and a half hours.

*9:45 AM, Resident #5 was observed sleeping on his bed with his shoes on.

*11:40 AM, Residents were observed in the dining room for lunch. A hospice aide was observed assisting Resident #2 and #10 with eating. Eight of the twelve residents (Resident #'s 1, 2, 3, 6, 7, 8, 9 and 10) required hands on assistance during the meal, but there was only normally 2 caregivers scheduled on the day shift.

At 11:55 AM, Resident #1 was observed twirling her spaghetti on her fork but did not bring the fork to her mouth. She then tried to cut the spaghetti with her fork, but was unable to balance the spaghetti on her fork. The resident struggled to get the spaghetti to stay on her fork but could not effectively transfer the spaghetti from her plate

R 008

IDAPA 16.03.22.600.06

D. INSUFFICIENT STAFFING

(PAGES 15-19)

Observations by surveyors have highlighted the need for intensive and specific training of staff members. While the survey was conducted during a major transition in facility Administration, there was also a change in employees.

PLAN OF CORRECTION:

Administrator and Nursing will identify areas of training based upon observations and implement new training areas to staff. See training calendar for the year. This will start in orientation and ensure that current staff members have the updated training monthly. This training will be documented and put in staff member's employee files.

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R 008	<p>Continued From page 16</p> <p>into her mouth. Staff were not observed to assist her. At 12:15 PM, Resident #1 had not eaten any spaghetti, but was observed trying to cut her bread stick length wise with her fork. She could not cut the bread stick. At 12:18 AM, after 23 minutes, a surveyor asked a staff member what kind of assistance Resident #1 required at meals. Staff then precaded to assist the resident with eating.</p> <p>*12:05 PM, Resident #11 was sitting near the fireplace without food. Residents #4 and #7 were observed not eating or receiving assistance from staff.</p> <p>*12:10 PM, one female resident was asleep at the table with a full plate of food in front of her.</p> <p>Throughout the meal, Resident #6 was observed wandering through the halls and in and out of the dining room and living rooms wearing a sock on one foot. The resident had no sock on the other foot and no shoes. At 11:40 AM, the resident's plate of food was placed on the table. Staff did not direct the resident to her full plate of food until 12:05 PM, twenty-five minutes after the plate was served.</p> <p>During the lunch meal, the two scheduled caregivers were not able to provide the necessary assistance required by all of the residents. When all the residents finally received the required assistance, six staff were observed helping residents with eating (the two scheduled caregivers, the caregiver orientee, the hospice aide, the new administrator and the LPN). The housekeeper from the "sister" facility was assisting with other tasks such as helping residents to and from the tables and clearing the tables.</p>	R 008	<p>Administrator and Nursing will also document training in proper use of equipment from DME companies when new equipment is delivered to residents.</p> <p>Administrator will re-evaluate seating arrangement in the dining room for best support to residents during meal times</p> <p>This was accomplished 2/17/2015</p> <p>There are always 3 staff present at meal times. They have been in-serviced with hands on to teach about assisting residents to the table on time. To assist with cutting up food and assistance when needing to feed the residents. The nurse is present at different meal times to assist and observe to help feed the residents. With nurse observation will help determine what more education staff will need. The in-service will be done and implemented Completed by 3/07/2015</p>	

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R 008	<p>Continued From page 17</p> <p>The following observations occurred on 1/15/15:</p> <p>*11:45 AM, twelve residents were observed eating lunch. Seven residents (#'s 1, 3, 6, 7, 8, 9 and 10) were observed being assisted by four caregivers and the new administrator. Resident #2 was being assisted by a hospice aide.</p> <p>The following interviews occurred on 1/14/15:</p> <p>*8:10 AM, three caregivers were observed in the facility when surveyors arrived. One caregiver stated two of them were scheduled and the third caregiver was orienting. The orientee stated, "this is my second day."</p> <p>*10:45 AM. Caregiver A stated, the typical staffing on day shift was a caregiver and a medication aide. She stated "We used to have three staff." She stated four residents required assistance to eat and two other residents required a two-person transfer. She stated all 14 residents required some type of assistance to meet their ADLs.</p> <p>*1:27 PM, Caregiver H stated "we never have more than 2 caregivers working on each shift. The only reason there are two caregivers today is because State is here." She stated, "Today there was five of us helping with lunch, that never happens!" She stated, "We need more help!" Caregiver H further stated, the dishwasher had not been working for a long time and "when you only have two caregivers, doing dishes by hand after each meal takes time away" from caring for the residents.</p> <p>*2:00 PM, the new administrator stated, "It was unacceptable to have two caregivers on each shift when so many of the residents required</p>	R 008		

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R 008	<p>Continued From page 18</p> <p>assistance." She stated, "Today was the first meal I have observed and it was evident that it took more than two caregivers to assist all these residents with their meals."</p> <p>The following interviews occurred on 1/15/15:</p> <p>*8:20 AM, the new administrator stated per the schedule, there were three caregivers scheduled on the day and evening shifts "up until last week." She stated, she did not know why this change occurred.</p> <p>*11:05 AM, Caregiver D stated staffing had decreased by one caregiver on the morning and the evening shifts in the past month, but she did not know why.</p> <p>E. LACK OF SUPERVISION OF DAY TO DAY PROCEDURES REGARDING STAFF COMMUNICATION AND MEDICATIONS:</p> <p>IDAPA 16.03.22.215.01 documents, "The administrator is responsible for assuring that policies and procedures required in...IDAPA 16.03.22, 'Residential Care or Assisted Living Facilities in Idaho' are implemented."</p> <p>On 1/14/15 at 9:10 AM, Diana Ray stated her first day was "yesterday," which she spent in the office cleaning up paperwork that was "laying on the floor and in stacks all over the office."</p> <p>The following interviews occurred on 1/15/15:</p> <p>*10:10 AM, Caregiver B stated the second week in December 2014, Resident #2 began to exhibit increased confusion so she reported this change to the LPN "multiple times" and "wrote it down on a piece of paper and slipped it under the nurse's</p>	R 008	<p>IDAPA 16.03.22.215.01</p> <p>E. Lack of supervision of day to day procedures regarding staff communication and medications.</p> <p>(Pages 19-22)</p> <p>facility contracted with Registered Nurse who delegated to Facility LPN Brandi King the day to day nursing functions of the facility. It was noted that facility LPN did not communicate with contracted RN regarding changes in condition of residents or medication errors, Contracted RN was in facility on a weekly basis for oversight.</p>	
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Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R925	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/24/2015
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NAME OF PROVIDER OR SUPPLIER STREAMSIDE ALZHEIMER CARE - STREAMSIDE	STREET ADDRESS, CITY, STATE, ZIP CODE 1333 SOUTH EDGEWATER CIRCLE NAMPA, ID 83686
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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 008	<p>Continued From page 19</p> <p>door. When I noticed nothing was happening, I finally called the family."</p> <p>*11:05 AM, Caregiver D stated if there was a problem with a resident, she would call the "on-call person in charge" and she would put an "FYI" note under the office door, but "only about 70% of these are followed up." Caregiver D further stated, controlled substances had gone missing earlier this month without a resolution.</p> <p>*1:45 PM, Caregiver E stated, "the owners need to come and check on [the facility] periodically. The management of this building is always next door [at a sister facility]." Caregiver E also stated there were "lots of errors" being made with medications. Such as, "pills popped out but not signed for or not given but signed for," controlled substances had gone missing and residents ran out of their medications because they were not re-ordered on time.</p> <p>*2:55 PM, Caregiver C stated, when she had concerns such as, medications or supplies ran low or residents had "non-emergent" medical concerns, she would put an "FYI" note under the office door. She further stated often her requests were "not followed up on. I don't know what happens to the FYI forms." Caregiver C stated medication problems included: residents' medications were not available because they were not re-ordered on time, pills were signed off as given but were not popped out of the medication blister packs and controlled substances had gone missing. She stated she told the LPN, but "nothing gets done." She further stated the LPN had instructed her to take medication from another resident's medication supply.</p>	R 008	<p>PLAN OF CORRECTION:</p> <p>Facility has hired a Registered Nurse who will be on site during the work week and as needed. The nurses take on call which they share. There is always a nurse available. This was accomplished on 2/12/2015</p> <p>Facility has also hired a Licensed Administrator to run the Operations and will be on site during the work week and as needed. The Administrator is also on call 24 hours a day This was accomplished on 1/13/2015</p> <p>Administrator and Nurse collaborated with Pharmacy to determine the most effective, safe and controllable means of managing resident medications. All narcotics sheets are now in a hard bound book. Narcotics are numbered such as one of two, two of two. The page numbers also correspond with the blister pack. Some of the medications that are liquids are also colored to help identify them more clearly and to assist with not making medication errors.</p> <p>Accomplished by 03/07/2015</p>	
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Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R925	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/21/2015
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NAME OF PROVIDER OR SUPPLIER STREAMSIDE ALZHEIMER CARE - STREAMSIDE	STREET ADDRESS, CITY, STATE, ZIP CODE 1333 SOUTH EDGEWATER CIRCLE NANIPA, ID 83586
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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 008	<p>Continued From page 19</p> <p>door. When I noticed nothing was happening, I finally called the family."</p> <p>*11:05 AM, Caregiver D stated if there was a problem with a resident, she would call the "on-call person in charge" and she would put an "FYI" note under the office door, but "only about 70% of these are followed up." Caregiver D further stated, controlled substances had gone missing earlier this month without a resolution.</p> <p>*1:45 PM, Caregiver E stated, "the owners need to come and check on [the facility] periodically. The management of this building is always next door [at a sister facility]." Caregiver E also stated there were "lots of errors" being made with medications. Such as, "pills popped out but not signed for or not given but signed for," controlled substances had gone missing and residents ran out of their medications because they were not re-ordered on time.</p> <p>*2:55 PM, Caregiver C stated, when she had concerns such as, medications or supplies ran low or residents had "non-emergent" medical concerns, she would put an "FYI" note under the office door. She further stated often her requests were "not followed up on. I don't know what happens to the FYI forms." Caregiver C stated medication problems included: residents' medications were not available because they were not re-ordered on time, pills were signed off as given but were not popped out of the medication blister packs and controlled substances had gone missing. She stated she told the LPN, but "nothing gets done." She further stated the LPN had instructed her to take medication from another resident's medication supply.</p>	R 008	<p>Cart audits are being done weekly. On Tuesday and one person was tasked to do all the ordering on Wednesday to ensure all medications will be on the cart. If refill need to be addressed by pharmacy it will give them a few days before the weekend to notify MD.</p> <p>Giving the facility a greater chance of NO medication errors. Accomplished by 03/07/2015</p>	
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Pg 20 part B

Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R925	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/21/2015
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NAME OF PROVIDER OR SUPPLIER STREAMSIDE ALZHEIMER CARE - STREAMSII	STREET ADDRESS, CITY, STATE, ZIP CODE 1333 SOUTH EDGEWATER CIRCLE NAMPA, ID 83686
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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 20</p> <p>On 1/15/15 at 2:35 PM The facility RN stated she was hired as the "contract RN" and was told that the facility's LPN completed all required resident assessments. She stated she was not aware she had to complete nursing assessments when residents were admitted to the facility or when residents experienced changes in condition. She stated she did not do face to face assessments of residents, but the LPN "would contact me when residents had changes" in their health or mental status. She stated she would review the information the LPN documented and then decided if she needed to further address any issues.</p> <p>On 1/16/15 at 4:30 PM, the LPN stated "I didn't know I had to keep the FYI notes the med aides gave me" about the residents. She stated, "I would read their notes, and follow up on their concerns and then many times shred the FYI notes because I didn't know the notes had to be kept for 3 years." The LPN further stated, "I did assess residents but I didn't always document the assessment or document in a note that I had followed up on residents health status."</p> <p>On 1/14/15, two incomplete "Controlled Drug Record" forms, for lorazepam, were found in a resident's record. One sheet had 14 of the 30 pills signed out as "given" to the resident, leaving 16 pills unaccounted for. The other sheet documented the facility had received 30 pills, however, none were signed out as "given" to the resident, leaving 30 pills unaccounted for. The facility LPN stated she could not account for the missing medication.</p> <p>The current administrator, did not provide adequate supervision to staff, including the nurses, to ensure all facility procedures were</p>	R 008		

Okay 2/20/15

Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R925	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/21/2015
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NAME OF PROVIDER OR SUPPLIER STREAMSIDE ALZHEIMER CARE - STREAMSH	STREET ADDRESS, CITY, STATE, ZIP CODE 1333 SOUTH EDGEWATER CIRCLE NAMPA, ID 83686
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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 008	<p>Continued From page 21</p> <p>operational. There were multiple problems with communication between caregivers, the nurses and the administrator regarding changes in residents' conditions. Further, there were multiple problems with the facility's medication system.</p> <p>E. NO RN ASSESSMENT WITH A CHANGE OF CONDITION:</p> <p>IDAPA 16.03.22.300.01 documents, "A licensed professional nurse (RN) must visit the facility at least once every ninety (90) days or when there is a change in the resident's condition."</p> <p>IDAPA 16.03.22.305 documents, "The licensed professional nurse (RN) must assess and document, including date and signature" the following:</p> <p>*305.01. "Conduct a nursing assessment of each resident's response to medications and therapies."</p> <p>*305.03. "Conduct a nursing assessment of the health status of each resident by identifying symptoms of illness, or any changes in mental or physical health status."</p> <p>*305.07. "Conduct a review of the resident's use of all prescribed and over-the-counter medications for side effects, interactions, abuse or a combination of these adverse effects."</p> <p>1. WHEN A RESIDENT EXPERIENCED MULTIPLE CHANGES OF CONDITION IN TWO WEEKS</p> <p>Resident #2's record documented she was an 89 year-old female who was admitted to the facility on 7/22/14, with a diagnosis of dementia.</p>	R 008	<p>IDAPA 16.03.22.300.01</p> <p>A registered Nurse did visit the facility weekly and at the request of the facility LPN for follow - up</p> <p>PLAN OF CORRECTION:</p> <p>Facility has hired a Registered Nurse who will be on site during the work week and as needed. Thw was accomplished on 2/12/2015</p> <p>implemented Resident concern form with R.N. to sign off. Stand up daily through the week with minutes taken, Tuesday morning meeting of Resident at Risk fo a double check system. Update NSA at that time</p> <p>Accomplished 03/03/2015</p>	
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Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R925	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/21/2015
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NAME OF PROVIDER OR SUPPLIER STREAMSIDE ALZHEIMER CARE - STREAMSII	STREET ADDRESS, CITY, STATE, ZIP CODE 1333 SOUTH EDGEWATER CIRCLE NAMPA, ID 83686
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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 008	<p>Continued From page 22</p> <p>On 1/14/15 at 6:05 AM, Resident #2 was observed sleeping in her room and was not wearing her oxygen. The oxygen tubing was laying on the floor with oxygen flowing into the rug.</p> <p>On 1/14/15 at 8:15 AM, Caregiver G stated, Resident #2 had been in the hospital with influenza. The caregiver stated when the resident returned from the emergency room she required total assistance with eating and all other ADLs. The caregiver further stated, prior to her illness, the resident required only minimal assistance.</p> <p>An NSA, dated 8/5/14, documented Resident #2 required assistance to cut up her food and required minimal assistance to meet her mobility, transferring, toileting, grooming and dressing needs. The resident had a significant weight loss between 9/2014 and 10/2014, however her NSA was not updated to reflect her change of condition from needing only minimal to needing total assistance or what dietary needs the resident required to prevent further weight loss.</p> <p>On 12/25/14 at 2:25 PM, the LPN documented, "Resident had temp of 101.2 with harsh cough, restlessness and confusion." She further documented, the resident was sent to the emergency room and returned within a few hours with new orders for an antibiotic to treat pneumonia and an urinary tract infection. There was no documentation the facility RN completed an assessment or monitored the resident's health status when Resident #2 returned from the emergency room on 12/25/14.</p> <p>Five days later, on 12/30/14, the LPN documented the resident was sent again to the</p>	R 008	<p>IDAPA 16.03.22.305</p> <p>F. No RN assessment with a change of condition</p> <p>305.01; 305.03; 305.07</p> <p>it is common practice in Idaho Assisted Living communities to contract with a Registered Nurse who delegates the above mentioned duties to a LPN for day to day attention. The contracted Registered nurse oversees the LPN's work and will look at documentation and follow up as necessary with residents, Administrator or Physician. This was the case with the Registered Nurse for Streamside. The Registered Nurse was in frequent communication with facility LPN and Administrator</p> <p>1. When a resident experienced multiple changes of condition in two weeks</p> <p>Facility LPN did not notify contracted RN of resident #2's changing condition. RN was available at all times during this period.</p>	
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Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R926	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/21/2015
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NAME OF PROVIDER OR SUPPLIER STREAMSIDE ALZHEIMER CARE - STREAMSIDE	STREET ADDRESS, CITY, STATE, ZIP CODE 1333 SOUTH EDGEWATER CIRCLE NAMPA, ID 83686
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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 008	<p>Continued From page 23</p> <p>emergency room, because her oxygen saturations were 83%, her temperature was 101.7 degrees and she had a harsh nonproductive cough. She further documented the resident returned to the facility later that day.</p> <p>On 12/31/14 at 7:00 PM, the LPN documented the resident continued to have a fever, low oxygen saturations of 89% while wearing oxygen and was "lethargic, not eating or drinking." She further documented the resident was sent back to the emergency room.</p> <p>There was no documentation the facility RN completed an assessment or monitored the resident's health status between 12/25/14 and 12/31/14, when the resident was sent to the emergency room three times.</p> <p>On 1/1/15 at 7:00 AM, the LPN documented, the resident returned from emergency room with diagnosis of "influenza" and hospice was initiated. There was no documentation the facility RN completed an assessment when the resident returned from the hospital.</p> <p>On 1/15/15 at 10:10 AM, Caregiver B stated Resident #2 developed a cough a few days before Christmas and had increased confusion. She stated she reported these changes to the facility LPN "multiple times." She stated "I wrote my concerns down on an FYI report, and slipped the report under the nurse's door." She stated "I noticed nothing had been done for the resident, so I finally called the family."</p> <p>On 1/15/15 at 11:05 AM, Caregiver D stated, Resident #2 had a cough that continued to get worse a few days before Christmas. She stated, the LPN was notified the resident's cough was</p>	R 008	<p>PLAN OF CORRECTION:</p> <p>LPN no longer works for company.</p> <p>Facility has hired a Registered Nurse who will be on site during the work week and as needed. Resident who go to the ER will trigger alert charting. The nurse will chart on the resident for 3 days and followed up with the (RAR) Resident at Risk.</p> <p>2. After Resident experienced weight loss.</p> <p>Resident #2's weight loss was noted under Ione Springer, Administrator and a different set of nurses</p> <p>According to records, Resident #2 weighed 112lbs lbs on December 5th 2014 and weighed in at 120lbs on January 1st 2015. This was a weight gain of 8lbs. Resident #2 was admitted to Hospice care on January 1,2015 and continued weight loss is an expected part of resident's decline.</p>	
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Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R925	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/21/2015
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NAME OF PROVIDER OR SUPPLIER STREAMSIDE ALZHEIMER CARE - STREAMSII	STREET ADDRESS, CITY, STATE, ZIP CODE 1333 SOUTH EDGEWATER CIRCLE NAMPA, ID 83688
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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 008	<p>Continued From page 24 getting worse.</p> <p>On 1/15/15 at 11:10 AM, Caregiver G stated she notified the nurse on a FYI report concerning the resident's cough.</p> <p>On 1/15/15 at 1:55 PM, Caregiver E stated, Resident #2 "was not feeling good" and became "more and more congested."</p> <p>On 1/16/15 at 2:35 PM, the RN stated she had not assessed Resident #2 prior to, or on 12/25/14, after the resident experienced a change of condition. Further, the RN stated she "still had not" been to the facility or assessed Resident #2 after the resident made several visits to the emergency department.</p> <p>Within two weeks, Resident #2 experienced significant changes of condition, was diagnosed with three separate infections which required the resident be sent to the emergency room three times. However, the facility RN had not observed or assessed the resident once during this time.</p> <p>2. AFTER A RESIDENT EXPERIENCED A WEIGHT LOSS</p> <p>According to her record, Resident #2 was an 89 year-old female who was admitted to the facility on 7/22/14, with a diagnosis of dementia.</p> <p>A NSA, dated 8/5/14, documented Resident #2 "may need food cut up." Refer to example #1 above.</p> <p>A nursing assessment, dated 9/10/14, documented Resident #2's weight was 118 pounds, was stable and had no changes. The assessment was not signed or dated by the</p>	R 008	<p>Nursing to monitor weight monthly unless otherwise order by physician. Resident has more than a 5 pound weight loss in a month need to notify MD . Nursing to intervene and do finger foods , assist with eating, encourage family to assist at meal times. Follow MD orders for Diet or new instruction for weight loss.</p> <p>PLAN OF CORRECTION:</p> <p>Administrator and Registered Nurse will review and assess all current residents for weight loss or discrepancies in assessments and bring up to date as of March 7th 2015</p> <p>Staff will also receive training on when and how to weigh resident for accuracy and consistency by March 7th 2015</p> <p>Registered nurse/ Administrator will communicate with family and Physicians as needed and required by March 7,2015</p> <p>Resident with 5 pounds or greater will trigger the RAR Resident at Risk</p>	
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Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R925	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/21/2015
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NAME OF PROVIDER OR SUPPLIER STREAMSIDE ALZHEIMER CARE - STREAMSII	STREET ADDRESS, CITY, STATE, ZIP CODE 1333 SOUTH EDGEWATER CIRCLE NAMPA, ID 83686
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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 25</p> <p>facility's RN.</p> <p>A nursing assessment, dated 10/30/14, documented Resident #2's weight was 110 pounds, was stable and had no changes. The LPN documented the resident had an 8 pound weight loss in 50 days, however did not make any recommendations. The assessment was not signed or dated by the facility RN.</p> <p>Nursing notes were reviewed from 9/26/14 through 1/5/15. There was no documentation from the LPN or RN regarding interventions for Resident #2's weight loss, or evidence the resident's physician had been notified.</p> <p>On 1/14/15 at 11:45 AM, a caregiver from a hospice agency was observed assisting Resident #2 to eat soup. The caregiver stated, the resident had not been feeling well since December and had lost weight. The hospice caregiver stated, Resident #2's dentures no longer fit, which made it difficult for her to chew and eat her food. She stated, there were times when the resident had refused to eat because she was sick and too tired to eat.</p> <p>On 1/15/15 at 8:25 AM, the LPN stated Resident #2 woke up on Christmas morning "septic." The LPN stated the resident was sent to the emergency room and was diagnosed with an urinary tract infection and pneumonia. She stated the resident's recent weight loss was from not feeling well and not wanting to eat or drink. The LPN stated she had not assessed the resident but she could tell the resident had lost weight because her clothing was too big and her dentures no longer fit.</p> <p>On 1/16/15 at 2:40 PM, the RN stated she had</p>	R 008		

Olaj 2/20/15

Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R925	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/21/2015
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NAME OF PROVIDER OR SUPPLIER STREAMSIDE ALZHEIMER CARE - STREAMSII	STREET ADDRESS, CITY, STATE, ZIP CODE 1333 SOUTH EDGEWATER CIRCLE NAMPA, ID 83686
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R 008	<p>Continued From page 26</p> <p>not assessed Resident #2. There was no documentation the LPN or RN had recommended or implemented interventions to modify Resident #2's diet after she experienced weight loss. There was no documentation the resident's physician was notified of the resident's weight loss.</p> <p>The facility failed to make recommendations, notify the physician, or implement interventions to ensure the resident's diet was modified after the facility documented an 8 pound weight loss on 10/30/14. Resident #2 had lost weight, was "lethargic, not eating or drinking."</p> <p>II. RESIDENT RIGHTS - CHEMICAL RESTRAINT:</p> <p>According to IDAPA 16.03.22.550.10, each resident must have the right to be free from any physical or chemical restraints.</p> <p>According to IDAPA 16.03.22.16, a chemical restraint is defined as: A medication used to control behavior or to restrict freedom of movement and is not a standard treatment for the resident's condition.</p> <p>IDAPA 16.03.22.305 documents, "The licensed professional nurse (RN) must assess and document, including date and signature" the following:</p> <p>*305.07. "Conduct a review of the resident's use of all prescribed and over-the-counter medications for side effects, interactions, abuse or a combination of these adverse effects."</p> <p>The Nursing 2014 Drug Handbook, documented "Zyprexa is used to treat acute manic episodes linked to bipolar disorder." A "Black Box Warning"</p>	R 008	<p>IDAPA 16.03.22.305</p> <p>II. Resident Rights – Chemical Restraint (pages 27-31)</p> <p>PLAN OF CORRECTION:</p> <p>*A Registered Nurse has been employed at facility to ensure that pre-admission; change of condition; and routine assessments are performed on each resident as required by State Regulations. Residents who are prescribed psychotropic medications will be assessed routinely and a Behavior Plan will be implemented prior to admission, and monitored by facility nurse. Appropriate redirections will</p>	
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Day 2/20/15

Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R925	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/21/2015
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NAME OF PROVIDER OR SUPPLIER STREAMSIDE ALZHEIMER CARE - STREAMSIDE	STREET ADDRESS, CITY, STATE, ZIP CODE 1333 SOUTH EDGEWATER CIRCLE NAMPA, ID 83686
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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 008	<p>Continued From page 27</p> <p>for elderly patients documented the drug may increase infection related death in elderly patients with dementia and was not an approved treatment of dementia related psychosis.</p> <p>Resident #2's record documented she was an 89 year-old female who was admitted to the secured Alzheimer's facility on 7/22/14, with a diagnoses of dementia. Resident #2's record documented the reason her family chose the secured facility was she had a history of wandering away from home multiple times.</p> <p>A Behavior Management Plan, dated 8/8/14, documented the resident's behavior was "Attempting to elope. Wanting to go home." Interventions included involve her in activities, give her chamomile tea and let her walk outside in the secured court yard with supervision. The plan further documented, the resident had a "PRN medication."</p> <p>From 8/7/14 through 1/15/15, caregivers and the former administrator's notes, documented Resident #2 had exhibited four behaviors and PRN medication's were given as an intervention for three out of the four behaviors.</p> <p>A LPN note to the physician, dated 9/28/14 at 11:49 AM, documented the resident had increased agitation and had been attempting to leave the facility. However, there was no documentation in the "Daily Behavior Monitoring Reports," the behavior tracking forms or the caregivers notes, that the resident exhibited behaviors during the month of September 2014.</p> <p>A physician's order, dated 9/28/14, documented the resident could take "Zyprexa 0.1 -1 [5mg] tab prn agitation."</p>	R 008	<p>IDAPA 16.03.22.305</p> <p>RESIDENT RIGHTS CHEMICAL RESTRAINT (PAGES 27-31)</p> <p>To be performed before any PRN medications are given to residents. It is mandated that PRN Psychotropic medications be authorized by a nurse after all redirection approaches have been implemented and failed. This direction is given to staff on EMAR.</p> <p>Nursing to use ABC Behavior Chain Antecedent, Behavior, Consequences staff to fill out behavior reports for each behavior. Staff to reassess in one week and try to find the triggers and change the Antecedent and Consequences</p> <p>Any resident who is violent or a danger to self or others will not be retained and will be issued an emergency discharge per State Regulations and the Administrator will assist family in finding appropriate housing for said resident. This will be updated and corrected by March 7th, 2015</p>	
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Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R925	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/21/2015
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NAME OF PROVIDER OR SUPPLIER STREAMSIDE ALZHEIMER CARE - STREAMSII	STREET ADDRESS, CITY, STATE, ZIP CODE 1333 SOUTH EDGEWATER CIRCLE NAMPA, ID 83686
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R 008	<p>Continued From page 28</p> <p>According to the September 2014 MAR, the resident was not given Zyprexa.</p> <p>On 10/6/14, a fax was sent to Resident #2's physician and documented "Resident is taking Zyprexa 5 mg q day PRN. This has been effective but staff state it would be helpful if she could have BID. May we get an order for BID?" The physician replied, "Zyprexa 5 mg BID prn agitation. Monitor for somnolence." The LPN noted the order, however there was no nurse documentation the resident's behaviors were evaluated before requesting the increase of Zyprexa.</p> <p>Although a request to increase Zyprexa was submitted to Resident #2's physician, there was no documentation in the resident's record, that she had exhibited behaviors during the month of October 2014.</p> <p>According to the October 2014 MAR, the resident received Zyprexa 32 times. There was no documented reason on the MAR, why the resident received the Zyprexa. There was no documentation the facility RN monitored the resident for somnolence per the physician's order.</p> <p>According to the November 2014 MAR, the resident received Zyprexa 19 times. There was no documented reason on the MAR, the behavior tracking forms or caregivers notes why the resident received the Zyprexa.</p> <p>A "Daily Behavior Monitoring Report," dated 11/18/14, documented Resident #2, had only one behavior in November, when she attempted to get out of the secured facility.</p>	R 008		
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Okay 2/20/15

Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R925	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/21/2015
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NAME OF PROVIDER OR SUPPLIER STREAMSIDE ALZHEIMER CARE - STREAMSII	STREET ADDRESS, CITY, STATE, ZIP CODE 1333 SOUTH EDGEWATER CIRCLE NAMPA, ID 83686
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R 008	<p>Continued From page 29</p> <p>According to the December 2014 MAR, the resident received Zyprexa 33 times. There was no documented reason on the MAR or caregivers notes why the resident received the Zyprexa. There was no documentation the facility RN monitored the resident for somnolence per the physician's order.</p> <p>The December 2014 MAR, documented Resident #2 received Zyprexa three times on 12/8/14. However, there was no documentation why the resident was given more Zyprexa than the physician prescribed or that the resident's physician or the facility nurse was notified of the additional dose.</p> <p>The December 2014 MAR, documented Resident #2 received Zyprexa three times on 12/31/14. However, there was no documentation why the resident was given more Zyprexa than the physician ordered or if the physician or the facility nurse was notified of the additional dose. The LPN documented, the resident had a low "oxygen saturation of 89%" while using oxygen and was lethargic, on 12/31/14. Even though the LPN identified this change in condition, there was no documentation the facility RN completed an assessment.</p> <p>A "Daily Behavior Monitoring Report," dated 12/7/14, documented Resident #2 had only one behavior when she was observed "trying to pull residents out of wheelchairs."</p> <p>A Shift Report, dated 12/11/14, documented a caregiver gave "Zyprexa at 12:45 PM," because Resident #2 tried to exit from the secured facility and had been "shopping" in others' stuff.</p> <p>A Shift Report, dated 12/21/14, documented a</p>	R 008		

Okay 2/20/15

Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R925	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/21/2015
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R 008	<p>Continued From page 30</p> <p>caregiver gave Zyprexa at 11:30 AM, for "exit seeking" and trying to "lift people from chairs."</p> <p>The December 2014 MAR documented Resident #2 continued to receive multiple doses of the sedating anti-psychotic medication, even after she had fallen ill enough to be transported to the emergency room multiple times in two weeks. Further, the facility RN did not conduct a review of the resident's medications for side-effects after the resident received numerous PRN doses of a sedating anti-psychotic medication.</p> <p>The facility failed to protect Resident #2's right to be free of chemical restraints when they gave an antipsychotic medication 84 times to the resident, when staff only documented the resident only exhibited 4 behaviors during that time period. Further, the facility RN did not conduct a review of the resident's medications for side-effects.</p> <p>CONCLUSION:</p> <p>The facility failed to provide adequate supervision which lead to the following:</p> <ul style="list-style-type: none"> * Staff were not aware of how many residents were residing in the secured facility or who the facility administrator was. * The facility admitted Resident #3, before they had determined if the resident was appropriate for admission. *The facility retained Resident #1, who was violent and a danger to others. * The current administrator, did not schedule sufficient staff to meet all of the required needs of the residents. * The current administrator also did not ensure adequate communication between caregivers, the nurses and herself regarding changes in residents' conditions or problems with the facility's 	R 008		
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Olney 2/20/15

Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R925	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/21/2015
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NAME OF PROVIDER OR SUPPLIER STREAMSIDE ALZHEIMER CARE - STREAMSII	STREET ADDRESS, CITY, STATE, ZIP CODE 1333 SOUTH EDGEWATER CIRCLE NAMPA, ID 83686
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R 008	<p>Continued From page 31</p> <p>medication system.</p> <p>* The facility failed to ensure a registered nurse completed the required nurse assessment for Resident #3 when she was admitted to the facility and Resident #2 when she experienced weight loss and multiple illnesses. Additionally, the facility failed to ensure Resident #2 was free from chemical restraints.</p> <p>These failures had the potential to affect 100% of the residents residing at the facility which resulted in inadequate care.</p>	R 008		
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Dray 2/20/15



Facility STREAMSIDE ALZHEIMER CARE	License # RC-925	Physical Address 1333 SOUTH EDGEWATER CIRCLE	Phone Number (208) 461-1172
Administrator Diana Ray	City NAMPA	ZIP Code 83686	Survey Date January 21, 2015
Survey Team Leader Maureen McCann	Survey Type Licensure and Follow-up	RESPONSE DUE: February 20, 2015	
Administrator Signature <i>Diana Ray</i>	Date Signed 1.21.15		

NON-CORE ISSUES

Item #	IDAPA Rule #	Description	Department Use Only	
			EOR Accepted	Initials
1	215.01	A) The administrator/owner did not complete an investigation of all incidents and accidents to include 46 missing controlled substance pills. B) The administrator did not sign and/or date all incident and accident reports.	A) 4/17/15 B) 4/17/15	MCC
2	215.02	Six caregivers, an outside agency nurse, an outside agency social worker and three family members did not know the name of the licensed administrator/owner who had been on record since 11/25/14.	3/4/15	MCC
3	215.13	The facility did not notify Licensing and Certification of a change in administrator within 72 hours.	3/4/15	MCC
4	220	Resident #3 did not have an admission agreement and the resident was admitted on 12/18/14 (27 days earlier).	3/4/15	MCC
5	225.02.b	The facility did not implement the least restrictive interventions for Resident's #1 and #2.	4/17/15	MCC
6	225.02.c	The facility did not review the effectiveness of the behavioral interventions used for Resident #1 and #2.	4/17/15	MCC
7	250.13.d	The facility housed 2 residents in a room which measured less than 160 square footage. <i>error MCC</i>		
8	250.13.L	Multiple closets in shared rooms did not have substantial closet dividers for the separation of residents' clothing.	4/17/15	MCC
9	260.06	Offensive odors were observed throughout the facility during the survey.	3/4/15	MCC
10	300	The facility alternated a licensed nurse and an administrator from a sister facility to take after hours calls from caregivers when residents experienced a change of condition. The administrator from a sister facility, who was not a licensed nurse, gave directions to unlicensed staff over the phone. Such as: a) Directing medication aides to give prn psychotropic medication when residents' exhibited behaviors. b) Directing a medication aid to take vital signs and check on a resident when the medication aide reported the resident's "eyes were swollen and lips were purple."	A) 4/12/15 B) 4/12/15 C) 4/12/15	MCC MCC MCC
11	300.01	A) The facility RN did not complete the 90 day required nursing assessments. B) The facility nurse did not delegate 2 of 3 medication aides prior to the aides assisting residents' with their medications.	A) 3/12/15 B) CDS	MCC MCC
12	305.02	A) Medications were not available as ordered by the residents' physicians. Medication aides were instructed "to borrow" the unavailable medications from other residents' medications. B) Resident #1 and #4's medications were not congruent with current physicians' orders.	A) 3/4/15 B) 3/4/15	MCC MCC
13	305.03	The facility RN did not complete a nursing assessment for 4 of 4 sampled residents when they experienced changes in their health and/or mental condition. ****PREVIOUSLY CITED ON 3/3/11****	4/18/15	MCC

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NON-CORE ISSUES

Item #	IDAPA Rule #	Description	Department Use Only	
			EOR Accepted	Initials
14	305.04	The facility licensed nurse did not make recommendations for: A) Resident #1 and #2's weight loss. B) Six residents who required assistance with eating such as different utensils or finger foods. C) When 2 residents returned from the hospital and required continuous oxygen. Neither resident was observed not wearing their oxygen during the survey. Their nasal cannulas with oxygen flowing, were observed lying on the floor in their rooms. ****PREVIOUSLY CITED ON 3/3/11****	A 4/21/15 B 4/21/15 C 4/21/15	MLC MLC MLC
15	305.07	The licensed nurse did not review Resident #4's medications for interactions or side effects when the resident was ordered two laxatives simultaneously and the resident experienced diarrhea. ****PREVIOUSLY CITED ON 3/3/11****	3/4/15	MLC
16	310.01.a	Medications were observed unsecured in a kitchen cabinet.	3/4/15	MLC
17	310.03	Forty-six controlled substance pills were not tracked and accounted for.	3/4/15	MLC
18	310.04.e	Behavioral updates were not included during 6 month psychotropic reviews sent to Resident #2's physician. ****PREVIOUSLY CITED ON 3/3/11****	3/4/15	MLC
19	320.01	Resident #3 did not have an NSA completed and the resident had resided in the facility since 12/18/14 (27 days). ****PREVIOUSLY CITED ON 3/3/11****	3/4/15	MLC
20	320.08	Resident #1, #2 and #4's NSA did not reflect the residents' current care needs after changes in condition including the initiation of outside services. ****PREVIOUSLY CITED ON 3/3/11****	3/4/15	MLC
21	335.03	Caregivers were not supplied items needed to wash their hands after toileting residents. There were no paper towels found in the facility during the facility tour. Several residents' bathrooms did not have liquid soap.	3/4/15	MLC
22	460.04	The facility routinely used plastic spoons during meals due to an insufficient number of silverware.	3/4/15	MLC
23	600.06.a	The administrator/owner did not schedule sufficient staff to meet all of the residents' care needs. Such as, there were 2 staff scheduled with 6 residents who required assistance with eating and two residents who required 2 staff assistance with transferring, toileting and showering.	3/4/15	MLC
23	625.01	3 of 7 staff did not have documentation they had completed 16 hours of orientation.	3/4/15	MLC
24	630.01	2 of 7 staff did not have documentation they had completed dementia training.	3/4/15	MLC
25	640	2 of 2 staff did not have documentation they had completed 8 hours of annual continuing education.	3/23/15	MLC



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Administrator Signature	Date Signed		
<i>Diana Ray</i>	1.21.15		

NON-CORE ISSUES

Item #	IDAPA Rule # 16.03.22.	Description	Department Use Only	
			EOR Accepted	Initials
26	711.08.e	The facility LPN shredded notes from the caregivers informing the nurse of residents' changes in condition.	3/4/15	JMC
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