



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. BUTCH OTTER - Governor
RICHARD M. ARMSTRONG - Director

LESLIE M. CLEMENT - Administrator
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888

May 24, 2011

CERTIFIED MAIL #: 7009 0820 0000 2807 1774

Stephenie Ellwood, Administrator
Gables Senior Living - Arrowhead Management Company
1405 Curlew Drive
Ammon, ID 83406

Dear Ms. Ellwood:

Based on the licensure and follow-up survey conducted by the Idaho Department of Health and Welfare ("Department") staff at Gables Senior Living - Arrowhead Management Company from April 19, 2011 through April 27, 2011, it has been determined that the facility failed to correct the inadequate care practices identified during the survey conducted on February 11, 2011. The facility was also found to have failed to protect residents from abuse. Additionally, the facility was found to have failed to correct eleven (11) of the punch list deficiencies cited on February 11, 2011. Two of these deficiencies, hot water temperatures exceeding 120 degrees and failing to offer snacks between meals, have been cited on three consecutive surveys. Therefore, as outlined in this letter, the Department is imposing several enforcement actions upon Gables Senior Living - Arrowhead Management Company.

I. PROVISIONAL LICENSE

These core issue deficiencies and repeat punch list deficiencies seriously impair the capacity of Gables Senior Living - Arrowhead Management Company to furnish safe and effective services, and place the health and safety of the residents in jeopardy. The deficiencies are described on the enclosed Statement of Deficiencies. As a result of the survey findings, a provisional license is issued effective May 27, 2011. The provisional license expires on August 27, 2011. The following administrative rule for Residential Care or Assisted Living Facilities in Idaho (IDAPA 16.03.22) gives the Department the authority to issue a provisional license:

935. ENFORCEMENT REMEDY OF PROVISIONAL LICENSE.

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

The conditions of the provisional license are as follows:

1. **Ban on all new admissions.** Readmission from the hospital will be considered after consultation between the facility, the resident/family and the Department. The ban on new admissions will remain in effect until the Department has determined that the facility has achieved full compliance with the requirements. The following administrative rules for Residential Care or Assisted Living Facilities in Idaho (IDAPA 16.03.22) give the Department the authority to impose the remedy of a limit on admissions:

920. ENFORCEMENT REMEDY OF LIMIT ON ADMISSIONS.

01. Notification of Limit on Admissions. The Department will notify the facility limiting admissions or limiting admissions of residents with specific diagnosis to the facility pending correction of deficiencies. Limits of admissions to the facility remain in effect until the Department determines the facility has achieved full compliance with requirements or have received written evidence and statements from the outside consultant that the facility is in compliance.

02. Reasons for Limit on Admissions. The Department may limit admissions for the following reasons:

- a. The facility is inadequately staffed or the staff is inadequately trained to handle more residents.*
- b. The facility otherwise lacks the resources necessary to support the needs of more residents.*

910. NON-CORE ISSUES DEFICIENCY.

02. First Follow-Up Survey. When the Licensing and Survey Agency finds on the first follow-up survey that repeat non-core deficiencies exist, the Department may initiate any of the following enforcement actions: a. A provisional license may be issued; b. Admissions to the facility may be limited; or c. The facility may be required to hire a consultant who submits periodic reports to the Licensing and Survey Agency.

2. A **registered nurse or licensed administrator consultant**, with experience working for a residential care or assisted living facility in Idaho as a registered nurse or administrator, shall be obtained and paid for by the facility, and approved by the Department. This consultant must have an Idaho nursing license or an Idaho Residential Care Administrator license, and may not also be employed by the facility or the company that operates the facility. The consultant must be on-site for a minimum of twenty (20) hours per week, and must not be utilized to complete routine nursing or administrative tasks for the facility. The consultant shall review all facility systems related to the core and non-core issues, assist the facility to identify needed changes, assist with a plan to implement the changes and then monitor correction and ongoing compliance. Enclosed, please see the consultant report directions. The consultant shall be allowed unlimited access to the facility and its systems for the provision of care to residents. The name of the consultant with the person's qualifications shall be submitted to the Department for approval no later than **May 31, 2011**.

3. The Department-approved consultant will submit a **weekly written report** to the Department commencing on **June 3, 2011**, and every Friday thereafter. The reports shall address progress on correcting the deficiencies listed on the Statement of Deficiencies and the Non-Core Issues Punch Lists.

4. The facility shall maintain, on an ongoing basis, the deficient area in a state of compliance in accordance with the submitted Plan of Correction.

5. The provisional license shall be prominently displayed in the facility.

6. A **permanent, full-time nurse**, who is licensed in the State of Idaho, and whose license is in good standing, shall be retained on a full-time basis (no less than 40 hours per week) and dedicated exclusively to the facility. The licensed nurse may not be the same individual as the consultant (described in #2

above). The nurses duties shall encompass all nursing related requirements described in IDAPA 16.03.22, Rules for Residential Care or Assisted Living Facilities in Idaho. The name and a copy of this nurses' license shall be submitted to our office by **June 10, 2011**.

7. When the consultant and the administrator agree that the facility is in full compliance, they shall notify the Department. The Department will conduct a follow-up survey to verify compliance.

The provisional license, which expires on August 27, 2011, shall not be extended. If the facility is unable to meet the terms of the provisional license or come into compliance with the rules for Residential Care or Assisted Living Facilities in Idaho (IDAPA 16.03.22), a new license will not be issued. The facility will be required to transfer the residents, and cease operations as a residential care or assisted living facility.

II. PLAN OF CORRECTION AND EVIDENCE OF RESOLUTION

Correction of these deficiencies must be achieved by **June 30, 2011**. **We urge you to begin correction immediately.**

The following administrative rules for Residential Care or Assisted Living Facilities in Idaho (IDAPA 16.03.22) give the Department the authority to plans of correction and evidence of resolution:

130. LICENSURE SURVEYS.

08. Plan of Correction for Core Issue Deficiencies. The facility must develop a plan of correction and return an acceptable plan of correction to the Licensing and Survey Agency, for all core-issue deficiencies, within ten (10) calendar days of receipt of the Statement of Deficiencies and Plan of Correction form.

09. Evidence of Resolution for Non-Core Deficiencies. The facility must provide evidence of resolution of non-core issues to the Licensing and Survey Agency, within thirty (30) calendar days of the exit conference. The facility may show evidence of resolution by providing receipts, pictures, and completed policies, training, schedules, and other records.

After you have studied the enclosed Statement of Deficiencies, please write a Plan of Correction (POC) 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** POC to us by **June 7, 2011**, and keep a copy for your records. Your license

depends upon the corrections made and the evaluation of the POC you develop. Failure to develop and submit an acceptable POC may result in further enforcement actions, including additional civil monetary penalties and revocation of the provisional license.

You have available the opportunity to question cited deficiencies 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 Care Program for a Level 1 IDR meeting. The request for the meeting must be made within ten (10) business days of receipt of the statement of deficiencies. The specific deficiencies for which the facility asks reconsideration must be included in the written request, as well as the reason for the request for reconsideration. The facility's request must include sufficient information for Licensing & Certification to determine the basis for the provider's appeal. If your request for informal dispute resolution is received after **June 10, 2011**, 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.

Non-core issue deficiencies were identified on the Punch List, a copy of which was reviewed and faxed to you on the date of the exit conference. The completed Punch List form and accompanying proof of resolution (e.g., receipts, pictures, policy updates, etc.) are to be submitted to this office by **May 27, 2011**. Failure to submit acceptable evidence of resolution may result in further enforcement actions, including additional civil monetary penalties and revocation of the provisional license.

III. CIVIL MONETARY PENALTIES

The following administrative rule for Residential Care or Assisted Living Facilities in Idaho (IDAPA 16.03.22) gives the Department the authority to impose a monetary penalty for this violation:

910. NON-CORE ISSUES DEFICIENCY.

03. Second Follow-Up Survey. *When the Licensing and Survey Agency finds on the second follow-up survey that repeat non-core deficiencies still exist, the Department may initiate the "Enforcement Remedy of Civil Monetary Penalties," as described in Section 925 of these rules.*

925. ENFORCEMENT REMEDY OF CIVIL MONETARY PENALTIES.

01. Civil Monetary Penalties. *Civil monetary penalties are based upon one (1) or more deficiencies of noncompliance. Nothing will prevent the Department from imposing this remedy for deficiencies which existed prior to the survey or complaint investigation through which they are identified. Actual harm to a resident or residents does not need to be shown. A single act, omission or incident will not give rise to imposition of multiple penalties, even though such act, omission or incident may violate more than one (1) rule.*

02. Assessment Amount for Civil Monetary Penalty. *When civil monetary penalties are imposed, such penalties are assessed for each day the facility is or was out of compliance. The amounts below are multiplied by the total number of occupied licensed beds according to the records of the Department at the time non-compliance is established.*

b. Repeat deficiency is ten dollars (\$10).

Should Gables Senior Living - Arrowhead Management Company fail to correct core or non-core deficiencies in the future, the Department will have no alternative but to impose civil monetary penalties.

Please be advised that you may contest these decisions by filing a written request for administrative review pursuant to IDAPA 16.05.03.300 no later than twenty-eight (28) days after this notice was mailed. Any such request should be addressed to:

**Randy May, Deputy Administrator
Division of Medicaid - DHW
P.O. Box 83720
Boise, ID 83720-0009**

If you fail to file a written request for administrative review within the time allowed, this decision shall become final.

Should you have any questions, or if we may be of assistance, please call our office at (208) 334-6626.

Sincerely,



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

JS/js

Enclosures

c: Melanie Belnap, Program Manager, Regional Medicaid Services, Region VII - DHW
Cathy Hart, Idaho State Ombudsman, Idaho Commission on Aging
Liz Delany, Ombudsman, Area V Agency on Aging
Susan Cronquist, Supervisor Adult Protection Area V
Randy May, Deputy Administrator, Division of Medicaid
Charina Newell, Deputy Attorney General, Idaho Department of Health and Welfare

WEEKLY CONSULTANT REPORTS

- Each report should be signed and dated.
- Identify the facility and the survey by date.
- Identify each issue under each tag in bulleted or numerical fashion.
- For each issue, describe steps taken that week to correct the deficiencies. Do not repeat/copy previous report information. Address what is new or different for that week.
- Once a deficiency is corrected, just note: "Corrected on MO/Day/Year" with a brief explanation of any new efforts to attain or maintain compliance, i.e.: "Checked 5 charts for current orders-all 5 ok."
- Describe what actions consultant is taking:
 - Spent 2 hours with facility nurse explaining delegation requirements, including need for face-to face observation of each staff before delegating to them.
 - Assisted B.O.M. to audit all staff files. Background checks currently in place for all but 2 staff. Documentation of 16 hour orientation in all staff files.
- Describe how facility has changed systems to ensure deficiency will not recur.
- Length of report will depend on number of issues identified during survey and how many weeks have gone by. (If consulting is going well & facility is making progress, the report would be less lengthy.)
- Address any concerns with facility being able to come back into compliance on time and any problems with facility not wanting to accept direction from consultant or failing to accomplish corrective action.
- All punch items should be corrected and EOR sent to L&C w/in 30 days. All core issues must be resolved within 45 days.
- When Consultant and Administrator agree facility has corrected all deficiencies and is back in compliance, send notification to L&C so a follow up visit can be scheduled.
- If administrator and consultant do not feel facility is back in compliance at end of 45 days, the follow-up survey will still be scheduled.
- Contact surveyors for clarification on tags and to consult with them about interventions you are planning to ensure corrections are appropriate for the deficient practice.



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FAX: (208) 364-1888

June 22, 2011

CERTIFIED MAIL #: 7009 0820 0000 2807 1859

Mark Stephensen, Administrator
Gables Senior Living - Arrowhead Management Company
1405 Curlew Drive
Ammon, ID 83406

FILE COPY

Dear Mr. Stephensen:

I. BACKGROUND

On May 27, 2011, a provisional license was issued to Gables Senior Living – Arrowhead Management Company. As discussed in the letter the Department sent to your facility, dated May 24, 2011, the provisional license was issued because Gables Senior Living - Arrowhead Management Company failed to correct the inadequate care practices identified during the February 2011 survey, failed to protect residents from abuse, and failed to correct eleven (11) punch list deficiencies.

II. FAILURE TO MEET THE TERMS OF THE PROVISIONAL LICENSE

The May 24, 2011 letter described the conditions of your facility's provisional license. Two of those conditions are as follows:

1. **Ban on all new admissions.** Readmission from the hospital will be considered after consultation between the facility, the resident/family and the Department. The ban on new admissions will remain in effect until the Department has determined that the facility has achieved full compliance with the requirements.
6. **A permanent, full-time nurse,** who is licensed in the State of Idaho, and whose license is in good standing, shall be retained on a full-time basis (no less than 40 hours per week) and dedicated exclusively to the facility. The licensed nurse may not be the same individual as the consultant (described in #2 above). The nurses duties shall encompass all nursing related requirements described in IDAPA 16.03.22, Rules for Residential Care or Assisted Living Facilities in Idaho.

It has come to the attention of the Department that Gables Senior Living failed to meet the above listed conditions of the provisional license issued on May 27, 2011. **The facility did not hire a full-time, licensed nurse, and the facility re-admitted a resident sometime between June 20, 2011 and June 21, 2011, with conditions that were not disclosed to the Department.** Facility staff called the

Department on June 20, 2011, stating a resident had been admitted to the hospital for pain in her legs, but the hospital "found no problems." It has since been revealed that while in the hospital, the resident was diagnosed with cellulitis (a diffuse inflammation of connective tissue with severe inflammation of dermal and subcutaneous layers of the skin). Due to the cellulitis, a PICC (peripherally inserted central catheter) line was inserted in the hospital. An unlicensed staff member from the facility reportedly went to the hospital to assess the resident and made the determination to readmit the resident with the PICC line. No licensed nurse assessed the resident prior to or upon her re-admission to the facility.

III. REVOCATION OF FACILITY LICENSE

If Gables Senior Living - Arrowhead Management Company, does not immediately comply with all conditions of the provisional license, pursuant to Idaho Code Section 39-3345 and IDAPA 16.03.22.940.01, 16.03.22.940.02.e, and 16.03.22.940.02.f, the Department will have no alternative but to proceed with revocation of the Residential or Assisted Living Facility License # RC-964 for Gables Senior Living - Arrowhead Management Company. Pursuant to IDAPA 16.03.22.930, the Department may impose temporary management to assure the health and safety and orderly transfer of the residents.

Should you have any questions, or if we may be of assistance, please call our office at (208) 334-6626.

Sincerely,



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

JS/js

c: Melanie Belnap, Program Manager, Regional Medicaid Services, Region VII - DHW
Cathy Hart, Idaho State Ombudsman, Idaho Commission on Aging
Marie Peterson, Ombudsman, Area VI Agency on Aging
Susan Cronquist, Supervisor Adult Protection Area V
Randy May, Deputy Administrator, Division of Medicaid
Charina Newell, Deputy Attorney General, Idaho Department of Health and Welfare
Curlew Investments, 1395 NW Main, Blackfoot, ID 83221
Brady Pilster, 2238 N. 550 W Hamsville, IT 84414
Gordon Arave, 52 W. 215 N. Blackfoot, ID 83221
Louis Kraml 680 Pendlebury Lane, Blackfoot, Idaho 83221



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Boise, Idaho 83720-0036
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June 23, 2011

Stephanie Tiede, Administrator
Grace Memory Care Of Nampa Llc
Grace Memory Care Of Nampa
422 11th Avenue South
Nampa, ID 83686

Dear Ms. Tiede:

On June 20, 2011, a follow-up visit to the complaint investigation survey of April 29, 2011, was conducted at Grace Memory Care Of Nampa Llc. The core issue deficiencies issued as a result of the 04/29/11, survey have been corrected.

Please bear in mind that nine non-core issue deficiencies were identified on the punch list and eight were identified as repeat punches. As explained during the exit conference, the completed punch list form and accompanying proof of resolution (e.g., receipts, photographs, policy updates, etc.) needs to be submitted to our office no later than July 20, 2011

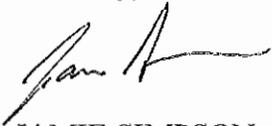
If the facility fails to submit acceptable evidence of resolution within sixty (60) days from when the facility was found out of compliance, or on a subsequent survey visit, it is determined that any of these deficiencies still exist, the Department will have no alternative but to initiate the enforcement of civil monetary penalties, as described in IDAPA 16.03.22.910.02 and IDAPA 16.03.22.925.

Please ensure the facility is continually monitoring its compliance with state rules, as further repeat punches identified during future surveys could result in enforcement actions including:

- a. Issuance of a provisional license
- b. Limitations of admissions to the facility
- c. Hiring a consultant who submits periodic reports to the Licensing and Certification
- d. Civil monetary penalties

Should you have questions, please contact me at (208) 334-6626.

Sincerely,

A handwritten signature in black ink, appearing to read "Jamie Simpson". The signature is fluid and cursive, with a large initial "J" and "S".

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

JS/sc

c: Pam Mason, Program Manager, Regional Medicaid Services, Region III – DHW

FORM APPROVED

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R964	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/27/2011
NAME OF PROVIDER OR SUPPLIER GABLES SENIOR LIVING - ARROWHEAD MAN		STREET ADDRESS, CITY, STATE, ZIP CODE 1406 CURLEW DRIVE ANIMON, ID 83406		
(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)	Initial Comments The following deficiencies were cited during the follow-up and licensure survey conducted from 4/19/2011 through 4/27/2011 at your residential care/assisted living facility. The surveyors conducting the survey were Karen Anderson, RN Team Coordinator Health Facility Surveyor Matt Hauser, OMRP Health Facility Surveyor Maureen McCann, RN Health Facility Surveyor	(R 000)	Please Note: I have typed in RED the commentary you already received from Stephanie Elwood. You already have her signature on the POC she submitted. I have then updated on this copy (in PURPLE) my comments on this version and have signed it as the current Administrator.	
	Survey Definitions: AP = Adult Protection BID = twice daily CNA = Certified Nursing Assistant LPN = Licensed Practical Nurse IV = intravenous NSA = Negotiated Service Agreement PICC line = peripherally inserted central catheter PO = by mouth Pt = patient R = right RN = Registered Nurse UAI = Uniform Assessment Instrument R 006 16 03 22 510 Protect Residents from Abuse The administrator must assure that policies and procedures are implemented to assure that all residents are free from abuse This Rule is not met as evidenced by	R 006	<i>POC Accepted 7/22/11 Karen Anderson, RN</i>	

Bureau of Facility Standards

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

4011

POYD12

Revised 03/04/09, Page 1 of 17

Mark Stephenson, Ph.D.

7/22/11

PRINTED: 07/07/2011
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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R964	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/27/2011
NAME OF PROVIDER OR SUPPLIER GABLES SENIOR LIVING - ARROWHEAD MAN			STREET ADDRESS, CITY, STATE, ZIP CODE 1405 CURLEW DRIVE ANIMON, ID 83406		
(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 006	<p>Continued From page 1</p> <p>Based on record review and interview, it was determined the facility failed to implement policies and procedures to protect 3 of 10 sampled residents (Residents #1, #6 and #7) and potentially 100% of the residents from abuse. The findings include:</p> <p>IDAPA 16.03.22.620 documents, "The administrator must assure that policies and procedures are implemented to ensure that all residents are free from abuse."</p> <p>IDAPA 16.03.22.010.01 documents, "Abuse. The non-accidental act of sexual, physical, or mental mistreatment, or injury of a resident through the action or inaction of another individual."</p> <p>The facility's "Operational Policies" documented the following:</p> <p>"Abuse, neglect and exploitation will not be tolerated. Any allegations or accusations will be duly treated and investigated by [Company's Name] to ensure protection and prevent reoccurrence. [Company's Name] will assure protection for the resident during the investigation. All allegations and investigations will be documented and maintained by..."</p> <p>1. Resident #7 was admitted to the facility on 2/17/09 with diagnosis which included dementia.</p> <p>Resident #7's NSA, dated 2/7/11, documented the resident required extensive assistance with transfers and needed to wear a gait belt at all times.</p> <p>A nursing assessment, dated 3/24/11, documented the resident's skin was intact but she had bruises. The pre-printed assessment form</p>	R 006	<p>RO06:</p> <p>Current policies are being reviewed by the administrator and nursing supervisor. Policies will be re-written to further describe the process of possible abuse.</p> <p>Staff training on the identification of possible abuse and proper notification to the RN and administrator will be completed by 6/15/11. Written disciplinary actions will be issued for any incidents not reported.</p> <p>All incident reports have been completed and all proper parties have been notified including A.P. and the local authorities. All of this is done under direction of the administrator.</p> <p>The facility R.N. is to assess all residents and document her findings.</p> <p>Documentation will be kept in the residents' file of the procedures taken. Residents will be monitored and any issues will be addressed by the R.N. and administrator. If a resident continues to be an issue a 30-day eviction notice will be given.</p> <p>Our system will be reviewed by our consultant and any further recommendations will be addressed. All policies and training will be completed by 6/15/11.</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R964	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ D. WING _____	(X3) DATE SURVEY COMPLETED R 04/27/2011
NAME OF PROVIDER OR SUPPLIER GABLES SENIOR LIVING - ARROWHEAD MAN		STREET ADDRESS, CITY, STATE, ZIP CODE 1405 CURLEW DRIVE AMMON, ID 83406		
IXA) 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 006	<p>Continued From page 2</p> <p>had "bruises" listed and the word "bruises" was circled by the nurse. The location or the size of the bruises were not described.</p> <p>A caregiver documented, on 3/30/11 (no time specified), "The resident had a large bruise to her right breast and upper right arm."</p> <p>A caregiver documented, on 3/30/11 at 2:00 PM, "Resident is not bearing any weight. She has a very large bruise on her right side and on her right breast. She is complaining of pain and doesn't like to be moved..."</p> <p>A caregiver documented, on 4/4/11 at 2:49 PM, "...she does have a bruise on her side that spready [sic] through her side and up through her chest and her arm..."</p> <p>From 3/30/11 through 4/4/11, for five days caregiver's documented the resident had a large bruise on her right breast and upper right arm. They also documented the resident was having pain when caregivers tried to move her. There were no documented RN assessment, incident reports or facility investigations regarding the resident's unexplained bruises or pain.</p> <p>On 4/21/11 at 10:55 AM, Resident #7 was observed sitting in a recliner in her room. Her left arm was in a sling. The resident stated, "My arm hurts unless I keep it like this." The resident was confused and was not able to answer questions regarding her injuries when interviewed.</p> <p>On 4/21/11 at 11:30 AM, a medication aide stated she was told the bruises were from use of the gait belt. She further stated, "(Resident #7's name) had a large dark blue/purple bruise on her right breast area." The medication aid stated, "I think</p>	R 006	<p>R006:</p> <p>A new Abuse Prevention policy has been written along with the protocol for the abuse investigation and reporting form. The staff was trained on the new policy on 7/20/11.</p> <p>Staff have been trained and are making appropriate use of our R.N. Communication form, to report any resident changes or significant observations to the facility R.N.</p> <p>The facility R.N. has completed all needed 90 day assessments, and new NSA's have been completed on all residents. The R.N. reports are very positively regarding staff use of the R.N. communication forms to alert her to changes in resident status. These forms lead to the addition of temporary care plan sheets (where appropriate) for up to 14 days. If special attention is needed for a longer period, an update of the regular NSA will be made.</p>	

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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R984	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/27/2011
NAME OF PROVIDER OR SUPPLIER GABLES SENIOR LIVING - ARROWHEAD MAN		STREET ADDRESS, CITY, STATE, ZIP CODE 1405 CURLEW DRIVE AMMON, ID 83406		
(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 006	Continued From page 3 when she was being transferred by only one caregiver that caused her pain and could have caused the bruising." On 4/21/11 at 12:24 PM, a hospice nurse stated, "I observed the bruise, it was on the outside of her right breast. The bruise spread from the breast and went up the inside of her right arm. I don't think it was caused by the gait belt because it was not consistent with marks made by a gait belt." She further stated, "The story I heard was she had a fall and was found on the floor laying on her right side." On 4/21/11 at 12:50 PM, the nursing supervisor/CNA stated, "I thought [Resident's name] bruises were caused by use of the gait belt. I didn't report the bruises to the RN or administrator, or complete an incident report." She further stated, "I did hear some talk about the possibility that her husband could have caused the bruising." On 4/21/11 at 5:30 PM, the administrator stated she had not completed an incident report regarding the bruise on the resident's breast, or investigated for possible abuse. There was no documented evidence in Resident #7's record the administrator or the facility nurse had investigated, followed-up, assured protection of the resident during the investigation. By not conducting a thorough investigation, the facility could not identify the source of the injury to rule out possible abuse and prevent reoccurrence. 2. Resident #1 was admitted to the facility on 12/29/10 with diagnoses which included developmental disabilities.	R 006		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R964	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/27/2011
NAME OF PROVIDER OR SUPPLIER GABLES SENIOR LIVING - ARROWHEAD MAN		STREET ADDRESS, CITY, STATE, ZIP CODE 1406 CURLEW DRIVE AMMON, ID 83406		
(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 006	Continued From page 4 Resident #1's NSA/UAI, dated 1/11/11, documented the resident "is frequently unable to discern and avoid situations in which he/she may be abused, neglected, or exploited." The NSA/UAI further documented the resident frequently had poor judgement and needed protection and supervision, because the resident would make unsafe or inappropriate decisions. An incident report, dated 3/15/11 at 8:40 PM, documented a resident reported that Resident #1 had gone into her room and attempted to get into her refrigerator and steal her snacks. The report documented, the resident stated Resident #1 was being aggressive so she hit Resident #1 with her phone. The incident report further documented the resident called the police on Resident #1. The administrator was notified and the police spoke to both residents about the incident. The incident report did not document whether or not Resident #1 sustained injuries. On 4/21/11 at 5:30 PM, the administrator stated the facility nurse had been designated to investigate, follow-up and implement preventative measures for all incidents, including abuse, but had not done so. There was no documented evidence in Resident #1's record the administrator or the facility nurse had investigated, followed-up or assured protection of the resident during the investigation, implemented preventative measures. The facility failed to protect Resident #1 from abuse. They did not investigate the incident of physical abuse, nor did they develop a plan to protect Resident #1 from further abuse. Additionally, they failed to report the abuse to Adult Protection or to follow their operational	R 006		

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NAME OF PROVIDER OR SUPPLIER GABLES SENIOR LIVING - ARROWHEAD MAN		STREET ADDRESS, CITY, STATE, ZIP CODE 1405 CURLEW DRIVE AMMON, ID 83406		
(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 006	<p>Continued From page 5 policy regarding abuse.</p> <p>3. Resident #6 was admitted on 9/22/09 with diagnoses which included cardiac problems.</p> <p>An incident report, found in another resident's record, dated 3/26/11, documented the other resident had hit Resident #6 at breakfast. There was no incident report found in Resident #6's record.</p> <p>There were no investigations, care notes, nursing assessments, or any other documentation in Resident #6's record regarding the physical altercation. There was no documentation that Adult Protective services had been notified.</p> <p>On 4/25/11 at 1:18 PM, when asked about the incident on 3/26/11, a caregiver stated Resident #6 had approached the table and accidentally knocked over the sugar bowl. Another resident who was sitting at the table got mad and hit Resident #6 in the face.</p> <p>On 4/25/11 between 1:10 PM and 2:00 PM, five caregivers stated they were aware of the altercation between Resident #6 and the other resident, but none recalled an investigation being completed.</p> <p>On 4/21/11 at 5:30 PM, the administrator stated the facility nurse had been designated to investigate, follow-up and implement preventative measures for all incidents, including abuse, but had not done so.</p> <p>The facility failed to investigate significant bruises of unknown origin for Resident #7, to rule out abuse. Further, the facility failed to protect Resident #1 and #6 from abuse, by not</p>	R 006		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R964	(X2) A. BLDG TYPE/PLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/27/2011
NAME OF PROVIDER OR SUPPLIER GABLES SENIOR LIVING - ARROWHEAD MAN		STREET ADDRESS, CITY, STATE, ZIP CODE 1405 CURLEW DRIVE AMMON, ID 83406		
(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	Continued From page 6 investigating incidents of physical abuse. The administrator did not ensure plans to protect Resident #1 and #8 from further abuse were developed and implemented. Additionally, the facility failed to report the incident with Resident #7 to Adult Protection or follow their operational policies. This resulted in failure to protect residents from abuse.	R 008	R008: <u>Supervision of Cares:</u> 1. Resident # 8's NSA was reviewed as well as documented care notes. A new care plan is being written to reflect changes in condition. Caregivers are being trained on proper documentation as well as notification when ADL's are not being done. Staff will also be trained on transferring and how to read and understand NSA's. All training will be completed by 6/15/11. All NSA's are being reviewed and rewritten to reflect the specific needs of each resident. All NSA's will be rewritten by 6/30/11.	
(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.	(R 008)	Anytime there is a change in condition the facility R.N. will review and document her recommendations. These will be addressed with the staff using a temporary care plan. If the change in condition continues after 14 days the change will be incorporated into the NSA. Staff are completing change of condition forms for any issues, the R.N. is addressing the issue and the nursing supervisor is following up. Furthermore, the change in condition forms are being modified to include an area for the administrator to document and sign acknowledging notification.	
	This Rule is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to provide adequate supervision to 5 of 10 sampled residents (# 1, 4, 7, 8 & 9). These findings include: I. SUPERVISION OF CARES IDAPA 16.03.22.012.25 Supervision - 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 facility is responsible for providing appropriate supervision based on each resident's Negotiated Service Agreement or other legal requirements. 1. Resident #8 was re-admitted to the facility on 3/8/11 after having a PICC line and pacemaker placed for treatment of congestive heart failure and cellulitis.			

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NAME OF PROVIDER OR SUPPLIER GABLES SENIOR LIVING - ARROWHEAD MAN		STREET ADDRESS, CITY, STATE, ZIP CODE 1405 CURLEW DRIVE AMMON, ID 83406		
(X4) IS 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}	Continued From page 7 Resident #8's NSA, dated 8/1/10, documented the resident required minimal assistance with mobility, was independent with transferring, and required extensive assistance with showers twice weekly. However, the NSA was not updated to include the increased assistance required after the resident was re-admitted on 3/8/11. Additionally, there was no written instructions to caregivers regarding proper care of the PICC line during showers. A "Temporary Care Plan," dated 3/7/11, written by the "nursing supervisor" (who was a CNA), documented "Resident is back from the hospital... Monitor him closely, on 2 hour checks and has a pic [sic] line which home health will be taking care of. Watch legs for redness, he will be needing assistance with showering, cover pic [sic] line, toileting etc encourage him to use call light & not get up on his own... If any questions please call [nursing supervisor's name]." A "Temporary Care Plan," dated 3/16/11, written by the nursing supervisor/CNA, documented the resident was back from the hospital. The care plan instructed staff to "monitor for increased confusion... Notify the [nursing supervisor/CNA's name], the facility RN and family..." On 4/19/11 at 2:30 PM, an interview was conducted with Resident #8's spouse. She stated she lived at the facility with her husband. Her husband had a recent decline in his health. He had a pacemaker placed and a PICC line inserted for IV medications. He had increased care needs and required more assistance with mobility, transfers and showers. Caregivers were not getting his showers done, or assisting with transfers and toileting, so she had to help him.	{R 008}	R008 Cont. 2. All outside agencies are being required to sign a contract with the facility stating they will provide appropriate documentation and care plans to the nursing supervisor. The facility R.N. is reviewing all outside agency notes and is following up on any issues. Staff are being trained on proper use of a gait belt. Training will be completed by 6/15/11. All NSAs are being reviewed and rewritten as needed. This will be completed by 6/30/11. All resident NSA's have been updated. Staff received training on reading and use of the NSA on 6/15/11 and 7/20/11. Documentation training for staff was conducted on 6/15/11 and 7/20/11. A "refusal of care" form has been adopted that is routed to the R.N., providing for proper follow-up, and notification of families and physicians. This, in conjunction with the R.N. Communication Form (change of condition form), are providing excellent information tools that have significantly impacted care. The R.N. has been working one on one with the home health/hospice agencies that are coming into the facility. She has clearly delineated our expectation and needs regarding documentation. She feels the response has been very good and the documentation needs are being fulfilled. Gait belt training was completed on 6/15/11.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R064	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/27/2011
NAME OF PROVIDER OR SUPPLIER GABLES SENIOR LIVING - ARROWHEAD MAN		STREET ADDRESS, CITY, STATE, ZIP CODE 1405 CURLEW DRIVE AMMON, ID 83406		
(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 8 On 4/19/11 at 3:16 PM, a caregiver checked the shower schedule and confirmed Resident #8's showers had not been documented as given for nine days. On 4/19/11 at 3:23 PM, the nursing supervisor/CNA stated she was not aware Resident #8 was not getting showered or assistance with transferring. She further stated, she did not have a system in place to ensure residents received showers as scheduled and relied on caregiver's to provide showers as scheduled. Additionally, she stated she did not know why Resident #8 had not been showered in 9 days.	(R 008)		
	On 4/20/11 at 9:37 AM, Resident #8 was observed sitting in his recliner in his room. Resident #8 stated, "I wish things were going better here. I am not getting the assistance I need. Staff are not trained and don't know what to do. I am supposed to get showered twice weekly. I had a doctor appointment yesterday and had to ask that I get a shower before going to see the doctor. I was embarrassed to go to the doctor, because it had been so long since I had a shower." He further stated, "caregivers don't always assist me with transfers or getting to the bathroom. I have had to wait a long time to get assistance or have my wife help me transfer and get to the bathroom. Some caregivers are better than others and help. Other caregivers say they will be right back to help and then they don't come back. I'm not sure if they are short staffed, or just not properly trained." Resident #8 required assistance with activities of daily living due to his change of health condition. The facility did not provide supervision to ensure Resident #8's ADLs were met. There was no			

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NAME OF PROVIDER OR SUPPLIER GABLES SENIOR LIVING - ARROWHEAD MAN				STREET ADDRESS, CITY, STATE, ZIP CODE 1405 CURLEW DRIVE AMMON, ID 83408			
(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>guidance from the facility RN or administrator regarding the resident's increased care needs.</p> <p>2. Resident #7 was admitted to the facility on 2/17/09 with diagnosis which included dementia.</p> <p>An NSA, dated 2/7/11, documented the resident required extensive assistance of one caregiver for mobility, transferring and toileting. It also documented the resident was required to wear a gait belt at all times.</p> <p>An RN assessment, dated 3/24/11, documented the resident received hospice services. The assessment did not include the reason why hospice care was started. The RN did not update the NSA to include the changes of the resident's care needs changes. The resident had a broken arm and required a two person assist for transfers. She had increased weakness and an inability to bear weight or hold her self up and required increased assistance for dressing and toileting.</p> <p>A hospice agency plan of care, dated 3/30/11, documented the resident had been admitted to hospice for "failure to thrive." The hospice RN documented, "Pt has a permanently broken left upper arm, no pain unless lifted by it. Pt very pleasantly confused. Unable to bear weight or hold self up during transfers. Staff report 2 person assist..."</p> <p>A caregiver documented, on 3/18/11 at 1:51 PM, "resident complained about legs hurting today..."</p> <p>A caregiver documented, on 3/28/11 at 3:06 PM, "resident is on hospice, no major change in her condition she is still very difficult to transfer took 3 people this morning to get her off the toilet and</p>	{R 008}					

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NAME OF PROVIDER OR SUPPLIER GABLES SENIOR LIVING - ARROWHEAD MAN		STREET ADDRESS, CITY, STATE, ZIP CODE 1405 CURLEW DRIVE AMMON, ID 83406		
(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 10 cleaned up..." A caregiver documented, on 3/30/11 at 2:09 PM, "Resident is not bearing any weight. She has a very large bruise on her right side and on her right breast. She is complaining of pain and doesn't like to be moved..." A caregiver documented, on 4/1/11 at 10:17 PM, "...Resident is getting harder to transfer and toilet." A caregiver documented, on 4/4/11 at 2:49 PM, "...she does have a bruise on her side that spready [sic] through her side and up through her chest and her arm...resident is getting weak, 2 (person) assist should be done it's hurting her doin [sic] it alone..." A caregiver documented, on 4/5/11 at 1:25 PM, "...while getting resident ready for lunch she had grabbed my left bicep and would not release, she stated I was hurting her and we had not even moved her from her chair. I explained I was just holding her belt and had not moved her yet...having a 2 person assist would help a lot [sic] better." On 4/19/11 at 1:13 PM, three caregivers stated Resident #7 required use of a gait belt and required a two person assist for transfers. On 4/19/11 at 1:20 PM, the nursing supervisor/CNA stated she was not aware the resident required a two person assist for transfers. She further stated, another resident required a two person assist, all other resident's transferred independently or with a one person assist.	(R 008)		

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{R 008}	<p>Continued From page 11</p> <p>On 4/19/11 at 5:46 PM, Resident #7 was observed being transferred from the wheelchair to her recliner with the assistance of one caregiver. The caregiver stated she could transfer the resident but it was easier for the resident when she was assisted by two caregivers.</p> <p>On 4/21/11 at 11:30 AM, a medication aid stated, "I felt the resident needed a two person assist when transferring her with the gait belt."</p> <p>Resident #7 had a decline and a significant change in condition resulting in increased pain and weakness. Not all caregivers interviewed were aware that the resident required a two person assist for transfers. The NSA was not updated to reflect the resident increased assistance so all caregivers had direction to safely and comfortably assist with transfers and cares</p> <p>The facility did not provide supervision to ensure Resident's #7 and #8 received the required assistance to meet their increased ADL needs after they experienced a significant change in condition.</p> <p>ASSISTANCE WITH EATING/PHYSICIAN ORDERED DIETS</p> <p>1. Resident #1's record documented he was admitted to the facility on 12/29/2010, with diagnoses which included developmental disabilities.</p> <p>A fax to Resident #1's physician, dated 2/10/11, documented the resident was "currently on chopped meats" and the physician ordered was to continue his chopped meats only diet.</p>	{R 008}	<p>R008 Cont.</p> <p><u>Assistance with eating and diets.</u> While the NSA's are being reviewed dietary needs will be addressed for each resident, including observation during meal times.</p> <p>The administrator and facility R.N. will coordinate to ensure that all diet orders are followed and that all dietary needs are addressed. Staff are receiving training on how to identify dietary needs in residents and the proper way to document and report these needs to the R.N. and administrator. All NSAs will be completed by 6/30/11. All staff training will be completed by 6/15/11.</p> <p>Furthermore, kitchen staff will be trained on what the dietary guidelines are and how to identify the needs of the residents. Meal cards will be updated to reflect these needs by 6/30/11 – along with the NSA's.</p> <p>Assistance with Medications: All residents who self-medicate have been assessed by the R.N. Staff were trained on the rules regarding residents self-medicating that staff are not to assist residents with insulin injections. Upon admission residents will be assessed for any insulin needs and those needs will be addressed by the R.N. All staff training will be done by 6/15/11.</p>	

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NAME OF PROVIDER OR SUPPLIER GABLES SENIOR LIVING - ARROWHEAD MAN		STREET ADDRESS, CITY, STATE, ZIP CODE 1405 CURLEW DRIVE AMMON, ID 83400		
(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>An NSA/UAI, dated 1/11/11, documented he required extensive assistance with eating meals, needed standby assistance to ensure he chewed his food properly, and that he had issues with choking and aspiration. There was no documentation in the NSA/UAI regarding the resident's current diet.</p> <p>Five meals were observed from 4/19/11 through 4/22/11. During all observed meals, staff did not provide standby assistance to monitor that Resident #1 chewed his food properly or to ensure he received only chopped meats.</p> <p>On 4/21/11 during lunch, Resident #1 was observed eating meats that were not chopped and staff did not provide standby assistance. Resident #1's tablemate stated he gave Resident #1 his serving of meat which was not chopped.</p> <p>On 4/21/11 at 5:30 PM, the administrator stated she retrained staff to supervise and assist residents during meals, "but apparently it was still not happening."</p> <p>The facility did not provide supervision to ensure Resident #1 was assisted with eating according to his NSA or received his physician's ordered diet of chopped meats. These failures resulted in inadequate care.</p> <p>2. Resident #9 was admitted to the facility on 11/5/08, with diagnoses a diagnosis of Parkinson's disease.</p> <p>On 4/19/11 at 2:59 PM, Resident #8 stated, she had some teeth pulled recently and has had a difficult time eating the food served to her.</p> <p>On 4/20/11 at 12:05 PM, the dietary manager</p>	(R 008)	<p>R008:</p> <p>The dietary manager has received updated dietary assessments/orders for each resident.</p> <p>As the resident NSA's were updated dietary concerns/needs were also addressed. The R.N. continues to randomly audit/observe the dining room routines to ensure that proper assistance is being provided as per NSA's.</p> <p>Resident meal cards have been updated and are in use for each meal.</p> <p>Assistance with Medications:</p> <p>The R.N. has completed all self-medication assessments and has essentially found all residents to be ineligible to self-medicate. Medications including OTC's have been removed from resident rooms and are being administered by certified med. Techs.</p>	

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NAME OF PROVIDER OR SUPPLIER GABLES SENIOR LIVING - ARROWHEAD MAN		STREET ADDRESS, CITY, STATE, ZIP CODE 1405 CURLEW DRIVE AMMON, ID 83406		
(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}	Continued From page 13 stated the resident had an order for a "soft diet". He further stated, "soft diet consists of soft meats." On 4/20/11 at 12:10 PM, Resident #9 was observed being served roast beef for lunch. The resident put a small piece of beef in her mouth and struggled to chew the meat for five minutes. She gave up and took the meat out of her mouth and set it on her plate. At 12:48 PM, the resident had not been able to eat any of the meat. She stated, "I am not able to chew the meat because I have so many missing teeth." At 1:00 PM, the resident was attempting to eat the rest of her lunch. Caregivers were not observed offer assistance or ask if she would like a different protein choice in place of her roast beef. The resident left the dining room with 75% of her meal remaining on her plate. On 4/20/11 at 5:15 PM, the administrator observed Resident #9 struggling to eat the baked cheese lasagna that was served. The resident explained to the administrator, that she was not able to chew the noodles, because she had so many missing teeth. Five meals were observed from 4/19/11 through 4/21/11. Resident #9 was observed being served a regular diet including meats, that she could not chew. During all observed meals, staff did not offer food substitutions that she could chew. Resident #9's NSA, dated 9/2010, documented the resident required minimal assistance with eating. The NSA was not updated to reflect the resident's dental issues or her inability to chew certain types of foods. A progress note, dated 3/7/11 at 4:18 PM,	{R 008}		

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NAME OF PROVIDER OR SUPPLIER GABLES SENIOR LIVING - ARROWHEAD MAN		STREET ADDRESS, CITY, STATE, ZIP CODE 1406 CURLEW DRIVE AMMON, ID 83408		
(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)	Continued From page 14 documented "Resident was complaining of mouth issues. She talked to nursing supervisor about it." A progress note, dated 3/25/11 at 3:53 PM, documented "Resident is cranky. She is complaining of her teeth hurting. She doesn't have anything for pain." There was no documentation in the progress notes that the facility RN had been notified or had assessed the resident concerning her mouth pain, her missing teeth, or her ability to chew food. The facility did not supervise that the food provided was appropriate for Resident #9, when she had loss of teeth and a decreased ability to chew foods. The facility failed to provide supervision to ensure diets for Residents #1 and #9 were implemented. These failures resulted in inadequate care. ASSISTANCE WITH MEDICATIONS Resident #7 was admitted to the facility on 2/17/09, with diagnoses of dementia and insulin dependent diabetes mellitus. An NSA, dated 2/7/11, documented the resident required extensive assistance with her medications. The NSA did not include her ability to self-administer the insulin. Under the section "Medication: Provider Instructions" was information that the facility RN would monitor medications and the nursing supervisor/CNA would report to the RN any concerns. A nursing assessment, dated 3/15/10 and 3/24/11, documented the resident was not able to	(R 008)		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R964	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/27/2011
NAME OF PROVIDER OR SUPPLIER GABLES SENIOR LIVING - ARROWHEAD MAN		STREET ADDRESS, CITY, STATE, ZIP CODE 1405 CURLEW DRIVE AMMON, ID 83406		
(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 15</p> <p>self-administer medications.</p> <p>On 4/19/11 at 1:45 PM, the nursing supervisor/CNA stated there was currently only one resident that self-administered insulin and she was alert and able to do so safely.</p> <p>On 4/20/11 at 3:16 PM, the LPN stated she was not aware if Resident #7 had been assessed by the facility RN to self-administer and inject her insulin.</p> <p>On 4/21/11 at 11:00 AM, the medication aide stated, "[Resident #7's name] is confused. Some days are better than others when it comes to her self-injecting insulin. I have seen her try to put the insulin syringe in a coffee cup on a bad day." She further stated, the resident required constant instruction from the medication aides to be able to self-inject her insulin.</p> <p>On 4/21/11 at 11:30 AM, Resident #7 was observed attempting to inject insulin into her abdomen. The medication aide placed the pre-filled insulin syringe into her right hand. The resident looked at the syringe and did not know what to do with the syringe, or how to use it. The medication aide had to instruct the resident step by step to be able to safely inject the insulin.</p> <p>On 4/21/11 at 5:30 PM, the administrator confirmed the resident was not able to safely self-administer her insulin and did not know the reason she had been allowed to do so.</p> <p>The facility did not supervise Resident #7's medication assistance to ensure it was appropriate; based on the RN's assessment, the resident's cognition and the NSA. Additionally, unlicensed medication aides are prohibited to</p>	{R 008}		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R004	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/27/2011
NAME OF PROVIDER OR SUPPLIER GABLES SENIOR LIVING - ARROWHEAD MAN			STREET ADDRESS, CITY, STATE, ZIP CODE 1405 CURLEW DRIVE AMMON, ID 83406		
(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)	Continued From page 16 perform preparation or administration of injections according to the Idaho Board of Nursing Rules. The facility did not ensure there was a licensed nurse to administer Resident #7's insulin. This failure resulted in inadequate care.	(R 008)			



Facility Name Facility: Gables Senior Living - Arrowhead management Company LLC. Ammon	Physical Address 1405 Curlew Drive	Phone Number (208) 535 - 0090
Administrator Stephanie Ellwood	City Ammon	ZIP Code 83406
Survey Team Leader Karen Anderson, RN	Survey Type Follow-up	Survey Date 4/27/2011

NON-CORE ISSUES PAGE 1 OF 3

ITEM #	RULE #	DESCRIPTION	DATE RESOLVED	I&C USE
1	009.02	One of four staff completed only a state police background check.	5/2/2011	GA
2	009.04	One of four staff did not submit fingerprints for a criminal history check within 21 days of hire.	5/2/2011	GA
3	152.05.b.iii	Five residents had bedrails. ***REPEAT PUNCH X 2***	4/25/2011	GA
4	225	Behavior plans for Residents #1, 4, 5 & 6 did not clearly describe A) the behavioral symptoms causing distress to the resident or infringing on other residents' rights or B) the interventions to be implemented by staff when the behavior occurs.	5/11/2011	GA
5	250.10	Hot water exceeded the maximum temperature of 120 degrees Fahrenheit. ***REPEAT PUNCH X 3***	4/26/2011	GA
6	250.15	Three residents stated call lights were not answered in a timely manner. Further, two residents stated although staff responded quickly to the call light, they turned it off, said they would return soon, but did not. ***REPEAT PUNCH X 2***	5/20/2011	GA
7	305.02	The facility did not ensure all PRN medications were available as ordered for 2 of 6 residents. ***REPEAT PUNCH X 2***	5/10/11	GA
8	305.03	The facility RN did not assess and document changes in medical condition for the following: Resident #6's pressure ulcer. Resident #7's significant health decline. Resident #8's significant health decline resulting in hospitalization. Resident #9's decreased ability to chew food.	5/25/11	GA
Response Required Date 5/27/2011	Signature of Facility Representative <i>Stephanie Ellwood</i>		Date Signed 4/27/2011	



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NON-CORE ISSUES PAGE 2 OF 3

ITEM #	RULE #	DESCRIPTION	DATE RESOLVED	I&C USE
9	305.06	The facility RN did not assess Residents #2 & 3's ability to self medicate. ***REPEAT PUNCH X 2***	5/20/2011	
10	310.04.a	The facility did not attempt non-drug interventions to assist and redirect Residents # 4, 5, & 6's behaviors. However, these residents were receiving psychotropic medications	5/20/2011	
11	310.04.c	The facility did not monitor or determine Residents #4, 5, & 6's continued need for psychotropic medications based on the resident's demonstrated behaviors.	5/20/2011	
12	350.02	The facility administrator did not document a complete investigation for all verbal and written complaints. ***REPEAT PUNCH X 2***	5/10/11	
13	350.04	The facility administrator did not provide a written response to complainants. ***REPEAT PUNCH X 2***	5/10/11	
14	451.02	The facility did not offer snacks to residents between breakfast and lunch and lunch and dinner. ***REPEAT PUNCH X 3***	5/20/11	
15	625.01	One of four staff did not complete 16 hours of orientation training within 30 days of hire. ***REPEAT PUNCH X 2***	5/2/11	
16	711.01	Behavioral plans for Residents #1, 4, 5, 6, & 10 did not document A) the time a specific behavior occurred, B) the intervention used or C) the effectiveness of the intervention.	5/20/11	
Response Required Date 5/27/2011		Signature of Facility Representative <i>Stephanie Ellwood</i>	Date Signed 4/27/2011	

