



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

LESLIE M. CLEMENT – DEPUTY DIRECTOR  
RANDY MAY – DEPUTY ADMINISTRATOR  
LICENSING AND CERTIFICATION  
P.O. Box 83720  
Boise, Idaho 83720-0036  
PHONE 208-334-6626  
FAX 208-364-1888

September 19, 2011

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

License #: Rc-964

Dear Mr. Stephenson:

On August 9, 2011, a second follow up survey and complaint investigation was conducted at Gables Senior Living - Arrowhead Management Company Llc. As a result of that survey, deficient practices were found. The deficiencies were cited at the following levels:

- 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.

This office is accepting your submitted plan of correction and evidence of resolution.

Should you have questions, please contact , Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 334-6626.

Sincerely,

*Karen Anderson, RN*

Karen Anderson, RN  
Team Leader  
Health Facility Surveyor  
Residential Assisted Living Facility Program

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



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August 19, 2011

FedEx Tracking #: 8696 9051 7991

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

**Re: Imposition of Temporary Management at Gables Senior Living – Arrowhead Management**

Dear Mr. Stephenson:

Please accept this notice that **temporary management** will be imposed at Gables Senior Living effective Monday, August 22, 2011. The provisional residential care facility license #RC-964 for Gables Senior Living - Arrowhead Management, located at 1405 Curlew Drive, Ammon, Idaho 83406, which expires on August 27, 2011, will not be renewed based on Department findings from the complaint investigation and follow-up survey conducted August 8 through 9, 2011. The findings, as discussed below, demonstrate that this facility is not in substantial compliance with the statutes and rules governing Residential and Assisted Living Facilities. The purpose of the temporary manager is to oversee operation of the facility and to assure safety of the facility's residents pending improvements being made to bring the facility back into substantial compliance. **Substantial compliance with the requirements of IDAPA 16.03.22 must be achieved no later than September 23, 2011.** If the licensee fails to pay the temporary manager on a weekly basis, or if the facility fails to come into compliance by September 23, 2011, the temporary manager shall be directed to conduct an orderly transfer of the residents. This action is being taken pursuant to Idaho Code Section 39-3345 and IDAPA 16.03.22.930, 16.03.22.900.05.a, 16.03.22.900.05.c, and 16.03.22.900.05.d.iii

In addition, you are hereby notified the following enforcement actions are continued:

1. **A ban on all new admissions pursuant to IDAPA 16.03.22.920.02.d. The ban on all admissions shall be in effect upon receipt of this notice and shall remain in effect until removed by the Department.**
2. **Should you choose not to abide by this condition, the Department will take immediate action to summarily suspend the facility's license and transfer residents under IDAPA 16.03.22.900.01.**

**BASIS FOR THE IMPOSITION OF TEMPORARY MANAGEMENT:**

The following is an explanation of the basis for the Department's action.

From February 7 through February 11, 2011, our office conducted a licensure, follow-up and complaint investigation survey at your facility. During the course of that survey, it was determined the facility had failed to protect residents from inadequate care by failing to identify and treat pressure ulcers; failing to provide physician ordered diets to protect residents from choking and aspiration; failing to coordinate and provide catheter care to prevent swelling, discomfort and infection; failing to provide assistance with transferring and mobility and failing to follow physician's orders. The facility was also cited for nineteen (19) non-core deficiencies.

During the follow-up and licensure survey conducted from April 19 through April 27, 2011, it was determined five of ten sampled residents were not receiving adequate care. Additionally, the facility received another core deficiency for failing to protect residents from abuse. The facility was also cited for twenty (20) non-core deficiencies, nine of which had been cited at the previous survey, and two of which were being cited for the third time. The facility was placed on a provisional license, required to hire a consultant and full time nurse, and a ban on new admissions was imposed. The facility was to correct the deficiencies and achieve substantial compliance with the rules for residential care or assisted living facilities in Idaho (IDAPA 16.03.22) no later than June 30, 2011.

On June 22, 2011, the facility was sent a letter warning they were failing to meet the conditions of the provisional license by re-admitting residents without authorization from the Department and by failing to hire a full time nurse.

On August 8 through 9, 2011, a follow-up and complaint investigation survey determined the facility continued to fail to protect residents from inadequate care by failing to identify pressure ulcers so they could be treated, and by failing to provide supervision of a resident's weight loss and dietary needs. The facility was also cited for three non-core issue deficiencies, two of which were repeat deficiencies.

### **POWERS AND DUTIES OF THE TEMPORARY MANAGER**

Pursuant to IDAPA 16.03.22.930, the powers and duties of the temporary manager shall be as follows:

The temporary manager has the authority to direct and oversee the management, hiring and discharge of any consultant or personnel, including the administrator of the facility. The temporary manager has the authority to direct the expenditure of the revenues of the facility in a reasonable and prudent manner, to oversee the continuation of the business and the care of the residents, to oversee and direct those acts necessary to accomplish the goals of the program requirements and to direct and oversee regular accounting. When the facility fails or refuses to carry out the directions of the temporary manager, the Department will revoke the facility's license.

- a. The temporary manager must observe the confidentiality of the operating policies, procedures, employment practices, financial information, and all similar business information of the facility, except that the temporary manager must make reports to the Department;
- b. The temporary manager may be liable for gross, willful or wanton negligence, intentional acts of omissions, unexplained shortfalls in the facility's fund, and breaches of fiduciary duty;
- c. The temporary manager does not have authority to cause or direct the facility, its owner, or administrator to incur debt, unless to bring the facility into compliance with these rules, or to enter into any contract with a duration beyond the term of the temporary management of the facility;
- d. The temporary manager does not have authority to incur, without the permission of the owner, administrator or the Department, capital expenditures in excess of two thousand dollars (\$2,000), unless the capital expenditures are directly related to correcting the identified deficiencies;

- e. The temporary manager does not have authority to cause or direct the facility to encumber its assets or receivables;
- f. The temporary manager does not have authority to cause or direct a facility, which holds liability or casualty insurance coverage, to cancel or reduce its liability or casualty insurance coverage; and
- g. The temporary manager does not have authority to cause or direct the sale of the facility, its assets or the premises on which it is located.

#### **RESPONSIBILITY FOR PAYMENT OF THE TEMPORARY MANAGER:**

All compensation and per diem costs of the temporary manager must be paid by the licensee, Gables Senior Living - Arrowhead Management. IDAPA 16.03.22.930.05. Should Gables Senior Living fail to make required, weekly payments to the temporary manager, by noon each Monday, the Department will have no alternative but to direct the temporary manager to conduct an immediate and orderly transfer of the residents to other facilities.

#### **DURATION OF TEMPORARY MANAGEMENT**

The temporary manager shall remain in place until the facility is brought into compliance with IDAPA 16.03.22, the rules for residential care or assisted living facilities in Idaho, as determined by a follow-up survey conducted by Department staff, or until every resident of the facility has been transferred to another facility.

#### **CORRECTION OF DEFICIENCIES**

Please find enclosed a copy of the Statement of Deficiencies. The temporary manager, shall 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)?
- ♦ What date will the corrective action(s) be completed by?

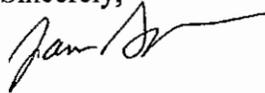
The temporary manager shall return the **signed and dated** Plan of Correction to us by **September 1, 2011**, and keep copies for the temporary manager and the facility's records. Correction of these deficiencies must be achieved no later than September 23, 2011. During the follow-up survey, if it is determined that the deficiencies still exist, or if a new core issue deficiency is identified, the Department shall direct the temporary manager to immediately transfer the residents. If it is determined the facility has been brought into compliance with program requirements as described in IDAPA 16.03.22, the licensee, Gables Senior Living - Arrowhead Management shall be granted a provisional license to resume operations.

You have available the opportunity to question cited deficiencies or this action through an informal dispute resolution (IDR) 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 (**September 1, 2011**). 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 **September 1, 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](http://www.assistedliving.dhw.idaho.gov) under the heading of Forms and Information. The IDR process does not delay the requirements for submission of the plan of correction in a timely manner.

Please bear in mind that non-core issue deficiencies were identified on the Punch List, a copy of which was reviewed and left at the facility during the exit conference and enclosed. The completed Punch List form and accompanying evidence of resolution (e.g., receipts, pictures, policy updates, etc.) are to be submitted to this office by **September 8, 2011**.

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/smo  
Enclosure

cc: Gordon Arave, 52 W. 215 N. Blackfoot, ID 83221  
Linda Armstrong – Adult Services Director, Area VI  
Melanie Belnap, Program Manager, Regional Medicaid Services, Region VII - DHW Leslie  
M. Clement, Deputy Director, Idaho Department of Health and Welfare  
Curlew Investments, 1395 NW Main, Blackfoot, ID 83221  
Cathy Hart, Idaho State Ombudsman, Idaho Commission on Aging  
Louis Kraml 680 Pendlebury Lane, Blackfoot, Idaho 83221  
Sheri Rogers, Western Healthcare, 1475 North Cole Road, Boise, ID 83704  
Randy May, Deputy Administrator, Division of Medicaid  
Charina Newell, Deputy Attorney General, Idaho Department of Health and Welfare  
Marie Peterson, Ombudsman, Area VI Agency on Aging  
Natalie Peterson, Chief Bureau of Long Term Care, Division of Medicaid,  
Brady Pilster, 2238 N. 550 W Hamsville, IT 84414

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 08/09/2011
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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
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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 000)	<p>Initial Comments</p> <p>The following deficiency was cited during a second follow-up survey and complaint investigation conducted from 8/8/11 through 8/9/11, at your residential care/assisted living facility. The surveyors conducting the survey were:</p> <p>Karen Anderson, RN Team Coordinator Health Facility Surveyor</p> <p>Matt Hauser, QMRP Health Facility Surveyor</p> <p>RaeJean McPhillips, RN, BSN Health Facility Surveyor</p> <p>Donna Henschled, LSW Health Facility Surveyor</p> <p>Gloria Keathley, LSW Health Facility Surveyor</p> <p>Survey Definitions:</p> <p>ADL = Activities of Daily Living BMI = Body Mass Index CNA = Certified Nursing Assistant Dysphagia = Refers to difficulty eating as a result of disruption in the swallowing process frq = frequently HH = Home Health MAR = Medical Assistance Record MS = Multiple Sclerosis NSA = Negotiated Service Agreement Pt = patient RCC = Resident Care Coordinator RN = Registered Nurse</p>	(R 000)		

Bureau of Facility Standards

TITLE

(X6) DATE

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

FORM

444

PQY013

If continuation sheet 1 of 11

*Mark Stephenson 8/31/11*

Bureau of Facility Standards

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 08/09/2011
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 1 Sched = Scheduled UAI = Uniform Assessment Instrument	{R 000}	<i>What corrective actions will be accomplished for those specific residents/personnel/areas found to have been affected by the deficient practice?</i>	
{R 008}	16.03.22.620 Protect Residents from Inadequate Care.  The administrator must assure that policies and procedures are implemented to assure that all residents are free from inadequate care.  This Rule is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to provide adequate supervision to 2 of 12 sampled residents (#7 & #12). The 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 #7 was admitted to the facility on 6/13/09, with diagnoses which included dementia and diabetes mellitus.  Resident #7's NSA, dated 7/28/11, documented the resident required moderate assistance with bathing and "Requires one person hands on assist with all bathing needs." A handwritten note documented, "Resident refuses to allow staff to shower her frequently. Is very modest about staff assisting." The NSA also documented the resident required moderate physical assistance	{R 008}	<ul style="list-style-type: none"> <li>The Department here states "Resident #12, however the resident being described is actually Resident # 13 on the resident identification list left at the time of survey. We will hereafter refer to Resident # 13. Resident # 13 has been moved from the facility.</li> <li>Resident # 7 will be moving to skilled nursing (██████████) prior to 9/1/11.</li> </ul> <p><i>How will you identify other residents/personnel/areas that may be affected by the same deficient practice and what corrective actions will be taken?</i></p> <ul style="list-style-type: none"> <li>All residents have the potential to be affected by the same practice.</li> <li>All staff will be made aware of the deficient practices and their role in protecting residents from inadequate care. Department specific meetings will be held to further explain staff duties and responsibilities.</li> </ul>	9/12/2011





Bureau of Facility Standards

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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		
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(R 008)	<p>Continued From page 4</p> <p>the resident would tell caregivers that she had her shower, even though she had not had a shower, as a way to avoid showering.</p> <p>On 8/9/11 at 1:45 PM, caregiver "C" stated, "I work the evening shift; I got a verbal report from the day shift at the beginning of my shift. The day caregivers report the showers that were given and any residents who still need a shower." The caregiver stated, "I was told the resident was independent with showers and the resident was modest and did not like caregivers to look at her during the shower."</p> <p>On 8/9/11 at 1:58 PM, caregiver "D" stated, "[Resident's name] does not receive showers on the 2:00 PM to 10:00 PM shift. I am told by day shift the resident received a shower. I didn't check the ADL/shower sheet to verify the information."</p> <p>On 8/9/11 at 2:05 PM, the RCC stated she was not aware of the resident's pressure ulcers until today. She stated, "I was told the resident had been refusing showers, but staff had not informed me of any skin issues." She further stated, staff were to report to her any shower refusals. She stated, "I look over the night shift reports to find out if residents refused showers." She did not know why caregivers only documented the two showers in July. She stated she checked the shower schedule and confirmed the resident had two showers documented in July and one documented shower on August 4, 2011.</p> <p>The facility did not provide supervision to ensure Resident #7 received showers as required. This failure resulted in harm when the resident developed two Stage III pressure ulcers. The wounds went unnoticed because the facility staff</p>	(R 008)	<ul style="list-style-type: none"> <li>• RN will address refusals of diet and supplements as well as concerns related to weight on the 90 day assessments.</li> <li>• RCC will audit weights Q day to ensure weights have been obtained as ordered. Results of weight audit will be communicated to the nurse and Administrator. Refusal to be weighed will be communicated to the RN through the refusal of care form who will then follow the refusal of care policy, as needed.</li> <li>• RCC will audit ordered supplements Q day to ensure supplements have been given. Results of supplement audit will be communicated to the nurse and Administrator. Refusal of supplements will be communicated to the RN through the refusal of care form who will then implement the refusal of care policy, as needed.</li> <li>• Administrator will develop a schedule for completion of random meal service and dining room observation audits through survey to ensure diets are served as ordered and assistance is given per directives of NSA.</li> <li>• Residents who develop new food intake issues will be identified through meal observation by caregivers, RCC meal audits, and kitchen staff. These new concerns will be communicated to RN via the RN Communication or Refusal forms.</li> </ul>	9/12/2011 9/12/2011 9/12/2011 9/12/2011

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13R084	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  R 08/09/2011
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 6</p> <p>did not ensure the resident's skin was monitored when they failed to provide her the assistance she required with showering.</p> <p><b>WEIGHT LOSS</b></p> <p>1. Resident #12 was admitted to the facility, on 9/1/09, with diagnoses including MS and dysphagia.</p> <p>A UAI, dated 8/31/10, documented the resident weighed 118 pounds in 2009 and 98 pounds on 8/31/10; a 22 pound weight loss in one year.</p> <p>An NSA, dated 9/17/10, documented Resident #12 "needs assistance with eating meals... Staff to assist as needed or requested." There was nothing documented regarding the resident's weight loss.</p> <p>A nursing assessment, dated 11/8/10, did not document the resident's weight nor or make any reference regarding the resident's previous weight loss.</p> <p>A fax to the resident's physician, dated 12/21/11, documented the "daughter is concerned about her weight and would like us to start her on Boost (nutritional supplement). Please specify if this is something we can do and how often." The physician responded, on 12/30/11, with a request for "current BMI and weight."</p> <p>A fax to the resident's physician, dated 12/31/11, documented, "We are unable to obtain a current weight due to her being non-weight bearing." The physician responded, on 1/4/11, stating a weight was needed to calculate a BMI. There was no further documentation found in the resident's record to indicate what was being done about</p>	(R 008)	<p><i>How will the corrective actions be monitored and how often will monitoring occur to ensure that the deficient practice will not recur?</i></p> <ul style="list-style-type: none"> <li>• Shower audits will be completed by the RCC and reviewed by the Nurse daily through survey compliance date. Administrator will be informed of results daily through survey compliance date. Following survey, audit frequency will be weekly X 4 and then monthly.</li> <li>• Weight audits will be completed by the RCC and reviewed by nurse daily through survey compliance date. Administrator will be informed of results daily through survey compliance date. Following survey, audit frequency will be weekly X 4 then monthly.</li> <li>• Meal service audits will be completed per schedule through survey. Results will be reviewed by Administrator, Nurse, RCC and Dietary Manager. Following survey, audit frequency will be weekly X 4 weeks, then monthly.</li> </ul>	<p>9/12/2011</p> <p>9/12/2011</p> <p>9/12/2011</p>

Bureau of Facility Standards

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(R 008)	<p>Continued From page 6</p> <p>obtaining a current weight. Also, there was no documentation of the resident's current weight.</p> <p>A fax, dated 1/25/11, documented an order for the resident to eat one cup of ice cream twice a day for a diagnosis of "weight loss."</p> <p>A "Modified Barium Swallow Report," dated 2/4/11, documented Resident #12 was referred for a modified barium swallow study due to concerns regarding significant weight loss. The results of the study indicated the resident had a "moderate oral dysphagia and mild pharyngeal dysphagia."</p> <p>A nursing assessment, dated 5/11/11, was completed by the facility RN. The resident's weight was not documented nor was there any reference to the resident's refusals to eat ice cream or Ensure.</p> <p>Resident #12's 2011 MARs documented the following:</p> <p>* February - The resident had an order to drink Ensure (nutritional supplement) three times a day with meals. It also documented, the ice cream was either refused or not documented as given 23 times and Ensure was either refused or not documented as given 36 times.</p> <p>* March - The resident refused ice cream 17 times.</p> <p>* April - The resident refused ice cream 47 times and refused Ensure 21 times.</p> <p>* May - The resident's ice cream was either not given or refused every time but one (a total of 61 times). Further it documented the Ensure was</p>	(R 008)		

Bureau of Facility Standards

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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
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(R 008)	<p>Continued From page 7</p> <p>either refused or not documented as given 21 times.</p> <p>*June - The resident's ice cream was either not given or refused 53 times. Further it documented the Ensure was either refused or not documented as given 8 times.</p> <p>*July - The resident's ice cream was either not given or refused 36 times. Further, it documented the Ensure was either refused or not documented as given 8 times.</p> <p>A nursing assessment, dated 6/29/11, did not document the resident's weight and did not make any reference to the resident's refusals to eat ice cream or drink Ensure.</p> <p>There was no documentation found regarding how staff could encourage ways to increase the resident's nutritional intake or what alternative high calorie snacks could be offered.</p> <p>The facility's "Refusal of Cares" forms documented the following:</p> <p>*6/25/11 - The resident refused her cup of ice cream at 2:30 PM. On 6/28/11, the RN documented "Noted. Will Monitor."</p> <p>*7/5/11 - The resident refused ice cream at 10:00 AM and 2:00 PM. On 7/6/11, the RN documented the resident reported she did not refuse ice cream but was in bed at 10:00 AM and did not want it "due to her condition." The RN further documented, "Will speak with RCC about having staff offer snacks when resident is up in chair."</p> <p>*7/19/11 - The resident refused ice cream at 10:00 AM. The RN again documented that staff</p>	(R 008)		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13R084	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  R 08/09/2011
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 8</p> <p>were educated to not give her ice cream if she was in bed because the resident said she would refuse it if she was in bed.</p> <p>*7/20/11 - The resident refused ice cream at 10:00 AM. On 7/21/11 the RN again documented she spoke with staff and asked them to offer a snack when the resident was up in a wheelchair.</p> <p>*7/21/11 - The resident refused ice cream at 10:00 AM. On 7/22/11 the RN documented for staff to wait until the resident got out of bed to offer her ice cream.</p> <p>There was no documentation found in Resident #12's record to address the resident's refusals from 2/1/11 until 8/25/11. There was no documentation the resident was informed of the consequences of her refusals. Further, there was no documentation the resident's physician was notified of the refusals.</p> <p>On 8/9/11 at 2:05 PM, a caregiver stated the resident gained weight after she was first admitted. The caregiver further stated, "She was so little I could just pick her up and transfer her." Further, the caregiver stated it was "hit and miss" with her getting ice cream because she often refused.</p> <p>On 8/9/11 at 2:10 PM, the RCC stated, "You could visibly see she had lost weight and the doctor prescribed ice cream and Ensure." Further, the RCC stated, "We only had a stand-up scale and with her MS we couldn't weigh her."</p> <p>On 8/9/11 a family member stated she reported the resident's weight loss to the former nursing supervisor, administrator and the current RCC,</p>	(R 008)		

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 08/09/2011
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 9</p> <p>sometime in November or December 2010. She stated, the resident's physician ordered ice cream but "she never got it." Further, the family member stated she was told the resident weighed 85 pounds when she left the facility and was admitted to the hospital and now had a permanent feeding tube.</p> <p>On 8/10/11 a former employoe (A) stated, "There was no way [Resident's name] could eat ice cream without help, so if the staff didn't offer to help her, she would refuse it."</p> <p>A note from an employee, dated 8/10/11, documented, "...She had an order for ice cream, but she often refused it."</p> <p>A note from an employee, dated 8/10/11, documented, "...Resident would refuse her sched ice cream magority [sic] of the time."</p> <p>A note from an employee, dated 8/10/11, documented, "...She would ever eat 2-3 bites and then go back to her room. It didn't really matter what was fixed, she just didn't eat."</p> <p>A note from a former employee (B), dated 8/11/11, documented "...in April I was moved to the laundry department and this was when I would assist with feeding [Resident's name] more often. About this time is when I noticed she was not eating as much..."</p> <p>From 8/31/10 to July 2011, Resident #12 lost another 11 pounds; approximately 33 pounds since admission to the facility. Although it was documented the resident would refuse both the Ensure and ice cream, for four months, the facility did not document that any other interventions were put into place. The facility failed to provide</p>	(R 008)		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13R904	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ D. WING _____	(X3) DATE SURVEY COMPLETED  R 08/09/2011
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 10 supervision of the resident's diet and weight loss issues, which resulted in inadequate care.  THIS IS THE THIRD TIME THE FACILITY HAS BEEN CITED FOR INADEQUATE CARE - SUPERVISION.	(R 008)		





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

August 18, 2011

Mark Stephenson, Administrator  
Gables Senior Living - Arrowhead Management Compan  
1405 Curlew Drive  
Ammon, ID 83406

Dear Mr. Stephenson:

An unannounced, on-site complaint investigation survey was conducted at Gables Senior Living - Arrowhead Management Company Llc from August 8, 2011, to August 9, 2011. During that time, interviews and record reviews were conducted with the following results:

**Complaint # ID00005160**

- Allegation #1:** An identified staff member did not complete fingerprinting for a criminal history background check within twenty-one days of hire per state rule.
- Findings #1:** On 8/9/11, the identified employee's record was reviewed and contained a copy of the criminal history and background check. The as-worked schedule was reviewed and the identified employee was not scheduled to work until after the background check was completed.
- On 8/9/11 at 9:00 AM, an office employee stated the identified employee was delayed in getting the fingerprinting done because of a family emergency. The employee had to take two weeks off and was not placed on the schedule until the background check was completed.
- Substantiated.** However, not cited as the employee was not scheduled to work until after the background check was completed.

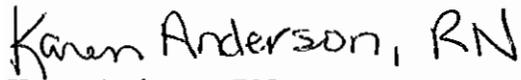
Mark Stephenson, Administrator

August 18, 2011

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As no deficiencies were cited as a result of our investigation, no response is necessary to this report. Thank you to you and your staff for the courtesies extended to us on our visit.

Sincerely,

Handwritten signature of Karen Anderson, RN in black ink.

Karen Anderson, RN

Health Facility Surveyor

Residential Assisted Living Facility Program

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



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August 18, 2011

Mark Stephenson, Administrator  
Gables Senior Living - Arrowhead Management Compan  
1405 Curlew Drive  
Ammon, ID 83406

Dear Mr. Stephenson:

An unannounced, on-site complaint investigation survey was conducted at Gables Senior Living - Arrowhead Management Company Llc from August 8, 2011, to August 9, 2011. During that time, observations, interviews, and record reviews were conducted with the following results:

Complaint # ID00005156

**Allegation #1:** An identified resident was not assisted with eating and experienced significant weight loss.

**Findings #1:** On 8/9/11, the identified resident's record was reviewed. A Uniformed Assessment Instrument, dated 8/31/10, documented the identified resident was able to feed herself. A Negotiated Service Agreement, dated 9/17/10, documented the resident "needs assistance with eating meals."

On 8/9/11 through 8/16/11, numerous interviews were conducted. The identified resident, a family member, another resident and two employees stated the resident did not consistently receive assistance with feeding. Two employees stated the resident was assisted with eating whenever she asked for it.

On 8/16/11, documentation was received from the facility. The administrator and nine employees documented the identified resident received assistance with eating.

Unsubstantiated. Due to conflicting information, it could not be proven the identified resident did not receive assistance with eating meals. However, it was confirmed the resident experienced a weight loss and was not assisted with supplements. The facility was issued a deficiency at IDAPA 16.03.22.520 for inadequate care for not providing supervision to ensure appropriate interventions were put into place to address the resident's weight loss. The facility was required to submit a plan of correction within 10 days.

Allegation #2: An identified resident did not receive a soft diet as ordered by the physician.

Findings #2: On 8/9/11, the identified resident's record was reviewed. The identified resident no longer resided at the facility. A therapy note, dated 2/8/11, documented a speech therapist recommended a diet consisting of "neurosoft solids." There was no documentation to clearly explain what foods would qualify as "neurosoft solids." A fax from the physician, dated 7/5/11, documented a "soft diet was ordered."

Between 8/9/11 and 8/16/11, numerous interviews were conducted. Three employees confirmed the resident was ordered a "soft diet." One employee stated she was not sure what a soft diet consisted of but stated the resident ate sandwiches which she considered soft. The cook stated the resident ate "more or less what she wanted and did get peanut butter and jelly sandwiches when she did not like what was served. One employee stated she "had heard" the resident was not getting soft food consistently. One caregiver stated when she assisted the identified resident with eating, the resident got foods like mashed potatoes, ground meats and other soft foods.

On 8/16/11, documentation was received from the facility administrator and eight employees. On 8/10/11, one employee documented the resident was on a "soft" diet but even if the meat was chopped up for her, the resident would not eat it and requested the meat whole. Two employees documented the resident had snacks in her room that were not consistent with a soft diet.

Unable to substantiate. Due to conflicting information, the allegation could not be proven during the complaint investigation.

Allegation #3: Call lights were not answered in a timely manner.

Mark Stephenson, Administrator  
August 18, 2011  
Page 3 of 3

Findings #3: On 4/27/11 the facility was issued a repeat deficiency for not answering call lights in a timely manner. They submitted evidence the problem was corrected on 5/20/11.

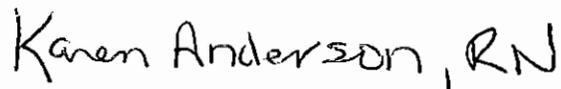
On 8/8/11 between 3:30 PM and 6:00 PM, approximately 25 residents were interviewed. None of them expressed concern with call lights being answered in a timely manner. Five residents stated that "things" had improved since the new administration had taken over. Two residents stated staff had "gotten much better" about answering call lights.

On 8/9/11 at 9:45 AM, a call light was activated in a resident's room by two surveyors. A caregiver responded within a minute.

Unsubstantiated.

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

Sincerely,



Karen Anderson, RN  
Health Facility Surveyor  
Residential Assisted Living Facility Program

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