



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK – ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
JAMIE SIMPSON – PROGRAM SUPERVISOR
RESIDENTIAL ASSISTED LIVING FACILITY PROGRAM
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: 208-364-1962
FAX: 208-364-1888

April 15, 2014

Hope Brackett, Administrator
Emeritus at Juniper Meadows
2975 Juniper Drive
Lewiston, Idaho 83501

License #: RC-595

Dear Ms. Brackett:

On February 6, 2014, a follow-up/revisit, state licensure survey was conducted at Emeritus at Juniper Meadows. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level(s):

- Core issues, which are described on the Statement of Deficiencies, and for which you have submitted a Plan of Correction.
- Non-core issues, which are described on the Punch List, and for which you have submitted evidence of resolution.

Your submitted plan of correction and evidence of resolution are being accepted by this office. Please ensure the corrections you identified are implemented for all residents and situations, and implement a monitoring system to make certain the deficient practices do not recur.

Thank you for your work to correct these deficiencies. Should you have questions, please contact Gloria Keathley, LSW, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 364-1962.

Sincerely,

GLORIA KEATHLEY, LSW
Team Leader
Health Facility Surveyor

GK/sc

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



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P.O. Box 83720
Boise, Idaho 83720-0009
EMAIL: ralf@dhw.idaho.gov
PHONE: 208-364-1962
FAX: 208-364-1868

February 20, 2014

CERTIFIED MAIL #: 7007 3020 0001 4050 8319

Hope Brackett, Administrator
Emeritus at Juniper Meadows
2975 Juniper Drive
Lewiston, Idaho 83501

Provider ID: RC-595

Ms. Brackett:

On February 6, 2014, a follow-up to the licensure survey of 10/31/2013 and a complaint investigation were conducted by our staff at Emeritus at Juniper Meadows. The facility was cited with a core issue deficiency for inadequate care for retaining three residents that the facility did not have the capability, capacity or services to provide appropriate care. Further, the facility failed to provide supervision to ensure the needs of residents were being met.

This core issue deficiency substantially limits the capacity of Emeritus At Juniper Meadows to provide for residents' basic health and safety needs. The deficiency is described on the enclosed Statement of Deficiencies.

PROVISIONAL LICENSE:

As a result of the survey findings, a provisional license is being issued effective 2/20/2014 and will remain in effect through 8/19/2014. Return the full license currently held by the facility to the Division of Licensing & Certification. The following administrative rule for Residential Care or Assisted Living Facilities in Idaho (IDAPA 16.03.22) gives the Department the authority to issue a provisional license:

935. ENFORCEMENT REMEDY OF PROVISIONAL LICENSE.

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

The conditions 1- 5 of the provisional license are as follows:

CONSULTANT:

1. A licensed residential care administrator consultant or RN Consultant, with at least three years' experience working as an administrator or RN for a residential care or assisted living facility in Idaho, shall be obtained and paid for by the facility, and approved by the Department. This consultant must be fully credentialed in the State of Idaho and may not also be employed by the facility or the company that operates the facility. The purpose of the consultant is to assist the facility in identifying and implementing appropriate corrections for the deficiencies. Please provide a copy of the enclosed consultant report content requirements to the consultant. The consultant shall be allowed unlimited access to the facility's administrative, business and resident records and to the facility staff, residents, their families and representatives. The name of the consultant with the person's qualifications shall be submitted to the Department for approval no later than February 28, 2014.
2. A **weekly written report** must be submitted by the Department-approved consultant to the Department commencing on **3/7/2014**. The reports will address progress on correcting the core deficiency identified on the Statement of Deficiencies as well as the non-core deficiencies identified on the punch list. When the consultant and the administrator agree the facility is in full compliance, they will notify the Department and request a follow-up survey be scheduled.

PLAN OF CORRECTION:

3. After you have studied the enclosed Statement of Deficiencies, please write a Plan of Correction by answering **each** of the following questions for **each** deficient practice:
 - ♦ What corrective action(s) will be accomplished for those specific residents/personnel/areas found to have been affected by the deficient practice?
 - ♦ How will you identify other residents/personnel/areas that may be affected by the same deficient practice and what corrective action(s) will be taken?
 - ♦ What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?
 - ♦ How will the corrective action(s) be monitored and how often will monitoring occur to ensure that the deficient practice will not recur (i.e., what quality assurance program will be put into place)?
 - ♦ By what date will the corrective action(s) be completed?

An acceptable, **signed** and **dated** Plan of Correction must be submitted to the Division of Licensing and Certification within **ten (10) calendar days of your receipt of the Statement of Deficiencies**. You are encouraged to immediately develop and submit this plan so any adjustments or corrections to the plan can be completed prior to the deadline.

EVIDENCE OF RESOLUTION:

4. Non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference. The following administrative rule for Residential Care or Assisted Living Facilities in Idaho (IDAPA 16.03.22) describes the requirements for submitting evidence that the non-core issue deficiencies have been resolved:

910. Non-core Issues Deficiency.

01. Evidence of Resolution. Acceptable evidence of resolution as described in Subsection 130.09 of these rules, must be submitted by the facility to the Licensing and Survey Agency. If acceptable evidence of

resolution is not submitted within sixty (60) days from when the facility was found to be out of compliance, the Department may impose enforcement actions as described in Subsection 910.02.a through 910.02.c of these rules.

The eleven (11) non-core issue deficiencies must be corrected and evidence (including but not limited to receipts, pictures, completed forms, records of training) must be submitted to this office by 3/8/2014.

CIVIL MONETARY PENALTIES

- 5. Of the eleven (11) non-core issue deficiencies identified on the punch list, four (4) of were repeat punches. Two (2) of the repeat deficiencies, 225.01 and 300.01, were cited on both of the two (2) previous surveys on 8/25/2010 and 10/31/2013.

The following administrative rules for Residential Care or Assisted Living Facilities in Idaho give the Department the authority to impose a monetary penalty for this violation:

IDAPA 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 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 noncompliance is established.

b. Repeat deficiency is ten dollars (\$10). (Initial deficiency is eight dollars (\$8)).

For the dates of 11/8/2013 through 2/6/2014:

Penalty	Number of Deficiencies	Times number of Occupied Beds	Times Number of days of non-compliance	Amount of Penalty
\$10.00	2	92	90	\$165,600

Maximum penalties allowed in any ninety-day period per IDAPA 16.03.22.925.02.c:

# of Occupied Beds in Facility	Initial Deficiency	Repeat Deficiency
3-4 Beds	\$1,440	\$2,880
5-50 Beds	\$3,200	\$6,400
51-100 Beds	\$5,400	\$10,800
101-150 Beds	\$8,800	\$17,600
151 or More Beds	\$14,600	\$29,200

Your facility had 92 occupied beds at the time of the survey. Therefore, your maximum penalty is: \$10,800.

Send payment of \$10,800 by check or money order, made payable to: Licensing and Certification

Mail your payment to:

**Licensing and Certification - RALF
PO Box 83720
Boise, ID 83720-0009**

Payment must be received in full within 30 calendar days from the date this notice is received. Interest accrues on all unpaid penalties at the legal rate of interest for judgments. Failure of a facility to pay the entire penalty, together with any interest, is cause for revocation of the license or the amount may be withheld from Medicaid payments to the facility.

ADMINISTRATIVE REVIEW

You may contest the provisional license, requirement for a consultant or civil monetary penalty by filing a written request for administrative review pursuant to IDAPA 16.05.03.300, which states: **the request must be signed by the licensed administrator of the facility, identify the challenged decision, and state specifically the grounds for your contention that this decision is erroneous.** The request must be received **no later than twenty-eight (28) days after this notice was mailed.** Any such request should be addressed to:

**Tamara Prisock, Administrator
Division of Licensing and Certification - DHW
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036**

Upon receipt of a written request that meets the requirements specified in IDAPA 16.05.03.300, an administrative review conference will be scheduled and conducted. The purpose of the conference is to clarify and attempt to resolve the issues. A written review decision will be sent to you within thirty (30) days of the date of the conclusion of the administrative review conference.

If the facility fails to file a request for administrative review within the time period, this decision shall become final.

INFORMAL DISPUTE RESOLUTION

Pursuant to IDAPA 16.03.22.003.02, you have available the opportunity to question the core issue deficiency through an informal dispute resolution process. If you disagree with the survey report findings, you may make a written request to the Supervisor of the Residential Assisted Living Facility Program for an IDR meeting. The request for the meeting must be in writing and must be made within ten (10) business days of receipt of the Statement of Deficiencies. The facility's request must include sufficient information for Licensing and Certification to determine the basis for the provider's appeal, including reference to the specific deficiency to be reconsidered and the basis for the reconsideration request. If your request for informal dispute resolution is received more than ten (10) days after you receive the Statement of Deficiencies, your request will not be granted. Your IDR request must be made in accordance with the Informal Dispute Resolution Process. The IDR request form and the process for submitting a complete request can be found at www.assistedliving.dhw.idaho.gov under the heading of Forms and Information.

FOLLOW-UP SURVEY

An on-site, follow-up survey will be scheduled after the administrator and consultant submit a letter stating that all deficiencies have been corrected and systems are in place to assure the deficient practices remain corrected. If at the follow-up survey, the core issue deficiency still exists, a new core issue deficiency is identified, non-core deficiencies have not been corrected, or the facility has failed to abide by the conditions of the provisional license, the Department will take further enforcement action against the license held by Emeritus at Juniper Meadows. Those enforcement actions will include one or more of the following:

- Revocation of the Facility License
- Summary Suspension of the Facility License
- Imposition of Temporary Management
- Limit on Admissions
- Additional Civil Monetary Penalties

Division of Licensing and Certification staff is available to assist you in determining appropriate corrections and avoiding further enforcement actions. Please contact our office at (208) 364-1962 if we may be of assistance, or if you have any questions.

Sincerely,



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

JS/sc

Enclosures

cc: Medicaid Notification Group

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R595	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/06/2014
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NAME OF PROVIDER OR SUPPLIER EMERITUS AT JUNIPER MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 2975 JUNIPER DRIVE LEWISTON, ID 83501
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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{R 000}	<p>Initial Comments</p> <p>The following deficiency was cited during the follow-up and complaint investigation survey conducted between February 4, 2014 and February 6, 2014 at your residential care/assisted living facility. The surveyors conducting the survey were:</p> <p>Gloria Keathley, LSW Team Coordinator Health Facility Surveyor</p> <p>Karen Anderson, RN Health Facility Surveyor</p> <p>Maureen McCann, RN Health Facility Surveyor</p> <p>Matt Hauser, QMRP Health Facility Surveyor</p> <p>Abbreviations:</p> <p>& = and 1:1 = one staff to one resident monitoring/care Approx = approximately BID = twice daily CHF = congestive heart failure cm = centimeter COPD = chronic obstructive pulmonary disease CPAP = continuous positive airway pressure machine used to help a person who has obstructive sleep apnea breathe more easily during sleep EMS = emergency medical services H.H. = home health Infect = infection LN = licensed nurse LPN = licensed practical nurse</p>	{R 000}	<p>RECEIVED MAR 05 2014 DIV OF LIC & CERT</p>	
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Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Hope Brackett</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>3/3/2014</i>
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Bureau of Facility Standards

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{R 000}

Continued From page 1
NSA = negotiated service agreement (care plan)
MAR = medication assistance record
OK = okay
O2 = oxygen
prn = as needed
RN = registered nurse
sats = saturation levels
w/ = with
x = times

{R 000}

The following is Emeritus at Juniper Meadows Plan of Correction to the Department of Health and Welfare of Deficiencies dated February 6th, 2014 and received at the community via certified mail on February 21, 2014. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions outlined in the Statement of Deficiencies. Rather, it is submitted as confirmation of our ongoing efforts to comply with all statutory and regulatory requirements. In this document, we have outlined specific actions in response to each allegation or findings. We have not presented all contrary factual or legal arguments, nor have we identified all mitigation factors.

R 008

16.03.22.520 Protect Residents from Inadequate Care.

R 008

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 retained 3 of 3 sampled Residents (#4, #7 & #11) who the facility did not have the capability, capacity or services to provide appropriate care. Resident #4 was admitted and retained with a wound that was not improving bi-weekly. Resident #11 was retained although she was aggressive with others. Resident #7 was retained after she stated she wanted to harm herself. Further, the facility failed to provide supervision to ensure 2 of 11 sampled residents (Residents #4 & #5) had their care needs met. The facility failed to assist Resident #4 with cleaning and dressing a scalp wound. The facility also failed to assist Resident #5 to obtain assistive devices the resident required to manage a chronic disorder. This resulted in inadequate care. The findings include:

16.03.22.520 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.

1. IDAPA 16.03.22.152.05. Policies of Acceptable Admissions, documents: "No resident will be admitted or retained who requires ongoing skilled nursing care not within the legally licensed authority of the facility.

x. A resident with an open wound that is not improving bi-weekly
e. A resident that is violent or a danger to himself or others

RETENTION:

Bureau of Facility Standards

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R 008	<p>Continued From page 2</p> <p>1. According to her record, Resident #4 was a 96 year-old female who was admitted to the facility on 8/3/12, with diagnosis of melanoma cancer lesion on the top of her head.</p> <p>IDAPA rule 16.03.22.152.05.b states that "No resident will be admitted or retained who requires ongoing skilled nursing care not within the legally licensed authority of the facility. Such residents include:</p> <p>x. A resident with an open wound that is not improving bi-weekly.</p> <p>On 2/4/14 at 2:30 PM, Resident #4 was observed sitting in her wheelchair in her room. Her head was observed to have a large, raised, scabbed area, on the top of her scalp. The resident stated the wound was caused from a cancerous tumor.</p> <p>On 2/5/14 at 9:50 AM, the LPN stated Resident #4's wound on her head was not expected to to improve. She stated she faxed the physician requesting home health daily because they the wound was not going to heal and would continue to open and close.</p> <p>Resident #4's record contained a nurse's note, dated 10/1/13 at 5:00 PM, that documented the resident was taking an antibiotic for an "open area" on her head. The LPN further documented, the wound had "drainage of yellow clear fluid."</p> <p>The LPN sent a fax to Resident #4's physician, on 11/4/13, which documented daily showers were "irritating" the wound on the resident's scalp and the area of the wound was increasing in size "approx 3 cm x 3 cm scabbed."</p>	R 008	<p>I. Corrective Action:</p> <p>Resident #4's wounds have been reevaluated by the physician, wound management clinic, and community Licensed Nurse. The NSA has been updated to reflect new physician treatment orders which includes outside agency coordination. A family conference has been completed to discuss current treatment plan. A Variance request was submitted and approval was received on February 21st 2014 from RALF Program Division of Licensing and Certification. Community staffs have been in-serviced on Resident #4's current NSA. The Licensed Nurse staff has also been in-serviced on the current physician orders and current treatment plan for Resident #4.</p> <p>Resident #7 has been evaluated by their physician and mental health provider regarding their past suicidal ideation event. The resident will continue to receive ongoing mental health support from a mental health professional. The resident's current behaviors have been evaluated by Licensed Nurse at this time. The resident's behavior tracking log has been updated to reflect the resident's current behaviors and specific interventions. The Resident's NSA has been updated to reflect new physician orders and current treatment plan, behaviors and specific interventions. A family care conference was completed regarding the current NSA, behaviors, and interventions. Community staffs were in-serviced on the resident's current NSA and behavior tracking sheet.</p> <p>Resident #11 is no longer a resident at the community.</p>	
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Bureau of Facility Standards

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R 008

Continued From page 3

The LPN, documented on a "skin monitoring flow sheet," dated 1/23/14, that Resident #4's wound on her scalp was 3 cm by 5 cm, and the wound had "Purulent Drainage" with a foul odor. The LPN assessed the wound again, on 1/29/14, and documented the wound had not changed, except there was no foul odor from the wound.

On 2/5/14 at 2:45 PM, the administrator stated she had not given Resident #4 a 30 day discharge notice because the wound was related to cancer.

The facility retained Resident #4, when she had a wound that would not improve bi-weekly.

2. According to her record, Resident #11 was a 72 year-old female who was admitted to the facility, on 03/19/12, with diagnoses including dementia and depression. Her record further documented she was discharged to another facility on 1/3/14.

IDAPA 16.03.22.152.05. Policies of Acceptable Admissions, documents: "No resident will be admitted or retained who requires ongoing skilled nursing care not within the legally licensed authority of the facility. Such residents include...

d. A resident that is violent or a danger to himself or others"

Resident #11's "Temporary Care Plans" were implemented on 9/27/13, 11/19/13 and 12/23/13, for aggressive behaviors. The care plans documented staff were to watch for an increase in anger or aggression. Interventions that were implemented included: changing surroundings, offering fluids, listening to resident's concerns, and separating Resident #11 from others when

R 008

II. How to Identify Other Residents:

The Resident Care Director completed a review of current residents. The audit included a review of physician orders and treatment plans for residents that were identified with a current skin issue and the NSA was updated if needed. Licensed Nurse staff received an in-serviced regarding skin and wound management that included a review of wound identification, company policy, and state regulation. Resident care staffs were rein-serviced on current resident skin issues and interventions.

The Resident Care Director has reviewed behavior events within the last 90 days to evaluate that behavior, treatment, and service plans are meeting the resident's needs. The Resident Care Director contacted the physician and updated NSAs as needed. Community staffs were rein-serviced to current resident behaviors and interventions.

III. Systemic Change:

d. A resident that is violent or a danger to himself or others

Those residents with identified aggressive and/or suicidal behavioral events will have an evaluation completed by the licensed nurse and the physician will be notified.

- 1) If a resident is evaluated to pose a risk to themselves or others, 911 will be contacted in addition to the physician, family, or responsible party. Resident care staff will take reasonable steps to

Bureau of Facility Standards

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R 008	<p>Continued From page 4</p> <p>she had behaviors.</p> <p>An incident report, dated 11/17/13 at 9:00 PM, Resident #11 "was found in another resident's room sleeping on the couch. Carestaff [sic] woke resident and redirected her back into her room to be changed and cleaned. Resident became angry and refused care. Resident was swearing at staff..." Resident #11's family was called and the family came to the facility to provide care to Resident #11.</p> <p>A "Behavior Assessment," dated 11/20/13, documented current behaviors were refusing showers, arguing with staff and wandering into other residents' rooms. There was no documentation on the behavior assessment regarding her aggression towards others.</p> <p>A "Service Note," dated 11/30/13, documented "Resident attempted to go into another resident's room. She was threatening to beat up the other resident."</p> <p>An incident report, dated 12/1/13 at 4:15 PM, documented Resident #11 was in the hallway yelling at another resident. The resident was yelling, "She is a liar and I am going to kick her butt." Resident #11 was separated and "family supports" were increased. Resident #11 was scheduled with one to one care.</p> <p>A "Daily Observation and Monitoring Worksheet," dated 12/2/13, documented Resident #11 was making threats to staff and other residents. She would tell them she would "kill all of them." The worksheets also documented Resident #11 was trying to break into another resident's apartment and was very aggressive on the evening shift.</p>	R 008	<p>promote the safety of the environment. The Resident Care Director will contact the physician and/or mental health professional to coordinate mental health services and urgent evaluation for those residents identified with suicidal ideation.</p> <p><u>x. A resident with an open wound that is not improving bi-weekly</u></p> <p>Caregiver will observe and report changes in the skin. If a concern is identified the community staff will notify LN. If immediate treatment is required community staff will provide first aid and notify LN.</p> <p>If open wound is not improving bi weekly Administrator and/or Resident Care director will coordinate with the resident, family, and physician to identify a plan of care that meets the resident's needs which may include requesting a variance and/or providing a discharge notice.</p> <p>IV. Monitoring:</p> <p>The Administrator and/or Resident Care Director will review those residents with identified behaviors weekly to support resident safety, behavior identification, implemented interventions and staff education.</p> <p>The Administrator and/or Resident Care Director will review those residents with identified skin issues weekly support resident safety,</p>	

Bureau of Facility Standards

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R 008	<p>Continued From page 5</p> <p>A "Service Note," dated 12/8/13, documented Resident was argumentative with staff. She "cussed" at staff and other residents. Resident #11 took another resident's walker away from her. Staff intervened and the resident became angry when redirected.</p> <p>An incident report, dated 12/16/13 at 10:15 AM, documented "Resident was in activity meowing like a cat, laughing and grabbed equipment acting like she was going to throw it at residents. Removed exercise equipment, resident became upset and tearful and left activity."</p> <p>An incident report, dated 12/18/13 at 1:30 PM, documented "Resident was in the housekeeping room...Went from nice to disruptive/angry... Resident raised her hand like she was going to hit staff and then left the area."</p> <p>A "Change of Condition" form, dated 12/23/13, documented under "Psychiatric/Mood" and "Behavioral Symptoms," the resident was easily agitated and confused. It further documented the resident had multiple behaviors including "aggressiveness" towards staff and other residents, both verbally and physically.</p> <p>An incident report, dated 12/23/13 at 10:30 AM, documented "Resident came to exercise and grabbed another resident by his shirt and would not let go... Resident grabbed the lid to the exercise equipment and hit the activity director."</p> <p>An incident report, dated 12/23/13 at 11:15 AM, "Resident walking down the hallway and other resident walking near her. [Resident's name] hit the other resident in arm as she was walking down the hall."</p>	R 008	<p>appropriate wound treatment, implemented interventions, and staff education.</p> <p>V. Date of Completion:</p> <p>This Plan of Correction will be completed on or before: March 23, 2014</p> <p>2. <u>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</u></p> <p>I. Corrective Action:</p> <p>Resident #4 wounds have been reevaluated by the physician, wound management clinic, and community Licensed Nurse. The NSA has been updated to reflect new physician treatment orders which includes outside agency coordination. A family conference has been completed to discuss current treatment plan. A Variance request was submitted and approval was received on February 21st, 2014 from RALF Program Division of Licensing and Certification. Resident care staff has been in-serviced on</p>	
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NAME OF PROVIDER OR SUPPLIER EMERITUS AT JUNIPER MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 2975 JUNIPER DRIVE LEWISTON, ID 83501
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R 008	<p>Continued From page 6</p> <p>A "Service Note," dated 12/23/13, documented "Resident had two altercations with two different residents...Family will look at a 1:1 caregiver."</p> <p>From 12/1/13 through 12/23/13, Resident #11 continued to be verbally and physically aggressive to staff and other residents. There was no documentation that a 1:1 was implemented to protect other residents.</p> <p>An incident report, dated 12/24/13 at 9:00 AM, documented "Resident was in the elevator with daughter. Resident made sexual comments towards another resident. Resident's daughter intervened." Resident #11 and the other resident were separated. Resident #11 was reminded this type of behavior was inappropriate.</p> <p>An incident report, dated 12/26/13 at 12:30 PM, documented "Resident was being assisted back to room by BOD [Business Office Director] who heard resident cussing at another staff member and then threatening to kill her. Resident hit BOD on the arm. Resident was very angry and was unable to be redirected or soothed at this time."</p> <p>A "Service Note," dated 12/27/13, documented "Resident continued verbal abuse of staff and other residents. She was banging on other residents' doors...Needs constant supervision."</p> <p>An incident report, dated 12/29/13 at 11:40 AM, documented "Resident grabbed another resident's walker in the dining room. When the other resident told her it was not hers, resident balled up her fist and threatened the resident. No contact was made, resident became angry and began swearing. Caregiver had difficulty getting resident redirected." The incident report documented the interventions used were: one to</p>	R 008	<p>Resident #4's current NSA. The Licensed Nurse staff has also been in-serviced on the current physician orders and current treatment plan for Resident #4.</p> <p>Resident #5 is currently out of the facility. The resident's CPAP mask has been obtained by the community. The resident will be evaluated for use of assistive devices and needed assistance prior to returning to community. Community staff have been rein-serviced on chronic illnesses such as COPD.</p> <p>II. How to Identify Other Residents:</p> <p>Resident Care Director and Administrator have reviewed current residents who have identified skin issues to validate that nursing assessments are complete. If there are identified concerns, the Resident Care Director and Administrator will determine follow up actions which may include but is not limited to re-education or disciplinary action with staff members.</p> <p>The Resident Care Director and Administrator have reviewed residents with assistive devices to validate that the nursing assessment has been completed and that the service plan is implemented based upon resident's needs.</p> <p>III. Systemic Change:</p> <p>The Resident Care Director and/or Administrator or designee will hold and participate in a daily meeting with resident care staff and Licensed Nurses to support proper supervision for resident's with identified skin issues. The meeting will also include a review of recent behavior incidents, current behavior tracking logs, LN assessments, and physician and outside</p>	
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R 008	<p>Continued From page 7</p> <p>one supervision, which was provided [by an outside agency]. Facility and outside agency staff were educated on dementia and redirection.</p> <p>An "Event First Responder Worksheet," dated 12/29/13 at 11:40 AM, documented when Resident #11 grabbed another resident's walker and threatened her, she was fearful of Resident #11.</p> <p>An "Event First Responder Worksheet," dated 12/29/13 at about 7:00 PM, documented "[Resident's Name] was calling everyone names again, as usual. She also punched me in the arm & tried to break her [1:1 Caregiver's Name] arm. [Random Resident's name] confided in me that [Resident's Name] told her she was going to kill her. Also told [Staff member's name] that she was going to gut her like a fish & play with her intestines."</p> <p>A "Daily Observation and Monitoring Worksheet," dated 12/30/13, documented Resident #11 was very aggressive. She refused to take her medications and was punching staff. The shift notes further documented the resident tried to follow another resident into their room, stood outside and "banged on the door."</p> <p>On 2/4/14 at 4:00 PM, the administrator stated Resident #11 was placed on one to one supervision until she was discharged. The administrator stated one to one supervision was implemented because Resident #11 had grabbed another resident's wheelchair and had shook her fist at the other resident.</p> <p>On 2/5/14 at 2:30 PM, a caregiver stated Resident #11 was hard to care for. She stated the resident "spiraled down quickly" and her</p>	R 008	<p>agency coordination, current treatment plans, updated interventions and plan of care on NSA.</p> <p>The Resident Care Director and Administrator or designee will hold and participate in a daily meeting with community staff to support proper supervision for residents with identified assistive device issues. Proper supervision for residents with assistive devices will include LN assessment as needed, and required training or re-inservicing for care staff.</p> <p>For the two areas above within the systemic change, the RN will complete a 90 day nursing assessment to support proper supervision and accurate NSA for residents.</p> <p>IV. Monitoring:</p> <p>The Administrator and/or Resident Care Director will review those residents with identified skin issues consistently to support proper supervision and that resident's needs are met.</p> <p>The Administrator and Resident Care Director will review those residents with assistive devices consistently to support accuracy and proper supervision.</p> <p>V. Date of Completion:</p> <p>This Plan of Correction will be completed on or before: March 23, 2014</p>	

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R 008	<p>Continued From page 8</p> <p>behaviors increased after the death of her friend that had resided at the facility. The caregiver further stated, staff would have to "step in" between Resident #11 and other residents to protect them.</p> <p>On 2/5/14 at 3:35 PM, a caregiver stated Resident #11 had aggressive behaviors. The caregiver stated she saw it mostly with staff. She further stated Resident #11 would scream, squeeze and grab at caregivers. Additionally, she stated she heard Resident #11 had "put her hands on another resident."</p> <p>On 2/5/14 at 3:55 PM, a caregiver stated she tried to keep Resident #11 away from others. The caregiver stated Resident #11 had "put her hands" on another resident and this resident was now afraid of Resident #11.</p> <p>On 2/6/14 at 10:50 AM, the facility nurse stated Resident #11 was started on one to one supervision, on 12/26/13, because of an incident that occurred on 12/23/13 with another resident.</p> <p>On 2/6/14 at 2:55 PM, Resident #8 stated Resident #11 tried to grab her, but she could not remember the rest of the incident. She further stated she did not want to get the other "person" in trouble.</p> <p>On 2/6/14 at 3:05 PM, a staff member stated Resident #11 came up behind Resident #8 and scared her. A staff member further stated, "residents and staff were afraid of her. I was afraid of her. You didn't know what you were going to get. She went from not bad to bad."</p> <p>Resident #11's record documented she started exhibiting aggressive behaviors around 11/17/13.</p>	R 008		
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R 008	<p>Continued From page 9</p> <p>The facility implemented interventions that were not effective to redirect Resident #11. One to one supervision was discussed on 12/5/13, but was not implemented until 12/28/13. However, Resident #11 continued be verbally and physically aggressive and had altercations with staff and other residents even after the one to one supervision was implemented.</p> <p>The facility retained Resident #11 although she was a danger to herself and others. Further, the facility was not able to manage her behaviors to keep the resident and others safe.</p> <p>3. According to her record, Resident #7, was an 82 year-old female who was admitted to the facility on 12/17/13, with diagnoses including depression.</p> <p>Resident #7's record documented she was evaluated to be capable of managing her own medications on 12/19/13, by the facility RN. Physician's orders, dated 1/7/14, documented she was taking 14 different medications, two of which were narcotics.</p> <p>An incident report, dated 12/24/13, documented "Resident came to staff complaining of pain, offered many interventions to address issue but resident became verbally aggressive with staff and accused them of not taking care of her and that if we were not going to do what she wanted then she should just kill herself." The incident report further documented, "contacted EMS to come and assess resident for suicidality and pain..." The incident report documented the resident remained in the community.</p> <p>The incident report was signed by the administrator, three days later, on 12/27/13.</p>	R 008		
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R 008	<p>Continued From page 10</p> <p>Resident #7's record did not contain an evaluation from a professional who was qualified to determine if she was a danger to herself after she made a suicide threat on 12/24/13.</p> <p>A behavior data sheet, dated 12/24/13, documented staff were to remove sharp objects and other implements that could cause harm to the resident.</p> <p>A "temporary care plan," dated 12/24/13, documented if Resident #7 threatened suicide, staff were to contact 911 and provide 1:1 care "until help arrives, remove sharp objects and other implements that may cause harm." The care plan was initialed, but not dated by staff. Additionally, there was no documentation found in the resident's record that dangerous items including medications were removed from the resident's room as documented in the care plan.</p> <p>A nursing note, dated 1/8/14, documented that on 12/24/13, Resident #7 "made statement re: suicidal ideation." The note further documented, EMS was called and the resident "was assessed by this LN and EMS for suicidal ideation...no further suicidal ideation noted since this time." There was no documentation that Resident #7 was evaluated by a professional who was qualified to determine if she was no longer a danger to herself.</p> <p>On 2/5/14 at 1:20 PM, the RN stated Resident #7 was upset about moving into the facility and made a statement that she wanted to kill herself. Emergency services were called, but the resident refused to go to the hospital. She confirmed, the resident was not evaluated by a professional who was qualified to determine whether she was a</p>	R 008		
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R 008	<p>Continued From page 11</p> <p>danger to herself. The RN stated, the resident continued to be a self-medicator after the incident.</p> <p>On 2/5/14 between 2:45 PM and 4:00 PM, three staff stated until today, they were not aware Resident #7 had made a suicide threat on 12/24/13. Two staff stated, management called them into the office "earlier today" to have them initial a temporary care plan for Resident #7. They stated they had never seen the care plan, that was dated 12/24/13, until today (2/5/14). Another staff stated she had not been trained on what to do if a resident threatened suicide nor had she seen the care plan until today.</p> <p>On 2/6/14 at 1:25 PM, the corporate RN confirmed, on the date of the incident, Resident #7 was not evaluated by anyone other than the LPN and EMS. When asked if Resident #7's medications were removed from her room, the corporate RN stated, the doctor did not request her medications be removed from her room "so we could not take her meds."</p> <p>On 2/6/14 at 1:40 PM, the administrator confirmed Resident #7 was only evaluated at the time of the incident by the emergency responders and had not been further evaluated by a mental health professional.</p> <p>Resident #7 made a threat of suicide on 12/24/13, but was not evaluated by a professional who was qualified to determine if the facility could safely retain her. Further, staff stated they were not aware of a suicide threat, or a temporary care plan regarding how to respond to a suicide threat, until 2/5/14, (forty-three) days later. The facility did not appropriately monitor Resident #7 after she made a suicide threat.</p>	R 008		
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R 008	<p>Continued From page 12</p> <p>The facility retained Resident #4 who had a wound that was not improving bi-weekly, Resident #11 who was a danger to others and Resident #7 who was not evaluated by a professional who was qualified to determine if she was a danger to herself.</p> <p>SUPERVISION:</p> <p>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.</p> <p>1. According to her record, Resident #4 was a 96 year-old female who was admitted to the facility on 8/3/12, with diagnoses of a melanoma cancer lesion on the top of her head.</p> <p>Resident #4's record contained an NSA, dated 10/8/13, which documented the resident had a "chronic lesion with scab on top of head." The NSA documented the resident required a one person assist with showering or bathing daily.</p> <p>On 2/4/13 at 2:30 PM, Resident #4 was observed sitting in a wheelchair in her room. The top of her head was observed to have a large, raised, crusted area. The resident stated the wound was caused from a cancerous tumor. Resident #4 stated her daughter would come to the facility daily to help clean her hair and put an ointment on her head, because staff were too busy to get it done.</p>	R 008		
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R 008	<p>Continued From page 13</p> <p>On 2/4/14 at 2:45 PM, Resident #4's daughter and granddaughter were interviewed. The resident's daughter stated her mother's head was not washed daily, the dressing were not changed, nor was the ointment applied to her wound daily as ordered by her physician. She stated her mother's wound was recently debrided because it had a thick scab covering the wound. The resident's daughter and granddaughter stated the wound would never heal because it was caused by cancer.</p> <p>Physician's orders, dated 9/26/13, documented "Bacitracin" ointment was to be applied to Resident #4's scalp with a clean dressing every day, "after washing."</p> <p>A nurse's progress note, dated 10/1/13 at 5:00 PM, documented the resident was taking an antibiotic for an "open area" to her cancer site and had "Drainage of yellow clear fluid. The LPN documented the physician ordered daily showers.</p> <p>Physician's orders, dated 10/22/13, documented Resident #4 was to have her scalp washed daily with "Johnson's Baby Shampoo."</p> <p>The October 2013 MAR, documented Resident #4, stopped receiving daily showers on 10/22/13. A handwritten note, documented on the MAR, "Stopped receiving daily showers" and "stop treatment" now being done by home health."</p> <p>There was no documentation in the record the resident received home health services for the month of October.</p> <p>There was no documentation found in Resident #4's record, the physician orders, dated 9/26/13 and 10/1/13, were discontinued.</p>	R 008		

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R 008	<p>Continued From page 14</p> <p>A fax sent to the physician, on 11/4/13, requested an order to have a home health evaluation done to determine if the resident would qualify for home health services. The physician signed the request and documented "As above ok" for a home health evaluation.</p> <p>A nurse's progress note, dated 11/11/13 at 12:30 PM, documented the cancer site on top of the resident's head was unchanged and was scabbed over. "Waiting for H.H. to start treating."</p> <p>The November 2013 MAR, documented "Stopped Getting Showers." Additionally, the MAR documented, on 11/7/13, treatments had been stopped and the "treatment" was being provided by home health.</p> <p>There was no documentation that home health evaluated the resident in November.</p> <p>The December 2013 MAR, documented "Stopped getting daily showers" and the dressing changes and Bacitracin were being done by "home health."</p> <p>A home health RN, documented an evaluation was conducted on 12/19/13. The RN documented "Patient did not meet criteria for skilled nursing need. Patient is a non-admit."</p> <p>A nurse's progress note, dated 12/29/13 at 6:00 PM, documented, the resident's wound had purulent "drainage" off and on for 2 days. A note was faxed to the physician regarding the drainage.</p> <p>The January 2014 MAR, documented "Stopped getting showers" and the treatments were being done by home health.</p>	R 008		
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R 008	<p>Continued From page 15</p> <p>A physician's order, dated 1/3/14, documented "Please try to do gentle shampoo - baby shampoo daily. Stop Bacitracin ointment."</p> <p>A nurse's progress note, dated 1/16/14 at 3:00 PM, documented, "Resident continues on an antibiotic for head infection." There was no documentation the nurse ensured wound care was implemented as ordered, despite the wound showing signs and symptoms of infection.</p> <p>A nurse's note, dated 1/29/14 at 1:00 PM, documented Resident #4 had a follow-up appointment with a physician for the wound on her scalp. The nurse documented, the physician ordered daily cleansing and application of Bacitracin to scalp twice a day.</p> <p>The February 2014 MAR, documented the resident's daily wound dressing, daily shampoo and daily Bacitracin ointment for her wound had been discontinued on 1/30/14.</p> <p>A review of the facility's shower records for Resident #4, from November 2013 through February 2014, documented the resident received assistance with showers 10 times in a three month timeframe, on the following dates.</p> <p>*11/23/13 *12/21/13 *1/10/14 *1/12/14 *1/15/14 *1/18/14 *1/24/14 *1/25/14 *1/31/14 *2/2/14</p>	R 008		
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NAME OF PROVIDER OR SUPPLIER EMERITUS AT JUNIPER MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 2975 JUNIPER DRIVE LEWISTON, ID 83501
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 008	<p>Continued From page 16</p> <p>The MARs from October 22nd through December 2013, documented home health was providing care of Resident #4's wound. However, a home health evaluation, which determined the resident was not eligible for services, was not done until 12/19/13. There was no documentation the facility implemented the physician's orders regarding the wound care for Resident #4.</p> <p>On 2/4/14 at 2:45 PM, Resident #4's daughter and granddaughter were interviewed. The resident's daughter stated the facility was not providing the care that was ordered by her physician. The daughter stated she had complained many times to facility staff about her mother not getting her head washed daily or having the ointment applied to her scalp as ordered by the physician. She stated, "Everyday, I'm the one who makes sure my mother's head is washed and I apply the ointment."</p> <p>On 2/5/14 at 9:50 AM, the LPN stated home health took over Resident #4's wound care in October 2013. She stated since that time, home health had been washing the resident's hair daily, providing dressing changes and ointment to her wound. She stated the care notes were not in the resident's record, but she would obtain the home health notes. The LPN, additionally stated Resident #4 had been refusing showers in January 2014 because she was not feeling well.</p> <p>The LPN was unable to provide evidence that home health had provided wound care to Resident #4 at any time.</p> <p>On 2/5/14 at 2:40 PM, the administrator provided a home health form, dated 12/19/13 at 1:48 PM. The home health RN, documented "Patient did</p>	R 008		

Bureau of Facility Standards

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R 008	<p>Continued From page 17</p> <p>not meet criteria for skilled nursing need. Patient is a non-admit." The administrator stated, she was not aware the medication aides had not been washing the resident's head daily and doing the dressing changes.</p> <p>The facility did not provide daily wound care including the antibacterial cream for Resident #4's cancerous wound for approximately four months. This resulted in the resident showing signs and symptoms of an infection.</p> <p>2. According to his record, Resident #5 was a 59 year-old male, who was admitted to the facility on 7/25/13, with diagnoses including COPD, sleep apnea and obesity. The resident was hospitalized during the survey and was not available for observation or interview.</p> <p>On 2/6/14 at 2:50 PM, the resident's room was toured. A CPAP machine was not observed until a caregiver stated she thought it was stored in the cabinet underneath the television. Upon opening the cabinet, the CPAP was found packed in a vinyl bag.</p> <p>An NSA, dated 9/11/13, documented the resident "completely manages" his own CPAP, oxygen and nebulizer treatment with required nursing oversight. "RN oversight at least every 90 days for evaluations and well checks and changes of condition."</p> <p>A physician's office visit note, dated 11/14/13, documented the "patient continues to sleep in a chair. He states in the past he was in a [hospital] bed. He has obstructive sleep apnea, and is not currently on CPAP. I think the [hospital] bed needs to be reinstated [sic]. He has enough shortness of breath that it does not allow him to</p>	R 008		
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Bureau of Facility Standards

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R 008	<p>Continued From page 18</p> <p>be in a regular bed, even with a wedge. The patient has very significant obstructive pulmonary disease."</p> <p>A physician's office visit note, dated 12/5/13, documented the "patient has completely untreated sleep apnea. He knows he has it. He has had diagnosis before. He has a [CPAP] machine, but he cannot use it because he does not have a mask...I told him he has to get into his CPAP and sleeping better for his overall general health. Referral to [physician's name] for pulmonary consulting. The document was "noted" on 12/6/13 by the facility nurse, but there was no corresponding documentation found in the resident's record addressing the requirement for the CPAP machine.</p> <p>A physician's office visit note, dated 12/18/13, documented "Regarding his obstructive sleep apnea, I recommend that he at least try resting with the CPAP on for awhile at night and when he wakes in the middle of the night, try getting up and being active for a while and then going back to bed." There was no corresponding documentation found in the resident's record addressing the requirement for the CPAP machine.</p> <p>A wound care clinic note, dated 1/30/14, documented Resident #5 had a "Acute Pulmonary" infection. His pulse oximeter readings were between 80 and 90%, and the resident remained "at high risk." The note also documented the resident had "Wheezes throughout lung."</p> <p>According to the Mayo Clinic website, "Normal pulse oximeter readings range from 95 to 100 percent, under most circumstances. Values under</p>	R 008		

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R 008	<p>Continued From page 19</p> <p>90 percent are considered low."</p> <p>Facility nurse progress notes documented the following:</p> <ul style="list-style-type: none"> * 1/30/14 at 12:30 PM, Resident had an "acute pulmonary infection." * 1/30/14 at 1:30 PM, Resident #5 had new orders for an antibiotic, prn inhalers for shortness of breath and was placed on "alert charting for 72 hours." The note also documented the resident reported an increase in shortness of breath, coughing and wheezing. * 1/31/14 at 4:45 PM, The resident's oxygen saturation was 85% on room air. A new physician's order was obtained for a prn nebulizer treatment. * 2/1/14 at 12:00 PM, The resident's oxygen saturation was "bouncing from 80 to 90." He was using the inhalers and nebulizer treatments. * 2/2/14 at 10:30 AM, Resident #5 was sent to the emergency department on 2/1/14 at 9:20 PM because his oxygen saturation was 78% and "less." He was diagnosed with "Acute Bronchitis & exacerbation [sic] of COPD"...Placed on alert charting...O2 sats 85-88%...Staff to check on O2 sats when in to see resident." There was no documented evidence that O2 checks were completed. * 2/4/14 at 9:30 AM, EMT's were called, on 2/3/14 at 10:30 PM, when the resident experienced shortness of breath and his O2 saturation was below 70%. At that time, the resident refused to go to the hospital. The facility nurse notified the physician in the morning on 2/4/14 when the 	R 008		

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R 008	<p>Continued From page 20</p> <p>resident's O2 saturation was 66%. The physician requested the resident be sent to the emergency room. The resident was admitted to the hospital and had not returned to the facility during the survey.</p> <p>Between 2/5/14 and 2/6/14, three caregivers were interviewed. Two caregivers stated they could not remember if the resident used his CPAP machine because he went to bed late and they did not see him in bed. The third caregiver stated he used the machine when he first moved into the facility, but after he changed rooms a month ago, she never saw him with it again.</p> <p>On 2/5/14 at 1:15 PM, the facility nurse confirmed the Negotiated Service Agreement documented the facility nurse was to provide "RN oversight at least every 90 days for evaluations and well checks and changes of condition," including Resident #5's use of the CPAP, oxygen and nebulizer machines. There was no documented evidence of a nursing assessment regarding any of these treatments even after the resident experienced an acute respiratory episode.</p> <p>The facility did not identify Resident #5's need for a hospital bed even after the resident slept in a chair for approximately 4 months due to shortness of breath. The resident did not receive a hospital bed, until the physician interviewed the resident and ordered one on 11/14/13.</p> <p>On 11/14/13, 12/5/13 and 12/18/13, Resident #5's physician documented the resident needed to be using his CPAP machine. There was no documentation in the resident's record that the administrator or the facility nurse had discussed the CPAP machine with Resident #5 or observed the machine to see if it required repair. Further,</p>	R 008		

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R 008	<p>Continued From page 21</p> <p>care staff were not aware that Resident #5's physician wanted him to use the CPAP machine.</p> <p>The facility failed to provide the necessary supervision to ensure Residents #4's and #5's, care needs were met as described in their NSAs. Furthermore, the facility failed to provide care according to physicians' orders or recommendations. These failures resulted in inadequate care.</p> <p>The facility retained Resident #4 with a wound that was not improving bi-weekly, Resident #11 who was aggressive with others and Resident #7 who had threatened suicide and had not been evaluated by a qualified professional. Further, the facility failed to provide supervision for Resident #4's wound care and the management of Resident #5's chronic illness. This resulted in inadequate care.</p>	R 008		
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Facility Emeritus At Juniper Meadows	License # RC-595	Physical Address 2975 Juniper Dr	Phone Number (208) 746-8676
Administrator Hope Brackett	City Lewiston	ZIP Code 83501	Survey Date February 6, 2014
Survey Team Leader Gloria Keathley	Survey Type Complaint Investigation and Follow-up	RESPONSE DUE: March 8, 2014	
Administrator Signature <i>Hope Brackett</i>	Date Signed 2/6/2014		

NON-CORE ISSUES

Item #	IDAPA Rule # 16.03.22.	Description	Department Use Only	
			EOR Accepted	Initials
1	153.01	The facility's abuse policy did not include contacting adult protection immediately or police if needed.	3-24-14	gk
2	159.01	The facility did not have a policy to ensure complete, accurate and authenticated residents' records per state rules. Such as, the facility staff stated they were instructed by management, to sign a form on 2/5/2014 that was dated 12/24(2013). Also an incident report, documented Resident #7 was sent to the hospital due to suicidal ideation. However the administrator stated the resident had not gone to the hospital.	3-24-14	gk
3	225.01 a-g	The facility did not evaluate residents' behaviors, such as, Resident #7's suicidal ideation and Resident #9's hoarding behaviors. ****Previously cited on 8/25/2010 and 10/31/2013****	3-24-14	gk
4	250.14	The facility did not provide a secure interior and exterior environment for residents with cognitive impairment.		
5	300.01	The facility nurse did not conduct a nursing assessment for the following residents' conditions: A) Resident #4's non-healing wound, B) Resident #5's leg wounds and ability to independently use a CPAP machine, C) Resident #7's change in mental health status and D) Resident #8's required 90 day nursing assessment. ****Previously cited on 8/25/2010 and 10/31/2013****	3-24-14	gk
6	310.04.e	The facility did not complete a 6 month psychotropic medication review for Resident's #1 and #9.	3-24-14	gk
7	350.01	The administrator was not notified of all incidents and complaints.	3-24-14	gk
8	711.02	Complaints and grievances made by residents or their families were not maintained in the residents' records. ****Previously cited on 10/31/2013****	3-24-14	gk
9	711.01.a-c	The facility did not track residents' behaviors. ****Previously cited on 10/13/2013****	3-24-14	gk
10	711.04	The facility did not document they had informed Resident #4 of the consequences of refusing showers, nor did the facility notify the physician of the resident's refusals.	3-24-14	gk
11	711.08.f	The facility did not maintain outside agency care notes such as Resident #5's Wound Clinic notes and Home Health notes describing the resident's wounds.	3-24-14	gk
12				
13				
14				



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK – ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
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RESIDENTIAL ASSISTED LIVING FACILITY PROGRAM
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February 20, 2014

Hope Brackett, Administrator
Emeritus at Juniper Meadows
2975 Juniper Drive
Lewiston, Idaho 83501

Ms. Brackett:

An unannounced, on-site complaint investigation survey was conducted at Emeritus at Juniper Meadows between February 4, 2014 and February 6, 2014. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00006306

Allegation #1: The facility retained a resident who was a danger to others.

Findings #1: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.520 for retaining a resident that was a danger to others. The facility was required to submit a plan of correction.

If you have questions or concerns regarding our visit, please call us at (208) 364-1962. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,

GLORIA KEATHLEY, LSW
Health Facility Surveyor
Residential Assisted Living Facility Program

GK/sc