



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: 208-334-6626
FAX: 208-364-1888

September 13, 2013

Timothy Pape, Administrator
Golden Years, Inc.
PO Box 1496
Meridian, ID 83680

License #: RC-1000

Dear Mr. Pape:

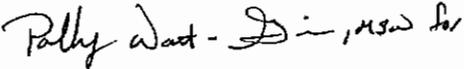
On June 3, 2013, a licensure and complaint investigation survey was conducted at Golden Years, Inc. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level(s):

- 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.

The submitted plan of correction and evidence of resolution are being accepted by this office. Please ensure the corrections that were 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 Karen Anderson, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 364-1962.

Sincerely,


Karen Anderson, RN
Team Leader
Health Facility Surveyor

KA/ftp

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



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June 17, 2013

CERTIFIED MAIL #: 7012 1010 0002 0836 0492

Brennen Meras
Golden Years, Inc.
PO Box 1496
Meridian, ID 83680

Dear Mr. Meras:

Based on the complaint investigation and state licensure survey conducted by Department staff at Golden Years, Inc between May 29, 2013 and June 3, 2013, it has been determined that the facility failed provide adequate care and supervision to residents.

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

You have an opportunity to make corrections and thus avoid a potential enforcement action. Correction of this deficiency must be achieved by **July 18, 2013**. **We urge you to begin correction immediately.**

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

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

Return the **signed and dated** Plan of Correction to us by **June 29, 2013**, and keep a copy for your records. Your license depends upon the corrections made and the evaluation of the Plan of Correction you develop.

In accordance with IDAPA 16.03.22.003.02, you have available the opportunity to question cited deficiencies through an informal dispute resolution process. If you disagree with the survey report findings, you may make a

Brennen Meras

June 17, 2013

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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. See the IDR policy and directions on our website at www.assistedliving.dhw.idaho.gov. If your request for informal dispute resolution is not received within the appropriate time-frame, your request will not be granted.

Please bear in mind that non-core issue deficiencies were identified on the punch list.

Please note: an additional non-core deficiency was cited but not included on the original punch list. The corrected punch list is attached. **Please make sure to sign and date this updated punch list and return it to us immediately.**

Five (5) of the twenty-five (25) non-core deficiencies cited were identified as repeat punches. Your evidence of resolution (e.g., receipts, pictures, policy updates, etc.) for each of the non-core issue deficiencies is to be submitted to this office by **July 3, 2013**.

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

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

Enforcement actions may include:

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

Your Food Establishment Inspection Report is also enclosed. Please sign and date in the location noted and return the yellow copy to us immediately with your signed and dated punch list.

Our staff is available to answer questions and to assist you in identifying appropriate corrections to avoid further enforcement actions. Should you have any questions, or if we may be of assistance, please contact us at (208) 334-6626 and ask for the Residential Assisted Living Facility program.

Sincerely,



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

KA/TFP

Enclosures

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC-1000	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/03/2013
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NAME OF PROVIDER OR SUPPLIER GOLDEN YEARS, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1455 WEST KIMRA STREET MERIDIAN, ID 83642
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R 000	<p>Initial Comments</p> <p>The following deficiency was cited during the licensure/follow-up and complaint investigation conducted on 5/29/13 through 6/3/13 at your residential care/assisted living facility. The surveyors conducting the survey were:</p> <p>Karen Anderson, RN Team Leader Health Facility Surveyor</p> <p>Donna Hescheid, LSW Health Facility Surveyor</p> <p>Survey Definitions: ADLs = activities of daily living ALF = Assisted Living Facility AM = morning aspiration = breathing in a foreign object, such as sucking food into the airway asap = as soon as possible CVA = cerebral vascular accident cuz = because d/c = discharge Dr = doctor dysphagia = difficulty swallowing EMS = emergency medical services ER = emergency room grams = grandmother IV - intravenous therapy is the infusion of liquid substances directly into a vein MAR = Medication Assistance Record mg = milligrams meds = medications NSA = Negotiated Service Agreement PM = night PO = By Mouth POA = Power of Attorney PRN = As Needed PT/INR = A test used to monitor the effectiveness</p>	R 000		
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Bureau of Facility Standards

TITLE

(X6) DATE

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

Bureau of Facility Standards

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R 000	Continued From page 1 of Coumadin therapy. A therapeutic level of 2-3 is optimal for most people. Q = every QD = every day res = resident RN = registered nurse TIA = transient ischemic attack Pt. = patient Q AM = Every Morning UAI = Uniform Assessment Instrument Vit K = Vitamin K helps blood to clot Wed = Wednesday	R 000		
R 008	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. This Rule is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to provide adequate supervision to 5 of 5 sampled residents (Residents #1, #2, #3, #4 & #5) and a Random Resident. These findings include: Supervision of Care and Services According to IDAPA 16.03.22.012.25, supervision is defined as "a critical watching and directing activity which provides protection, guidance, knowledge of the residents general whereabouts, and assistance with activities of daily living. The administrator is responsible for providing appropriate supervision based on each resident's Negotiated Service Agreement or other legal requirements."	R 008		

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R 008	<p>Continued From page 2</p> <p>A. Supervision of Medications Assistance and Monitoring of Medications</p> <p>1. Resident #4, an 83 year-old female, was admitted to the facility on 6/29/12 with diagnoses of hypertension, CVA and history of TIAs.</p> <p>Resident #4's record documented she required an anticoagulant medication for stroke prevention.</p> <p>A fax that included physician's orders, dated 9/26/12, documented "Coumadin 5 mg take 1 tablet (Wednesday and Friday), take 1/2 tablet all other days."</p> <p>The September 2012 MAR, documented Resident #4, received 5 mg of Coumadin daily, from 9/26/12 through 9/30/12. However, the resident should have received 1/2 tablet on 9/27/12, 9/29/12 and 9/30/12. According to the MAR, the resident was given 5 mg of Coumadin for a total of 5 days.</p> <p>A fax, from a home health nurse, was sent to a physician on 10/1/12. The nurse documented "Patient was given 5 mg QD because the ALF did not have signed orders for the change." On the bottom of the fax, a physician made the following changes to the Coumadin doses, based on Resident #4's PT/INR lab results. The order was changed to, "Coumadin 5 mg for 5 days, then decrease the dose to 2.5 mg for 2 days."</p> <p>The October 2012 MAR, documented that Resident #4 was given 5 mg of Coumadin for a total of 7 days.</p> <p>A physician's order, dated 10/8/12, documented "Hold Coumadin until further advised."</p>	R 008		

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R 008	<p>Continued From page 3</p> <p>A physician's order, dated 10/11/12, documented "Coumadin 5 mg x 4 days, then 2.5 x 3 days."</p> <p>The October 2012 MAR, documented from 10/12/12 to 10/23/12, Resident #4 was given 5 mg of Coumadin for a total of 12 days. According to the physician's order, the 5 mg of Coumadin should have been given on 4 days. Resident #4 was given 5 mg of Coumadin for 7 days, resulting in a double dose of Coumadin.</p> <p>On 10/8/12 at 2:45 PM, an incident report documented Resident #4's physician called the facility and "requested the resident be transported to hospital because PT/INR levels were too high. Dr stated they would check her for a bleed and possibly give her IV with Vit K." The house manager documented she notified the facility RN and the administrator. The incident report was not signed by the nurse until 10/21/12 at 7:28 PM, 13 days after the incident. The administrator signed the incident report, on 12/12/12 at 12:25 PM, two months after the incident.</p> <p>A physician's order, dated 10/25/12, documented "Hold dose today." The MAR documented 5 mg of Coumadin was given on 10/25/12.</p> <p>A fax to the physician from a home health nurse, dated 10/26/12, documented, "Coumadin was given 2.5 mg yesterday." The physician changed the order to "Coumadin 2.5 mg for 4 days, then give 5 mg for 3 days."</p> <p>The October 2012 MAR documented, on 10/26/12, the Coumadin was held. The medication aides documented the resident received 5 mg of Coumadin on 10/27/12 through 10/31/12. According to the physician's order, the</p>	R 008		

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R 008	<p>Continued From page 4</p> <p>2.5 mg of Coumadin should have been given 4 days. The resident received a double dose of Coumadin for 4 days.</p> <p>A physician's order, dated 10/31/12, documented "Coumadin dose 2.5 mg" on Friday, Saturday, Sunday and Monday. Then give "5 mg" on Tuesday, Wednesday and Thursday.</p> <p>During the month of October 2012, Resident #4's Coumadin dose was changed 6 times and the MAR was not updated to reflect the physician's order changes. On 10/8/12, the resident was transported by ambulance to the hospital with a high PT/INR level. During the month of October the facility documented the resident was given an incorrect dose of Coumadin 14 times.</p> <p>A physician's order, dated 11/1/12, documented "Coumadin dose 2.5 mg x 6 days, 5 mg one day."</p> <p>The November 2012 MAR, documented that Coumadin was held on 11/1/12. Medication aides documented the resident received 5 mg of Coumadin from 11/2/12 through 11/8/12. The resident received a double dose of Coumadin for 6 days.</p> <p>A physician's order, dated 11/2/12, documented "Coumadin dose hold x 10, then 2.5 mg QD."</p> <p>According to the November 2012 MAR, Resident #4 received 5 mg of Coumadin for 7 days, from 11/2/12 through 11/8/12, even though the physician had ordered for the Coumadin dose to be held for 10 days.</p> <p>A physician's order, dated 11/12/12, documented "Coumadin dose 2.5 mg x 7 days"</p>	R 008		

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R 008	<p>Continued From page 5</p> <p>The November 2012 MAR, documented the resident received 5 mg of Coumadin from 11/12/12 through 11/16/12. This resulted in the resident receiving a double dose of Coumadin for 5 days.</p> <p>A physician's order, dated 11/16/12, documented "Coumadin dose 5 mg x 1 day, 2.5 mg x 6 days."</p> <p>The November 2012 MAR, documented Resident #4's Coumadin was held on 11/17/12 and 11/18/12. The MAR further documented 5 mg of Coumadin was given from 11/19/12 through 11/30/12, which would have been a double dose of Coumadin for 10 days.</p> <p>During the month of November, medication aides documented the resident was given the incorrect dose of Coumadin 27 times.</p> <p>The December 2012 MAR, documented that 5 mg of Coumadin was ordered 2 days per week on "Wednesday and Friday." The other 5 days, the resident was to receive 1/2 tablet which would equal 2.5 mg of Coumadin. It was unclear from the documentation on the MAR, if the resident received 5 mg of Coumadin daily, or if a half of a tablet was given the other 5 days, on "Monday, Tuesday, Thursday, Saturday and Sunday." The medication aides documented that 5 mg of Coumadin was given from 12/1/12 through 12/12/12.</p> <p>A physician's order, dated 12/13/12, documented "DC Coumadin."</p> <p>On 5/30/13 at 11:45 AM, the administrator stated there had been a lot of staff changes, including house managers that had come and gone over the past few months. He stated, there had not</p>	R 008		

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R 008	<p>Continued From page 6</p> <p>been medication errors regarding Resident #4, only staff communication issues.</p> <p>On 5/30/13 at 1:10 PM, the facility RN, stated the home health nurse was managing Resident #4's Coumadin and she was unaware of any problems.</p> <p>From 9/26/12 through 12/13/12, Resident #4 had changes to her Coumadin dose 12 times, which were not implemented. On 10/8/12, Resident #4 was transported to the hospital because to her PT/INR blood levels were too high. The facility failed to provide supervision to ensure Resident #4's Coumadin was managed or monitored appropriately, placing Resident #4 at a high risk to have a significant bleed.</p> <p>2. Resident #3, a 92 year-old female, was admitted to the facility on 7/2/12, with a diagnosis of dementia.</p> <p>A physician's order for lorazepam (an antianxiety medication), dated 4/18/13, documented the resident was to receive 0.5 mg every 8 hours, as needed for anxiety.</p> <p>The following behaviors were documented in the progress notes for May 1 - 22, 2013:</p> <p>*5/1 - Resident "was obsessed with wanting to find her purse this evening. I do not believe she has a purse here. But she was very caught up on the thought of it for quite a while. I was about to give her a PRN for anxiety to help her relax but then she decided to go to sleep."</p> <p>*5/4 - Resident "has been very confused about why she is here and keeps asking me when she will be leaving to go home."</p>	R 008		
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R 008	<p>Continued From page 7</p> <p>*5/14 - Resident became a little "agitated" at lunch with another resident because she felt she was being "bossed around."</p> <p>According to the May 2013 MAR, from 5/1/13 to 5/23/13, the resident did not receive any lorazepam for "anxiety, pacing and crying." Then on 5/23 she received one dose in the morning because she "woke up crying and pacing."</p> <p>A fax from the facility's house manager to the resident's physician, dated 5/24/13, documented a request for the lorazepam 0.5 mg twice a day due to the resident becoming "more anxious [sic], pacing and crying." The fax was signed by the facility RN on 5/24/13.</p> <p>A fax from the physician's office to the facility, dated 5/28/13, documented the facility requested to have the lorazepam scheduled twice a day, as she was using the "PRN's regularly." The physician ordered the lorazepam 0.5 mg twice a day at 8:00 AM and 8:00 PM.</p> <p>On 5/26, the facility started giving the resident the lorazepam twice a day and the following behaviors occurred:</p> <p>*5/27 - "Seemed to be in less than content state today. She was very bothered in general and made an effort to talk to me about her problems; however, I was not able to understand because she was not making sense. At one point she was complaining a lot about pain. I offered Tylenol and she accepted. She seemed to be overall uncomfortable most of the day. 8 PM anxiety PRN seemed to have no effect at all."</p> <p>*5/28 at 2:44 PM - "Resident has been confused</p>	R 008		

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R 008	<p>Continued From page 8</p> <p>most of day, had changed her clothing four times since awaking."</p> <p>*5/28 at 6:36 PM - The resident was "very confused. Lots of wandering and agitation....seems very difficult for her to relax tonight." At 9:35 PM, - The resident "got up and paced around for a few minutes. I went to her and suggested that she put on her pjs and relax. She thought she needed to go sit at the table. I told her it is night time and all she needed to do was go to bed." At 9:54 PM, she came out of her room wearing a different shirt and different pants with her pajama shirt over her other shirt. She was "confused" and unable to comprehend what the staff were instructing her to do. At 9:50 PM, the caregiver called the house manager to discuss her concerns about Resident #3's "recent behavioral changes." At 12:57 PM, the resident was in her room "muttering and grunting and talking to herself." The caregiver told the resident "she needed to get into bed and lay down and try to sleep. I had to keep saying it over and over before she understood."</p> <p>*5/30 at 6:17 AM - The resident was "up and down" all night very confused "rambling and incoherent" when trying to explain herself.</p> <p>On 5/29/13 at 9:23 AM, the house manager stated Resident #3 had a "change in mental status." She stated the resident had increased confusion for a "couple of days, but last night the resident was extremely confused." She stated the resident was unable to dress herself, put words together or use the bathroom. The house manager stated she informed the facility nurse, and she planned be at the facility later today to "assess" her.</p>	R 008		

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R 008	<p>Continued From page 9</p> <p>The last nursing assessment found in the resident's record was dated 3/30/13, at that time the resident had "no significant changes."</p> <p>On 5/29/13 at 3:11 PM, a caregiver stated Resident #3 had been "different" the last two days. She stated the resident "freaked out last night." The caregiver stated, "It was like a light switch went off. I told her to get into bed and she didn't comprehend what to do."</p> <p>On 5/29/14 at 3:28 PM, a caregiver stated Resident #3 was able to tell them when she was feeling anxious. Stated she spoke to the RN because of the resident's increased anxiety and the facility had just "got the order today." However, the facility had been giving the resident lorazepam twice a day since 5/26/13.</p> <p>On 5/30/13 at 1:10 PM, the facility nurse stated she was at the facility on 5/29/13 to check Resident #3's new medication. She stated she had not assessed the resident on 5/29/13 and was not made aware of any mental status changes. She stated she approved the request to increase the lorazepam based on what the house manager told her. The RN confirmed she had not looked at the MAR for prior usage or progress notes to verify the need for increasing the lorazepam.</p> <p>Prior to receiving a medication increase of lorazepam, on 5/24/13, Resident #3 had only received lorazepam once for "confusion." When the resident began receiving two scheduled doses of the lorazepam per day, the facility began documenting significant mental status changes. The facility RN signed off on the medication change without verifying the need for the medication or determining if the resident's mental</p>	R 008		

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R 008	<p>Continued From page 10</p> <p>status changes were related to the medication or if there had been an actual physical cause for those changes.</p> <p>The last nursing assessment found in the resident's record was dated 3/30/13, and at that time the resident had "no significant changes."</p> <p>The facility failed to provide adequate supervision to ensure residents medications were monitored and assisted appropriately. The lack of supervision had the potential to cause Resident #2 and #4, significant changes in their health and mental status.</p> <p>B. Supervision of Change of Condition/Nursing Involvement</p> <p>1. Resident #3, a 92 year-old female, was admitted to the facility on 7/2/12, with a diagnosis of dementia.</p> <p>A progress note, dated 12/3/12 at 6:00 AM, documented the resident was "throwing up and she wanted to use the bathroom." The caregiver went back to the room at "approximately" 12:00 AM to check on the resident and "found her lying on the floor." There was no further documentation regarding this incident. However, the progress notes from 12/4/12 through 12/7/12, documented the resident was in the hospital for four days.</p> <p>An incident report, dated 12/15/12, documented Resident #3 called the caregiver into her room and told the caregiver that she was "hurting down in her private area and wanted staff to look at it." As the resident was standing up, the caregiver saw a "big ball of something coming out of resident's vagina, it was the size of a baseball." At 6:20 PM, the caregiver called a male caregiver,</p>	R 008		

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R 008	<p>Continued From page 11</p> <p>who was on call for the house manager, and at 6:30 PM, the facility nurse was called. The resident was picked up at 7:29 PM by her son who took her to the hospital. The incident report further documented, the daughter would schedule a follow-up appointment . The incident report was signed by the administrator, on 1/1/13, but was not signed by the facility nurse.</p> <p>A nursing note, dated 12/15/12, documented the nurse received a call from a caregiver "regarding client needing to go to the ER due to an urgent matter. Okay to give meds early. Son coming to pick her up." There was no further documentation from the facility nurse regarding what the "urgent matter" was.</p> <p>A progress note, dated 12/16/12 at 7:00 AM, documented the paperwork from the emergency department was on the medication cart and staff were to "call the nurse if [Resident #3's name] uterus prolapses. She will come in and take care of it."</p> <p>There was no further documentation found from the facility nurse regarding what instructions she provided to the caregivers for Resident #3's prolapsed uterus.</p> <p>A progress note, dated 12/16/12 at 2:46 PM, documented the resident's uterus was "prolapsed most of the day today. We did get directives from [name of caregiver] that was passed down from the emergency room nurse, that we can push it back in if we feel comfortable doing so or we can call the facility nurse and she will come over and deal with it."</p> <p>A progress note, dated 12/16/12 at 9:51 PM, documented the "staff checked her private area a</p>	R 008		

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R 008	<p>Continued From page 12</p> <p>few times, res was able to push the tissue back in without staff assisting..."</p> <p>A progress note, dated 12/17/12 at 3:55 PM, documented the resident's son "conveyed that for now just to assist res with prolapse, and help to make her comfortable."</p> <p>There was no documentation by the facility nurse, of written instructions for caregivers, the nurse had delegated this task to the caregivers, or had evaluated the resident to determine if the task was appropriate for unlicensed staff to perform.</p> <p>A progress note, dated 12/21/12 at 10:20 PM, documented there were "no details" about the resident's follow-up appointment. There was no further documentation in the resident's record regarding the prolapsed uterus after this date.</p> <p>Additionally, Resident #3, sustained a significant skin tear on her right arm when she was admitted to a hospital. The facility did not ensure the resident was assessed by the facility RN after she was discharged from the hospital. A progress note, documented the following:</p> <p>On 12/24/12 at 2:37 PM, the resident had a skin tear on her right arm that was recently discovered, "but was from her hospital stay." There was no prior documentation regarding the skin tear. However, it had been 17 days since the resident was in the hospital. There was no documentation the facility nurse had assessed the resident's skin tear.</p> <p>On 5/30/13 at 10:35 AM, a previous house manager stated, "I worked at the facility for 6 months, during that time I only saw the facility RN come to the facility 3 times." She stated, " I asked</p>	R 008		

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R 008	<p>Continued From page 13</p> <p>the administrator for help, because we needed to order Tegaderm to put over [Resident #3's name] wound on her arm. We didn't have any supplies to dress the skin tear." She stated, "I couldn't get any help so I brought a Tegaderm that I had from home and used it to cover her skin tear, because the wound was seeping out of the dressing from the hospital."</p> <p>The last nursing assessment found in the resident's record was dated 3/30/13, and at that time the resident had "no significant changes."</p> <p>2. Resident #2, an 89 year-old female, was admitted to the facility on 4/5/13 with diagnoses which included a history of compression fractures and rheumatoid arthritis.</p> <p>A nursing assessment, dated 4/5/13, documented the resident was admitted with a history of a lower spine compression fracture and had "occasional" pain. There were no other nursing assessments found in the resident's closed record.</p> <p>An NSA, dated 4/9/13, documented Resident #2 required minimal assistance with bathing, dressing, hygiene and toileting.</p> <p>A Progress Note, dated 4/27/13 at 2:28 PM, documented it took staff an hour to get the resident dressed because she was in "a lot of pain, crying." There was no documentation the facility nurse had been notified of the resident's increased pain and the change in Resident #2's level of care.</p> <p>A Progress Note, dated 4/27/13 at 8:04 PM, documented the resident had been having "more severe pain than usual since the time she awoke this morning." The resident was "moaning and in</p>	R 008		

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R 008	<p>Continued From page 14</p> <p>tears" because of the "severity" of her pain when being transferred from a recliner to her wheelchair. There was no documentation the facility nurse was notified of the severity of the resident's pain.</p> <p>A Progress note, dated 4/30/13 at 11:14 PM, documented the resident "seemed very confused and a little out of it" when being transfer to her bed. The resident sat on the toilet for 14 minutes which was "not like her at all" and while brushing her teeth, she would fall asleep. "She just did not seem like herself and was saying a few things that did not make sense."</p> <p>A nursing note, dated 5/1/13, documented the resident was having a lot of pain in her back which "wasn't being managed by pain meds." There was no further documentation from the nurse regarding what to do about the resident's increased pain. Further, there was no RN assessment of the resident's increased pain and confusion.</p> <p>The facility's Admission/Discharge register documented Resident #2 was discharged from the facility on 5/6/13. However, the home health nurse stated the resident was transferred to the hospital on 5/3/13. There was no further documentation found in the resident's record after 5/1/13 regarding the resident's change of condition or transfer to the hospital.</p> <p>On 5/29/13 at 2:45 PM, a caregiver stated the resident had "severe back pain." The caregiver stated that the day the resident was transferred out, she was unable to dress the resident because the pain was so severe, the resident could not be moved.</p>	R 008		

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R 008	<p>Continued From page 15</p> <p>On 5/30/13 at 9:40 AM, a caregiver stated the resident was a "high level of care" and it took "over 45 minutes" each day to get her washed, dressed and out to the breakfast table. She stated the resident required "so much help," it was difficult to see to the other residents' needs.</p> <p>On 5/30/13 at 11:35 AM, the home health nurse stated Resident #2 was "pretty debilitated." She stated the resident called her on 4/27/13 and told her she was "not getting the help she was suppose to." The nurse stated she felt the resident was above the facility's level of care and alternative placement options were discussed at a case conference. The nurse stated that from the time the resident was admitted to home health, there had been no conferences with the administrator or other facility staff. The home health nurse stated she had never met or talked to the facility nurse. She stated she had received a call from the house manager on 5/3/13, regarding staff not being able to move the resident in bed. The home health nurse stated she instructed staff to call 911.</p> <p>The facility documented Resident #2 had "severe pain" and increased confusion for four days. However, the resident was not sent to the hospital until 5/3/13, which was 7 days after being in so much pain it took staff an hour to dress her. During this time, there was no documented involvement by the facility nurse.</p> <p>3. Resident #1 was an 87 year-old female, admitted to the facility on 3/21/13, with diagnoses including Parkinson's disease and Lewy body dementia.</p> <p>Progress notes documented the following:</p>	R 008		

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R 008	<p>Continued From page 16</p> <p>*4/7/13 at 7:09 PM - "Refused to take a PRN (calms forte) when staff felt it was necessary for the safety of other residents when [Resident #1's name] started attempting to throw her dinner." The administrator was called and "advised" the caregiver to call the daughter. The daughter came and assisted the resident with taking the PRN.</p> <p>There was no documentation the facility nurse was notified of the resident's behavior on 4/7/13. The administrator instructed staff to have the family address the issue and a PRN was given without the nurse's direction.</p> <p>*5/4/13 at 7:42 PM - "While I was administering meds, [Resident #1's name] was scratching a scab on her upper, right arm and it began to bleed.</p> <p>*5/5/12 at 6:43 PM - "Has two open sores, one on her upper right arm and one on the back of her right shoulder. They are both very red and irritated and cause her a lot of pain. I suspect they may be infected by my observation."</p> <p>There was no further documentation by the facility RN, to address Resident #1's open sores, or her behavior that required a PRN medication be used as an intervention. The most current RN assessment, was dated 3/21/13, and documented the resident was "very confused, pleasant."</p> <p>*5/16/13 at 3:11 PM - "Resident out to the Dr. this morning, physician signed new med update."</p> <p>*5/28/13 at 8:44 PM - "After her shower I could tell she was physically exhausted. I asked her if her back hurt. She said she hurt all over. I gave</p>	R 008		
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R 008	<p>Continued From page 17</p> <p>her a Haldol PRN." Resident #1's record did not contain an order for Haldol. There was no documentation the facility nurse was called before a caregiver "gave the resident Haldol," which is mostly prescribed and used, as an antipsychotic medication.</p> <p>Supervision of Change of Condition/Weight Loss</p> <p>1. Resident #4, an 83 year-old female, was admitted to the facility, on 6/29/12 with diagnoses of hypertension, CVA and history of TIAs.</p> <p>Resident #4's NSA, was dated 1/21/13, and documented the resident had occasional swallowing difficulty but could feed herself and required staff to make sure they assisted her with snacks. The NSA, documented "Staff will monitor weight..." However, the NSA was not developed until seven months after the resident's admission to the facility. The NSA was signed by a house manager and the facility RN. The NSA was not signed by the administrator, the resident, or her POA.</p> <p>A nursing assessment, dated 6/29/12, did not include the resident's current weight upon admission. However, the facility RN documented the resident required her pills cut in half due to occasional swallowing difficulty.</p> <p>A nursing assessment, dated 9/30/12, documented the resident had a change of condition and had swallowing problems. The facility RN documented in the comment section of her assessment that Resident #4's "NSA's & UAI's" would need to be updated due to her change in condition. The assessment did not include the resident's weight.</p>	R 008		

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R 008	<p>Continued From page 18</p> <p>On 9/25/12, a home health note documented Resident #4's weight was 167 pounds.</p> <p>On 11/5/12, a home health note documented the resident's weight was 155 pounds. From 9/25/12 until 11/5/12, Resident #4, had lost 12 pounds in 41 days.</p> <p>On 11/19/12, Resident #4 had an appointment with her physician. The resident was weighed at the physician's office and her weight was documented at 145 pounds. There was a recommendation to consider hospice due to continued weight loss. The resident had lost another 10 pounds in 14 days for a total of 22 pound weight loss.</p> <p>On 11/30/12, a fax from a home health agency, documented a request to Resident #4's physician, "May we keep her at weekly visits due to continued weight loss/swallowing /aspiration issues?" The order was signed and dated by the physician on 11/30/12, for the resident to continue services with home health.</p> <p>A physician's order, dated 12/1/12, documented Resident #4 was admitted to hospice for a "decline in condition."</p> <p>There were no further nursing assessments, from the facility RN found in Resident #4's closed record. Additionally, there was no documentation found in the resident's record that staff had monitored Resident #4's weights.</p> <p>A nursing assessment, dated 12/29/12, documented the resident was on hospice and required cueing for eating. The facility RN assessment did not include the resident's current weight. The RN documented, "Resident has</p>	R 008		

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R 008	<p>Continued From page 19</p> <p>gained weight in past year. She had gained close to 15 lbs."</p> <p>On 5/30/13 at 10:20 AM, a hospice RN stated the administrator was not involved with what was going on with the residents. She stated, the facility's owner and administrator rely on the house manager to handle everything. She stated, she had never met the facility RN or communicated with her.</p> <p>On 5/30/13 at 11:45 AM, the administrator stated he was not aware of Resident #4's weight loss.</p> <p>The facility admitted Resident #4 on 6/29/12, and had not developed an NSA until 1/21/13. The resident experienced a significant weight loss of 12 pounds in 41 days. The facility nurse was not aware of the weight loss and documented the resident had gained weight. The facility did not provide appropriate supervision to ensure there was nurse involvement when the resident experienced a significant change in condition and was placed on hospice.</p> <p>5. A Random Resident:</p> <p>On 5/29/13 at 11:00 AM, the random resident was observed in his room, curled up on his bed laying on his right side.</p> <p>On 5/29/13 at 12:20 PM, the random resident was observed in his room. Stated he was not eating because his "stomach hurt."</p> <p>On 5/29/13 at 12:25, the house manager stated she had contacted the RN and she was coming in later today to check on the resident.</p> <p>On 5/30/13 at 10:30 AM, EMS personnel were</p>	R 008		

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R 008	<p>Continued From page 20</p> <p>observed in the random resident's room. The house manager stated to EMS that the resident was "acting normal yesterday and just started throwing up blood this morning." The caregiver stated he was "fine and ate dinner last night." The house manager stated she was unsure if the facility RN had assessed the resident last night.</p> <p>On 5/30/13 at 1:10 PM, the facility nurse stated she was at the facility on 5/29/13, after 6 PM. She stated she had not been informed about the random resident having stomach pains.</p> <p>C. Supervision of Dietary Needs</p> <p>1. Resident #4 was an 83 year-old female admitted to the facility, on 6/29/12, with diagnoses including pneumonitis due to inhaling food/vomitus and dysphagia due to cerebrovascular disease.</p> <p>A physician's order, dated 9/26/12, documented an order for "[Thick-It]" powder 1 to 2 teaspoons with every meal.</p> <p>A physician's order from a home health agency, dated 10/01/12, documented the resident was to have liquids thickened with all meals.</p> <p>A physician's order request from a home health agency, dated 11/6/12, documented an order for speech therapy to provide dysphagia treatment, including electrical stimulation if applicable, designed to facilitate and restore a functional safe swallow and reduce the risk of aspiration.</p> <p>A physician's order request from a home health agency, dated 11/29/12, documented an order for weekly nursing visits due to "continued weight loss/swallowing/aspiration issues."</p>	R 008		

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NAME OF PROVIDER OR SUPPLIER GOLDEN YEARS, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1455 WEST KIMRA STREET MERIDIAN, ID 83642		
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R 008	<p>Continued From page 21</p> <p>On 11/29/12, the speech therapist documented a barium study visit was conducted and Resident #4 required thickened liquids with all meals.</p> <p>On 5/29/13 at 5:24 PM, a family member stated Resident #4 had an order for "[Thick-It]" to be used for liquids in September 2012. She stated, "I'm not certain all the staff really understood what a dysphagia diet was suppose to be." She stated, "there was some confusion between staff, some staff weren't sure if "[Thick-It]" was suppose to be mix in all of her liquids, or if they only needed to use "[Thick-It]" in her beverages during meals." She stated, "In October, the facility had thick-it available, but they must have used because the hospice nurse brought "[Thick-It]" in for staff to use in December, as there wasn't any available in the facility.</p> <p>On 5/30/13 at 10:35 AM, a hospice RN stated the resident was admitted to hospice on 12/1/12. The hospice RN stated the facility did not have "[Thick-It]" for the resident so she brought it in for staff to use in all of her beverages. The hospice nurse stated, "I made sure she had it."</p> <p>On 5/30/13 at 11:20 AM, the owner stated, there was a problem with the previous house manager and the "[Thick-It]" was not being used. She said the house manager was fired because of it. The owner further stated, she had a meeting with the family and ombudsman and they all felt it was best to part ways.</p> <p>An undated text message sent to the owner by a family member, documented maybe Resident #4 was possibly "too much for your facility to handle." The text message from a family member, further documented, "I can't honor a contract [NSA] that</p>	R 008		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC-1000	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/03/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN YEARS, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1455 WEST KIMRA STREET MERIDIAN, ID 83642		
(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 22</p> <p>I haven't seen nor agreed to. So, I'll just try to move her asap."</p> <p>An undated text message sent to a family member, from the facility owner, at 6:56 PM, documented, "...the "[Thick-It]" issue was resolved, one staff member was let go and the other was written up. We had a staff meeting the day we were supposed to meet and addressed the concerns..." The text message further documented, the facility had completed Resident #4's NSA for a conference meeting. The text message documented, "your grams is not to [sic] much for our facility. and [sic] if you still choose to not give us a chance to resolve your concerns and plan to remove your grams a 30 day is required by law and she will need to stay in the facility until that time is up."</p> <p>An undated text message, from a family member replied to the facility's owner at 8:56 PM. The following message was documented, "I have been very understanding...there comes a point where grams safety is more important than hurting peoples egos. Red flags have lead [sic] me to research, and I have strong, valid reservations about the level of care my gram has/has not received."</p> <p>An undated text message was sent to a family member from the facility's owner at 9:30 PM, and documented "what the f*@# is she talking about...She is nut [sic] and if things haven't been fixed its cuz [former house manager's name] is a f*@3tard and we fired her and have been trying to fix her high maintance [sic] demands...man I'm pissed."</p> <p>On 5/29/13 at 10:00 AM, the administrator confirmed he was aware of the issue with the</p>	R 008		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC-1000	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/03/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN YEARS, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1455 WEST KIMRA STREET MERIDIAN, ID 83642		
(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 23</p> <p>"[Thick-It]" but had not handled the situation. He stated there were a lot of "family dynamics" and the "general manager" handled the issue of the "[Thick-It]" and the other concerns from the family.</p> <p>Resident #4 did not receive thickened liquids as ordered by her physician.</p> <p>2. Resident #1 was an 87 year-old female admitted to the facility, on 3/21/13, with diagnoses including Parkinson's disease and Lewy body dementia.</p> <p>A nursing assessment, dated 3/21/13, documented the resident "needs food chopped up."</p> <p>An NSA, dated 4/11/13, documented the resident was on a "mechanically altered" diet.</p> <p>A physician's order, dated 5/16/13, documented the resident was to have a soft diet with meat chopped in a food processor.</p> <p>On 5/29/13 at 12:20 PM, the resident was observed eating chicken that had been cut into large pieces and served without gravy.</p> <p>On 5/29/13 at 12:22 PM, the house manager stated the resident did not "like" her food mechanically altered and the family requested she be served a regular diet. However, there was no request to the resident's physician to change Resident #1's diet to a regular diet.</p> <p>On 5/30/13 at 1:10 PM, the facility nurse stated Resident #1 had an order for a mechanical soft diet. She stated she was told by staff they were cutting the resident's food "finely." She confirmed she was not familiar with Idaho Diet Manual</p>	R 008		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC-1000	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/03/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN YEARS, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1455 WEST KIMRA STREET MERIDIAN, ID 83642		
(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 24 guidelines for a mechanical soft diet. On 5/31/13 between 8:55 AM and 9:47 AM, four caregivers were interviewed. The caregivers stated the facility did not have any residents on a special diet. One caregiver stated Resident #1's food was "chopped up" and another stated Resident #1 did not have a special diet ordered. The facility did not provide Resident #1 with a mechanical soft diet as ordered which placed her at an increased risk of choking or aspiration. Additionally, the facility did not follow physician's orders to use "[Thick-It]" in Resident #4's beverages which increased Resident #4's risk of aspiration.	R 008		



ASSISTED LIVING
Non-Core Issues
Punch List

Facility Name Golden Years, Inc	Physical Address 1455 West Kimra Street	Phone Number 208 888-2800
Administrator Brennen Meras	City Meridian	Zip Code 83642
Team Leader Karen Anderson	Survey Type Licensure + Complaint	Survey Date 06/03/13

NON-CORE ISSUES

Item #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	L&C USE
1	009.01	The facility did not have a completed Criminal and History for 2 of 6 employees. Previously cited 3/23/12.	7/15/13	KA
2	009.06.c	Three of 6 employees did not have an Idaho State Police background check completed. Previously cited 3/23/12.	7/15/13	KA
3	210	There were no daily activities provided to residents as observed on 5/29/13 through 5/31/13.	7/15/13	KA
4	215.08	The administrator did not ensure the facility's policy and procedures were followed for investigations of accidents, incidents and allegations of missing narcotics.	7/15/13	KA
5	215.09	The administrator did not ensure reportable incidents were sent to Licensing and Certification.	7/15/13	KA
6	225.01	Resident #1 and #3 did not have behavior management plans to identify or evaluate behaviors.	8/26/13	KA
7	225.02.b	The facility did not use the least restrictive interventions for Resident #1's behaviors.	8/26/13	KA
8	250.15	The facility did not have a call system available for each resident as many residents' pendent alarms were missing.	7/15/13	KA
9	305.03	The facility nurse did not assess Resident #1, #2 #3 #4 & #5's change of condition, as well as, a Random Resident's choking incident and another Random Resident's complaints of stomach pain. Previously cited 3/23/12.	7/15/13	KA
10	310.01.d	The facility nurse allowed unlicensed staff to bubble-pack Residents' medications.	7/15/13	KA
11	310.01.e	The house manager walked away without observing a resident take his medications.	7/15/13	KA
12	320	Resident #4 did not have a NSA for six months.	8/26/13	KA
13	320.03	Resident #1, #3 & #4, NSAs were not signed by all parties.	8/26/13	KA
Response Required Date 07/03/13	Signature of Facility Representative		Date Signed	



Facility Name Golden Years, Inc	Physical Address 1455 West Kimra Street	Phone Number 208-888-2800
Administrator Brennen Meras	City Meridian	Zip Code 83642
Team Leader Karen Anderson	Survey Type Licensure, Follow-up and Complaint	Survey Date 06/03/13

NON-CORE ISSUES

Item #	RULE# 16-03-22	DESCRIPTION	DATE RESOLVED	L&C USE
14	330.06	Survey staff did not have immediate access to resident and facility records.	7/15/13	KA
15	335.03	There were no paper towels observed in residents' rooms who required assistance with personal cares. **Previously cited 3/23/12	7/15/13	KA
16	451.01.d	The facility did not follow the planned menu or document substitutions.	7/15/13	KA
17	451.02	Snacks were not observed to be offered during the survey.	7/15/13	KA
18	600.06	Caregivers left residents unsupervised while taking their breaks.	8/26/13	KA
19	710.07	Resident #3 did not have a completed uniform assessment.	7/15/13	KA
20	711.03 a & b	There was no evidence of a discharge notice for Resident #4.	7/15/13	KA
21	711.08.e	The facility did not document the facility RN was notified when residents had changes of condition.	7/15/13	KA
22	711.08.f	The facility did not have notes of care and services from outside agencies. **Previously cited on 3/23/12	7/15/13	KA
23	711.12	Caregivers did not document reasons why PRN medications were given.	7/15/13	KA
24	730.02	The facility did not maintain records for 3 years which included personnel on duty at any given time, and the first and last name of each employee and their position.	7/15/13	KA
25	220.02	The administrator did not sign admission agreements on the day of, or prior to the day of admission. A copy of the admission agreement was not provided to the resident, their guardian or legal representative.	7/15/13	KA
26	350.04	The administrator did not provide a written response to complaints within 30 days.	7/15/13	KA
Response Required Date 07/03/13	Signature of Facility Representative		Date Signed	



HEALTH & WELFARE Food Establishment Inspection Report

Residential Assisted Living Facility Program, Medicaid L & C
 3232 W. Elder Street, Boise, Idaho 83705
 208-334-6626

Critical Violations Noncritical Violations

Establishment Name <u>Golden Years</u>			Operator <u>Breman Hares</u>		
Address <u>1455 W Kimra Meridian</u>					
County <u>Ada</u>	Estab #	EHS/SUR #	Inspection time:	Travel time:	
Inspection Type:	Risk Category: <u>High</u>	Follow-Up Report: OR	On-Site Follow-Up:	Date: _____	
Items marked are violations of Idaho's Food Code, IDAPA 16.02.19, and require correction as noted.					

# of Risk Factor Violations	<u>0</u>	# of Retail Practice Violations	<u>1</u>
# of Repeat Violations	<u>0</u>	# of Repeat Violations	<u>0</u>
Score	<u>0</u>	Score	<u>1</u>
A score greater than 3 Med or 5 High-risk = mandatory on-site reinspection		A score greater than 6 Med or 8 High-risk = mandatory on-site reinspection	

RISK FACTORS AND INTERVENTIONS (Idaho Food Code applicable sections in parentheses)

The letter to the left of each item indicates that item's status at the inspection.

Demonstration of Knowledge (2-102)		COS	R	Potentially Hazardous Food Time/Temperature		COS	R
<u>Y</u>	1. Certification by Accredited Program; or Approved Course; or correct responses; or compliance with Code	<input type="checkbox"/>	<input type="checkbox"/>	<u>Y</u>	15. Proper cooking, time and temperature (3-401)	<input type="checkbox"/>	<input type="checkbox"/>
	Employee Health (2-201)			<u>Y</u>	16. Reheating for hot holding (3-403)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u>	2. Exclusion, restriction and reporting	<input type="checkbox"/>	<input type="checkbox"/>	<u>Y</u>	17. Cooling (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
	Good Hygienic Practices			<u>Y</u>	18. Hot holding (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u>	3. Eating, tasting, drinking, or tobacco use (2-401)	<input type="checkbox"/>	<input type="checkbox"/>	<u>Y</u>	19. Cold Holding (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u>	4. Discharge from eyes, nose, and mouth (2-401)	<input type="checkbox"/>	<input type="checkbox"/>	<u>Y</u>	20. Date marking and disposition (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
	Control of Hands as a Vehicle of Contamination			<u>Y</u>	21. Time as a public health control (procedures/records) (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u>	5. Clean hands, properly washed (2-301)	<input type="checkbox"/>	<input type="checkbox"/>		Consumer Advisory		
<u>Y</u>	6. Bare hand contact with ready-to-eat foods/exemption (3-301)	<input type="checkbox"/>	<input type="checkbox"/>	<u>Y</u>	22. Consumer advisory for raw or undercooked food (3-603)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u>	7. Handwashing facilities (5-203 & 6-301)	<input type="checkbox"/>	<input type="checkbox"/>		Highly Susceptible Populations		
	Approved Source			<u>Y</u>	23. Pasteurized foods used, avoidance of prohibited foods (3-801)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u>	8. Food obtained from approved source (3-101 & 3-201)	<input type="checkbox"/>	<input type="checkbox"/>		Chemical		
<u>Y</u>	9. Receiving temperature / condition (3-202)	<input type="checkbox"/>	<input type="checkbox"/>	<u>Y</u>	24. Additives / approved, unapproved (3-207)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u>	10. Records: shellstock tags, parasite destruction, required HACCP plan (3-202 & 3-203)	<input type="checkbox"/>	<input type="checkbox"/>	<u>Y</u>	25. Toxic substances properly identified, stored, used (7-101 through 7-301)	<input type="checkbox"/>	<input type="checkbox"/>
	Protection from Contamination			<u>Y</u>	26. Compliance with variance and HACCP plan (8-201)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u>	11. Food segregated, separated and protected (3-302)	<input type="checkbox"/>	<input type="checkbox"/>		Conformance with Approved Procedures		
<u>Y</u>	12. Food contact surfaces clean and sanitized (4-5, 4-6, 4-7)	<input type="checkbox"/>	<input type="checkbox"/>				
<u>Y</u>	13. Returned / re-service of food (3-306 & 3-801)	<input type="checkbox"/>	<input type="checkbox"/>				
<u>Y</u>	14. Discarding / reconditioning unsafe food (3-701)	<input type="checkbox"/>	<input type="checkbox"/>				

Y = yes, in compliance N = no, not in compliance
 N/O = not observed N/A = not applicable
 COS = Corrected on-site R = Repeat violation
 = COS or R

Item/Location	Temp	Item/Location	Temp	Item/Location	Temp	Item/Location	Temp
<u>Chicken (oven)</u>	<u>165°</u>	<u>beef casserole</u>	<u>39.5°</u>	<u>spanish rice</u>	<u>40.4°</u>		
<u>Chicken (cooked) fridge</u>	<u>42.3°</u>	<u>(fridge)</u>		<u>(fridge)</u>			

GOOD RETAIL PRACTICES (X = not in compliance)

	COS	R		COS	R		COS	R
<input type="checkbox"/> 27. Use of ice and pasteurized eggs	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> 34. Food contamination	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 42. Food utensils in use	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 28. Water source and quantity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 35. Equipment for temp. control	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 43. Thermometers/Test strips	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 29. Insects/rodents/animals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 36. Personal cleanliness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 44. Warewashing facility	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 30. Food and non-food contact surfaces: constructed, cleanable, use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 37. Food labeled condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 45. Wiping cloths	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 31. Plumbing installed; cross-connection; back flow prevention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 38. Plan food cooking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 46. Utensil & single-service storage	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 32. Sewage and waste water disposal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 39. Thawing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 47. Physical facilities	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 33. Sinks contaminated from cleaning maintenance tools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 40. Toilet facilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 48. Specialized processing methods	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/> 41. Garbage and refuse disposal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 49. Other	<input type="checkbox"/>	<input type="checkbox"/>

OBSERVATIONS AND CORRECTIVE ACTIONS (CONTINUED ON NEXT PAGE)

Person in Charge (Signature) _____ (Print) _____	Title _____	Date <u>5/31/13</u>	Follow-up: (Circle One) <u>Yes</u> (No)
Inspector (Signature) <u>Donna Henschel</u> (Print) <u>Donna Henschel</u>			



Residential Assisted Living Facility Program, Medicaid L & C
3232 W. Elder Street, Boise, Idaho 83705
208-334-6626

Page 2 of 2
Date 5/31/13

Establishment Name <i>Gables Years</i>	Operator <i>Brennan Mares</i>	
Address <i>1455 W. Kima, Meridian</i>		
County, Estab # <i>Ada</i>	EHS/SUR.#	License Permit #

OBSERVATIONS AND CORRECTIVE ACTIONS (Continuation Sheet)

34. The caregiver wore gloves while plating food, touched several different things during the process and then picked up rolls with the same gloves. COS - instructed staff on importance of wearing gloves only when touching ready-to-eat foods and washing hands between tasks.

Person in Charge	Date	Inspector <i>Donna Henschel</i>	Date <i>5/31/13</i>
------------------	------	------------------------------------	------------------------



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: 208-334-6626
FAX: 208-364-1888

June 17, 2013

Brennen Meras, Administrator
Golden Years, Inc.
PO Box 1496
Meridian, ID 83680

Dear Mr. Meras:

An unannounced, on-site complaint investigation survey was conducted at Golden Years, Inc between May 29 and June 3, 2013. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00005919

Allegation #1: The facility administrator did not sign resident admission agreements.

Findings #1: Substantiated. The facility was issued a non-core deficiency at IDAPA 16.03.22.220.02 for the administrator not signing admission agreements prior to, or on the day of admission. The facility was required to submit evidence of resolution within 30 days.

Allegation #2: The residents and/or family members did not receive copies of their admission agreements.

Findings #2: Substantiated. The facility was issued a non-core deficiency at IDAPA 16.03.22.220.02 for not providing a copy of the admission agreement to the resident, their guardian or legal representative. The facility was required to submit evidence of resolution within 30 days.

Please bear in mind that non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference, on **June 3, 2013**. The completed punch list form and accompanying evidence of resolution (e.g., receipts, pictures, policy updates, etc) are to be submitted to this office within thirty (30) days from the exit date.

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

Karen Anderson
Health Facility Surveyor
Residential Assisted Living Facility Program

KA/TFP



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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RESIDENTIAL ASSISTED LIVING FACILITY PROGRAM
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: 208-334-6626
FAX: 208-364-1888

June 17, 2013

Brennen Meras, Administrator
Golden Years, Inc.
PO Box 1496
Meridian, ID 83680

Dear Mr. Meras:

An unannounced, on-site complaint investigation survey was conducted at Golden Years, Inc between May 29 and June 3, 2013. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00005887

Allegation #1: The facility did not provide "thick-it" in resident drinks.

Findings #1: Substantiated. The facility was cited a core deficiency at IDAPA 16.03.22.520 for not providing thick-it to residents as ordered. The facility was required to submit a plan of correction within 10 days.

Allegation #2: The facility did not provide mechanically altered diets.

Findings #2: Substantiated. The facility was issued a core deficiency at IDAPA 16.03.22.520 for not providing mechanically altered diets as ordered by the residents' physicians. The facility was required to submit a plan of correction within 10 days.

Allegation #3: The facility did not assist residents with eating when required.

Findings #3: Unsubstantiated. Insufficient evidence was available to substantiate the allegation.

Allegation #4: The facility did not provide activities for residents.

Findings #4: Substantiated. The facility was issued a non-core deficiency at IDAPA 16.03.22.210 for not providing an on-going activity program. The facility was required to submit evidence of resolution within 30 days.

Brennen Meras, Administrator
June 17, 2013
Page 2 of 2

Allegation #5: The facility administrator did not respond in writing to resident/resident family complaints.

Findings #5: Substantiated. The facility was issued a non-core deficiency at IDAPA 16.03.22.350.04.

Allegation #6: The facility did not assist residents with medications as ordered.

Findings #6: Substantiated. The facility was issued a core deficiency at IDAPA 16.03.22.520 for not providing assistance and monitoring of medications. The facility was required to submit a plan of correction within 10 days.

Allegation #7: The facility did not assist residents with toileting needs when required.

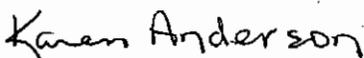
Findings #7: Unsubstantiated. Insufficient evidence was available to substantiate the allegation.

A core issue deficiency was identified during the complaint investigation. Please review the cover letter, which outlines how to develop a Plan of Correction. The Plan of Correction must be submitted to our office within 10 (ten) calendar days of receiving the Statement of Deficiencies.

Please bear in mind that non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference, on **June 3, 2013**. The completed punch list form and accompanying evidence of resolution (e.g., receipts, pictures, policy updates, etc) are to be submitted to this office within thirty (30) days from the exit date.

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
Health Facility Surveyor
Residential Assisted Living Facility Program

KA/TFP

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