



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

May 21, 2015

Julie Pendleton, Administrator
Desano Place Village Memory Care
1015 E Avenue K
Jerome, Idaho 83338

Provider ID: RC-995

Ms. Pendleton:

On April 1, 2015, a state licensure/follow-up/revisit and complaint investigation were conducted at Desano Place Village Memory Care. 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: 208-364-1888

April 13, 2015

CERTIFIED MAIL #: 7007 3020 0001 4050 8869

Julie Pendleton, Administrator
Desano Place Village Memory Care
1015 E Avenue K
Jerome, Idaho 83338

Ms. Pendleton:

On April 1, 2015, a state licensure/follow-up/revisit and complaint investigation were conducted by Department staff at Desano Place Village Memory Care. The facility was cited with a core issue deficiency for failing to protect residents from inadequate care.

This core issue deficiency substantially limits the capacity of Desano Place Village Memory Care 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 April 13, 2015 and will remain in effect until October 10, 2015. Upon receipt of this provisional license, return the license currently held by the facility. 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- 2 of the provisional license are as follows:

PLAN OF CORRECTION:

1. 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:

2. 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 two (2) 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 May 1, 2015.

ADMINISTRATIVE REVIEW

You may contest the provisional license 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 above specified 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 submits 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 Desano Place Village Memory Care. 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
- 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

Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R995	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/06/2015
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NAME OF PROVIDER OR SUPPLIER DESANO PLACE VILLAGE MEMORY CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1015 E AVENUE K JEROME, ID 83338
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{R 000}	<p>Initial Comments</p> <p>The following deficiency was cited during the follow-up survey and complaint investigation conducted between 03/31/2015 and 04/1/2015 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>Rae Jean McPhillips, RN, BSN Health Facility Surveyor</p> <p>Survey Definitions: APS = Adult Protection Services res = resident</p>	{R 000}	<p>Preface Remarks:</p> <p>DeSano Place Village is a secure, fenced and locked down 16-bed assisted living home designed for persons with Alzheimer's and related dementias, like Parkinson's, Lewy body dementia, and Vascular-caused dementia. Suffice it to say that our staff encounter behaviors, with most of our residents at one time or another, as these disease processes affect all areas of the brain, eventually. When reviewing historical camera footage at DeSano Place Village, in our common areas, where many of these reported behaviors occurred, it is apparent that a majority of resident behaviors had been caused or escalated by staff attempts at involvement.</p>	
{R 008}	<p>16.03.22.520 Protect Residents from Inadequate Care.</p> <p>The administrator must assure that policies and procedures are implemented to assure that all residents are free from inadequate care.</p> <p>This Rule is not met as evidenced by: Based on record review and interview, it was determined the facility retained 1 of 1 sampled Residents (#1) who was violent and a danger to other residents and staff. The findings include:</p> <p>According to IDAPA 16.03.22.152.05.e, a resident will not be admitted or retained who is violent or a danger to himself or others.</p>	{R 008}	<p>Basically, staff did not use the calm approach or demeanor they were trained to use, therefore causing many of the behaviors reported. Recent footage from our cameras in common areas (post survey) show this unfortunately continues to be true with not all, but many of our staff.</p> <p>All staff members and administration is trained in behavioral management strategies at hiring, and periodically.</p>	

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Residential Care/Assisted Living

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{R 008}	<p>Continued From page 1</p> <p>According to his record, Resident #1 was a 66 year-old male, admitted to the facility on 10/25/13, with diagnoses of Parkinson's, dementia and psychosis.</p> <p>An admission agreement, signed and dated by the administrator and the resident on 11/13/14, documented, "Furthermore, no resident, per either corporate policy or as per current rules and regulations will be admitted or retained who requires or possesses any of the following...any person who is violent or who has a history of being violent or poses a danger to self or others."</p> <p>A "Needs Assessment/Service Agreement," dated 5/29/14, documented under "assaultive/destructive behavior," that Resident #1 could become combative and resistive when redirected. It further documented, Resident #1 grabbed staff by the wrists and pushed staff away. Additionally, it documented Resident #1 attempted to choke a staff member on 5/19/14 and required assistance of two staff members to keep both residents and staff safe.</p> <p>A "Physician Progress Note," dated 10/1/14, documented, "...Nursing staff reports that the patient has been more agitated and aggressive than normal...She states that a few nights ago they had to call the police due to his aggression and combativeness. Patient admits to episodes of irritability and agitation..."</p> <p>A "Behavior Program" for Resident #1, dated 10/20/14, documented he was physically aggressive and resistive with cares.</p> <p>A "Nursing Assessment" dated 10/20/14, documented Resident #1 had a sudden onset of aggression towards outside agency staff. It</p>	{R 008}	<p>They have been warned that loud music, vacuums, TV shows in the common areas, slamming of doors, banging dishes in kitchen, speaking loudly around residents, talking about private matters over resident's heads, arguing with a resident, or ignoring the resident they are working around etc., causes or strongly contributes to residents displaying adverse behaviors.</p> <p>All behavior is communication! When a resident displays a behavior, he or she may be thirsty, hungry, needing to toilet, may be lonely or uncomfortable in some way. Unaddressed need may result in adverse behavior.</p> <p>Staff had been trained in behavior management provided by the IHCA, State Website, and privately, in the past. the administrator, owner, and nurses have modeled appropriate response to behavior, as have some of our staff who have taken the training and modeling to heart and who demonstrate they understand that our residents should be spoken to and about with courtesy, respect and in a tone that conveys caring and emotional support.</p> <p>We are, if nothing else, accountable and have already begun to research</p>	

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{R 008}	<p>Continued From page 2</p> <p>further documented, after reviewing the camera footage, there was no provocation that would have caused the "eruption of aggression."</p> <p>A "Physician Progress Note," dated 12/11/14, documented "...Aggression has been a continual problem over the last several months.... The facility where he lives has been very good as[sic] re-directing [sic] the patient but despite this his aggression has progressed to the point that the administrator of the facility is concerned for her staff and other residents...."</p> <p>A "Resident/Visitor Event Report," dated 12/17/14, documented Resident #1 charged at another resident and knocked him over.</p> <p>A "Resident/Visitor Event Report," dated 1/1/15, documented Resident #1 responded "violently" to a caregiver. He grabbed her wrists and tried to bite her when she attempted to provide cares. The report documented the caregiver's wrist were red and swollen from the incident and caregivers "backed off" and gave the resident "wide girth" and time. After some time passed, Resident #1 was still "violent and verbally aggressive."</p> <p>A "Resident/Visitor Event Report," dated 1/3/15, documented Resident #1 grabbed another resident from behind by the neck, while seated in a recliner. It further documented, Resident #1 was asked why he did this and he stated, "Because I saw him hit staff."</p> <p>A "Nursing Assessment" dated 1/20/15, documented Resident #1, had behavioral issues over the past ninety days and had been severe enough to warrant medication adjustments.</p> <p>Resident #1's September 2014 through March</p>	{R 008}	<p>how we will be changing our policies and procedures to create more USEFUL and MEANINGFUL behavior plans (BMP's), AND to provide more targeted behavior management training AND follow-up with our employees. What has been missing is the implementation of consequences to staff for NOT using the methods staff have been trained in to prevent behaviors from occurring and/or escalating in the first place!</p> <p>This survey resulted from complaints. By the nature of the complaints, it is very apparent that they were made from currently or recently employed, but absent employees. We choose to believe this was a call to action for making changes, rather than an indictment by angry staff. We have chosen to pursue a proactive response to these complaints, and this POC response is designed to meet a need to ensure our staff members are more comfortable with their jobs and skills, and to make our residents feel safe in the dementia care residence.</p> <p>R008 16.03.22.520 Protect Residents from Inadequate Care. This rule was not met as evidenced by: See summary statement of deficiencies as cited by surveyors:</p>	

Residential Care/Assisted Living

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{R 008}	<p>Continued From page 3</p> <p>2015 progress notes, documented the following behaviors:</p> <p>*9/20/14-caregivers tried to provide incontinent care to the resident. He tried to hit the caregivers with a closed fist.</p> <p>*9/27/14-struck at caregivers when they attempted to assist him with cares. He "charged" at caregivers, tried to hit them and cursed at them. The resident was "dangerous" to caregivers and other residents and it was "his fourth incident of violence in two days." The resident wanted a gun and to climb over the kitchen counters.</p> <p>*9/30/14-was aggressive with cares. He tried to bite caregivers on the leg and arm. He did pinch and punch a caregiver in the face. He additionally held caregiver's wrist and pushed at the caregivers with his feet. Caregivers called police and APS to "protect the integrity of staff and secure the safety of the res."</p> <p>*10/14/14-was aggressive toward caregivers. He pushed and cursed at caregivers. Further, he "stormed off angry and asked for a gun."</p> <p>*10/5/14-ran with a chair and stopped behind a caregiver that was sitting down.</p> <p>*10/16/14-was violent towards caregivers when they attempted to assist him with cares. He head-butted, kicked, and grabbed tightly onto caregivers' wrists. At 4:49 AM, caregivers attempted to help him with incontinent care and he grabbed and squeezed their arms.</p> <p>*10/16/14-Resident #1 was taken into the shower, he was "good" and then he suddenly had a "mood change" and became combative and violent. He</p>	{R 008}	<p>Please review the following 8 point plan as our plan of correction response:</p> <p>1. Behaviors displayed by residents will be monitored quantitatively and qualitatively for severity and frequency by the administrator on a monthly basis. Violent behaviors that are not measurably reduced in both severity or frequency by all means possible, including through use of medication, will trigger a discharge plan.</p> <p>A discharge plan may include:</p> <ol style="list-style-type: none"> Transfer to acute-care facility for medical care Transfer to a geri-psych hospital Transfer back to care of the family <p>Unfortunately, at this writing no local geri-psych hospital is in operation, which complicates discharge possibilities.</p> <p>2. Behavior plans will be developed on all current residents. Narrative behavior data sheets for staff recording have already been in place, but are being expanded with stem questions for staff to answer explicitly. The administrator, in consultation</p>	<p>April 17, 2015</p> <p>April 24, 2015</p>
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Residential Care/Assisted Living

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{R 008}	<p>Continued From page 4</p> <p>kicked, head-butted, grabbed and twisted caregiver's wrist and pushed three caregivers with force.</p> <p>*10/17/14-was combative and verbally abusive to caregivers. He punched and cursed caregivers during care.</p> <p>*10/17/14-Resident #1 became upset with another resident and tried to hit them.</p> <p>10/21/14-argued with caregivers and tried to "charge at others with chairs." He also made comments about "guns and killing others."</p> <p>*10/25/14-grabbed another resident by their arms. He "didn't squeeze or leave a mark."</p> <p>*10/29/14-was verbally aggressive and paced around the house, going into other residents' rooms.</p> <p>*11/2/14-was belligerent to caregivers and wanted a gun because he thought he needed to be protected.</p> <p>*11/28/14-tried to hit a caregiver with a lamp and then tried to smash it against a table.</p> <p>*12/8/14-Resident #1 "exhibited some "extreme verbal threats" towards caregivers."</p> <p>*12/11/14-became aggressive with a caregiver. As the caregiver was walking to the kitchen, the resident came up behind her. She was able to close the kitchen door and he "hit the door."</p> <p>*1/1/15-Resident #1 was initially cooperative with caregivers while changing his under garment, but became violent, grabbed the caregiver's wrists</p>	{R 008}	<p>with staff nurse, is required to investigate each behavior narrative and respond accordingly; and make adjustments to BMP at least every 72 hours.</p> <p>BMP's will be re-addressed after every staff reported behavioral event to determine:</p> <ul style="list-style-type: none"> a) effectiveness of interventions, b) need to change interventions and or environment, c) need for MD evaluation, or nurse assessment for physical problems or illness that could be a contributing factor to behavior, and, d) investigation of staff contribution to behavioral problem or resolution. <p>Investigations of events and changes to plan will be documented and staff will be apprised of changes that staff may be required to implement.</p> <p>All behavior plans will note that if behaviors continue, regardless of our appropriate attempts in prevention or intervention, that we may need to consult with resident's MD and seek medication to assist with behavioral management.</p> <p>Please see sample of an actual behavior management plan (BMP)</p>	<p>April 24, 2015 and ongoing</p>

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{R 008}	<p>Continued From page 5</p> <p>and began to twist them. The caregiver was able to get loose and left the area. When the caregiver came back later, the resident again twisted her wrists and cursed at her. The resident was assisted back to bed, but got back up and started "violently" throwing objects around his room.</p> <p>*1/4/15-ran down the hallway with another resident in a wheelchair and almost hit other residents.</p> <p>*1/7/15-squeezed caregivers' hands and kicked at the caregivers when they tried to put his feet on the bed.</p> <p>*1/27/15-kicked, grabbed and squeezed caregiver's hands and arms and tried to punch the caregivers.</p> <p>*2/2/15-was physically and verbally aggressive with residents and caregivers.</p> <p>*2/2/15-was at the dinner table, a caregiver attempted to assist him. Resident #1 was holding his fork tightly and threatened to stab the caregiver and other residents. When the caregiver attempted to take the fork, the resident threw his milk. He was assisted to his room to calm down but he came running back out and tried to jump over furniture. The resident tried to "attack" residents and staff.</p> <p>*3/21/15-was looking for a gun because "caregivers were against him."</p> <p>Resident #1's "Narrative Behavior Data Sheet," for October 2014 through March 2015, documented the following:</p> <p>*10/27/14-twisted caregiver's wrist and pulled the</p>	{R 008}	<p>developed since this survey, with resident name redacted, as an example of DeSano Place Village behavioral plan, and consequences. This behavioral plan was developed for resident # 2 on survey.</p> <p>3. A new policy will be developed to assure that the administrator will create a comprehensive behavior management plan on all residents, at admission, two weeks after admission, and periodically, indicating behaviors</p> <p>and triggers and how to prevent and respond correctly to exhibited, adverse behaviors. Each plan will also reference that if staff caused or adversely contributed to behaviors in residents they will be confronted by the administration and informed that behavior change on part of staff will be expected or he or she risks termination.</p> <p>It is not enough for us to train; staff must internalize and use techniques or we waste everyone's time and put everyone at risk for injury.</p>	<p>May 1, 2015</p>

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{R 008}	<p>Continued From page 6 caregiver on top of him.</p> <p>*11/1/14-swearing and walking up to others. He would get in their personal space and refuse to move.</p> <p>*11/5/14-in the kitchen and was wanting something. He was assisted to the hallway and when the caregiver tried to shut the kitchen door, he blocked the door. When the caregiver assisted him out of the way, he kicked the door and broke the door and door jam.</p> <p>*11/23/14-was compliant until a caregiver tried to assist him with his incontinent brief. Resident #1 punched the caregiver in the side of the head, kicked caregivers in the stomach and twisted their wrists. He attempted to bite a caregiver on the neck and he later "boasted" he could have bit her in the "jugular vein."</p> <p>*11/24/14-tried to grab caregiver's wrists and joked about hurting caregivers the night before and stated, "he would do it again."</p> <p>*11/28/14-picked up a lamp and started to swing it around and attempted to break it. He physically threatened to hit the caregiver with it. Caregivers called the nurse and owner.</p> <p>*12/3/14-Resident #1 got a hold of a four foot piece of plastic pipe that a plumber left. Caregivers tried to get the pipe away from him. but he would not let go. The plumber was able to talk Resident #1 into giving him the pipe</p> <p>*12/11/14-told caregivers out of "nowhere" he was "gonna put one between her eyes." He tried to follow staff into the kitchen. Staff was able to close and lock the door behind her. Resident #1</p>	{R 008}	<p>3. All families/POA's and guardians of residents will be informed by letter that if all attempts to prevent, ameliorate, or stop behaviors are not successful, and a resident's behavior is deemed to be violent; the resident will, by necessity, have to be immediately discharged into the care of the family, unless placement can be immediately made to an acute care facility or a geri-psych hospital. Our admission policies and procedures will re-inforce this change and all representatives of newly admitted residents will be informed at admission of this policy.</p> <p>4. If law enforcement has to be contacted for uncontrollable violent behaviors, or if behaviors have seriously injured another resident, an immediate discharge notice will be issued. The resident will be isolated and a one-to-one personal care provider will be assigned to resident until discharge or transfer is completed, at resident expense. Such information will also be included in the facility Admission Agreement, and it will be pointed out to families/resident at admission. The Office of Aging and Adult Protection will be consulted for assistance in finding a suitable facility or placement to re-locate resident.</p>	<p>May 1, 2015</p>

Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R995	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 04/06/2015
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NAME OF PROVIDER OR SUPPLIER DESANO PLACE VILLAGE MEMORY CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1015 E AVENUE K JEROME, ID 83338
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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 7</p> <p>hit the door. He then followed a second staff and "had behaviors." Resident #1 passed a third staff and told her next time it was going to be her that he hits. Caregivers then avoided Resident #1, because of his violent behavior feeling "threatened" and "afraid" of him.</p> <p>*12/17/14-lunged towards another resident and "attacked" him to the floor.</p> <p>*1/3/15-went up behind another resident and wrapped his hands around the other resident's neck. It took three staff about thirty seconds to get him away from the other resident.</p> <p>*1/23/15-pushed another resident in a wheelchair. Caregiver tried to move the other resident, but Resident #1 blocked the caregiver's way, and grabbed her wrists and would not let go. When she did get loose, Resident #1 went up to another resident and wrapped his hands around the resident's neck. He then let go of the resident's neck and walked away.</p> <p>*2/1/15-was asked by caregiver to hand over a cup of milk he was going to dump on the floor. He walked over and threw the cup at the caregiver.</p> <p>*2/2/15-was at the dining room table. A caregiver tried to assist him with his meal. Resident #1 was holding a fork and stated he would stab her and everyone else. He was "combative and out of control."</p> <p>*2/3/15-was standing near the counter and wanted to stab everyone.</p> <p>*2/19/15-grabbed a caregiver's wrists tightly and she could not get away. Other caregivers had to intervene.</p>	{R 008}	<p>5. DeSano Place Inc. will hire a consultant with experience in geri- psych behavioral health (Certified in CPI) to provide interim staff training and on-site approach training, modeling, and coaching to implement staff behavior change. The consultant will document training, effectiveness, and staff behavioral change and report to administration.</p> <p>6. Staff will be assessed for appropriate performance regarding respectful, dignified and calm approach to all while interacting with residents during ADL's, activities, and in their approach with interactions between residents. Staff will also be monitored and observed on camera, as well, and clips will be recorded and saved to use as training and monitoring tools.</p> <p>Staff will be expected to learn and use the modalities they are trained to use. Failure to do so will incur a re-training and re-evaluation program period. Repeated failure to use techniques as trained and documented (i.e., proper tone/demeanor/staff behavior required to work successfully with this unique and special population) will result in disciplinary action and/or termination.</p>	<p>May 15, 2015</p> <p><i>Completed DATE</i></p> <p>June 1, 2015 and ongoing</p>

Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R995	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/06/2015
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NAME OF PROVIDER OR SUPPLIER DESANO PLACE VILLAGE MEMORY CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1015 E AVENUE K JEROME, ID 83338
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{R 008}	<p>Continued From page 8</p> <p>*2/25/15-refused care and kicked caregivers.</p> <p>*3/12/15-"rammed" into other residents with a dining room chair.</p> <p>*3/29/15-grabbed a caregiver's hands and arms tightly and would not let go.</p> <p>On 3/31/15 at 10:05 AM, the administrator stated staff were trained on how to approach residents that were resistive to cares. She further stated, Resident #1 was protective of women and if he felt a woman was threatened, he would react aggressively.</p> <p>3/31/15 at 2:00 PM, Employee A stated Resident #1 was violent and the violence was a daily occurrence, until recently. She further stated, she felt the resident's behaviors were ignored most of time by management. Additionally, she stated the resident attacked from behind and was very "unpredictable."</p> <p>On 3/31/15 at 2:25 PM, Employee B stated Resident #1 could be difficult and was resistive to cares. She further stated, he would clench his fists and had a look in his eyes when he was angry. Additionally, she stated Resident #1 "would come at you" and had been violent in the past with staff.</p> <p>On 3/31/15 at 2:30 PM, Employee C stated, Resident #1 was a good fellow on good days and on bad days he was combative and attacked people from behind. He was combative more with staff and visitors, if they were men.</p> <p>On 3/31/15 at 2:43 PM, Employee D stated, Resident #1's "behaviors" started after dinner, but</p>	{R 008}	<p>In all instances referenced, no one was seriously injured. However, we want to do all possible to ensure no one IS ever injured. DeSano Place, Inc. will train, monitor, counsel and retrain all our staff in proven behavior management technique; staff will be expected to perform satisfactorily in addressing behaviors, or we will find staff who will perform satisfactorily and consistently as trained.</p> <p>7. Job analysis will be conducted to determine what changes need to occur to facilitate a quiet, controlled, and reduced stress environment for both residents and staff alike.</p> <p>8 DeSano Place, Inc. will pay to certify through a nationally-recognized, well-recommended, person-centered, abilities-based, dementia-care behavior management program, key employees to become certified trainers in behavior management. Once trained and certified, these employees will train remaining staff and newly- hired employees in behavior management philosophy, techniques, appropriate documentation and follow-up. It will be mandated that all current and new employees train in the new behavior management program.</p>	<p>July 1, 2015</p> <p>October 2015</p>

Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R995	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/06/2015
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NAME OF PROVIDER OR SUPPLIER DESANO PLACE VILLAGE MEMORY CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1015 E AVENUE K JEROME, ID 83338
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{R 008}	<p>Continued From page 9</p> <p>she had never seen him get violent. She further stated, when he had behaviors it was best to "back off" and "not reward the behavior."</p> <p>On 3/31/15 at 2:50 PM, Employee E stated, Resident #1 could be very resistive to cares and could become very angry. She stated staff needed to give him space and reapproach. She stated a few months ago, Resident #1 should have been discharged for his violence.</p> <p>On 3/31/15 at 2:55 PM, Employee F stated, Resident #1 was resistive to cares and was extremely strong.</p> <p>On 4/1/15 at 9:05 AM, Employee G stated when Resident #1 said no, or get away, staff needed to leave him alone and give him space. She further stated, it was all about approach with him.</p> <p>On 4/1/15 at 1:00 PM, Employee H stated Resident #1 could be unpredictable.</p> <p>On 4/1/15 at 1:45 PM, Employee I stated Resident #1 was unpredictable and felt he was a danger to others.</p> <p>The facility retained Residents #1 who was violent and a danger to others. Resident #1 attempted to choke other residents two times on 1/3 and 1/23. He was violent and physically aggressive with staff more than 19 times from 9/20/14 through 3/29/15 by hitting, head-butting, kicking and twisting wrists. This resulted in inadequate care.</p>	{R 008}	<p>There will also be refresher courses for all staff annually or more often as needed. All staff will be monitored for acceptable and satisfactory interaction with all residents. All training and staff behavior change, or lack of, will be documented on performance appraisals. If retraining staff does not achieve the documented outcome/expectations required of staff; then staff will be disciplined, retrained and/or terminated. Staff will experience consequences for not performing satisfactorily in how they treat and interact with our residents. In the meantime, staff will be provided written communication about our expectation and resolve about how they approach our residents and that they are being closely observed for their own behavior with residents.</p> <p>In Summary:</p> <ol style="list-style-type: none"> Residents at DeSano Place Village Memory Care will be provided adequate care in all activities and interactions. All staff, including PCA's, housekeepers, nurses and administration will be re-trained in behavioral management techniques by a certified, nationally- based program, and will be monitored for 	<p><i>April 24, 2015, and at interviews for new hires from this date forward.</i></p>

their effectiveness, in short order by a consultant, and in the future by key employees who have been nationally certified. Failure to perform as expected will have serious consequences, including job termination.

3. Residents who become physically violent, injure someone or for whom we cannot provide appropriate, humane behavioral control in our residence will be provided an immediate discharge notice and provided 1:1 care until he or she is transferred from our location. The facility will not retain a resident who is violent or a danger to others.

4. Policies and procedures will be changed to reflect these changes with respect to behavioral management in our Memory care facility.

5. The environment will be assessed and changed as prudent in order to reduce resident and staff stressors.

6. Behavior plans will be developed, followed, and monitored in a timely fashion.

7. Quantitative and qualitative data will be monitored regarding BMP effectiveness.

8. Staff will be held accountable for how he or she approaches and interacts with residents, and this data will be entered into performance appraisals.

 4/17/15

Julie Pendleton,
Administrator
DeSano Place Village
Memory Care

pg 11



Facility DESANO PLACE VILLAGE MEMORY CARE	License # RC-995	Physical Address 1015 E AVENUE K	Phone Number (208) 595-1589
Administrator Julie Pendleton	City JEROME	ZIP Code 83338	Survey Date April 1, 2015
Survey Team Leader Gloria Keathley	Survey Type Complaint Investigation and Follow-up		RESPONSE DUE: May 1, 2015
Administrator Signature 	Date Signed 4/1/15		

NON-CORE ISSUES

Item #	IDAPA Rule #	Description	Department Use Only	
			EOR Accepted	Initials
1	152.05.b.ii	The facility had bedrails. ***Previously cited on 7/23/14***	05-4-15	gk
2	225	The facility did not develop a behavioral management plan for Resident #2.	5-7-15	gk
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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 13, 2015

Julie Pendleton, Administrator
Desano Place Village Memory Care
1015 E Avenue K
Jerome, Idaho 83338

Provider ID: RC-995

Ms. Pendleton:

An unannounced, on-site complaint investigation was conducted at Desano Place Village Memory Care between March 30, 2015 and April 1, 2015. During that time, observations, interviews, and record reviews were conducted with the following results:

Complaint # ID00006687

Allegation: The facility did not arrange emergency services or have the nurse assess residents when they sustained injuries caused by falls.

Findings: Unsubstantiated.

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

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



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April 13, 2015

Julie Pendleton, Administrator
Desano Place Village Memory Care
1015 E Avenue K
Jerome, Idaho 83338

Provider ID: RC-995

Ms. Pendleton:

An unannounced, on-site complaint investigation was conducted at Desano Place Village Memory Care between March 30, 2015 and April 1, 2015. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00006837

Allegation #1: The facility retained residents who were violent or a danger to others.

Findings #1: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.152.05.e for retaining a resident that was violent or a danger to other residents and staff. 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

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



IDAHO DEPARTMENT OF
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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 13, 2015

Julie Pendleton, Administrator
Desano Place Village Memory Care
1015 E Avenue K
Jerome, ID 83338

Provider ID: RC-995

Ms. Pendleton:

An unannounced, on-site complaint investigation was conducted at Desano Place Village Memory Care between March 30, 2015 and April 1, 2015. During that time, observations, interviews, and record reviews were conducted with the following results:

Complaint # ID00006895

Allegation #1: The facility did not develop behavior management plans for residents after they demonstrated aggressive behaviors towards other residents.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.225 for not developing a behavior management plan for an identified resident. The facility was required to submit evidence of resolution within 30 days.

Allegation #2: The facility admitted residents who had histories of physical and verbal aggression.

Findings: Unsubstantiated. However, the facility was cited at IDAPA 16.03.22.225 for not developing a behavior management plan.

Allegation #3: The facility used medications to restrain residents.

Findings: Unsubstantiated.

Julie Pendleton, Administrator

April 13, 2015

Page 2 of 2

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

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