



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

June 15, 2015

Sam Stoddard, Administrator
Homestead Assisted Living Centers - Rexburg
408 West Main Street
Rexburg, Idaho 83440

Provider ID: RC-815

Mr. Stoddard:

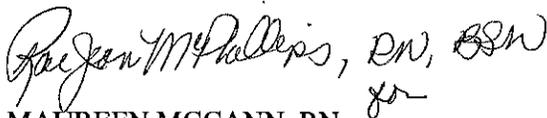
On April 16, 2015, a state licensure/follow-up survey and complaint investigation were conducted at The Homestead Assisted Living Center, Inc. of Rexburg. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level(s):

- 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 Maureen McCann, RN, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 364-1962.

Sincerely,


MAUREEN MCCANN, RN

Team Leader
Health Facility Surveyor

MM/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: raif@dhw.idaho.gov
PHONE: 208-364-1962
FAX: 208-364-1888

May 1, 2015

CERTIFIED MAIL #: 7007 3020 0001 4050 8890

Sam Stoddard, Administrator
Homestead Assisted Living Center Inc of Rexburg
360 West 3500 North
Rexburg, Idaho 83440

Mr. Stoddard:

On April 16, 2015, a state licensure/follow-up survey and complaint investigation were conducted by Department staff at The Homestead Assisted Living Center, Inc. of Rexburg. The facility was cited with core issue deficiencies for failing to protect residents from abuse and for failing to protect residents from inadequate care.

These core issue deficiencies substantially limit the capacity of The Homestead Assisted Living Center, Inc. of Rexburg to provide for residents' basic health and safety needs. The deficiencies are described on the enclosed Statement of Deficiencies.

PLAN OF CORRECTION:

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:

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 twenty one (21) 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 16, 2015.**

CIVIL MONETARY PENALTIES

Of the twenty one (21) non-core issue deficiencies identified on the punch list, two (2) were repeat punches. One (1) of the repeat deficiencies was cited on both of the two (2) previous surveys, 5/13/2009 and 1/26/2011.

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

IDAPA 925. ENFORCEMENT REMEDY OF CIVIL MONETARY PENALTIES.

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

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

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

For the dates of 1/16/2015 through 4/16/2015:

Penalty	Number of Deficiencies	Times number of Occupied Beds	Times Number of days of non-compliance	Amount of Penalty
\$10.00	1	53	90	\$ 47,700

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

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

Your facility had 53 occupied beds at the time of the survey. Therefore, your maximum penalty is: \$10,800.

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

Licensing and Certification

Mail your payment to:

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

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

ADMINISTRATIVE REVIEW

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

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

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

If the facility fails to file a request for administrative review within the 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 deficiencies still exists, a new core issue deficiency is identified or the non-core deficiencies have not been corrected, the Department will take further enforcement action against the license held by The Homestead Assisted Living Center, Inc. of Rexburg. 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 or Ban on Admissions
- Additional Civil Monetary Penalties

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

Sincerely,



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

JS/sc

Enclosure

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING	(X3) DATE SURVEY COMPLETED 04/16/2015
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NAME OF PROVIDER OR SUPPLIER HOMESTEAD ASSISTED LIVING CENTERS - RI	STREET ADDRESS, CITY, STATE, ZIP CODE 408 WEST MAIN STREET REXBURG, ID 83440
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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R ODO	<p>Initial Comments</p> <p>The following deficiency was cited during the Licensure Survey and Complaint Investigation conducted between 4/13/15 and 4/16/15 at your residential care/assisted living facility. The surveyors conducting the survey were:</p> <p>Maureen McCann, RN Team Coordinator Health Facility Surveyor</p> <p>Rae Jean McPhillips, BSN, RN Health Facility Surveyor</p> <p>Karen Anderson, RN Health Facility Surveyor</p> <p>Matt Hauser, QMRP Health Facility Surveyor</p> <p>Survey Definitions:</p> <p>ADLs = Activities of Daily Living NSA = Negotiated Service Agreement RN = Registered Nurse UAI = Universal Assessment Instrument</p>	R OOD	<p>On April 16, 2015, a state survey and complaint investigation was conducted at The Homestead Assisted Living. Listed below are the core issues that were cited and the Plan of Correction for each situation:</p> <p>R 006 16.03.22.510 - Protect residents from abuse. The administrator must assure that policies and procedures are implemented to assure that all residents are free from abuse.</p>	
R DDB	<p>16.03.22.510 Protect Residents from Abuse.</p> <p>The administrator must assure that policies and procedures are implemented to assure that all residents are free from abuse.</p> <p>This Rule is not met as evidenced by: IDAPA 16.03.22.510 documents: "REQUIREMENTS TO PROTECT RESIDENTS FROM ABUSE. The administrator must assure that policies and procedures are implemented to</p>	R 006		

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 6-11-15
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Bureau of Facility Standards

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R 006	<p>Continued From page 1</p> <p>assure that all residents are free from abuse."</p> <p>On 4/15/15, the facility's "Alleged Abuse Policy" was reviewed. The policy documented: If an employee "witnesses an act or has any knowledge of resident abuse" the employee "shall immediately," call it to the attention of his/her immediate supervisor, obtain the names of witnesses, staff and residents involved, complete a facility incident report to include the names of everyone involved, and sign, date and immediately submit the form to the facility administrator. The facility administrator shall report the incident to the proper authorities within 4 hours of the incident and conduct an investigation and make a determination on further action within 5 working days.</p> <p>Based on record review, observations and interviews, it was determined the facility did not implement their abuse policy when the administrator failed to investigate, or report an incident of a sexual nature that occurred between two residents. As a result, neither resident was protected from potential abuse. The findings include:</p> <p>Resident #6's record documented he was a 91 year-old male, admitted to the facility on 10/2/14, with a diagnosis of dementia. The resident was discharged from the facility on 12/10/14.</p> <p>Resident #6's NSA, dated 10/2/14, documented he was independent with mobility within the facility, and "He may wander just a bit but just needs direction to his room."</p> <p>According to her record, Resident #7 was an 87 year-old female, admitted to the facility on 8/31/13, with diagnoses of dementia and</p>	R006	<p>PLAN OF CORRECTION:</p> <p>The Homestead Assisted Living respectfully does not agree with the State of Idaho's conclusion regarding this situation. The staff at The Homestead redirected the residents with dementia and all residents involved were kept safe and free from abuse. In an effort to maintain state compliance and provide the safest experience for our residents the following is our plan of correction.</p> <p>The following corrective actions have been accomplished for the specific residents that were found to have been affected by the deficient practice:</p> <ol style="list-style-type: none"> 1- Resident # 6 was discharged from the facility on 12-10-14 he is no longer residing at our facility. Resident # 7 still resides at our facility. Since resident #6 is not living at our facility any possibility of another situation with resident # 6 is not possible. There have not been any further issues with regards to resident # 7. 	
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R 006	<p>Continued From page 2</p> <p>psychosis.</p> <p>Resident #7's NSA, dated 2/23/15, documented she required extensive assistance to dress and undress, total assistance for bathing, and extensive assistance for mobility. Her UAI, dated 2/11/14, documented under "Orientation, ..Is confused about who other males in the building are. Is unaware of date." Under "Judgement," her UAI documented, "Tries to leave building. Wants other residents' husbands."</p> <p>A local hospital "Admission History and Physical," dated 11/7/14, documented the following regarding Resident #7: "She had Alzheimer's diagnosed with onset around 2013, perhaps 2012. During the interview, the patient was obviously confused, unable to answer questions. I asked her, for example, if she had any surgery, and she told me, 'When the dogs do.'" The report further documented, "...patient is unable to verbalize her concerns due to extreme confusion."</p> <p>On 4/13/15 at 3:35 PM, Resident #7 was observed sitting in the living room area of the facility. Upon introduction, the resident was not able to answer interview questions. A caregiver stated the resident required assistance to meet all of her ADL needs and was not capable to request assistance.</p> <p>On 4/15/15 at 9:55 AM, Caregiver D and Caregiver E stated, Resident #7 was not able to make an informed decision about having a consensual sexual encounter with Resident #6.</p> <p>On 4/13/15 at 4:20 PM, the house manager stated caregivers reported to her that Resident #6 and Resident #7 had been observed holding</p>	R 006	<p>The facility will identify other residents/ personnel/ areas that may be affected by the same deficient practice by:</p> <ol style="list-style-type: none"> 1- The facility staff has received additional training, by the administrator, on the subject of abuse, potential alleged abuse, and what to watch for to prevent and recognize abuse. That training took place at an all staff meeting on 4-23-15. (See attachment A). A facility wide memo was also sent out to all staff outlining our abuse policy on 5-1-15. (See attachment B). This will help staff to be aware and identify any other residents that could be affected. 2- On 4-21-15 the administrator invited the social worker from adult protection to come to our department meeting. A training was conducted by adult protection. (See attachment C) <p>The following systemic changes have been put in place to help ensure that the deficient practice does not recur:</p>	
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Bureau of Facility Standards

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R 006	<p>Continued From page 3</p> <p>hands and kissing often. She stated Resident #6's wife was aware and had complained about the residents having a relationship. The house manager stated, she spoke to Resident #6 about the situation and reminded him it was not "appropriate." She stated caregivers reported to her that Resident #6 was found in Resident #7's room with his pants down. The house manager stated she instructed caregivers to closely watch both residents and keep them separated. The house manager stated, she instructed caregivers to document their observations on the daily care notes.</p> <p>Resident #6 and #7's daily care notes, were reviewed from 10/14/14 through 12/10/14. There was no documentation found in the daily care notes about Resident #6 and #7 being together in an intimate or sexual nature. Additionally, no incident reports or written investigations were documented regarding Resident #6 and Resident #7.</p> <p>On 4/14/15 at 11:04 AM, the administrator stated staff reported the incident to the house manager and the house manager informed him about the incident. He stated, the house manager told him that Resident #6 and Resident #7 were found alone in Resident #7's room, both with their pants down, but their genitals were not exposed. He further stated, he asked some questions to a few caregivers, but did not document his investigation or report the incident to Adult Protection, because he did not believe anything inappropriate had occurred. The administrator stated, he was only aware of one incident, and Resident #6 moved out of the facility on 12/10/14, the day after the incident.</p> <p>On 4/14/15 at 3:10 PM, Caregiver B stated, he</p>	R006	<ol style="list-style-type: none"> 1- The facility staff has received additional training, by the administrator, on the subject of abuse, potential alleged abuse, and what to watch for to prevent and recognize abuse. That training took place at an all staff meeting on 4-23-15. (See attachment A). A facility wide memo was also sent out to all staff outlining our abuse policy on 5-1-15. (See attachment B). This will help staff to be aware and identify any other residents that could be affected. 2- The facility Abuse Policy has been integrated into our new hire packet so all new employees will sign off that they have read and understand the policy. (See attachment D) 3- The administrator will meet each week with the facility nurse, house manager, and applicable others to discuss each resident and identify any residents that could be affected and what we can do to help ensure the prevention of abuse. 	
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R 006	<p>Continued From page 4</p> <p>had heard about an incident which occurred in October 2014. Caregiver B further stated, that Caregiver C found both residents without clothing or undergarments in Resident #7's room.</p> <p>On 4/14/15 at 5:00 PM, Caregiver C stated, "Last October, while working the evening shift, I was completing the evening bed checks and I observed [Resident #6's name] in [Resident #7's name] room wearing only his undershirt and an incontinent brief." Caregiver C stated, Resident #7 was sitting on her bed wearing her "underclothing." The caregiver stated he placed a robe over Resident #6 and separated the residents. He further stated, he documented the incident and reported it to the house manager. The caregiver stated, after the incident he was not questioned about the incident by anyone from the facility management team.</p> <p>There was no documentation found in Resident #6's or #7's records regarding the incident that occurred in October 2014.</p> <p>On 4/15/15 at 9:30 AM, the administrator stated, he did not realize there had been more than one incident until last night, on 4/14/15. He stated he called Caregiver C, and was told about the incident that happened in October 2014. The administrator stated he did not document his telephone conversation with Caregiver C, nor had he initiated an investigation of either incident.</p> <p>On 4/15/15 at 9:45 AM, Caregiver D stated, she was working with Caregiver F when they observed Resident #6 with his genitals exposed in Resident #7's room. She stated the incident occurred in late November 2014. Caregiver D stated, Resident #6 was observed to have a "semi hard erection" when they entered Resident</p>	R 006	<p>4- Throughout the year periodic staff training will be conducted on the topic of abuse.</p> <p>5- The house manager will read through all staff daily logs and flag any and all logs that the administrator/facility nurse should be aware of, including logs regarding potential abuse. The administrator/ nurse will document on any flagged logs as needed and respond appropriately through contacting adult protective services, medical professionals for an evaluation as required, staff training, memos, and daily logs.</p> <p>6- Behavior management logs will also be reviewed by the house manager and communicate to the administrator and facility nurse. The administrator/ nurse will document on any flagged logs as needed and respond appropriately through contacting adult protective services, medical professionals for an evaluation, staff training, memos, and daily logs.</p> <p>7- At anytime when it is applicable the facility administrator will follow the Abuse Policy and contact adult protective services and</p>	
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NAME OF PROVIDER OR SUPPLIER
HOMESTEAD ASSISTED LIVING CENTERS -RI

STREET ADDRESS, CITY, STATE, ZIP CODE
408 WEST MAIN STREET
REXBURG, ID 83440

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 006	<p>Continued From page 5</p> <p>#T's room. Caregiver D said Resident #6 was upset and yelled at them for entering the room and interrupting them. She stated she separated the residents and reported the incident to the house manager and the administrator. Caregiver D stated she was instructed to closely watch both residents throughout the day and keep them separated. The caregiver further stated, the administrator instructed her to document a "less inflammatory" account of the incident in the daily progress notes. Caregiver D stated she wrote a note on 11/26/14.</p> <p>A daily progress note, dated 11/26/14, documented "[Resident #6's name] can sometimes be flirtatious in a sexual manner and say crude things to the staff and other residents."</p> <p>On 4/15/15 at 2:50 PM, Caregiver F stated she walked into Resident #6's room and Resident #7 was observed in his room. She stated, Resident #6 was "helping" Resident #7 take off her shirt. She stated Resident #1's shirt was half way up her torso, with "her abdomen exposed." The caregiver stated, the incident happened sometime in November when she was working with Caregiver D. Caregiver F further stated, after she reported the incident to Caregiver D, she was not questioned about the incident by anyone from the facility management team.</p> <p>The facility did not follow their abuse policy to determine if sexual abuse had occurred between Resident #6 and #7. According to caregiver interviews, Resident #6 and #7 were found together in a room, partially clothed on at least two occasions. The facility did not immediately report the incidents to Adult Protection. Additionally, the administrator did not protect Resident #6 and Resident #7, when he did not</p>	R 006	<p>applicable others to help ensure the safety of the residents.</p> <p>The plan of correction will be monitored in the following ways:</p> <ol style="list-style-type: none"> 1- The administrator will meet each week with the facility nurse, house manager, and applicable others to discuss each resident and identify any residents that could be affected and what we can do to help ensure the prevention of abuse. 2- The house manager will read through all staff daily logs and flag any and all logs that the administrator/facility nurse should be aware of, including logs regarding potential abuse. The administrator/ nurse will document on any flagged logs as needed and respond appropriately through contacting adult protective services, medical professionals for an evaluation as required, staff training, memos, and daily logs. 3- Behavior management logs will also be reviewed by the house manager and communicate to the administrator and facility nurse. The administrator/ nurse will document on any 	

Bureau of Facility Standards

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408 WEST MAIN STREET
REXBURG, ID 83440

{X4} ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	{X5} COMPLETE DATE
R 006	Continued From page 6 implement the facility's abuse policy and procedures. The facility failed to protect Resident #6 and Resident #7, and potentially 100% of the residents from abuse, when allegations of sexual encounters were not reported to Adult Protection or investigated.	R 006	flagged logs as needed and respond appropriately through contacting adult protective services, medical professionals for an evaluation, staff training, memos, and daily logs.	
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 (Resident #6), who was a danger to himself. The findings include:</p> <p>IDAPA 16.03.22.152.05.e documents, the facility will not retain residents who are a danger to themselves.</p> <p>Resident #6's record documented he was a 91 year-old male, admitted to the facility on 10/2/14, with a diagnosis of dementia. The resident was discharged from the facility on 12/10/14.</p> <p>Resident #6's NSA, dated 10/2/14, documented he was independent with mobility, required some help with "communicating his needs, if asked questions he will respond better." The NSA further documented, the resident did not have behaviors except, "he may wander just a bit but just needs direction to his room."</p> <p>An initial nursing assessment, dated 10/7/14,</p>	R 008	<p>4- When it is required the facility administrator will follow the Abuse Policy and contact adult protective services and applicable others to help ensure the safety of the residents.</p> <p>The corrective action plan will be completed by: May 8, 2015</p> <p>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.</p> <p>PLAN OF CORRECTION:</p> <p>The following corrective actions have been accomplished for the specific residents that were found to have been affected by the deficient practice</p>	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER: 13R815	(X2) MULTIPLE CONSTRUCTION A. BUILDING:- _____ B. WING	(X3) DATE SURVEY COMPLETED 04/16/2015
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NAME OF PROVIDER OR SUPPLIER HOMESTEAD ASSISTED LIVING CENTERS • RI	STREET ADDRESS, CITY, STATE, ZIP CODE 408 WEST MAIN STREET REXBURG, ID 83440
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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R 008	<p>Continued From page 7</p> <p>documented Resident #6 was "alert, confused and forgetful." The assessment did not include whether the resident had a history of depression or behaviors.</p> <p>The house manager, sent a fax to Resident #6's physician on 10/31/14, to inform the physician the resident had been "very tired and depressed." She documented, Resident #6 "has been talking to staff concerning some suicidal tendencies and wanting to end it all." The house manager further documented, the resident's wife "feels that any medication for these situations will make it worse for him." She documented, "We are concerned about [Resident #6's name] and if there is anything you would like us to do for him concerning the depression and suicidal tendencies?" The physician wrote a reply on the bottom of the fax that documented, "if [Resident #6's wife's name] is against treating him my hands are tied."</p> <p>Daily care notes, were reviewed from 10/14/14 through 12/10/14. The notes documented Resident #6 had exhibited signs of depression and wanting to kill himself.</p> <p>On 10/30/14 at 9:15 PM, a caregiver documented she went into Resident #6's room and he told her that he was "about to write a suicide note and kill himself..." The caregiver documented she told an "oncoming employee to watch [Resident #6's name]" because he had stated he wanted to kill himself. The caregiver additionally documented, she told Resident #6's wife, the facility nurse, the administrator and the house manager. The caregiver documented she sent a fax to the resident's physician concerning his "behavior." The caregiver documented Resident #6's wife told her she did not want the resident on "any</p>	R 008	<p>1- Resident # 6 was discharged from the facility on 12-10-14. During his stay at The Homestead Assisted Living this resident never harmed himself nor did the staff see any attempt to. He was safe and protected during his stay.</p> <p>2- When the resident's suicidal threats were brought up to the administrator resident #6's wife was called and she did not want to pay any extra cost in medication even through the doctor wanted to prescribe a new order. His wife also had brought up that he has talked like this for a long time. The facility was concerned about his threats so the administrator contacted the wife and strongly encouraged resident # 6's wife that she agree to allow the doctor to prescribe a medication to help with his depression, and she did. The new medication helped resident # 6 until he was discharged from our facility.</p> <p>The facility will identify other residents/ personnel/ areas that may be affected by the same deficient practice by:</p>	
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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER: 13R815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING	(X3) DATE SURVEY COMPLETED 04/16/2015
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NAME OF PROVIDER OR SUPPLIER
HOMESTEAD ASSISTED LIVING CENTERS -RI

STREET ADDRESS, CITY, STATE, ZIP CODE
**408 WEST MAIN STREET
REXBURG, ID 83440**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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R OOS	<p>Continued From page 8</p> <p>medications whatsoever." The caregiver documented, she would report the information to the administrator and the facility nurse. The caregiver further documented, the house manager instructed caregivers to place Resident #6 on "1/2 hour watches and it needs to be evaluated if he is appropriate for assisted living."</p> <p>There was no documented evidence the resident was evaluated by a medical professional to determine if the resident was a danger to himself.</p> <p>On 11/13/14, a nurse from an outside agency documented on the daily care notes, "[Resident #6's name] was very upset today and keeps saying he has nothing to live for and that he is ready to die." The nurse documented, she talked to Resident #6's wife, to see if the wife would consider allowing a medication to improve his mood.</p> <p>On 11/15/14, a caregiver documented she helped the resident after dinner and "he was very upset about his 'plans' being ruined. He got very upset with me because I did not seem sorry about his situation." The caregiver did not document what plans had been ruined.</p> <p>On 11/16/14, a caregiver documented, "He has been really low and sad today. He kept thinking his wife would not come, and that no one cared for him...."</p> <p>On 11/18/14, a caregiver documented, Resident #6 "seemed very happy and full of energy today, but at the same time he kept talking about suicide or walking out in front of a car."</p> <p>On 11/23/14, a caregiver documented, Resident #6's wife said, when she "attempted to chat" with</p>	ROOS	<p>1- The facility staff has received additional training, by the administrator, on the subject of inadequate care with regards to a resident with suicidal tendencies. That training took place at an all staff meeting on 4-23-15. (See attachment A) On 5-4-15 a facility wide memo was also sent out to all staff outlining how to respond with a resident with suicidal tendencies. (See attachment E). This will help staff to be aware and identify any other residents that could be affected.</p> <p>The following systemic changes have been put in place to help ensure that the deficient practice does not recur:</p> <p>1- The facility staff has received additional training, by the administrator, on the subject of inadequate care with regards to a resident with suicidal tendencies. That training took place at an all staff meeting on 4-23-15. (See attachment A) On 5-4-15 a facility wide memo was also sent out to all staff outlining how to respond with a resident with suicidal tendencies. (See attachment E). This will help staff to be aware and identify any other residents that could be affected.</p>	
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Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER HOMESTEAD ASSISTED LIVING CENTERS • RI	STREET ADDRESS, CITY, STATE, ZIP CODE 408 WEST MAIN STREET REXBURG, ID 83440
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R 008	<p>Continued From page 9</p> <p>the resident, he had not been "in any mood to even talk to her." The caregiver documented, the resident's wife told her that Resident #6 "was talking quite a bit about death...."</p> <p>There was no documentation Resident #6 was evaluated when he continued to make statements about death and "wanting to end it all."</p> <p>The house manager, sent a fax to Resident #6's physician, on 11/25/14, which documented Resident #6's wife was concerned about the resident's depression and continued comments about wanting to "end it all." She documented, the resident's wife "now states that it would be okay for us to visit with you again to see about getting something to treat these issues." The fax further documented, a request to have the physician order a medication for "his depression and suicidal tendencies." The physician ordered an antidepressant.</p> <p>On 4/14/15 at 3:58 PM, the facility RN stated she had been in contact with the resident's wife and with the physician when Resident #6 talked about wanting to die. The RN stated, "I talked to his wife about his depression and statements of wanting to die and she refused to allow us to give him any medications." She further stated, she requested the resident be sent to be evaluated by his physician but she was told by the physician if the wife would not let him prescribe any medications to help treat his depression, then there was nothing the physician could do to help the resident.</p> <p>Resident #6 made statements of wanting to "kill himself" and verbalized a plan of how he would commit suicide. The nurse, the house manager and the caregivers documented the resident was</p>	R 008	<p>2-The facility Policy about how to respond when a resident is suicidal has been integrated into our new hire packet so all new employee will sign off that they have read and understand the policy. (See attachment D)</p> <p>3-The administrator will meet each week with the facility nurse, house manager, and applicable others to discuss each resident and identify any residents that may be affected and take any action necessary.</p> <p>4-Throughout the year periodic staff training will be conducted on this topic.</p> <p>5-The staff has been trained to immediately contact their supervisor in the event that a resident has suicidal tendencies. They have also been instructed to not leave the resident alone until they can be sent out for evaluation to ensure they are safe.</p> <p>6- The house manager will read through all staff daily logs and flag any and all logs that the administrator/facility nurse should be aware of in regards to depression or other significant changes that could lead to suicidal tendencies. The administrator/nurse will document on any flagged logs as needed and respond appropriately through contacting</p>	
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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING	(X3) DATE SURVEY COMPLETED 04/16/2015
NAME OF PROVIDER OR SUPPLIER HOMESTEAD ASSISTED LIVING CENTERS - RI		STREET ADDRESS, CITY, STATE, ZIP CODE 408 WEST MAIN STREET REXBURG, ID 83440		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 008	Continued From page 10 extremely depressed. Resident #6's physician was notified in October and November 2014, regarding the resident's depression and suicidal ideations, however the resident was not evaluated to determine if he was a danger to himself or appropriate to remain in the facility. The facility retained Resident #6 after he had suicidal ideations and did not have him evaluated by a medical professional. This resulted in inadequate care.	R 008	medical professionals for an evaluation, staff training, memos, and daily logs. 7-Behavior management logs will also be reviewed by the house manager and communicate to the administrator and facility nurse. The administrator/ nurse will document on any flagged logs as needed and respond appropriately through contacting medical professionals for an evaluation, staff training, memos, and daily logs. The plan of correction will be monitored in the following ways: 1-The administrator will meet each week with the facility nurse, house manager, and applicable others to discuss each resident and identify any residents that may be affected and take any action necessary. 2-The house manager will read through all staff daily logs and flag any and all logs that the administrator/facility nurse should be aware of in regards to depression or other significant changes that could lead to suicidal tendencies. The administrator/ nurse will document on any flagged logs as needed and respond appropriately through contacting medical professionals for an evaluation, staff training, memos, and logs. 3-Behavior management logs will also be reviewed by the house manager and communicate to the administrator and facility nurse. The administrator/ nurse will document on any flagged logs as needed and respond appropriately through contacting medical professionals for an evaluation, staff training, memos, and logs. The corrective action plan will be completed by: May 8, 2015	

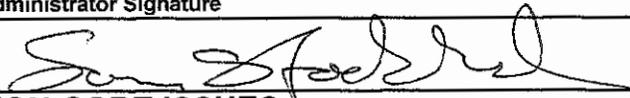


Facility HOMESTEAD ASSISTED LIVING CENTER, INC. OF REXBURG	License # RC-815	Physical Address 408 WEST MAIN STREET	Phone Number (208) 356-9800
Administrator Sam Stoddard	City REXBURG	ZIP Code 83440	Survey Date April 16, 2015
Survey Team Leader Maureen McCann, RN	Survey Type Licensure and Complaint Investigation	RESPONSE DUE: May 16, 2015	
Administrator Signature 	Date Signed 4-16-15		

NON-CORE ISSUES

Item #	IDAPA Rule # 16.03.22.	Description	Department Use Only	
			EOR Accepted	Initials
1	225.01	The facility did not evaluate Residents' exhibited behaviors.	6/12/15	Mme
2	225.02	The facility did not develop interventions for each residents' exhibited behaviors.	6/12/15	Mme
3	250.10	The hot water in the memory care unit exceeded 120 degrees.	COS 4/15/15	Mme
4	260.06	Maintenance equipment, such as power tools, were left unattended.	6/12/15	Mme
5	305.01	The facility nurse did not document an assessment regarding Resident #8's wound vac.	6/12/15	Mme
6	305.03	The facility nurse did not document assessments when residents' experienced changes in their physical condition such as, Resident #1 & #8's wounds. Additionally, she did not document assessments when residents experienced mental status changes such as, Resident #6's verbalized suicidal ideations and Resident #9's increased behaviors. ***Previously cited on 5/13/09 & 1/26/11***	6/12/15	Mme
7	305.04	The facility nurse did not make recommendations when Resident #8 was re-admitted with a wound vac.	6/12/15	Mme
8	305.08	The facility nurse did not provide education to staff regarding Resident #8's wound vac.	6/12/15	Mme
9	310.03	The facility did not track all controlled medications.	6/12/15	Mme
10	310.04.a	The facility did not document non-drug interventions that were used prior to initiating psychotropic medications. (Resident #'s 4, 5, 6 & 9).	6/12/15	Mme
11	350.02	The administrator did not complete an investigation and written report of each incident, complaint or allegation of abuse.	6/12/15	Mme
12	350.03	The administrator did not ensure residents were protected after allegations of sexual inappropriateness were reported.	6/12/15	Mme
13	350.04	The administrator did not provide a written response to complainants within 30 days.	6/12/15	Mme
14	350.05	The administrator did not notify Adult Protection after an allegation of sexual abuse.	6/12/15	Mme
15	405.01.b	Extension cords and multi-adapters were observed in numerous areas throughout the buildings.	6/12/15	Mme
16	430.05.g	Caregivers were instructed to call outside agency nurses when assisting residents' with PRN medications.	6/12/15	Mme
17	430.05.i	Caregivers were instructed to call outside agency nurses when residents' experienced changes of condition.	6/12/15	Mme



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Survey Team Leader Maureen McCann, RN	Survey Type Licensure and Complaint Investigation		RESPONSE DUE: May 16, 2015
Administrator Signature 	Date Signed 4-16-15		

NON-CORE ISSUES

Item #	IDAPA Rule # 16.03.22.	Description	Department Use Only	
			EOR Accepted	Initials
18	711.01	The facility did not track all residents' behaviors as required by rule.	6/12/15	Mue
19	711.08.c	Facility staff did not accurately document all unusual events.	6/12/15	Mue
20	711.08.e	The facility staff did not document when they notified the facility nurse. <i>***Previously cited on 1/26/11***</i>	6/12/15	Mue
21	730.01	The facility did not have an employee record for the maintenance personal.	6/12/15	Mue
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IDAHO DEPARTMENT OF

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: Rowburg
 Operator: John Veddard
 Address: 407 W. Main St
 County: Madison Estab #: EHS/SUR #:
 Inspection time: noon Travel time:
 Inspection Type: 700 Risk Category: High
 Follow-Up Report: OR On-Site Follow-Up:
 Date: Date:
 Items marked are violations of Idaho's Food Code, IDAPA 16.02.19, and require correction as noted.

# of Risk Factor Violations	<u>1</u>	# of Retail Practice Violations	<u>0</u>
# of Repeat Violations	<u>1</u>	# of Repeat Violations	<u>0</u>
Score	<u>8</u>	Score	<u>8</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
<u>Y</u> N	1. Certification by Accredited Program; or Approved Course; or correct responses; or compliance with Code	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N	2. Exclusion, restriction and reporting	<input type="checkbox"/>	<input type="checkbox"/>
Good Hygienic Practices			
<u>Y</u> N	3. Eating, tasting, drinking, or tobacco use (2-401)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N	4. Discharge from eyes, nose and mouth (2-401)	<input type="checkbox"/>	<input type="checkbox"/>
Control of Hands as a Vehicle of Contamination			
<u>Y</u> N	5. Clean hands, properly washed (2-301)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N	6. Bare hand contact with ready-to-eat foods/exemption (3-301)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N	7. Handwashing facilities (5-203 & 6-301)	<input type="checkbox"/>	<input type="checkbox"/>
Approved Source			
<u>Y</u> N	8. Food obtained from approved source (3-101 & 3-201)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N	9. Receiving temperature / condition (3-202)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N <u>N/A</u>	10. Records: shellstock tags, parasite destruction, required HACCP plan (3-202 & 3-203)	<input type="checkbox"/>	<input type="checkbox"/>
Protection from Contamination			
<u>Y</u> N <u>N/A</u>	11. Food segregated, separated and protected (3-302)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N <u>N/A</u>	12. Food contact surfaces clean and sanitized (4-5, 4-6, 4-7)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N	13. Returned / reservice of food (3-306 & 3-801)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N	14. Discarding / reconditioning unsafe food (3-701)	<input type="checkbox"/>	<input type="checkbox"/>

	Potentially Hazardous Food Time/Temperature	COS	R
<u>Y</u> N <u>N/O</u> <u>N/A</u>	15. Proper cooking, time and temperature (3-401)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N <u>N/O</u> <u>N/A</u>	16. Reheating for hot holding (3-403)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N <u>N/O</u> <u>N/A</u>	17. Cooling (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N <u>N/O</u> <u>N/A</u>	18. Hot holding (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N <u>N/O</u> <u>N/A</u>	19. Cold Holding (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N <u>N/O</u> <u>N/A</u>	20. Date marking and disposition (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N <u>N/O</u> <u>N/A</u>	21. Time as a public health control (procedures/records) (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
Consumer Advisory			
<u>Y</u> N <u>N/A</u>	22. Consumer advisory for raw or undercooked food (3-603)	<input type="checkbox"/>	<input type="checkbox"/>
Highly Susceptible Populations			
<u>Y</u> N <u>N/O</u> <u>N/A</u>	23. Pasteurized foods used, avoidance of prohibited foods (3-801)	<input type="checkbox"/>	<input type="checkbox"/>
Chemical			
<u>Y</u> N <u>N/A</u>	24. Additives / approved, unapproved (3-207)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N	25. Toxic substances properly identified, stored, used (7-101 through 7-301)	<input type="checkbox"/>	<input type="checkbox"/>
Conformance with Approved Procedures			
<u>Y</u> N <u>N/A</u>	26. Compliance with variance and HACCP plan (8-201)	<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>MOSURF</u>	<u>40.5</u>	<u>Phunk (Served)</u>	<u>115</u>				
<u>Mayo</u>	<u>41.0</u>	<u>Garden Potatoes (Served)</u>	<u>180</u>				

GOOD RETAIL PRACTICES (= 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 type="checkbox"/> 34. Food contamination	<input 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. Plant 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) [Signature] (Print) Sam Stoddard Title Admin Date 4-16-15
 Inspector (Signature) [Signature] (Print) MURRAY WEAVER Date 4/15/15
 Follow-up: (Circle One) Yes No



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

Page 2 of 2
Date 4/15/15

Establishment Name Homestead AL of Kamburg		Operator Jan Stoddard
Address 208 W. Main St Kamburg, ID 83440		
County Estab #	EHS/SUR.#	License Permit #

OBSERVATIONS AND CORRECTIVE ACTIONS (Continuation Sheet)

10) Several staff were observed not changing their gloves in between tasks after contaminating the phone. The staff continued to handle ready to eat foods and with the contaminated gloves.

The facility is required to send LAC evidence of resolution within 10 days, by 4/26/15.

COA accepted 4/24/15 MUC

Person in Charge Jan Stoddard	Date 4/16/15	Inspector Ann A. McCall	Date 4/15/15
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IDAHO DEPARTMENT OF
HEALTH & WELFARE

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May 1, 2015

Sam Stoddard, Administrator
Homestead Assisted Living Centers - Rexburg
408 West Main Street
Rexburg, Idaho 83440

Provider ID: RC-815

Mr. Stoddard:

An unannounced, on-site complaint investigation was conducted at The Homestead Assisted Living Center, Inc. of Rexburg between April 13, 2015 and April 16, 2015. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00006915

Allegation #1: The facility did not notify Adult Protection after a potential sexual abuse incident.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.350.04 for the administrator not notifying Adult Protection after an employee notified the administrator of potential sexual abuse incident between two residents. The facility was required to submit evidence of resolution within 30 days.

Allegation #2: The facility did not protect residents after a potential sexual abuse incident.

Findings: Substantiated. The facility was issued a core deficiency at IDAPA 16.03.22.510, for not implementing a plan to protect residents after a potential sexual abuse incident. 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,

MAUREEN MCCANN, RN
Health Facility Surveyor
Residential Assisted Living Facility Program

MM/sc

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