



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

December 15, 2015

Jill Williams, Administrator
Rigby Country Living-Rural Assisted Living Facilities, LLC
4202 East 300 North
Rigby, Idaho 83442

Provider ID: RC-914

Ms. Williams:

On September 18, 2015, a healthcare licensure and follow-up survey was conducted at Rigby Country Living-Rural Assisted Living Facilities, LLC. 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 with one exception. **You have yet to submit acceptable evidence of resolution for cited deficiency 225.01 – The facility did not evaluate residents' behaviors to identify specific behaviors.** 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

October 5, 2015

Certified Mail: 7007 3020 0001 4050 9040

Jill Williams, Administrator
Rigby Country Living-Rural Assisted Living Facilities, LLC
4202 East 300 North
Rigby, Idaho 83442

Ms. Williams:

On September 18, 2015, a state licensure/follow-up and complaint investigation survey was conducted by Department staff at Rigby Country Living-Rural Assisted Living Facilities, LLC. The facility was cited with a core issue deficiency for September 18, 2015 for failing to protect residents from inadequate care.

This core issue deficiency substantially limits the capacity of Rigby Country Living-Rural Assisted Living Facilities, LLC to provide for residents' basic health and safety needs. The deficiency is 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.

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 sixteen (16) 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 **October 17, 2015**.

CIVIL MONETARY PENALTIES

Of the sixteen (16) non-core issue deficiencies identified on the punch list, five (5) were repeat punches. One (1) of the repeat deficiencies was cited on both of the two (2) previous surveys, August 8, 2013 and May 11, 2011.

350.04 – The administrator did not provide a written response to all complainants.

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 June 20, 2015 through September 18, 2015:

| Penalty | Number of Deficiencies | Times number of Occupied Beds | Times Number of days of non-compliance | Amount of Penalty |
|---------|------------------------|-------------------------------|--|-------------------|
| \$10.00 | 1 | 23 | 90 | \$20,700 |

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 23 occupied beds at the time of the survey. Therefore, your maximum penalty is: \$6,400.

Send payment of \$6,400 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 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

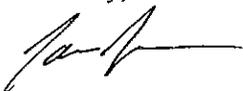
An on-site, follow-up survey will be scheduled after the administrator submits a letter stating that all deficiencies have been corrected and systems are in place to assure the deficient practices remain corrected. If at the follow-up survey, the core issue deficiency still exists, a new core issue deficiency is identified, non-core deficiencies have not been corrected, the Department will take further enforcement action against the license held by Rigby Country Living-Rural Assisted

Living Facilities, LLC. 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

Core Items – Statement of Deficiencies – Rigby Country Living

Survey Date: 09/15/2015 – 9/18/2015

16.03.22.000 Initial Comments

The following deficiencies were cited during a licensure, follow-up survey and complaint investigation conducted on 9/15/15 through 9/18/15, at your residential care/assisted living facility. The surveyors conducting the survey were:

Gloria Keathley, LSW
Team Leader
Health Facility Surveyor

Karen Anderson, RN
Health Facility Surveyor

Lisa Bennett, RN
Health Facility Surveyor

Survey Abbreviations:

Dermis=the layer of the skin below the epidermis
EMS= Emergency Medical Service
Epidermis= the surface of the skin
NSA= Negotiated Service Agreement
PSR=Psychosocial Rehabilitation Specialist

16.03.22.520 – Inadequate Care

"Inadequate Care. When a facility fails to provide the services required to meet the terms of the Negotiated Service Agreement, or provide for room, board, activities of daily living, supervision, first aid, assistance and monitoring of medications, emergency intervention, coordination of outside services, a safe living environment, or engages in violations of resident rights or takes residents who have been admitted in violation of the provisions of Section 39-3307, Idaho Code."

Based on observation, interview and record review, it was determined the facility retained 1 of 1 sampled resident's (Resident #1) who was a danger to himself. Additionally, the facility failed to provide emergency medical treatment for 1 of 7 sampled residents' (Resident #1). The facility also failed to protect the right to be treated with dignity and respect for 2 of 7 sampled residents (Resident #1, #2) and 2 additional residents interviewed during the survey. This had the potential to affect 100% of the residents living in the facility. The findings include:

16.03.22.520-11 Acceptable Admission and Retention

I. Acceptable Admission and Retention

IDAPA 16.03.22.152.05.e, a resident will not be admitted or retained...that is violent or a danger to himself or others.

Resident #1's record documented, he was a 38 year-old male, who was admitted to the facility on 6/24/14, with a diagnosis of schizoaffective disorder.

Resident #1's NSA, dated 8/1/15, documented the resident required supervision related to having "suicidal thoughts."

Caregiver Observation Notes documented the following:

*6/14/15 at 1:45 PM, Resident #1 told a caregiver he wanted to go to a psychiatric unit to be evaluated because he was suicidal. The caregiver documented, "he told me he would slit his wrist with the razor he has. He brought it to me and I threw it away."

*6/15/15 at 12:30 AM, Resident #1 told a caregiver he wanted to sleep near the kitchen due to having suicidal thoughts.

*7/12/15 at 6:15 PM, "Resident cut himself with a pop can 2 times today...First time I called [Name of a crisis agency]" and was advised to call EMS. Resident #1 refused to go out by ambulance. The caregiver further documented, "I walked away to pee and to check on another resident and he cut himself again." The caregiver documented he called the crisis line again and was instructed to call the resident's PSR worker. The caregiver documented, the resident's PSR worker was not available, and Resident #1 had to wait until the next day to be evaluated at the behavioral health center. The caregiver documented he removed the pop cans after the first incident from the hall and checked the resident's room and emptied his trash. The caregiver documented, "I kept [Resident #1' name] by me or the other staff...he told me he wanted more smokes cause he ran out, he can't tell me or the guy at [Name of crisis agency] or cops why he is acting this way."

*8/4/15 at 9:00 PM, Resident #1 told a caregiver he needed to talk. Resident #1 stated he was mad at the administrator for not "giving him his money today." The caregiver asked what he had done and the resident did not reply. The caregiver asked again, "what did you do" and the resident showed the caregiver his left wrist. The caregiver documented he cleaned and covered the wound.

Caregiver Service Notes related to behaviors documented the following:

*8/4/15 at 8:53 PM, Resident #1 exhibited self-harm by cutting his left wrist.

*8/17/15 at 6:34 AM, the resident exhibited self-harm. A caregiver documented, "I went out to check [Resident #1's name] wrists from his [sic] telling me that he cut it, then he pulled his wrist up into his jacket. I tried to pull his wrist out of the jacket and he motioned his cigarette at me like he was going to burn me. I pulled the cigarette out of his fingers and he pulled it back causing it to break...I raised his hand again, I told him I had to see how bad it was and he refused. I called [Administrator's name] and left a message, and then I called [caregiver's name] to see when she would be here to hopefully get his wrist taken care of."

*9/4/15 at 11:42 AM, Resident #1 exhibited behaviors that were "demanding..., uncooperative..., does not communicate or socialize... and self-abuse." The note documented staff talked to the resident about his behaviors and told the resident he had smoked all his cigarettes and if he calmed down, staff would give him one cigarette each hour. The note documented the resident showed staff his wrist and the wound was cleaned and a Band-Aid was applied.

Observations and Interviews:

On 9/15/15 at 2:25 PM, Resident #1 was observed in his room. Emergency numbers were posted on the wall next to his bed. Resident #1 stated he could call and talk to someone at the crisis center or his PSR worker when he felt like he wanted to harm himself. Resident #1 stated he used empty pop cans to cut his wrist when he felt suicidal.

On 9/15/15 at 2:37 PM, a caregiver stated Resident #1's behaviors included harming himself by using empty pop cans to cut his wrist. She stated staff were to call the administrator, or "911" when the resident exhibited harmful behaviors. The caregiver stated, if the resident was not sent out of the facility, staff had been instructed to conduct a "suicide watch" which included keeping Resident #1's room door open, and a staff member in the hallway at all times.

On 9/16/15 at 9:30 AM, the administrator stated, Resident #1 made statements saying, 'If I don't get my cigarettes, I'm going to do something to myself.' The administrator further stated, she called his PSR worker

and all three of them came up with a plan. The administrator stated the plan was, "if the resident would agree he wouldn't harm himself, he could have 1 cigarette per hour." The administrator stated, the plan was not written or signed by Resident #1, as it was a "verbal agreement."

On 9/16/15 at 11:30 AM, three caregivers stated, Resident #1 had cut his wrist using pop cans. They stated the resident had anxiety and relied on smoking to calm down. They stated the resident would say things such as, 'If I don't get my cigarettes, I'm going to cut myself.' The caregivers stated, when the resident made suicidal threats, we placed him on a "suicide watch". The caregivers additionally stated they had no documentation regarding the incident or tracking of the "suicide watch."

On 9/16/15 at 1:55 PM, the assistant administrator stated, Resident #1 used a pop can to cut his arm on 9/4/15. She stated the injury was only a superficial scratch, and an incident report was not completed. The assistant administrator additionally stated, staff were told to keep all empty pop cans locked in the kitchen to prevent Resident #1 from harming himself.

On 9/17/15 at 9:20 AM, Resident #1's room was observed to have a trash can next to his bed that contained several empty pop cans.

On 9/17/15 at 4:15 PM, Resident #1 stated he was serious when he made statements about hurting himself. An observation was made of the resident's wound on his left wrist. The wound presented as a gouge that was approximately 2 inches in length and approximately 1 inch in width and had scab covering all but the center of the wound.

On 9/17/15 at 4:30 PM, Resident #1's PSR worker stated, he was not notified of the 9/4/15 incident, until 9/7/15, three days later. The PSR worker observed the resident's wound and stated, "I would have sent him out of the facility to be evaluated for self-harm."

On 9/17/15 at 5:16 PM, the facility nurse stated she received a call from a caregiver on 9/5/15, regarding Resident #1 cutting his wrist. The nurse stated, the caregiver reported the cut on his wrist was "not much" and they put a Band-Aid on it.

Resident #1 was retained after he made statements to the administrator, the assistant administrator, caregivers and outside agencies that he wanted to harm himself and intentionally carried out that threat. The facility retained Resident #1 when he was a danger to himself. This resulted in inadequate care.

16.03.22.520-07 Emergency Intervention

II. Emergency Medical Treatment

Resident #1's record documented he was a 38 year-old male, who was admitted to the facility on 6/24/14, with diagnosis of schizoaffective disorder.

Resident #1's NSA, dated 8/1/15, documented the resident required supervision related to having "suicidal thoughts."

Caregiver Observation Notes documented the following:

*6/14/15 at 1:45 PM, Resident #1 stated he wanted to be sent to a psychiatric hospital and told a caregiver he was suicidal. The note further documented, the resident stated he wanted to slit his wrist with a "razor."

*6/15/15 at 12:30 AM, Resident #1 stated he wanted to "sleep near the kitchen due to having suicidal thoughts."

Although Resident #1 stated he wanted to be evaluated for his suicidal thoughts on 6/14 and 6/15/15, there was no documentation the resident was sent to be evaluated by a medical professional.

On 7/12/15 at 6:15 PM, the "Resident cut himself with a pop can 2 times today..." The staff called the crisis line and staff were advised to call EMS. The note documented, the EMS team arrived and the resident "refused" to be taken by ambulance. A caregiver documented, "I walked away to pee and checked on another resident" and by the time the caregiver returned to check on Resident #1 had "cut himself again." The caregiver documented the resident's PSR worker was not available to take the resident to be evaluated by a medical professional and the resident remained at the facility.

There was no documentation found in the resident's record that he had been evaluated by a medical professional or assessed by the facility nurse after he cut his wrist twice on 7/12/15.

*8/4/15 at 9:00 PM, Resident #1 stated he needed to talk because he was mad at the administrator for not giving him his money that day. The caregiver documented, she asked the resident what he had done, and the resident did not reply. The caregiver asked again and the resident showed the caregiver his left wrist. The caregiver documented she cleaned and covered the wound.

On 8/4/15 (time not documented), the administrator documented in her personal diary, "[Resident #1] went to the crisis center for a scratch." The entry was initialed and dated on 9/16/15, by the administrator.

Although, the resident was "deemed safe" to return to the facility by the crisis center after the incident on 8/4/15, there was no documentation the facility nurse assessed the status of the wound on his wrist, or evaluated his risk of suicide.

On 8/17/15 (time not documented), the administrator documented, "When I came in [Caregiver's name] told me about [Resident #1's name]. I asked [Resident #1's name] and he told me that he didn't cut his wrist he was just messing around." The entry was initialed and dated on 9/16/15, by the administrator.

There was no incident report, behavior monitoring report, caregiver notes or nursing notes regarding the incident that occurred on 8/17/15.

On 9/4/15 at 11:42 AM, a caregiver documented on a "Behavior Monitoring Form," that Resident #1 showed her the cut on his arm. The caregiver documented, she cleaned the wound and put a Band Aid over it.

There was no documentation the facility nurse assessed the status of Resident #1's wounds after caregivers documented he had cut his left wrist 4 times.

On 9/15/15 at 2:25 PM, Resident #1 was observed in his room and stated he felt suicidal when he cut his wrist with empty pop cans. He stated he had cut his wrist several times and sometimes he was sent out to be evaluated, and other times he was not. The resident stated, whenever he cut his wrist or made statements that he had suicidal thoughts, he was serious and wanted to harm himself. The resident stated the facility nurse had never assessed his wounds or provided medical treatment.

On 9/16/15 at 11:30 AM, three caregivers stated, Resident #1 cut his wrist using pop cans. One of the 3 caregivers stated she had to "play doctor" and bandage the wound when the resident cut his wrist. All three caregivers stated, the resident made suicidal threats, and when he was not sent out to be evaluated, caregivers placed him on a "suicide watch."

From 6/14/15 through 9/4/15, Resident #1 made suicidal threats and cut his wrist on 4 separate occasions. There was no documentation the facility nurse had assessed Resident #1 after cutting his wrist. Nor was there documentation he had been sent out for medical treatment.

On 9/17/15 at 4:15 PM, Resident #1 stated he was serious when he made statements to harm himself. An observation was made of the resident's wound on his left wrist. The wound presented as a gouge that was approximately 2 inches in length, 1 inch in width and had depth that went through the epidermis and dermis layers of skin. There was a thick scab covering all but the center of the wound.

On 9/17/15 at 4:30 PM, Resident #1's PSR worker observed a picture of the resident's wound and stated, the

resident should have had a psychiatric evaluation, as well as, a medical evaluation of the wound. The PSR worker stated he was not notified of the incident until 9/7/15, three days after the incident occurred.

On 9/17/15 at 5:16 PM, the facility nurse stated she received a call from a caregiver on 9/5/15, regarding Resident #1 cutting his wrist. The nurse stated, the caregiver reported the cut on his wrist was "not much" and they put a Band Aid over the wound. The nurse stated she did not assess the wound based on the caregiver's phone call.

The facility failed to provide emergency medical treatment when Resident #1 cut his wrist resulting in a wound which was more serious than a "scratch" and failed to have a psychiatric exam conducted on Resident #1. This failure resulted in inadequate care.

16.03.22.520-10 Resident Rights

III. Resident Rights

According to IDAPA 16.03.22.001.02, "the purpose of a residential care or assisted living facility in Idaho is to provide choice, dignity and independence to residents while maintaining a safe, humane, and home-like living arrangement for individuals needing assistance with daily activities and personal care."

IDAPA 16.03.22.550.03.b. "Each resident has the right to be treated with dignity and respect." IDAPA 16.03.22.550.03.b.i also documents residents have, "The right to be treated in a courteous manner by staff."

Resident #2's record documented, she was a 21 year-old female, who was admitted to the facility, on 6/24/15, with diagnoses that included anxiety, major depression and severe psychotic behavior.

On 9/15/15 at 3:20 PM, during the tour of the facility, Resident #2 stated around 9/8/15, the administrator called her a "conniving little bitch," stating she "made things up" and "nobody in their right mind would take her." Resident #2 stated she was moving out of the facility into a certified family home. She further stated, the administrator "cornered her in the bathroom" and it was "very scary" because the administrator was "in her face." Resident #2 stated the incident caused her anxiety and she had an "extreme panic attack." She additionally stated, she went to her room and locked herself in her dog's crate and told herself, "I am a bad girl. I am a dog." She further stated, the assistant administrator came into her room with the mail and found her in the dog crate. The assistant administrator asked her why she was in the dog's crate and then stated "here is your mail" and then left her room. Additionally, Resident #2 stated the administrator was always disclosing personal information about residents in front of everyone which "violates resident rights."

On 9/15/15 at 3:40 PM, Resident A stated staff could be a "poop" and were "short" with residents. Resident A further stated the administrator "yelled down hallways" and violated rights by yelling at Resident #2, who the administrator was having issues with, in front of others.

On 9/15/15 at 2:00 PM, Resident #1 stated the administrator was rude to others and when residents tried to talk to her she would "walk off." The resident stated, the administrator took his pack of cigarettes away from him for self-harming behaviors. Resident #1 stated the administrator told him, "if I was good, she would give me my pack of cigarettes back." The resident stated the administrator "held" his pack of cigarettes for 4 days.

On 9/16/15 at 11:00 AM, Resident B stated the administrator could get "real omery with me." Resident B further stated, the administrator was "mean" and would "yell at ya." Resident B demonstrated how the administrator yelled at people by shouting in a loud, harsh tone, startling everyone in the dining area. Resident B additionally stated the administrator was not very tolerant of residents.

On 9/16/15 at 4:45 PM, the assistant administrator stated on the morning of 9/9/15 she observed Resident #2 in her dog's crate. She asked the resident why she was in the dog crate and Resident #2 replied the administrator called her a "conceited little bitch." The assistant administrator further stated, the administrator wrote about the incident in her diary and the assistant stated she initialed the administrator's entry.

On 9/16/15 AT 4:55 PM, when asked why she did not fill out an incident report regarding Resident #2's episode involving the dog crate, the administrator stated, "I just wrote it in my diary."

On 9/16/15 at 5:40 PM, a caregiver stated the administrator was rude to residents. She further stated, the administrator became angry when Resident #2 spent the night at a certified family home and then stated she wanted to move out of the facility.

On 9/17/15 at 4:40 PM, the administrator stated she spoke with Resident #2 on 9/8/15, about her wanting to move out of the facility and into a certified family home. Further, the administrator stated she did not know about Resident #2 being in a dog crate.

On 9/17/15 at 4:42 PM, the assistant administrator stated she observed Resident #2 in the dog crate on 9/9/15 at 9:00 AM. The assistant administrator stated she asked Resident #2 to come out of the crate and the resident refused. The assistant administrator stated she pretended she was the resident's dog and demonstrated how she talked to Resident #2 in a "dog voice" to come out. The assistant administrator left the room after Resident #2 refused to come out of the crate.

A page from the administrator's "diary," dated 9/8/15, documented a resident went to the administrator and told her Resident #2 said the administrator called her names like "conceited little bitch." The administrator documented, "Of course I wouldn't do that."

There was no other documentation in the resident's record nor was there an investigation into residents being treated disrespectfully.

The facility did not protect residents' right to be treated with dignity and respect when the administrator used disrespectful phrases or "yelled" at residents, discussed residents' personal information in front of others and took Resident #1's pack of cigarettes away without his consent.

The facility retained Resident #1 who was a danger to himself. Additionally, the facility failed to provide emergency medical treatment and psychiatric treatment for Resident #1. The facility also failed to protect Resident #1, Resident #2 and two other residents' right to be treated with dignity and respect. This had the potential to affect 100% of the residents living in the facility. These failures resulted in inadequate care.



| | | | |
|---|---|---|-----------------------------------|
| Facility RIGBY COUNTRY LIVING | License # RC-914 | Physical Address 4202 EAST 300 NORTH | Phone Number (208) 745-9096 |
| Administrator Jill Williams | City RIGBY | ZIP Code 83442 | Survey Date September 18, 2015 |
| Survey Team Leader Gloria Keathley, LSW | Survey Type Licensure, Follow-up and Complaint Investigation | RESPONSE DUE: October 17, 2015 | |
| Administrator Signature <i>Jill Williams</i> | Date Signed 9/18/15 | | |

NON-CORE ISSUES

| Item # | IDAPA Rule # | Description | Department Use Only | |
|---------------|-------------------|---|---------------------|----------|
| | | | EOR Accepted | Initials |
| 1 | 009.06.c | One of 5 staff members did not have a State Only background check. | 10-16-15 | JK |
| 2 | 225.01 | The facility did not evaluate Resident #'s 1, 2, 5 & 6, behaviors to identify specific behaviors. | | |
| 3 | 225.02 | The facility did not develop interventions for each behavioral symptom. | 11/24/15 | J |
| 4 | 260.06 | The interior and exterior of the facility was not maintained in a clean, safe and orderly manner. For example, carpets were observed worn and stained. A broken blind was observed in a room. A toilet that was located between 2 residents' rooms was inoperable. Mildew like substance was observed in a shower located in the bathroom near room #1. Kitchen hand washing sink trim around outside of the sink was chipped and needed repaired. The kitchen screen door did not close completely and was not rodent proof. The ice machine had a black mildew like substance on the inside. Large deep gouges were observed in walls. Trim was missing throughout the facility. Cobwebs were observed in the living room. The fascia on the outside of the facility needs painted. | 11-24-15 | J |
| 5 | 300.01 | Resident #4 did not have a 90 day nursing assessment in his record or available in the facility. — error g/c | | |
| 6 | 305.03 | The facility nurse did not assess Resident #1, 5 & 7 when they had significant changes in their health and mental status. ***Previously cited on 8/8/13*** | 11/24/15 | J |
| 7 | 310.04.e | The psychotropic medication reviews did not include behavioral updates to residents' physicians. | | |
| 8 | 350.02 | The administrator did not complete an investigation and written report of each incident, complaint or allegation of abuse. ***Previously cited on 8/8/13*** | 10-16-15 | J |
| 9 | 350.04 | The administrator did not provide a written response to all complainants. ***Previously cited on 5/11/11 & 8/8/13*** | | |
| 10 | 350.05 | The administrator did not notify Adult Protection when an allegation of verbal abuse was made known. | 10-16-15 | J |
| 11 | 350.07 | The facility did not report injuries of unknown origin to Licensing and Certification. | 10-16-15 | J |
| 12 | 705.06 | The administrator did not sign, or date each financial transaction when it occurred. — error | | |
| 13 | 710.06 | The facility did not complete a social history for Resident #2. | 10-16-15 | J |
| 14 | 711.01 | The behavior management tracking record did not include the date, time or effectiveness of interventions used. | 11/24/15 | J |



| | | | |
|---|---|---|-----------------------------------|
| Facility RIGBY COUNTRY LIVING | License # RC-914 | Physical Address 4202 EAST 300 NORTH | Phone Number (208) 745-9096 |
| Administrator Jill Williams | City RIGBY | ZIP Code 83442 | Survey Date September 18, 2015 |
| Survey Team Leader Gloria Keathley, LSW | Survey Type Licensure, Follow-up and Complaint Investigation | RESPONSE DUE: October 17, 2015 | |
| Administrator Signature <i>Jill Williams</i> | Date Signed 9/18/15 | | |

NON-CORE ISSUES

| Item # | IDAPA Rule # 16.03.22. | Description | Department Use Only | |
|--------|---------------------------|---|---------------------|----------|
| | | | EOR Accepted | Initials |
| 15 | 711.08.c | The facility did not document their response to unusual events/incidents. ***Previously cited on 8/8/13*** | 10/16/15 | JL |
| 16 | 711.08.e | There was no documented evidence the nurse was notified when residents had changes of condition. ***Previously cited on 8/8/13*** | 10-16-15 | JL |
| 17 | 711.08.f | Not all outside notes were available in residents' records. | | |
| 18 | 730.02 | The as-worked schedule did not document the time the nurse was at the facility. | 10-16-15 | JL |
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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

October 5, 2015

Jill Williams, Administrator
Rigby Country Living-Rural Assisted Living Facilities, LLC
4202 East 300 North
Rigby, Idaho 83442

Provider ID: RC-914

Ms. Williams:

An unannounced, on-site complaint investigation was conducted at Rigby Country Living-Rural Assisted Living Facilities, LLC between September 15, 2015 and September 18, 2015. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # 5483

Allegation #1: The administrator did not respond to complainants in writing.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.350.04 for not responding to complainants in writing. The facility was required to submit evidence of resolution within 30 days.

Allegation #2: Residents did not receive appropriate therapeutic diets.

Findings: Unsubstantiated.

Allegation #3: The facility did not have behavior management plans for residents who had behaviors.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.225.01 and IDAPA 16.03.22.225.02 for not evaluating residents who had behaviors and for not developing interventions for each behavior. The facility also received a deficiency at IDAPA 16.03.22.711.01 for the behavior tracking record not including date, time or the effectiveness of the interventions used. The facility was required to submit evidence of resolution within 30 days.

Allegation #4: The facility did not respond in a timely manner to a resident's record request.

Jill Williams, Administrator
October 5, 2015

Findings: Unsubstantiated.

Allegation #5: The facility retained residents who were a danger to themselves.

Findings: Substantiated. The facility was issued a core deficiency at IDAPA 16.03.22.152.05.e for retaining residents who were a danger to themselves. The facility was required to submit a plan of correction within 10 days.

Allegation #6: Residents were not being supervised.

Findings: Unsubstantiated. This does not mean the incident did not take place; it only means that the allegation could not be proven.

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
HEALTH & WELFARE

C.L. "BUTCH" OTTER – GOVERNOR
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RESIDENTIAL ASSISTED LIVING FACILITY PROGRAM
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: 208-364-1962
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October 5, 2015

Jill Williams, Administrator
Rigby Country Living-Rural Assisted Living Facilities, LLC
4202 East 300 North
Rigby, Idaho 83442

Provider ID: RC-914

Ms. Williams:

An unannounced, on-site complaint investigation was conducted at Rigby Country Living-Rural Assisted Living Facilities, LLC between September 15, 2015 and September 18, 2015. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # 5556

Allegation #1: The facility did not protect residents' right to be treated with dignity and respect.

Findings: Substantiated. The facility was issued a core deficiency at IDAPA 16.03.22.550 for not treating residents with dignity and respect. The facility was required to submit a plan of correction within 10 days.

Allegation #2: The facility did not report suspected abuse.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.350.05 for not reporting allegations of verbal abuse to Adult Protection. The facility was required to submit evidence of resolution within 30 days.

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
HEALTH & WELFARE

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P.O. Box 83720
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October 5, 2015

Jill Williams, Administrator
Rigby Country Living-Rural Assisted Living Facilities, LLC
4202 East 300 North
Rigby, Idaho 83442

Provider ID: RC-914

Ms. Williams:

An unannounced, on-site complaint investigation was conducted at Rigby Country Living-Rural Assisted Living Facilities, LLC between September 15, 2015 and September 18, 2015. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # 5671

Allegation #1: The facility has had bed bugs for the past 5 months.

Findings: Substantiated. However, the facility was not cited as they were proactive and pursued the treatment of ridding the facility of bedbugs.

Allegation #2: The administrator did not provide a written response to the complainant.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.350.04 for not responding to complainants in writing. The facility was required to submit evidence of resolution within 30 days.

Allegation #3: The facility did not keep documents signed and dated by both parties regarding personal spending money accounts.

Findings: Unsubstantiated.

Allegation #4: The facility did not ensure residents received emergency care.

Findings: Substantiated. The facility was issued a core deficiency at IDAPA 16.03.22.520 for residents not receiving emergency medical care. The facility was required to submit a plan of correction.

Jill Williams, Administrator
October 5, 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,

A handwritten signature in black ink, appearing to read 'G. Keathley', with a long horizontal flourish extending to the right.

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
HEALTH & WELFARE

Food Establishment Inspection Report

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

Critical Violations Noncritical Violations

| | | | |
|--|-------------------------------|---|---|
| Establishment Name <u>Ridby Country Living</u> | | Operator <u>Ridby Country Living</u> | |
| Address <u>4202 East 300 North</u> | | | |
| County <u>Boise</u> | Estab # | EHS/SUR # | Inspection time: _____ Travel time: _____ |
| Inspection Type: | Risk Category: <u>High</u> | 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 | _____ |
| # of Repeat Violations | _____ | # of Repeat Violations | _____ |
| Score | <u>1</u> | Score | _____ |
| 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 |
|-----------|---|--------------------------|--------------------------|
| (Y) N | 1. Certification by Accredited Program; or Approved Course; or correct responses; or compliance with Code | <input type="checkbox"/> | <input type="checkbox"/> |
| | Employee Health (2-201) | | |
| (Y) N | 2. Exclusion, restriction and reporting | <input type="checkbox"/> | <input type="checkbox"/> |
| | Good Hygienic Practices | | |
| (Y) N | 3. Eating, tasting, drinking, or tobacco use (2-401) | <input type="checkbox"/> | <input type="checkbox"/> |
| (Y) N | 4. Discharge from eyes, nose and mouth (2-401) | <input type="checkbox"/> | <input type="checkbox"/> |
| | Control of Hands as a Vehicle of Contamination | | |
| (Y) N | 5. Clean hands, properly washed (2-301) | <input type="checkbox"/> | <input type="checkbox"/> |
| (Y) N | 6. Bare hand contact with ready-to-eat foods/exemption (3-301) | <input type="checkbox"/> | <input type="checkbox"/> |
| (Y) N | 7. Handwashing facilities (5-203 & 6-301) | <input type="checkbox"/> | <input type="checkbox"/> |
| | Approved Source | | |
| (Y) N | 8. Food obtained from approved source (3-101 & 3-201) | <input type="checkbox"/> | <input type="checkbox"/> |
| (Y) N | 9. Receiving temperature / condition (3-202) | <input type="checkbox"/> | <input type="checkbox"/> |
| Y N (N/A) | 10. Records: shellstock tags, parasite destruction, required HACCP plan (3-202 & 3-203) | <input type="checkbox"/> | <input type="checkbox"/> |
| | Protection from Contamination | | |
| (Y) N N/A | 11. Food segregated, separated and protected (3-302) | <input type="checkbox"/> | <input type="checkbox"/> |
| (Y) N N/A | 12. Food contact surfaces clean and sanitized (4-5, 4-6, 4-7) | <input type="checkbox"/> | <input type="checkbox"/> |
| (Y) N | 13. Returned / reserve of food (3-306 & 3-801) | <input type="checkbox"/> | <input type="checkbox"/> |
| (Y) N | 14. Discarding / reconditioning unsafe food (3-701) | <input type="checkbox"/> | <input type="checkbox"/> |

| | Potentially Hazardous Food Time/Temperature | COS | R |
|-----------------|--|--------------------------|--------------------------|
| Y N (N/O) N/A | 15. Proper cooking, time and temperature (3-401) | <input type="checkbox"/> | <input type="checkbox"/> |
| Y N (N/O) (N/A) | 16. Reheating for hot holding (3-403) | <input type="checkbox"/> | <input type="checkbox"/> |
| Y N (N/O) N/A | 17. Cooling (3-501) | <input type="checkbox"/> | <input type="checkbox"/> |
| Y N (N/O) N/A | 18. Hot holding (3-501) | <input type="checkbox"/> | <input type="checkbox"/> |
| (Y) N (N/O) N/A | 19. Cold Holding (3-501) | <input type="checkbox"/> | <input type="checkbox"/> |
| (Y) N (N/O) N/A | 20. Date marking and disposition (3-501) | <input type="checkbox"/> | <input type="checkbox"/> |
| Y N (N/O) (N/A) | 21. Time as a public health control (procedures/records) (3-501) | <input type="checkbox"/> | <input type="checkbox"/> |
| | Consumer Advisory | | |
| (Y) N N/A | 22. Consumer advisory for raw or undercooked food (3-603) | <input type="checkbox"/> | <input type="checkbox"/> |
| | Highly Susceptible Populations | | |
| Y N (N/O) N/A | 23. Pasteurized foods used, avoidance of prohibited foods (3-801) | <input type="checkbox"/> | <input type="checkbox"/> |
| | Chemical | | |
| Y N (N/A) | 24. Additives / approved, unapproved (3-207) | <input type="checkbox"/> | <input type="checkbox"/> |
| Y (N) | 25. Toxic substances properly identified, stored, used (7-101 through 7-301) | <input type="checkbox"/> | <input type="checkbox"/> |
| | Conformance with Approved Procedures | | |
| Y N (N/A) | 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>Collage cheese fridge</u> | <u>43°</u> | | | | | | |
| <u>Front salad fridge</u> | <u>43°</u> | | | | | | |

GOOD RETAIL PRACTICES (X = not in compliance)

| | COS | R | | COS | R | | COS | R |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> 27. Use of ice and pasteurized eggs | <input type="checkbox"/> | 42. Food utensils/in-use | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> 28. Water source and quantity | <input type="checkbox"/> | 43. Thermometers/Test strips | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> 29. Insects/rodents/animals | <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"/> | 45. Wiping cloths | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> 31. Plumbing installed; cross-connection; back flow prevention | <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"/> | 47. Physical facilities | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> 33. Sinks contaminated from cleaning maintenance tools | <input type="checkbox"/> | 48. Specialized processing methods | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | <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) <u>Lisa Bennett</u> | (Print) <u>Lisa Bennett</u> | Title _____ | Date <u>9.15.15</u> |
| Inspector (Signature) <u>Lisa Bennett</u> | (Print) <u>Lisa Bennett</u> | Date <u>9.15.15</u> | Follow-up: Yes (Circle One) <u>(N)</u> |



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

Page 2 of 2
Date 9.15.15

| | |
|---|---|
| Establishment Name <u>Rigby Country Living</u> | Operator <u>Rigby Country Living</u> |
| Address <u>4200 East 300 North</u> | |
| County Estab # EHS/SUR.# | License Permit # |

OBSERVATIONS AND CORRECTIVE ACTIONS (Continuation Sheet)

25 Cleaning chemicals stored over bin of potatoes. Kitchen staff educated on proper storage. Corrected on site. Potato bin moved away from chemicals to another shelf.

| | | | |
|--|----------------------|-------------------------------------|------------------------|
| Person in Charge <u>[Signature]</u> | Date <u>11/15</u> | Inspector <u>Lisa H. Bennett</u> | Date <u>9.15.15</u> |
|--|----------------------|-------------------------------------|------------------------|