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

January 19, 2016

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

Provider ID: RC-995

Ms. Pendleton:

On November 20, 2015, a core deficiency follow-up survey was conducted at Desano Place Village Memory Care. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level(s):

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

Your submitted evidence of resolution and plan of correction 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
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PHONE: 208-364-1962
FAX: 208-364-1888

December 9, 2015

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

Ms. Pendleton:

On November 20, 2015, a core deficiency follow-up survey and complaint investigation were conducted by Department staff at Desano Place Village Memory Care. The facility was cited with core issue deficiencies for failing to protect residents from abuse. Further, the facility was issued a repeat core issue deficiency for continuing to retain a resident who was violent and a danger to other residents and staff.

These core issue deficiencies substantially limit the capacity of Desano Place Village Memory Care to provide for residents' basic health and safety needs. The deficiencies are described on the enclosed Statement of Deficiencies.

PROVISIONAL LICENSE:

As a result of the survey findings, the provisional license, issued on April 13, 2015 will remain in effect. The following administrative rule for Residential Care or Assisted Living Facilities in Idaho (IDAPA 16.03.22) gives the Department the authority to issue a provisional license:

> ***935. ENFORCEMENT REMEDY OF PROVISIONAL LICENSE.***
> *A provisional license may be issued when a facility is cited with one (1) or more core issue deficiencies, or when non-core issues have not been corrected or become repeat deficiencies. The provisional license will state the conditions the facility must follow to continue to operate. See Subsections 900.04, 900.05 and 910.02 of these rules.*

The conditions of the provisional license are as follows:

BAN ON ADMISSIONS:

Ban on all new admissions. Readmission from the hospital will be considered after consultation between the facility, consultant, the resident/family and the Department. The ban on new admissions will remain in effect until the Department has determined that the facility has achieved full compliance with the Department's licensing and certification requirements. The following administrative rule for Residential Care or Assisted Living Facilities in Idaho (IDAPA 16.03.22) gives the Department the authority to impose a remedy of a limit on admissions:

920. Enforcement Remedy of Limit of Admissions.
02. Reasons for Limit on Admissions. *The Department may limit admissions for the following reasons:*
a. *The facility is inadequately staffed or the staff is inadequately trained to handle more residents.*

The limitation on admissions shall remain in effect until the Department determines the facility has achieved full compliance with IDAPA 16.03.22.

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 eleven (11) non-core issue deficiencies must be corrected and evidence (including but not limited to receipts, pictures, completed forms, records of training) must be submitted to this office by **December 20, 2015**

ADMINISTRATIVE REVIEW

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

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

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

administrative review conference.

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

INFORMAL DISPUTE RESOLUTION

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

FOLLOW-UP SURVEY

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

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

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

Sincerely,

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

JS/sc

Enclosure

cc: Medicaid Notification Group

CORE ISSUES

Facility	License #	Physical Address	Phone Number
Desano Place Village Memory Care	RC-995	1015 East Avenue K	208-595-1589
Administrator	City	Zip Code	Survey Date
Julie Pendleton	Jerome	83338	11/20/2015
Survey Team Leader	Survey Type		Response Due
McCann, Maureen	Core Deficiency Follow-Up		
Administrator Signature	Date Signed		

Item #	Rule	Description
1	16.03.22.000 Initial Comments	The following core deficiencies were cited during the follow up and complaint investigation survey conducted between 11/16/15 and 11/20/15, at your residential care/assisted living facility. The surveyors conducting the survey were: Maureen McCann, RN Team Coordinator Health Facility Surveyor Karen Anderson, RN Health Facility Surveyor Abbreviations: 1:1 = one to one, staff to resident & = and @ = at ABHR (Ativan, Benadryl, Haldol and Reglan) BM = bowel movement

		BMP = behavioral management plan EMTs = emergency medical technician's IM = intramuscular MAR = medication assistance record meds = medications mg = milligrams ml = milliliter prn = as needed Res = resident stat = now tx = treatment w = with
2	16.03.22.510 Requirements To Protect Residents From Abuse.	Based on observation, interview and record review, it was determined the facility failed to implement policies and procedures to protect 2 of 4 sampled residents (#2 and #4) and potentially 100% of the residents from physical abuse after allegations of abuse were reported. The findings include: Idaho Statute 39-5303 requires that all staff employed by a residential care facility serving vulnerable adults, shall immediately report allegation of abuse to the commission, otherwise known as Adult Protection. IDAPA 16.02.33.510 documents, "The administrator must assure that policies and procedures are implemented to assure that all residents are free from abuse." The facility's abuse policy and procedure documented the facility would "report as soon as possible (within in 4 hours of knowledge) to local law enforcement (9-1-1) and the Idaho Office of Aging at 736-2122 when there is a reasonable cause to believe that abuse...has occurred." The policy also documented, "Any employee, including the administrator, who is suspected or alleged to have perpetrated any abuse, will be

		placed immediately on unpaid leave of absence from work until the investigation is completed" and "will not be allowed access to the resident...until the authorities have made a determination of guilt or innocence." In May of 2015, Licensing and Certification received a complaint the facility did not protect vulnerable residents from abuse by caregivers when the facility did not immediately report allegations of abuse to adult protection and allowed caregivers access to the residents before an investigation was conducted. In September of 2015, Licensing and Certification received another complaint the facility did not immediately report allegations of abuse to adult protection. I. Caregiver A, a female employee, worked at the facility from April 2015 through September 2015. Resident #4's record documented he was an 86 year-old male, who was admitted to the facility on 7/13/15, with a diagnosis of Alzheimer's dementia. On 11/16/15 at 4:00 PM, Resident #4 was observed ambulating in the living room of the facility. A caregiver was observed assisting the resident to an activity. The resident was speaking incoherently and was unable to form understandable words or sentences during the observation. A handwritten note, dated 9/11/15 at 9:22 PM, documented a co-worker witnessed Caregiver A "kick" Resident #4. Caregiver A's employee file was reviewed on 11/18/15. An unsigned, undated note documented the following regarding a

		video clip from the facility's cameras. The video clip was dated 9/11/15, and timed between 9:15 PM and 9:30 PM: "In time fame [sic] 9:15 - 9:30, I witnessed [Caregiver A's name] grab [Resident #4's name] arm...walked him with struggle to the couch. As she sat Resident down, Resident kicked staff, (unsure if contact was made). Staff kicked Resident back! I didn't hear what was said but in camera you can see staff was physically upset! House supervisor was notified @ 11:15 PM on 9/11." The administrator's investigation report was reviewed on 11/20/15. The report documented the following regarding the 9/11/15 video clip from the facility's cameras: * "9/11/15 at 21:22:06. Camera 5, rough tx by [Caregiver A's name], kicking back at [Resident #4's name], finger in his face." "See camera 14, @ 21:19 – [Caregiver A's name] is talking to with [Resident #4's name]...struggle ensues w [Caregiver A's name] forcing [Resident #4's name] toward the living room." On 11/17/15 at 10:00 AM, the administrator stated Caregiver A was terminated on 9/14/15 for physical abuse after an incident when the caregiver had been "rough" with a resident. On 11/18/15 at 5:17 PM, the owner of the facility stated she was informed of the abuse allegation on 9/12/15, by the co-worker who observed the incident. The owner stated, "I should have viewed the camera when it was reported to me, but didn't." She stated Caregiver A was not terminated until 9/14/15. On 11/19/15 at 2:59 PM, the administrator stated she was out of town on 9/11/15 and did not have cell phone coverage. She further stated Caregiver A was not immediately suspended and

		continued to work after the allegation was made. The facility as-worked staff schedule for September 2015 was reviewed on 11/19/15. According to the schedule, Caregiver A worked two more evening shifts on 9/12/15 and on 9/13/15. Between 11/16/15 and 11/20/15, sixteen individuals were interviewed to include facility staff and outside agency staff. The following statements were made by the interviewees: * Caregiver A was observed to "kick a resident." * Caregiver A "yelled and cursed at residents." * Caregiver A was "so abusive..." * Caregiver A was "so abusive...Staff would report concerns to the administrator" but "nothing had been put in place or changed" to address Caregiver A's rough treatment with residents. * Abuse allegations were "reported to the administrator many times and were brushed under a rug." * "It took several reports" of abuse to administration, "to get rid of" Caregiver A. On 11/19/15 at 11:00 AM, the caregiver who observed the incident on 9/11/15 stated she reported the incident to the administrator "within 24 hours." She stated she did not notify Adult Protection, "I called the administrator the next morning [on 9/12/15] at 5:00 AM and she said she would take care of it."

		The administrator stated she documented her interviews with all staff but did not report the abuse allegation to Adult Protection immediately. The facility did not follow their abuse policy to protect residents from abuse when a caregiver was allowed to continue to work after an allegation of abuse. Further, the facility did not follow State Statue when they did not report an allegation of abuse to Adult Protection immediately. II. Caregiver B was a female employee who worked at the facility from 10/13/13 to 7/16/15. Resident #2's record documented she was an 87 year-old female, who was admitted to the facility on 12/30/11, with a diagnosis of dementia. On 11/16/15 at 3:45 PM, Resident #2 was observed ambulating in the dining and living room of the facility. The resident was interviewed but unable to respond to questions in understandable words. On 11/17/15, the administrator's investigation of a 4/28/15 incident was reviewed. The investigation included a statement by the co-worker who witnessed the alleged abuse. The co-worker documented, Resident #2 slapped Caregiver B on the arm and then Caregiver B "grabbed res arms and pinched res on her left leg when we were done changing res and walked out of the room..." The report documented Caregiver B's said "she was sick and tired of getting beat up" by Resident #2 and the resident "is going to be the one that makes her quit." The co-worker further documented two additional residents' were also "treated rough" by Caregiver B on 4/28/15 at 5:30 AM. The co-worker documented the administrator was notified by

		a text message on 4/29/15 at 5:30 AM. The administrator documented on the bottom of the report, she was texted by the co-worker on 4/28/15 and she would speak to Caregiver B, "today 4/29/15 and asking her to write her statement." An "Attendance and Performance Log" for Caregiver B, dated 4/30/15, documented Caregiver B, "will be taken off all shifts for two weeks and will receive Behavior Management training. She will be monitored closely while working w/other caregivers and supervisors for any improvement and/or reoccurring behavior. She may be moved to another facility where she has less interaction w/residents that display potentially provoking problematic behavior." A "Report of Suspected Abuse..." form, dated 7/17/15, documented the following regarding Caregiver B: * "Tone of voice was very 'short' towards the resident during a messy BM change that required two staff members. Staff member that 'complained' or reported to administrator states that staff member 'abusing' also grabbed resident tightly around the residents' left calf." The form did not document the date of the alleged abuse incident." Between 11/16/15 and 11/20/15, sixteen individuals were interviewed to include facility staff and outside agency staff. The following statements were made by the interviewees: * Caregiver B had "been abusive to resident." * Caregiver B had fake fingernails and residents were observed with "fingernail shaped bruises" and "skin tears" on their arms. When the caregiver was moved to a different building, the residents in that building began to develop the same bruises

		and skin tears. Further, there were no new bruises and skin tears on residents' arms in the 1st building. * Caregiver B "kept her job after allegations of abuse were made against her" in April 2015. "The second time [in July of 2015], she was terminated but did continue to work at least for 24 hours after the incident." * Caregiver B had been "accused of abuse several times. It took a long time to "get rid of" her. On 11/17/15 at 9:50 AM, the administrator stated, in April 2015 a co-worker reported she witnessed Caregiver B pinch Resident #2 on her left leg above her knee. The administrator stated Caregiver B was taken off the schedule and provided re-training. She stated Caregiver B was transferred to work in the other building on the facility's campus. The administrator stated she terminated Caregiver B on 7/16/15, when other caregivers reported Caregiver B had been "verbally rough" with residents in the other building. The facility failed to protect 100% of the resident's from verbal and physical abuse when Caregiver A and Caregiver B were allowed to continue to work after multiple allegations of abuse. Further, the facility did not report Caregiver A's allegation of abuse to Adult Protection.
3	16.03.22.520-11 Acceptable Admission and Retention	According to IDAPA 16.03.22.152.05.e, a resident will not be admitted or retained who is violent or a danger to himself or others. On 4/6/15, the facility received a core deficiency for retaining a resident who was violent and a danger to staff and to other residents. The facility submitted a plan of correction to be implemented by 4/24/15. The plan included the following:

		* Behavior plans would be developed for all current residents and the "administrator, in consultation with staff nurse, is required to investigate each behavior narrative and respond accordingly; and make adjustments to BMP at least every 72 hours." * Behaviors will be "monitored quantitatively and qualitatively for severity and frequency by the administrator on a monthly basis. Violent behaviors that are not measurably reduced in both severity and frequency by all means possible, including through the use of medication, will trigger a discharge plan." Between 11/16/15 and 11/20/15, a follow-up survey was conducted to evaluate the implementation of the facility's plan of correction. Based on record review and interview, it was determined the facility continued to retain 1 of 1 sampled residents (Resident #1) who was violent and a danger to other residents and staff. This was the same resident the facility retained and received the core deficiency for on 4/6/15. The findings include: According to his record, Resident #1 was a 67 year-old male, admitted to the facility on 10/25/13, with diagnoses of Parkinson's disease, dementia and psychosis. An admission agreement, signed and dated by the administrator and the resident on 11/13/14, documented, "Furthermore, no resident, per either corporate policy or as per current rules and regulations will be admitted or retained who requires or possesses any of the following...any person who is violent or who has a history of being violent or poses a danger to self or others."

		Between 11/16/15 and 11/20/15, sixteen individuals were interviewed to include facility staff and outside agency staff, regarding Resident #1's behaviors. The following were statements made by the interviewees: * "His behaviors increased in the spring after the last survey." He would "grab our wrists," be found "climbing on the counter trying to get into the kitchen, bend silverware out of shape...We had training, but we were not qualified to deal with him...He was so violent, I was scared around him." * "He was violent, grabbing wrists, he was strong. We had to block his punches." * "He would give us scary looks like he wanted to hurt us...He wasn't sent out of the facility because there was no place to send him." * "He would squint his eyes and look at us like he wanted to hurt us." * Caregivers "were fearful to be left alone with" Resident #1, because "of his behaviors." * "He was unpredictable. He would grab other residents. He would attack you, grab you and not let go." * "He put another resident into a choke-hold." The documentation "disappeared" from the computer system. A "Behavior Management Plan" for Resident #1, initiated on 5/5/15 and updated on 10/16/15, documented Resident #1 would "grab at people or sneak up on people and strike

		them...grab staffs' wrists and squeeze tight often lasting for up to 10 minutes. It is typically associated with bulging eyes and high anxiety." Staff interventions were to include: * Providing 1:1 with the resident * Observing for body language such as "Large, wild looking stare...rapid walk...close proximity to another man" and redirecting "using calm, soothing tone," or offer food or to take him outside. * Introduce Resident #1 to male visitors and re-direct him away from other male residents. * If Resident #1 appears to be aggressive, "move others out of his reach" and call the administrator or nurse. * "Uncontrolled physical aggression or any repeated attempt of aggression will require that Law Enforcement" be contacted. An incident report, dated 6/23/15, documented a female resident had bent over to pick up something in a hallway when Resident #1 "rapidly approached her trying to kick at her and possibly hit her." When a caregiver intervened, Resident #1 "grabbed" the caregiver's wrists, "refused to let go" and "would not calm down." A second caregiver contacted law enforcement when the caregivers could not calm Resident #1 down or get him to release his grip on the caregiver's wrists. Resident #1 was transported and admitted to a hospital. A "Notice of Transfer or Discharge of Resident-Initiated by Administrator" form, dated 6/23/15, documented a discharge notice was "being initiated" for Resident #1 "if behavior cannot be controlled."

		"Staff Report of Resident Behavior" forms regarding Resident #1 documented the following between 5/23/15 and 10/26/15: * 5/23/14 at 12:30 AM: Resident #1 "went after me trying to punch me." The caregiver left the resident's room but he followed her down the hall, "still trying to hit and attack" her. * 6/7/15 at 9:30 PM: When staff assisted the resident to get ready for bed, Resident #1 "squeezed staff's hands, refusing to let go, attempted to throw staff on bed. Attempted to box with staff." * 6/13/15 at 2:35 PM: Two staff tried to assist Resident #1 down off of the kitchen counter which he was climbing on. "He grabbed onto the staff around wrists & began to squeeze. He would not let go. He mumbled something about an intruder." * 6/29/15 at 8:45 AM: Resident #1 grabbed another resident's arm and hand, squeezing them. Resident #1 was "shaking, not eating, eyes bulging, unhappy." The caregiver asked Resident #1 to let go of the other resident and "started to pry his hands off of" the other resident and called to another caregiver for help. * 7/10/15 at 7:30 AM: Resident #1 "began to kick the leg of the table very hard. The table leg sounded as if it was going to break." He "was mumbling about a woman who was tied down." Resident #1's behaviors are "unpredictable and irratic [sic]." * 8/13/15 at 11:25 AM: Resident #1 asked a caregiver to assist him to the bathroom. He "then grabbed my wrists and started widening his eyes and pursing his lips together. I asked him to

		please let go because he was hurting me but he wouldn't. I eventually was able to pull the call light with my teeth" and another caregiver "came to help with cares while he still had my wrists." The caregiver further documented this behavior lasted "roughly 30 minutes." * 8/22/15 at 2:45 PM, 3:15 PM and 3:30 PM: A caregiver saw Resident #1 "charging at me. I had no time to react...He grabbed my left wrist/hand. His knuckles were turning white because of how hard he was holding on to me." The caregiver called to two other caregivers and when they arrived, Resident #1 "put his mouth on my arm and tried to bite me. We pushed his head away." The caregiver documented, Resident #1 "came after me again and got a hold of my arm." She also documented, Resident #1 went after her a third time when the caregiver was assisting another resident, "he was starring [sic] me down and came after me." The report further documented Resident #1 "grabbed a hold of" another caregiver when she was trying to get the resident to let go of the first caregiver and he "kicked at" a third caregiver. * 8/24/15 at 7:30 PM: "He grabbed a hold of my wrists and refused to let me toilet him or change his clothing. He was cussing and told me to leave the room. Another staff had to intervene." "He was wide eyed and cussing." * 8/29/15 at 11:15 AM: Another male resident grabbed Resident #1's wrists. Resident #1 then grabbed the other resident's wrists. Resident #1 punched the other resident in the arm. * 8/31/15 at 8:30 PM: The "Resident balled up his fist, was pushing tables and chairs and became agitated when staff needed to help resident with toileting." The report further

		documented, "Left him alone for a while. Requested lorazepam. Resident stated he was agitated." Nurse notes documented the following 7/5/15 at 10:11 AM: "Late entry: On Wed nite [sic], July 1, I received a phone call from staff who were frustrated with resident not taking his medication, and cheeking or spitting out his meds. Just the day before, staff had to call Law enforcement and EMTs to help us get resident to settle down and stop his aggression toward staff. The officers and EMT's were very helpful and they allowed [Resident #1's name] to grab their arms instead of staff's arms. When camera footage was observed, Staff had approached resident as per their training, but hallucinations continued to plague resident. Behaviors had then begun to escalate after about 5 days of Geodon....and resident had been given prn Lorazepam and ABHR cream to try to help curb aggressive outbursts, charging of other residents, etc. On 7/1/15, I called [physician's name] and was authorized to give 5mg/ml, one ml IM stat, and oral 5 mg Haldol routinely aggressive behavior." A "Nursing assessment," dated 7/14/15, documented Resident #1 "has had difficulties with increased behaviors with aggressiveness with others especially toward staff and on occasions with other male residents and male visitors...His aggressive behaviors are sporadic and unpredictable. The behaviors can be elicited by his delusions and hallucinations. He has had many medication changes to help decrease his behavioral disturbances and negative behaviors. His doctors think there is little that can help him since his disease is so far advanced...If resident behavior disturbances don't improve soon, discharge or Hospice care may need to be considered if there is no other choices or courses to take with this resident for his safety and the safety of others."

		Resident #1's record contained multiple changes in physician's orders for the following psychotropic medications between 6/1/15 and 7/15/15: * Ativan * gabapentin * depakote * Geodon * Haldol * Seroquel * morphine (ordered for "agitation") * ABHR cream (Ativan, Benadryl, Haldol, Reglan) Resident #1's June 2015 through August 2015 MARs were reviewed. The MARs documented Resident #1 received 51 "as needed" doses of behavior modifying medications, including Haldol IM four times, between 6/1/15 and 8/26/15. The majority of the reasons documented the "as needed" medications were given included: "aggression," "anxiety" or "agitation." Despite the resident's continued aggressive behaviors even with the numerous use of prn medications, including four IM injections of Haldol, the facility retained Resident #1. The facility did not implement their plan of correction in response to the 4/6/15 core deficiency. The facility continued to retain Resident #1 who was violent and a danger to others. ***THIS WAS A REPEAT DEFICIENCY***

IDAHO DEPARTMENT OF HEALTH & WELFARE

DIVISION OF LICENSING & CERTIFICATION
P.O. Box 83720
Boise, ID 83720-0036
(208) 364-1962 Fax: (208) 364-1888

ASSISTED LIVING
Non-Core Issues Punch List

Facility	License #	Physical Address		Phone Number
DESANO PLACE VILLAGE MEMORY CARE	RC-995	1015 E AVENUE K		(208) 595-1589
Administrator	**City**		**ZIP Code**	**Survey Date**
Julie Pendleton	JEROME		83338	November 20, 2015
Survey Team Leader	**Survey Type**			**RESPONSE DUE:**
Maureen McCann, RN	Complaint Investigation and Follow-up			December 20, 2015
Administrator Signature	**Date Signed**			
	11/20/15			

NON-CORE ISSUES

Item #	IDAPA Rule # 16.03.22.	Description	Department Use Only: EOR Accepted	Initials
1	159.01	The facility did not ensure residents' records were accurately maintained. Caregivers reported they were instructed to change their electronic documentation to not include residents aggressive behaviors. Further, caregivers reported hand-written documentation of residents aggressive behaviors "disappeared."	12/31/15	[illegible]
2	215.09	The administrator did not identify and monitor patterns of incidents to develop interventions to prevent reoccurrence.	12/31/15	[illegible]
3	330.02	The facility did not maintain caregivers' shift report logs for three years.	12/31/15	[illegible]
4	350.03	The facility did not protect residents from abuse when they allowed caregivers to work after allegations of abuse were made known.	12/31/15	[illegible]
5	350.04	The administrator did not respond in writing to complainants within 30 days.	12/31/15	[illegible]
6	350.05	The facility did not notify Adult Protection immediately when physical abuse was reported.	1/4/16	[illegible]
7	711.01.a	The facility did not document the date and time behaviors were observed.	12/31/15	[illegible]
8	711.01.b	The facility did not document the interventions that were used when residents exhibited behaviors.	12/31/15	[illegible]
9	711.01.c	The facility did not document the effectiveness of the interventions.	12/31/15	[illegible]
10	711.08.c	Not all incidents of residents behaviors were documented. Caregivers reported they were instructed to change their documentation to not include aggressive behaviors the residents exhibited.	1/4/16	[illegible]
11	711.12	The facility did not always document the reasons when PRN medications were given.	12/4/16	[illegible]
12				
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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

December 09, 2015

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

Provider ID: RC-995

Julie Pendleton:

Complaint #: 5609

An unannounced, on-site complaint investigation was conducted at Desano Place Village Memory Care between November 16, 2015 and November 20, 2015. During that time, observations, interviews or record reviews were conducted with the following results:

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

Finding: Substantiated. The facility received a core deficiency at IDAPA 16.03.22.520, for retaining a resident who had aggressive behaviors and was a danger to others.

Allegation #2: The facility did not protect residents after allegations of resident abuse by caregivers were reported to administration.

Findings: Substantiated. The facility received a core deficiency at IDAPA 16.03.22.510, for not protecting residents from abuse after allegations of resident abuse by caregivers were reported to administration.

Allegation #3: The facility did not immediately report allegations of resident abuse by caregivers to Adult Protection.

Findings: Substantiated. The facility received a non-core deficiency at IDAPA 16.03.22.350.05, for not reporting allegations of resident abuse to Adult Protection immediately.

Allegation #4: The facility required caregivers to change their documentation regarding residents' behaviors and destroyed caregiver shift logs.

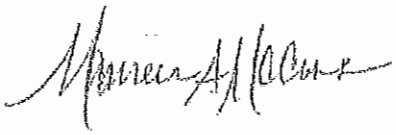
Findings: Substantiated. The facility received a non-core deficiency at IDAPA 16.03.22.159.01, for not ensuring residents' records were accurately maintained and at IDAPA 16.03.22.330.02, for not maintaining caregiver shift logs for three years.

Allegation #5: The facility did not schedule a sufficient number of staff to meet all of the residents' needs.

Findings: Unsubstantiated.

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

Sincerely,



Maureen McCann, RN
Health Facility Surveyor
Residential Assisted Living Facility Program

MM/sc

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

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December 09, 2015

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

Provider ID: RC-995

Julie Pendleton:

Complaint #5685

An unannounced, on-site complaint investigation was conducted at Desano Place Village Memory Care between November 16, 2015 and November 20, 2015. During that time, observations, interviews or record reviews were conducted with the following results:

Allegation #1: The facility did not immediately report allegations of abuse by caregivers to Adult Protection.

Findings: Substantiated. The facility received a non-core deficiency at IDAPA 16.03.22.350.05, for not reporting allegations of abuse to Adult Protection immediately.

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