IDAHO DEPARTMENT OF HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

LESLIE M. CLEMENT - Administrator
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888

June 24, 2010

CERTIFIED MAIL #: 7005 1160 0000 1506 8530

Kayleen Parke, Administrator
Downey Care Center LLC
P.O. Box 344
Downey, ID 83234

FILE COPY

Dear Ms. Parke:

Based on the state relicensure survey conducted by our staff at Downey Care Center LLC on **June 21, 2010,** we have determined that the facility failed to provide a safe living environment for a resident who was at risk for elopement.

This core issue deficiency substantially limits the capacity of Downey Care Center LLC to furnish services of an adequate level or quality to ensure that residents' health and safety are safe-guarded. The deficiency is described on the enclosed Statement of Deficiencies.

You have an opportunity to make corrections and thus avoid a potential enforcement action. Correction of this deficiency must be achieved by **August 5, 2010. We urge you to begin correction immediately.**

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

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

Return the **signed** and **dated** Plan of Correction to us by **July 7, 2010,** and keep a copy for your records. Your license depends upon the corrections made and the evaluation of the Plan of Correction you develop.

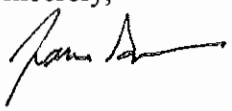
You have available the opportunity to question cited deficiencies through an Informal Dispute Resolution (IDR) process. If you disagree with the survey report findings, you may make a written request to the Supervisor of the Residential Assisted Living Program for a Level 1 IDR meeting. The request for the meeting must be made within ten (10) business days of receipt of the statement of deficiencies (**July 7, 2010**). The specific deficiencies for which the facility asks reconsideration must be included in the written request, as well as the reason for the request for reconsideration. The facility's request must include sufficient information for Licensing & Certification to determine the basis for the provider's appeal. If your request for IDR is received after **July 7, 2010,** your request will not be granted. Your request must me made in accordance with the IDR 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.

Please bear in mind that non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference. The completed punch list form and accompanying proof of resolution (e.g., receipts, pictures, policy updates, etc.) are to be submitted to this office by **July 21, 2010**.

If, at the follow-up survey, it is found that the facility is not in compliance with the rules and standards for residential care or assisted living facilities, the Department will have no alternative but to initiate an enforcement action against the license held by Downey Care Center LLC.

Should you have any questions, or if we may be of assistance, please call our office at (208) 334-6626.

Sincerely,



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

JS/sm

Enclosures

PRINTED: 06/22/2010
FORM APPROVED

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R756	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2010
NAME OF PROVIDER OR SUPPLIER DOWNEY CARE CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 351 EAST CENTER DOWNEY, ID 83234		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	Initial Comments The following deficiency was cited during the standard survey conducted at your residential care/assisted living facility. The surveyors conducting the survey were: Donna Henscheid, LSW Team Coordinator Health Facility Surveyor Maureen McCann, RN Health Facility Surveyor Abbreviations: NSA = Negotiated Service Agreement RN = Registered Nurse	R 000		
R 008	16.03.22.520 Protect Residents from Inadequate Care. The administrator must assure that policies and procedures are implemented to assure that all residents are free from inadequate care. This Rule is not met as evidenced by: Based on observation, record review and interview it was determined the facility did not provide a safe living environment to 1 of 1 sampled residents (Resident #4) who was at risk for elopement. Tha findings include: On 6/16/10 at 3:15 PM, the facility was observed to have two sets of double doors leading into the front entrance. A lock release button was located inside the first set of doors. Once the lock release button was pushed, it allowed the second set of doors to open and an alarm to sound inside the facility. The building had two long wings, one	R 008	Correction for R 008 July 6, 2010 1. What corrective actions(s) will be accomplished for those specific Residents, personnel, and areas found to have been affected by the deficient practice? a) Staff will continue the practice of Re-directing the resident as needed b) Staff will provide stand-by assistance to the resident with wandering or elopement tendencies as much as possible and will notify the Administrator. c) Continuing education will be given To each staff member on proper Techniques needed to provide assistance and redirection to the resident demonstrating wandering tendencies. Documentation will also be covered in the cont. ed. d) Continuing education will be Provide to each staff member Related to the beginning signs Of the resident with wandering Or elopement tendencies.	

Bureau of Facility Standards

TITLE (X6) DATE

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

STATE FORM 6899 N33I11 If continuation sheet 1 of 5

Kaylen Parke Administrator 7/6/10

PRINTED: 06/22/2010
FORM APPROVED

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R756	(X2) MULTIPLE CONSTRUCTION A. BUILDING ___ B. WING ___	(X3) DATE SURVEY COMPLETED 06/21/2010
NAME OF PROVIDER OR SUPPLIER DOWNEY CARE CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 351 EAST CENTER DOWNEY, ID 83234		

(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 1 facing east and one facing west. There were exits on each wing and the north side of the building. The east exit had a locked door with a key pad to release the lock. The west exit had double doors with a doorbell-type alarm that sounded when the door was opened. A mesh "Stop" sign was also observed across the right side of the double doors. The north exit had a ramp approximately 12 to 15 feet long that led to double doors. A motion detector was observed on the ceiling above the entrance to the ramp. A mesh "Stop" sign was observed across the right side of the double doors. On 6/17/10 at 12:15 PM, the north exit door was opened by a surveyor. After walking by the motion detector two or three times, the alarm was noted to sound. No staff were observed to check who had set off the alarm. Resident #4 was admitted to the facility on 7/7/08, with diagnoses including dementia. An NSA, dated 11/21/09, documented under the behavior section, "...does forget on occation [sic]. Staff assists with reminders with items such as meal time, come to activities, etc." There was no documentation of the resident exhibited wandering behaviors. An "Incident Report," date 3/15/10, documented Resident #4 eloped out the back door (north exit) and was found walking down the street by a community member. The community member called the facility to let them know she was out. A staff member "ran" down the street to bring the resident back to the facility. The nurses instruction on the report documented, "Keep [Resident #4's name] close to staff as much as possible, it's o.k. if she stays in the common room	R 008	2. 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? a) Thru the dementia training staff will understand and be able to assist in identifying beginning behaviors in residents that may be related to dementia, and the reporting of any out of the ordinary behaviors to the facility R.N. b) Dementia training is given twice a year by our facility R.N. Our next Dementia Training Is scheduled for October 2010. c) All staff have been asked to take the online Dementia class and have it completed by July 31, 2010 d) Scheduling of Peak alarm to install mag locks on the north double doors. This will increase security to the building and for the residents.	

Kaylen Burke Administrator 7/6/10

PRINTED: 06/22/2010
FORM APPROVED

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R756	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 06/21/2010
NAME OF PROVIDER OR SUPPLIER DOWNEY CARE CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 351 EAST CENTER DOWNEY, ID 83234		

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R 008	Continued From page 2 as encouraged. Staff reports they will try to keep her close to them. One staff assigned at all times." A "Monthly Nursing Assessment," dated 6/4/10, documented the resident "tends to wander but can be redirected." "Resident Notes" documented the following: *2/18/10 - Resident was "very busy walking the halls, organizing her room. Voices her opinion about going home." *3/18/10 - "See incident report on [Resident #4's name] 'walk'." *4/6/10 - The resident "walks and walks and walks" and is a "pleasant little lady when she has things to keep her busy." *5/21/10 - The resident was "very restless" and "concerned about going home" from 10:00 PM to 5:30 AM. *5/25/10 - The resident had "paced and worried for the last two nights." She was "waiting for her kids to come take her home." *6/15/10 - Resident #4 was "very agitated today and yesterday. She went outside trying to leave multiple times. She's worried her family doesn't know where she is, among other things. She seems to have calmed down a little bit but continues to try to leave." On 6/17/10 at 8:50 AM, a random resident stated Resident #4 "got out the back ramp. She went by my window and [caregiver's name] went out to get her. She wasn't gone very long."	R 008	3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? a) We reviewed at staff meeting on our June 23rd meeting, that when the staff hear the door bell (alarm) the staff are to visibly acknowledge who is entering & leaving the building. b) Peak alarm was contacted on June 18th, 2010 to schedule a Time to come to Downey Care Center Give ideas and put in a bid for the instillation of new mag locks for the north double doors. c) A representative from Peak Alarm came to the Care Center on June 22nd 2010 and completed an assessment of the double doors. d) A bid was faxed to Downey Care Center on Thursday, June 24, 2010 Peak Alarm is able to schedule to Come to the facility the week of July 6th, 2010 to install the new mag locks.	

Kaylen Sake Administrator 7/6/10

PRINTED: 06/22/2010
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NAME OF PROVIDER OR SUPPLIER DOWNEY CARE CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 351 EAST CENTER DOWNEY, ID 83234		

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R 008	Continued From page 3 On 6/17/10 at 10:45 AM, a caregiver stated Resident #4 "got outside" on 6/15/10. The caregiver stated the resident had also "gotten out" of the facility two days prior to 6/15, because the front door was "propped open." The caregiver stated staff were instructed to have one caregiver stay around the kitchen/common area to keep an eye on Resident #4. She stated that was not "always possible" because the other residents required assistance. She stated when staff were in the rooms at the far end of the wings, the alarms could not be heard. On 6/17/10 at 12:30 PM, two random residents were observed talking about going for a walk and taking Resident #4 with them. Laughing, one of the random residents said, "I bet she would like me to take her for a walk." On 6/18/10 at 8:30 AM, the facility RN stated she was unaware Resident #4 had wandered out of the building since the incident on 3/15/10. She stated, "If I had known, I would have pushed [administrator's name] to put an alarm on that door." She further stated, in March she had discussed with the owner/administrator getting key pad alarms on the doors without them. On 6/18/10 at 9:10 AM, the administrator stated she had discussed installing a second set of doors, like the ones on the front, on both wings of the building. The administrator did not state what plans they had for the north exit. She stated the resident had not had a desire to go outside and the "Stop" signs had been working until now. On 6/21/10 at 10:50 AM, another caregiver stated, "She has got out before. The first time I got her back in because I had seen her. I noticed	R 008	4. 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)? a) Staff will check on the resident in concern, every 15 minutes, while awake and 30 min while sleeping until the new mag locks are installed. b) Staff will document on the check off list every 15 minutes/30 min at night, that the resident checks have been done. c) If additional help is required, the administrator, or another staff member will come in and provide one-on-one assistance with the resident of concern. d) The above was put into action immediately. Chart documentation started July 6, 2010. 5. Any future incident resulting resident safety, will be reported to the State "Hot Line", within twenty-for hours of of the incident, by the administrator or the administrator designee.	

Kathleen Parker Administrator 7/6/10

PRINTED: 06/22/2010
FORM APPROVED

Bureau of Facility Standards

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R 008	Continued From page 4 they put her on another med and she has calmed down." On 9/19/07, the facility was cited at IDAPA 250.14 for not providing a secure interior environment for residents with dementia. The facility's evidence of resolution included "checking into a security system that has a key pad." However, on 3/16/10, with the current system in place, Resident #4 eloped from the facility and on two other occasions got outside unsupervised. The facility failed to protect Resident #4 from potential harm by not providing a safe living environment. This failure resulted in inadequate care.	R 008	(Refer to #1-5 of plan of corrections) pages 1-4	

Bureau of Facility Standards
STATE FORM 6899 N33I11 If continuation sheet 5 of 5

Kaylen Clarke Administrator 7/6/10

IDAHO DEPARTMENT OF
HEALTH & WELFARE

MEDICAID L & C – RALF PROGRAM
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-6626 fax: (208) 364-1888

ASSISTED LIVING
Non-Core Issues
Punch List

Facility Name	Physical Address	Phone Number
Downey Care Center	301 E. [illegible]	847-3683
Administrator	**City**	**ZIP Code**
Kaylee Parke	Downey	83234
Survey Team Leader	**Survey Type**	**Survey Date**
[illegible]	[illegible]	21 May 2010

NON-CORE ISSUES

ITEM #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	L & C USE
1	215.01	The administrator did not authorize in writing a designee to act in her absence.		8/3/10 DH
2	225	The facility did not develop a behavior management plan for Resident #4's elopement.		8/3/10 DH
3	250.10	The water temperatures on both ends of facility exceeded 120°.		8/3/10 DH
4	305.04	The facility nurse did not make recommendations to the administrator regarding Resident #1's difficulty swallowing and increased needs with eating.		8/3/10 DH
5	305.05	The facility nurse did not conduct a review of previous recommendations to reposition Resident #2 every 2 hours.		8/3/10 DH
6	16 SH 310.01F	The caregiver did not watch a random resident take his medication ~~and began to~~ error DH		8/3/10 DH
7	310.04 e	Psychotropic medication Reviews were not conducted on Residents #3 and 4's medications.		8/3/10 DH
8	320.01	NSAs were not updated to reflect the residents' specific		8/3/10 DH

Response Required Date	Signature of Facility Representative	Date Signed
21 May 2010		

IDAHO DEPARTMENT OF
HEALTH & WELFARE

MEDICAID L & C – RALF PROGRAM
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-6626 fax: (208) 364-1888

ASSISTED LIVING
Non-Core Issues
Punch List

Facility Name	Physical Address	Phone Number
Downey Care Center	351 E. Center	897-5683
Administrator	**City**	**ZIP Code**
Kayleen Parke	Downey	83234
Survey Team Leader	**Survey Type**	**Survey Date**
Donna Henscheid	Standard	6/21/10

NON-CORE ISSUES

ITEM #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	L & C USE
8	Cont. –	needs. i.e: Resident #1's mobility, transferring & eating. Resident #2's repositioning needs. Resident #3's eating, toileting & transferring. Resident #4's behaviors.		
9	335.03	Facility staff did not wash hands when changing gloves and did not always change gloves in between care tasks.		8/3/10 DH
10.	350.02	The administrator did not complete an investigation and written report with 30 days of each incident.		8/3/10 DH
11	350.07	The facility did not report Resident #4's elopement to Licensing and Certification.		8/3/10 DH
12	450	The facility did not meet the standards of the Idaho Food Code. See attached Food Inspection Report. (Per Idaho Food Code a response / correction is required in 10 days)		8/3/10 DH

Response Required Date	Signature of Facility Representative	Date Signed
7/21/10		

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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Boise, ID 83720-0036
(208) 334-6626 fax: (208) 364-1888

ASSISTED LIVING
Non-Core Issues
Punch List

Facility Name	Physical Address	Phone Number
Downey Care Center	351 E. Center	897-5683
Administrator	**City**	**ZIP Code**
Kayleen Parke	Downey	83234
Survey Team Leader	**Survey Type**	**Survey Date**
Donna Henscheid	Standard	6/21/10

NON-CORE ISSUES

ITEM #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	L & C USE
13	451.02	Snacks were not offered in between meals.		8/3/10 DH
14	600.06	The administrator did not schedule sufficient staff during all hours to provide the required 2 person assistance with transfers for Residents #2 and 3.		8/3/10 DH
15	711.04	The staff did not document Resident #3's refusal of meals.		8/3/10 DH
16	711.08.b	The staff did not consistently document when they had provided assistance with medications. (many holes in MARS)		8/3/10 DH
17	711.11	The staff did not document the reason the medications were refused.		8/3/10 DH

Response Required Date	Signature of Facility Representative	Date Signed
7/21/10		

Date 17 Jun 10 Page 1 of 3

IDAHO DEPARTMENT OF HEALTH & WELFARE

Food Establishment Inspection Report

Food Protection Program, Office of Epidemiology
450 West State Street, Boise, Idaho 83702 208-334-5938

Critical Violations		Good Retail Practices	
# of Risk Factor Violations	5	# of Retail Practice Violations	
# of Repeat Violations	0	# of Repeat Violations	
Score	5	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	

Establishment Name: Downey Care Center	Operator: Kayleen Parke
Address: 501 E. Center St	City: Downey Zip: 83234
County: Downey Estab #: EHS/SUR.#:	Inspection time: NOON Travel time:
Inspection Type: STANDARD 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.

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	☐	☐
	Employee Health (2-201)		
Y (N)	2. Exclusion, restriction and reporting	☐	☐
	Good Hygienic Practices		
(Y) N	3. Eating, tasting, drinking, or tobacco use (2-401)	☐	☐
(Y) N	4. Discharge from eyes, nose and mouth (2-401)	☐	☐
	Control of Hands as a Vehicle of Contamination		
Y (N)	5. Clean hands, properly washed	☐	☐
(Y) N	6. Bare hand contact with ready-to-eat foods/exemption (3-301)	☐	☐
(Y) N	7. Handwashing Facilities (5-203 & 6-301)	☐	☐
	Approved Sources		
(Y) N	8. Food obtained from approved source (3-101 & 3-201)	☐	☐
(Y) N	9. Receiving temperature / condition (3-202)	☐	☐
Y N (N/A)	10. Records: shellstock tags, parasite destruction, required HACCP plan (3-202 & 3-203)	☐	☐
	Protection from Contamination		
(Y) N N/A	11. Food segregated, separated and protected (3-302)	☐	☐
Y (N) N/A	12. Food contact surfaces clean and sanitized (4-5, 4-6, 4-7)	☐	☐
(Y) N	13. Returned / roservice of food (3-306 & 3-801)	☐	☐
(Y) N	14. Discarding / reconditioning unsafe food (3-701)	☐	☐

	Potentially Hazardous Food Time/Temperature	COS	R
Y N (N/O) N/A	15. Proper cooking, time and temperature (3-401)	☐	☐
(Y) N N/O N/A	16. Reheating for hot holding (3-401)	☐	☐
Y (N) N/O N/A	17. Cooling (3-403)	☒	☐
Y N (N/O) N/A	18. Hot Holding (3-501)	☐	☐
Y N (N/O) N/A	19. Cold Holding (3-501)	☐	☐
(Y) N N/O N/A	20. Date marking and disposition (3-501)	☐	☐
Y N N/O (N/A)	21.Time as a public health control (procedures/records) (3-501)	☐	☐
Y N N/O N/A	**Consumer Advisory**		
Y N (N/A)	22. Consumer advisory for raw or undercooked food (3-603)	☐	☐
	Highly Susceptible Populations		
(Y) N N/O N/A	23. Pasteurized foods used, avoidance of prohibited foods (3-801)	☐	☐
	Chemical		
(Y) N N/A	24. Additives / approved, unapproved (3-202.12)	☐	☐
(Y) N	25. Toxic substances properly identified, stored, used (7-101 through 7-301)	☐	☐
	Conformance with Approval Procedures		
Y N (N/A)	26. Compliance with variance and HACCP plan (8-201)	☐	☐

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
Spaghetti in warmer	165.4						
Chili sauce in	63.1						

Refrig cooled during night

GOOD RETAIL PRACTICES (☒ = not in compliance)

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

OBSERVATIONS AND CORRECTIVE ACTIONS (CONTINUED ON NEXT PAGE)

Person in Charge (Signature) (Print) Title Date

Inspector (Signature) [signature] (Print) [signature] Date 17 JUN 2010

Follow-up: (Circle One) Yes No

IDAHO DEPARTMENT OF HEALTH & WELFARE

Food Establishment Inspection Report

Food Protection Program, Office of Epidemiology
450 West State Street, Boise, Idaho 83702
208-334-5938

Date 17 Jun 10

Establishment Name	Operator
Downey Care Center	Kaylen Parker
Address: 551 E. Center St	Downey 83234
County / Estab # / EHS/SUR.#	License Permit #

OBSERVATIONS AND CORRECTIVE ACTIONS (Continuation Sheet)

(1) The 2 caregivers on duty were preparing lunch. They stated they had not received Idaho Food Code training since they were hired at the facility. Both denied ever receiving food, knowing correct cooking temperatures, cooling temperatures or times. Further they were not familiar with exclusion or reporting, proper food contact surface cleaning & sanitizing, and when asked when they should wear gloves while handling, preparing and serving food, they both replied, "all of the time."

7/6/10 - received evidence of correction on this date. D. Henscheid

(2) Both caregivers on duty were not aware of exclusion or reporting requirements.

7/6/10 - Received evidence of correction on this date. D. Henscheid

(3) Both caregivers on duty were observed not changing gloves each time they assisted residents to get to the dining table, then return to the kitchen, nor before assisting residents with medication, then returning to the kitchen. Both caregivers also were observed to not always wash their hands when changing gloves.

7/6/10 - Received evidence of correction on this date. D. Henscheid

(4) Both caregivers were not aware of the rules regarding sanitizing work surfaces. General degreaser was used, or "I fill the sink with water and squirt some bleach in, but I wasn't told how much."

7/16/10 - Received evidence of correction. D. Henscheid.

(5) A large pot of chicken soup prepared on night shift was

Person in Charge	Date	Inspector	Date
		Allen A. Miller	17 Jun 10

CFP00-02-02

IDAHO DEPARTMENT OF HEALTH & WELFARE

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

Food Establishment Inspection Report

Date 17 Jun 10

Establishment Name	Operator
Downey Care Center	Kayleen Park
Address 337 E. Center ST	Downey 83234
County Estab # EHS/SUR.#	License Permit #

OBSERVATIONS AND CORRECTIVE ACTIONS (Continuation Sheet)

temped at 63.1 degrees at 1335 on the next afternoon. This soup was to be used for dinner that evening.
COS: Soup discarded by staff.

Items 1-4 require correction within 10 days. Ended facility on 21 Jun 2010 - correction required by 01 July 2010. The facility kitchen will be re-inspected on-site at the follow-up survey.

Person in Charge	Date	Inspector	Date
		Maureen A. McCann	17 Jun 10