

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) 334-5747 FAX: (208) 364-1811

October 10, 2007

Sandra Eggebraaten, Administrator Pennsylvania House 2087 S Tollgate Way Boise, ID 83709

License #: RC-880

Dear Ms. Eggebraaten:

On August 9, 2007, a complaint investigation, initial licensure survey was conducted at Wolfe Creek Assisted Living Communities, Inc-Pennsylvania House. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level(s):

• Non-core issues, which are described on the Punch List, and for which you have submitted evidence of resolution.

This office is accepting your submitted evidence of resolution.

Deier, MSW

Should you have questions, please contact Polly Watt-Geier, MSW, Health Facility Surveyor, Residential Community Care Program, at (208) 334-6626.

Sincerely,

POLLY WATT-GEIER, MSW

Team Leader

Health Facility Surveyor

Residential Community Care Program

PWG/sc

c:

Jamie Simpson, MBA, QMRP Supervisor, Residential Community Care Program



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August 23, 2007

Sandra Eggebraaten, Administrator Wolfe Creek AL Communities, Inc-Pennsylvania House 2087 S Tollgate Way Boise, ID 83709

Dear Ms. Eggebraaten:

On August 9, 2007, a complaint investigation, initial licensure survey was conducted at Wolfe Creek Assisted Living Communities, Inc-Pennsylvania House. The facility was found to be providing a safe environment and safe, effective care to residents.

The enclosed form, stating no core issue deficiencies were cited during the survey, is for your records only and need not be returned.

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 evidence of resolution (e.g., receipts, pictures, policy updates, etc.) are to be submitted to this office by September 8, 2007.

Should you have any questions about our visit, please contact me at (208) 334-6626.

Sincerely,

JAMIE SIMPSON, MBA, QMRP

Supervisor

Residential Community Care Program

JS/slc

Enclosure

STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 13R880 08/09/2007 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **809 PENNSYLVANIA STREET WOLFE CREEK AL COMMUNITIES, INC-PENN! BOISE, ID 83706** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DATE DEFICIENCY) R 000 Initial Comments R 000 The residential care/assisted living facility was found to be in substantial compliance with the Rules for Residential Care or Assisted Living Facilities in Idaho. No core issue deficiencies were cited during the initial health care survey and complaint investigation conducted at your facility. The surveyors conducting the initial health care survey and complaint investigation were: Polly Watt-Geier, MSW Team Coordinator Health Facility Surveyor Debbie Sholley, LSW Health Facility Surveyor Rachel Corey, RN Health Facility Surveyor

Bureau of Facility Standards

TITLE

(X6) DATE



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August 23, 2007

Sandra Eggebraaten, Administrator Wolfe Creek AL Communities, Inc-Pennsylvania House 2087 S Tollgate Way Boise, ID 83709

Dear Ms. Eggebraaten:

On August 9, 2007, a complaint investigation survey was conducted at Wolfe Creek Assisted Living Communities, Inc-Pennsylvania House. The survey was conducted by Rachel Corey, RN, Polly Watt-Geier, LSW and Debra Sholley, Social Worker. This report outlines the findings of our investigation.

Complaint # ID00002954

Allegation #1:

The facility does not have 7 days of non-perishable or 2 days of perishable foods

available in the house to follow the scheduled menu.

Findings:

Based on observation on 8/9/07, it was determined that 7 days of non-perishable and 2 days of perishable foods were available in house to follow the scheduled menu.

Conclusion:

Unsubstantiated. Although it may have occurred, it could not be determined during

the complaint investigation.

Allegation #2:

The House Manager followed an identified resident into her room, grabbed her and

kissed her on the cheek without her permission.

Findings:

Based on interview, it was determined that sufficient evidence existed to conclude

that the house manager kissed the identified resident on the cheek without her

permission.

On 8/9/07 at 11:15 a.m., the administrator stated the former house manager did kiss the identified resident on the cheek. She stated that he didn't mean anything sexual but was just showing he cared, as he was frequently observed to show his affection through touching. The former house manager had to be counseled on appropriate

Sandra Eggebraaten, Administrator August 23, 2007

Page 2 of 3

touch with the facilitie's population of residents. However, after complaints of residents feeling uncomfortable, the house manager was transferred to an all male facility.

Conclusion:

Substantiated. However, the facility was not cited as they acted appropriately by investigating the issue and transferred the house manager after reports of the identified resident feeling uncomfortable.

Allegation #3:

The House Manager called the identified resident by endearments like honey, sugar, baby, dear and the resident has asked him not to because it made her uncomfortable.

Findings:

Based on interview, it was determined the former house manager called the identified resident terms of endearments such as honey, sugar, baby and dear.

On 8/9/07 at 10:04 a.m., a random resident stated that former house manager called the identified resident terms of endearments such as "cookie."

On 8/9/07 at 11:15 a.m., the administrator stated the former house manager would put his arm around the identified resident and call her terms of endearment. The administrator stated the former house manager did not mean anything sexual by it, as he was observed showing his affection frequently in this way. However, the former house manager was transferred to an all male facility after the identified resident complained of feeling uncomfortable.

Conclusion:

Substantiated. However, the facility was not cited as they acted appropriately by investigating the identified residents complaint and transferring former house manager to an all male facility.

Allegation #4:

An identified resident needs to be to day treatment in the mornings; he leaves around 7:30 am and the house manager does not get up until 8 or 9 am. The resident has not received his morning medications for 2 to 3 months.

Findings:

Based on interview, it was determined that identified resident did not receive morning medications before leaving for day treatment.

On 8/9/07 at 11:15 a.m., the administrator stated that it was brought to her attention from residents other than identified resident, that former house manager was not getting up early enough to assist residents with medications before they left for day treatment. The house manager was counseled about behavior with no improvement and was then replaced by a new house manager.

Conclusion:

Substantiated. However, the facility was not cited as they acted appropriately by counseling the house manager and seeking further action when no improvement was observed. It was observed that under the new manager, the residents were receiving medications at scheduled times.

Sandra Eggebraaten, Administrator August 23, 2007 Page 3 of 3

Allegation #5:

An identified resident who is diabetic reused her lancet to check her blood sugar.

Findings:

Based on observation, it could not be determined the identified resident had reused

her lancet to check her blood sugar.

Based on observation on 8/9/0, resident was observed to follow appropriate steps to

independently check blood sugar.

Conclusion:

Unsubstantiated. Although it may have occurred, it could not be determined during

the complaint investigation.

As no deficiencies were cited as a result of our investigation, no response is necessary to this report. Thank you to you and your staff for the courtesies extended to us on our visit.

Sincerely,

POLLY WATT-GEIER, MSW

Team Leader

Health Facility Surveyor

Residential Community Care Program

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PWG/sc

c:

Jamie Simpson, MBA, QMRP, Supervisor, Residential Community Care Program

Polly Watt-Geier, MSW, Health Facility Surveyor



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August 23, 2007

Sandra Eggebraaten, Administrator Wolfe Creek Al Communities, Inc-Pennsylvania House 2087 S Tollgate Way Boise, ID 83709

Dear Ms. Eggebraaten:

On August 9, 2007, a complaint investigation survey was conducted at Wolfe Creek Assisted Living Communities, Inc-Pennsylvania House. The survey was conducted by Rachel Corey, RN, Polly Watt-Geier, MSW and Debra Sholley, LSW. This report outlines the findings of our investigation.

Complaint # ID00003039

Allegation #1:

Former House Manager touched an identified female resident on her arm and lower back and called her terms of endearment which made her feel uncomfortable and violated her dignity and respect.

Finding:

Based on interview, it was determined the former house manager did touch the identified female residents on their arms and lower backs, however it was not done in a sexual manner.

The identified resident was no longer at the facility and therefore could not be interviewed.

On 8/9/07 at 10:04 a.m., an identified resident who was at the facility during the time the allegation occurred, confirmed that the former house manager touched the identified resident's arm and lower back and called her terms of endearment like, "cookie." However, she stated the touching had not been done in a sexual manner.

On 8/9/07 at 11:15 a.m. administrator was interviewed stating the former house manager frequently showed affection by touching their backs and arms. The former house manager was moved to an all male facility after complaints about the female residents feeling uncomfortable.

Sandra Eggebraaten, Administrator August 23, 2007 Page 2 of 5

Conclusion:

Substantiated. However, the facility was not cited as they acted appropriately by investigating complaints and concluding that while the touching was not sexual it did cause the identified resident to feel uncomfortable. Therefore, the house manager was transferred to an all male facility and counseled on appropriate interactions with residents.

Allegation #2:

An identified resident who was insulin dependant diabetic did not recieve insulin and blood glucose testing according to physicians orders.

Findings:

Based on interviews, it was determined the identified resident did not receive glucose testing according to physician orders.

On 8/9/07 at 11:15 a.m., the administrator confirmed the former house manager did not assist the identified resident with glucose testing and insulin administration consistently as ordered. The house manager was frequently counseled on proper assistance with medication. When no improvement was observed, the house manager was transferred to another facility thinking that behavior would improve in a new environment.

The identified resident confirmed on 8/9/07 at 10:04 a.m. that insulin and blood glucose testing was done periodically and not consistent with physician orders. However, the resident stated the current house manager was appropriately assisting with blood glucose testing and insulin as ordered.

Conclusion:

Substantiated. However, the facility was not cited as they acted appropriately by counseling the former house manager and taking action when improvement was not seen. The current house manager was observed assisting the resident with blood glucose testing and insulin as ordered.

Allegation #3:

An indentified resident who used a walker for ambulation was verbally abused by the former house manager.

Findings:

Based on interview, it could not be determined the identified resident was verbally abused by the former house manager.

On 8/907 at 10:04 a.m. the identified resident stated that while the former house manager was angry with her at times, he never called her names or was derogatory towards her.

On 8/907 at 11:45 a.m. the administrator stated she did not recall the former house manager using degrading words toward the identified resident.

Conclusion:

Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation.

Sandra Eggebraaten, Administrator August 23, 2007 Page 3 of 5

Allegation #4:

Residents were not receiving meals according to the menu and their dietary needs.

Findings:

Based on interview, it was determined the former house manager did not ensure meals were prepared according to the menu and dietary needs of the residents.

On 8/9/07 at 10:04 a.m., a random resident stated the menu was never followed by the former house manager and rice was served at every meal.

On 8/907 at 11:45 a.m., the administrator stated that when she entered the facility one weekend, there was very little food available to prepare meals for the residents. Additionally, she state the former house manager was not buying food according to the menu.

Conclusion:

Substantiated. However, the facility was not cited as they acted appropriately by counseling the house manager on meal planning. When no improvement was seen, the house manager was replaced.

Allegation #5:

An identified resident was not receiving morning medications on time. However, the former house manager would initial the MAR as if the resident received the medication at the appropriate time.

Findings:

Based on interview and record review, it was determined the identified resident was not receiving morning medications and MARs were initialed as if the resident received medication on time.

On 8/9/07 at 11:15 a.m. the administrator stated the former house manager did not get up early enough to assist the identified resident with medication administration. It was brought to the administrator's attention only when other residents complained, as the identified resident never expressed concern. The former house manager was counseled about behavior and when there was no improvement observed, he was replaced with a new house manager.

Record review on 8/9/0, revealed all morning medications were initialed as given on time during the time period which the former house manager worked.

Conclusion:

Substantiated. However, the facility was not cited as they acted appropriately by counseling the house manager and taking further action when no improvement was observed. It was not observed that under the new house manager, residents were not receiving medications as ordered.

Allegaton #6:

Medications did not get started at the time as ordered because the former house manager would stack the orders in a pile on his desk and never look at them again.

Finding:

Based on interview, it was determined residents did not get medications as ordered by physician at the time as ordered.

Sandra Eggebraaten, Administrator August 23, 2007 Page 4 of 5

On 8/9/07 at 11:15 a.m. the administrator stated the former house manager would allow medication orders to pile up on the desk and never look at them. As a result, medications did not get filled as ordered. The house manager was counseled about behavior, but refused to act appropriately.

Conclusion:

Substantiated. However, the facility was not cited as they acted appropriately by counseling the former house manager and replaced the former house manager when the behavior did not improve.

Allegation #7:

A resident had the house manager lock up \$700 in the office. The money was the resident's rent money. The house manager was the only one that had a key to the office. The \$700 came up missing and the house manager claimed to have no knowledge as to where the money went.

Findings:

Based on interview, it could not be determined the identified resident's \$700 was stolen by the former house manager.

The administrator on 8/9/07 at 11:15 a.m., stated the former house manager reported to her that \$700 of the identified resident's rent money came up missing, but there was no way to prove former house manger stole the money. The administrator stated the identified resident was not held accountable for rent that month and a new system of managing money was developed as a result.

Conclusion:

Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation.

Findings #8:

Based on interview it was determined the former house manager kissed an identified resident on the cheek.

On 8/9/07 at 11:15 a.m. the administrator stated the former house manager kissed the identified resident on the cheek, but did not intend it to be in a sexual manner. The administrator stated the house manager wanted to show that he cared, but did not have the knowledge to recognize inappropriate touch when caring for the facilities's population. The former house manager was counseled about inappropriate touch. However, the former house manager was transferred to an all male facility after residents continued to feel uncomfortable.

Allegation:

The former house manager kissed an identified resident on the cheek causing her to feel uncomfortable.

Conclusion:

Substantiated. However, the facility was not cited as they acted appropriately by investigating the house manager's behaviors and transferred him when residents expressed complaints of feeling uncomfortable.

Sandra Eggebraaten, Administrator August 23, 2007 Page 5 of 5

As no deficiencies were cited as a result of our investigation, no response is necessary to this report. Thank you to you and your staff for the courtesies extended to us on our visit.

Sincerely,

Tally Watt-Diec, MSW POLLY WATT-GEIER, MSW

Team Leader

Health Facility Surveyor

Residential Community Care Program

PWG/sc

Jamie Simpson, MBA, QMRP, Supervisor, Residential Community Care Program c:

Polly Watt-Geier, MSW, Health Facility Surveyor



BUREAU OF FACILITY STANDARDS P.O. Box 83720 Boise, ID 83720-0036 (208) 334-6626 fax: (208) 364-1888

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Administrator, S City / ZIP Code						
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Survey	Team Leader	√ Survey Type	pr manifestra	Survey Date		
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NON-CORE ISSUES						
ITEM #	RULE# 16.03.22	DESC	RIPTION		DATE RESOLVED	BFS USE
1	310.01	The facility did not have	a varione for over	the		9/21/01PW
		Counter, bulk medication	s for residents 1,2,8	3,		
2	600.06.b	Weekend carequer worked) without CRR / Filst	aid		1011014
		Cortification.				100 100 20
3.	711.07	Facility old not maintain Careplans from outside				7/07/AJG
		Service providers le Dau	treatments and mest	ul healthi		
1 ,		RSP serulus.	,	<u> </u>		
4.	711.08 E	Staff Ju not notify R. Not	Change in residents	physical	nu.	9/21/5 WH
		or mental conditions (i.R.U not involved with medical decisons				
		on 7/12/07 For resident #2)	<i>-</i>		.,	
5	7.11.08F	Notes of care and services	From outside Senice pi	ovider		alariana
		(Daytreatments/mental health &	PSIC Services) not ma	ntained,		
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Respon	se Required Date	Signature of Facility Representative			Date Signed	
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