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HEALTH & WELFARE

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January 18, 2012

Amy Rackham, Administrator  
Homestead Assisted Living Center Inc Of Rexburg  
360 West 3500 North  
Rexburg, ID 83440

Dear Ms.. Rackham:

An unannounced, on-site complaint investigation survey was conducted at The Homestead Assisted Living Center, Inc. Of Rexburg from January 11, 2012, to January 11, 2012. During that time, observations, interviews, and record reviews were conducted with the following results:

**Complaint # ID00005225**

- Allegation #1:** The facility did not contact the appropriate authorities when a resident was found to have bruises of unknown origin.
- Findings #1:** On 1/11/12, the identified resident's record was reviewed. It contained an incident report, dated 9/2/11, documenting the resident had bruises on her wrists. It further documented the facility made a report to Adult Protection Services (APS), moved the resident to another room to make her feel more secure and reported the incident to Licensing and Certification. The incident report also documented the facility did an investigation into the cause of the bruises along with a police investigation that was conducted.
- On 1/11/12 at 8:30 AM, APS and the Ombudsman confirmed the facility had called and made a report to them about the bruises. They expressed no concerns on how the facility conducted their investigation.
- On 1/11/12 at 12:50 PM, a caregiver on duty the evening the bruises were discovered, stated she called the house manager immediately and management responded.
- Unsubstantiated.
- Allegation #2:** There were no staff in the building on September 6, 2011, between 7:30 PM and 7:50 PM, when the one assigned staff went to another building to get a recipe.
- Findings #2:** On 1/11/12, the as worked staff schedule was reviewed for September 6, 2011. The as worked schedule documented there were two staff on duty that evening.

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During the tour of the facility, 10 residents stated staff were available when they called for help. On 1/11/12 between 10:00 AM and 1:00 PM, seven caregivers were interviewed and stated it was against policy to leave a building if another caregiver was not on duty. They further stated they notified another caregiver if they had to leave the building. The caregivers stated they were unaware of a time when a caregiver left the building leaving residents unattended.

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

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,

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

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