



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

C.L. "BUTCH" OTTER – GOVERNOR  
RICHARD M. ARMSTRONG – DIRECTOR

LESLIE M. CLEMENT—DEPUTY DIRECTOR  
LICENSING AND CERTIFICATION  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE 208-334-6626  
FAX 208-364-1888

**CERTIFIED MAIL #7007 3020 0001 3745 8023**

March 23, 2012

Louis Adamson, Administrator  
Carefix-Safe Haven Homes Of Burley  
1703 Almo Avenue  
Burley, ID 83318

Dear Mr. Adamson:

On January 20, 2012, Carefix Safe Haven Home of Burley, received core deficiencies for which a provisional license and enforcement actions were imposed. One of the conditions of the provisional license was that a consultant would submit weekly written reports to the department. The reports were to address progress on correcting the core and non-core deficiencies. Additionally, the facility was cited for non-core deficiencies. The survey cover letter, sent to the facility on February 3, 2012, specified that the facility needed to submit acceptable evidence of resolution for the non-core issues by **February 19, 2012**. As of today, **March 26, 2012**, we have not received acceptable evidence of resolution for four (4) of the punch list non-core deficiencies cited at IDAPA 16.03.22.225.01, 300.01, 300.02 and 711.01.

Enclosed is another copy of the Punch List identifying the non-core deficiencies. Please immediately submit acceptable evidence of resolution for the remaining punch list deficiencies and have your consultant submit the consultant reports for the past two Fridays.

If the facility does not meet all conditions of the provisional license by **March 30, 2012**, the Department will have not alternative but to impose additional enforcement actions including limiting admissions to the facility and imposing civil monetary penalties.

Our staff is available to answer questions and to assist you in identifying appropriate corrections. Should you require assistance or have any questions about our visit, please contact us at (208) 334-6626.

Sincerely,

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

Enclosure



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

C.L. "BUTCH" OTTER – GOVERNOR  
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Boise, Idaho 83720-0009  
PHONE 208-334-6626  
FAX 208-364-1888

**CERTIFIED MAIL #: 7007 3020 0001 3745 7866**

February 3, 2012

Louis Adamson, Administrator  
Carefix-Safe Haven Homes of Burley  
1703 Almo Avenue  
Burley, ID 83318

Dear Mr. Adamson:

Based on the Complaint Investigation survey conducted by Department survey staff at Carefix Management & Consulting Inc, Db a Safe Haven Homes of Burley on **January 20, 2012**, we have determined that the facility failed to protect residents from abuse and from inadequate care.

**I. Provisional License and Enforcement Actions:**

These core issue deficiencies substantially limit the capacity of Carefix Management & Consulting Inc, Db a Safe Haven Homes of Burley 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. As a result of the survey findings, the Department is issuing the facility a provisional license, effective February 3, 2012, through August 1, 2012. 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 noncore 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:

- 1. The facility has voluntarily hired an outside consultant to assist with the identification and correction of issues. The consultant will submit a weekly written report to the Department commencing on February 10, 2012 and every Friday thereafter. The**

**reports will address progress on correcting the deficiencies on the Statements of Deficiencies and Non-Core Issues Punch Lists.**

- 2. The facility will maintain, on an ongoing basis, the deficient area in a state of compliance in accordance with the submitted Plan of Correction;**
- 3. A provisional license is issued which is to be prominently displayed in the facility. Upon receipt of this provisional license return the full license, currently held by the facility.**
- 4. When the consultant and the administrator agree the facility is in full compliance, they will notify the Department and a follow-up survey will be conducted.**

Please be advised that you may contest this decision by filing a written request for administrative review pursuant to IDAPA 16.05.03.300. **no later than twenty-eight (28) days after this notice was mailed.** Any such request should be addressed to:

**Debby Ransom, R.N., R.H.I.T**  
**Bureau Chief, Licensing and Certification**  
**Department of Health and Welfare**  
**P.O. Box 83702**  
**Boise Id 83720-0009**

If you fail to file a request for administrative review within the time allowed, this decision shall become final.

## **II. Plan of Correction:**

You have an opportunity to make corrections and thus avoid further enforcement action. Correction of this deficiency must be achieved by **March 5, 2012.** **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)?

What date will the corrective action(s) be completed by?

Return the **signed** and **dated** Plan of Correction to us within ten (10) calendar days of your receipt of this letter, 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 process. If you disagree with the survey report findings, you may make a written request to the Supervisor of the Residential Care 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. 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 informal dispute resolution is received more than ten (10) business days after you receive this letter, 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](http://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 **February 19, 2012**.

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 further enforcement action against the license held by Carefix Management & Consulting Inc, Dba Safe Haven Homes of Burley. Those enforcement actions may include limiting admissions to the facility, civil monetary penalties and revocation of the facility license.

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  
Program Supervisor  
Residential Assisted Living Facility Program

JS/smo

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION</b>	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  _____	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>entire</u> B. WING _____	(X3) DATE SURVEY COMPLETED
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NAME OF FACILITY <u>CARE SAFE HAVEN Homes of Burley</u>	STREET ADDRESS, CITY, STATE, ZIP CODE <u>1703 Almo Avenue, Burley, ID, 83318</u>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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16.03.22.510 - ABUSE	<p>On 1/11/12, an Immediate Danger was called when the facility failed to take steps that would ensure protection of Residents after Resident #2 threatened to stab other Residents; Retrieved a rock or brick from out doors and attempted to follow through with his threat to go inside the facility and smash Resident #1 in the head with it; and after he attempted to assault other residents with a heavy, dining room chair.</p> <p>On 1/12/12, through 1/13/12, the facility failed to take steps that would ensure protection of the Residents after Resident #3 told a caregiver, who worked the Night Shift on 1/11/12, that he wanted to "cut Residents feet off" and told two Residents, on 1/11/12, that he wanted to "cut people up at Night." RALF</p>		<p>Jan 12, 2012 11:15am Spoke w/ Scott Burpee, Owner of facility - Administr. Cathy Rupe is on leave due to death in <sup>Permar</sup> facility and Scott is not willing to sign this document. Verified w/ Mr. Burpee the following immediate corrections:</p> <ol style="list-style-type: none"> <li>1. Resident #2 has been discharged from the facility.</li> <li>2. Resident #3 has been taken to Dr. and will not be re-admitted until he is deemed safe by a medical professional.</li> <li>3. Staff who allegedly purposely overdosed a resident has been placed on administrative leave pending outcome of an investigation into the incident. Jamie Simpson, Supervisor</li> </ol>	
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13R931	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 01/20/2012
NAME OF PROVIDER OR SUPPLIER  CAREFIX-SAFE HAVEN HOMES OF BURLEY		STREET ADDRESS, CITY, STATE, ZIP CODE 1703 ALMO AVENUE BURLEY, ID 83318		
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R 000	<p><b>Initial Comments</b></p> <p>The following deficiencies were cited during a complaint investigation conducted on 1/11/2012 through 1/20/2012, at your residential care/assisted living facility. The surveyors conducting the survey were:</p> <p>Karen Anderson, RN Team Leader Health Facility Surveyor</p> <p>Matt Hauser, QMRP Health Facility Surveyor</p> <p>Abbreviations used in this report:</p> <p>@ = at &amp; = and # = number Admin = administrator AM = morning BMP = behavior management plan DE = Designated Examiner EVE = evening hr(s) = hours MAR (s) = medication assistance record med = medication meds = medications mg = milligrams NOC = graveyard or night NSA = Negotiated Service Agreement NSA/UAI = Negotiated Service Agreement and uniform assessment instrument combined PM = evening PRN = as needed PSR = psychosocial rehabilitation psych = psychiatric PTSD = post traumatic stress disorder Res = resident</p>	R 000		

Bureau of Facility Standards

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



TITLE

Administrator

(X6) DATE

2/17/12

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R 000	Continued From page 1  sic = indicates that the quoted words appear exactly as in the original source SOB = "son of a b..ch" UAI = uniform assessment instrument w/ = with	R 000		
R 006	16.03.22.510 Protect Residents from Abuse.  The administrator must assure that policies and procedures are implemented to assure that all residents are free from abuse.  This Rule is not met as evidenced by: Based on record review, observations and interview, it was determined the facility did not implement their abuse policy and procedures. As a result 8 of 9 residents were not protected from abuse. This put all of the residents in immediate danger. The findings include:  On 1/11/12, an immediate danger was called by the survey team for not protecting residents from abuse when Resident #2 was retained at the facility after he had been verbally and physically abusive to other residents. Resident #2 was transferred to another facility operated by the same owner on the evening of 1/11/12.  The facility's abuse policy defines the following terms: - "ABUSE-is defined as the willful infliction of injury, unreasonable confinement, intimidation, punishment with resulting physical harm, pain, or anguish, or deprivation by an individual (including a caretaker) of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well being." - "VERBAL ABUSE-is defined as any use of oral, written, or gestured language that includes	R 006	Residents that demonstrate unsafe behaviors will have a continually updated and reviewed behavior management plan. To assist in tracking changes in behaviors, implementation of a behavior management check sheet will also be used to visually guide staff on progression with residents. This will give the staff a head start to notify the administrator on concerns of escalation.  The administrator will follow policy and procedures to identify, investigate and communicate to the Commission on Aging any time the facility has reasonable cause to believe a vulnerable	

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R 006	<p>Continued From page 2</p> <p>disparaging and/or derogatory terms to residents or their families,..."</p> <p>- "MENTAL ABUSE-is' defined as, but not limited to, humiliation, harassment, threats of punishment, or..."</p> <p>The facility's abuse policy documented the facility would ensure that any allegation of abuse would be identified, reported and investigated. The policy also stated assurance of protection would be provided and interventions to prevent reoccurrence would be initiated. The policy also stated this process would be documented. Additionally, the facility's policy documented if the facility had "reasonable cause to believe that a vulnerable adult" was being or had been abused, it would immediately be reported to the "Idaho Commission on Aging or the area agency of aging (Adult Protection)."</p> <p>On 1/11/12 through 1/13/12, during a complaint investigation, observations were made of all residents residing in the facility. The residents' ages ranged from 29 years old through 90 years old.</p> <p>Resident #2 was a 29 year old male, who was admitted to the facility on 12/9/11. His diagnoses included schizoaffective disorder/bipolar type, personality disorder, PTSD and polysubstance dependence.</p> <p>A discharge summary from a psychiatric hospital, dated 11/14/11, documented Resident #2 was considered "high risk for assault" and had a history of assaultive behaviors when "irritated by other patients."</p> <p>A "Psychiatric Evaluation," dated 11/22/11, documented Resident #2 had "suicidal and</p>	R 006	<p>adult is or was being abused. Staff will be trained and tested to ensure a thoroughly understanding on behavioral concerns. Residents will be interviewed prior to admission for their appropriateness based on our admission assessment policies being preformed by the administrator. The administrator will also follow up on the residents appropriateness regularly to ensure that escalation has not occurred impacting their eligibility of retention in the facility.</p>	

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R 006	<p>Continued From page 3</p> <p>homicidal ideation" such as wanting to "beat up" or "kill" his neighbor for coughing too loud. The evaluation further documented, the resident had hallucinations of seeing himself "stabbing other people."</p> <p>Interviews were conducted with eight residents, on 1/11/12 through 1/19/12. All residents stated Resident #2's behaviors caused them distress. The residents stated they were afraid of Resident #2, as he yelled at, cursed at, threatened and attacked them and/or other residents at the facility. They stated, the administrator and the caregivers were aware of the verbal, mental and physical abuse exhibited by Resident #2, however nothing was done about it.</p> <p>Interviews were conducted, from 1/11/12 through 1/19/12, with caregivers. Eight of nine caregivers interviewed stated Resident #2 yelled at, cursed at, threatened and attacked the other residents at the facility. They stated the administrator was aware other residents were staying in their rooms to avoid him. All caregivers stated nothing had been put in place or changed to address Resident #2's behaviors and protect other residents. Caregivers further stated, they had not received training on providing care to residents with mental illness. Eight of nine caregivers, stated they had not received training on how to intervene if a resident was violent. They stated at times, they were afraid of Resident #2, because he was explosive and unpredictable.</p> <p>On 1/11/12 at 3:40 PM, Caregiver A stated, Resident #2 would get agitated by other residents. She stated, "he told me he wanted to stab some of the residents here. Residents are afraid of him and stay in their rooms to avoid him."</p>	R 006	<p>Corrective actions have been taken into effect beginning with the discharge of resident #2 on January 11th 2012. Resident #1 was also discharged on January 21th 2012. All other residents are being monitored regularly for changes in behaviors via our behavior management check sheet. Three times a week the administrator will review the behavior management check sheet. He/she will then communicate any concerns to the nurse and healthcare provider for proper corrective actions that may need to be taken. Training and testing of the employees will be preformed to ensure accuracy in their documentation of behaviors as well as the handling of behavioral situations when they arise. All of these actions will be implemented by February 24th 2012.</p>	

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R 006	Continued From page 4  On 1/11/11 at 3:55 PM, Caregiver D stated, "I noticed things changed after Resident #2 moved in." She continued, "For example, [Resident #2's name] escalates with agitation fast and provokes other residents by yelling and swearing up a storm, causing conflicts."  On 1/11/12 at 3:10 PM, Caregiver I stated that during an incident on 1/7/12, Resident #2 pushed her against the medication cart preventing her from intervening. She stated, "I know two of the female residents are afraid of him."  On 1/11/12 at 2:00 PM, Random Resident D stated, "[Resident #2's name] flips out in anger fits, screaming and yelling [f...off], and yells out threatening to stab [Resident #1's name, and a name of another resident]." She further stated, "I am afraid of him, so I stay in my room most of the time."  On 1/11/12 at 2:24 PM, a resident stated, "I was told by a caregiver that [Resident #2's name] wanted to stab me. He also called me a b..tch." He stated, "I feel uncomfortable going to sleep at night with him roaming around."  On 1/11/12 at 2:40 PM, a different resident stated, "[Resident #2's name] cusses and yells a lot. He is a big beer drinker and gets mad if he doesn't have beer to drink. The resident stated, "I have told caregivers and the administrator that he needs to be out of here."  On 1/13/12 at 10:35 AM, Random Resident C stated, "I saw [Resident #2's name] take a fork out of the kitchen drawer and say out loud, he was going to stab a resident in the back with the fork." Random Resident C stated, "the	R 006		

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R 006	<p>Continued From page 5</p> <p>administrator is aware of everything going on here, but she refuses to do anything about it"</p> <p>On 1/17/12 at 11:49 AM, Caregiver B stated, "We called the administrator and told her what [Resident #2's name] had said to the residents, and trying to start arguments by yelling at them." She told us it was part of Resident #2 behaviors. The caregiver stated, "Now residents stay in their rooms most of the time to avoid him."</p> <p>On 1/18/12 at 9:27 AM, Caregiver F stated, Resident #2 lived at the facility for approximately a week when he started to say things like, "I want to stab all the residents and cut them up and blow up the facility." She stated Resident #2 would say things like that in front of the residents and she could tell it bothered them. She said, "I told the administrator what the resident had been saying." Caregiver F continued, "And the administrator's answer would be; If the medications aren't working give him beer."</p> <p>On 1/11/12 at 5:30 PM, the administrator stated, Resident #2 had a "potty mouth" but she was not aware he cursed at other residents. She stated, "I was not aware [Resident #2's name] told staff or residents that he was going to stab residents." She stated, the caregivers or the residents had not told her about that. She stated, "I have observed residents isolating in their rooms, but I did not know why."</p> <p>On 1/11/12 at 6:18 PM, Caregiver I stated; Resident #2 had gotten drunk approximately one week after being admitted to the facility and started cursing at residents and making gestures to intimidate them. The caregiver stated he raised his arms out and above his head and would lunge forward at them.</p>	R 006			

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R 006	Continued From page 6  A police report, dated 12/18/11, documented the police were called to the facility because "a resident (Resident #2) was out of control and causing damage to the property, throwing things and breaking things."  The administrator did not document the incident or document interventions to ensure protection to all residents was provided.  On 1/17/12 at 3:40 PM, Caregiver C stated, "I called the police on [Resident #2's name] in December when he got angry and threw a cup of juice across the kitchen table and nearly missed hitting [Random Resident B's name] in the head with the cup." She stated, "He got up from the table and punched the door and went outside, picked up the picnic table and threw it across the back yard." She further stated, "I called the police." The administrator was at the facility when the police arrived.  After the incident on 12/18/11, Resident #2 remained at the facility. No methods to protect other residents from abuse were implemented.  On 1/7/12, a second police report documented they were called to the facility because Resident #2, "Threw a chair" at another resident during a resident to resident altercation.  An incident report, dated 1/7/12 at 10:00 PM, documented police were called to the facility because Resident #2 threw a chair at another resident. The report documented the administrator gave both residents a warning they would be discharged from the facility if there were any more problems. It further documented Resident #1 was sent to his room and Resident	R 006		

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R 006	Continued From page 7  #2 went outside to "cool off." There was no documentation of what measures were implemented after the incident to ensure the other residents would be protected from further abuse.  A caregiver's note, dated 1/7/12, documented Resident #1 and Resident #2 got into a fight and Resident #2 picked up a chair and threw it across the dining room table. The caregiver documented she was not able to intervene, because Resident #2 pushed her against the medication cart and Resident #4 had to intervene. She documented, after the incident, Resident #2 went outside to smoke and Resident #1 was restricted to his room.  On 1/12/12 at 9:45 AM, Resident #4 stated, he intervened during the incident on 1/7/12, because Resident #2 was going to bash Resident #1 over the head with the chair. Resident #4 stated that Resident #2 was screaming and cussing the entire time during the incident. Resident #4 stated, "[Resident #2's name] told me he had a shit list of grudges that included, stabbing the piss out of us, starting with [Resident #1's name]." Resident #4 further stated, "I'm not able to rest at night with him in the facility." He stated, "I don't understand why [Resident #2's name] wasn't put on restrictions after the incident and has been allowed to roam the facility."  On 1/13/12 at 8:30 AM, Random Resident A stated he witnessed the altercation between Residents #1 and #2. He said Resident #1 and #2 were fighting all day. He stated he did not sleep well at night because Resident #2 was up most nights and worried he could be attacked by Resident #2 during the night.	R 006		

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R 006	<p>Continued From page 8</p> <p>On 1/12/12 at 1:45 PM, Caregiver A stated, "I gave [Resident #2's name] everything medication wise to help decrease his agitation." She stated, "After the altercation, (on 1/7/12) the administrator and I took [Resident #2's name] to buy beer hoping to keep him calm. When we got back to the facility, [Resident #2's name] picked up a rock and told us he was going to go inside and kill that [SOB]." Caregiver A stated, "I took the rock away from him and the administrator just stood there and didn't say anything to the resident or try to intervene." She stated, neither her nor the administrator documented the incident or wrote up an incident report. She said the administrator did not put interventions in place to make sure residents were protected from further abuse.</p> <p>All nine caregivers interviewed, from 1/11/12 through 1/19/12, stated no new interventions or precautions were implemented for Resident #2, prior to surveyors entering the facility on 1/11/12.</p> <p>On 1/11/12 at 9:50 AM, the administrator confirmed she knew about the resident to resident altercation between Resident #1 and Resident #2, and completed an incident report. The administrator denied having knowledge of any other altercations involving Resident #2. When asked if she had reported the incident to Adult Protection, she stated she did not know she was supposed to. When shown a copy of the facility's policies and procedures, she stated she had not read them.</p> <p>The administrator did not know where the facility's abuse policy was kept or what it instructed staff or her to do if she was to receive an allegation of abuse.</p>	R 006		

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R 006	Continued From page 9 Resident #2 was admitted to the facility on 12/9/11, with a history of assaultive behaviors. During the 33 days he resided at the facility he was mentally, verbally and physically abusive towards residents. Eight caregivers confirmed they witnessed Resident #2's assaultive behaviors and had informed the administrator. Eight residents stated they feared Resident #2. However, no investigation took place by the administrator to determine if abuse had occurred. Additionally, Adult Protection was not notified to determine if abuse had occurred. Because no investigation took place regarding Resident #2's behaviors, interventions were not put in place to protect the residents to ensure their safety. The facility failed to protect all residents from abuse which resulted in an immediate danger.	R 006		
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, the facility failed to protect 1 of the 4 sampled resident's (Resident #1) rights to retain his assistive device and not be confined to his room. The facility did not provide a safe living environment for 8 of 9 residents' residing in the facility when 2 of 4 sampled residents (Resident #2 and #3) were admitted and retained who were a danger to themselves and others. Further, the facility failed to provide an appropriate level of supervision for 1 of 4 sampled residents (Resident #2), which had the potential to affect 100% of the residents residing in the facility. The	R 008		

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R 008	Continued From page 10 findings include:  I. RESIDENT RIGHTS  IDAPA 16.03.22.011.08 defines Inadequate Care as: "When a facility...engages in violations of resident rights...."  According to IDAPA 16.03.22.550.10 Requirements for Residents' Rights, "The administrator must assure that polices and procedures are implemented to assure that residents' rights are observed and protected.....Freedom from Abuse, Neglect, and Restraints. Each resident must have the right to be free from physical, mental or sexual abuse, neglect, corporal punishment, involuntary seclusion,....."  Further, according to IDAPA 16.03.22.550.04.c Requirements for Residents' Rights, "The administrator must assure that ....Each resident has the right to retain and use his own personal property in his own living area so as to maintain individuality and personal dignity."  IDAPA 16.03.22.225 Requirements for Behavior Management, states, "....The facility must develop an intervention for each behavioral symptom.... and the intervention needs to be the least restrictive."  The facility's "ABUSE REPORTING POLICY", undated, defines "Involuntary Seclusion...as separation of a resident from other residents, from his/her room, or confinement to his/her room against a resident's will, or the will of his/her guardian or representative."  Resident #1's NSA/UAI, dated 9/27/11,	R 008	Upon admission to the facility all residents are given a copy of the resident rights these are also reviewed with them at time of admission to ensure their understanding. The resident signs in acknowledgment of the understanding and receipt of the residents rights. Residents rights posters are displayed in the facility at all times for immediate review.  Residents that demonstrate unsafe behaviors will be encourage to be involved in their own behavioral management plan. This will assist the resident in being aware of their rights in the event that an inappropriate behavior occurs. Residents or their designated guardian will sign prepared behavior management plans to acknowledge they have reviewed the plan.	

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R 008	<p>Continued From page 11</p> <p>documented he was admitted to the facility on 9/13/11, with diagnoses which included severe depression, chronic headaches, and a history of seizures. In the section titled "Habilitation Needs and Special Equipment", the NSA/UAI documented, "uses a cane at times to assist with mobility when he feels unsteady."</p> <p>A "Universal Incident/Occurrence Report," dated 1/7/12 at 10:00 PM, documented a caregiver had notified the administrator of an incident at 10:02 PM, where a resident threw a chair at another resident and the administrator had instructed the caregiver to call the police. The administrator documented on the incident report, on 1/8/12, that "Residents were given a final warning that next time both residents would be discharged."</p> <p>A police report, dated 1/7/12 at 10:11 PM, documented Resident #1 called the police and reported a male subject (Resident #2) called him a name and then threw a chair at him. The police report further documented a staff member at the facility told the police this had been an ongoing fight, and the residents were able to solve the problem civilly.</p> <p>The caregiver documented the following on 1/7/12, Resident #1 and Resident #2 had a physical altercation. Resident #2 threw a chair at Resident #1. Afterwards Resident #1 was sent to his room by staff and called the police to come to the facility.</p> <p>The administrator documented on 1/7/12, that she was contacted at 10:02 PM regarding the incident between Residents #1 and #2. The note further documented, the administrator was told the residents were sitting together and attempting to "work out their differences." According to the</p>	R 008	The administrator will track behaviors weekly and as needed to verify changes in residents behavior interactions. The administrator will use the behavior management check sheet to insure proper intervention and documentation of the resident's plan. All of these corrections will be fully implemented but February 24th 2012.	

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R 008	<p>Continued From page 12</p> <p>note, Resident #2 called Resident #1 a "Mother....er." The note further documented, Resident #1 "then stood up and started to swing his cane and as [Resident #1's name] was doing that [Resident #2's name] picked up a chair to block him and the chair landed on the table." The caregiver on duty had Resident #1 go to his room and Resident #2 go outside to "cool off." The administrator documented Resident #2 called her and Resident #1 called the police. The note additionally documented, two other residents (Resident #4 and Random Resident A) witnessed the incident. The note documented Resident #1 would not be able to have his cane unless he was up walking, and the cane would be kept at the medication cart. There was no documentation the two residents, who witnessed the incident, were interviewed.</p> <p>Resident #1 was interviewed on 1/11/12 from 9:15 AM through 9:45 AM. He stated he had an ongoing verbal altercation, on 1/7/12, with another resident (Resident #2). Resident #1 stated he felt Resident #2 was harassing him by calling him names and making fun of him. Resident #1 stated, Resident #2 attempted to assault him by throwing a heavy chair at him. He stated he called the police on 1/7/12 around 10:00 PM, and the police arrived, but did not do anything. He further stated, since the incident he had to stay in his room and call for permission to be escorted from his room. He also said since the incident, staff took his cane away and he was no longer allowed to use it.</p> <p>During an interview, on 1/12/12 at 9:45 AM, Resident #4, who witnessed the 1/7/12 altercation between Resident #1 and Resident #2, stated he heard a "ruckus with lots of screaming and cussing in the kitchen and he came out to see</p>	R 008		

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R 008	<p>Continued From page 13</p> <p>what was going on." He said he saw Resident #1 sitting at the table and Resident #2 picked up a heavy roller chair over his head. Resident #4 said he struggled with Resident #2 for control of the chair, and the chair fell down on the table. He stated the chair hit him in his surgical stitches in his belly and hit his hand as it fell. When asked if he knew what the facility had done to keep this from happening again, Resident #4 stated staff took Resident #1's cane away from him and forced him to stay in his room and he could not come out of his room without a staff escort.</p> <p>Random Resident A was interviewed on 1/13/12 at 8:30 AM. He stated he witnessed the altercation between Residents #1 and #2. He said Resident #1 did not attempt to swing or hit Resident #2 with his cane. He stated Resident #2 picked up a chair and attempted to throw it at Resident #1. Random Resident A stated after the incident, Resident #1's cane was taken away from him and he was forced to stay in his room and could not leave without asking staff to escort him.</p> <p>Throughout the survey, from 1/11/12 through 1/20/12, all residents were interviewed. All residents stated they had never seen Resident #1 hit or threaten others with his cane. They all stated they felt it was Resident #2 causing the problems. All residents stated that after the altercation, Resident #1 was confined to his room and could not leave without requesting staff to escort him. They also stated staff had taken the residents cane away from him.</p> <p>Nine caregivers were interviewed throughout the survey from 1/11/12 through 1/20/12. Eight of the nine caregivers stated they had never witnessed Resident #1 use his cane to hit or threaten</p>	R 008		

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R 008	Continued From page 14  others. All nine caregivers said that after the incident, Resident #1's cane was taken from him and he had to stay in his room, unless staff escorted him.  Resident #1's undated, "Behavior Care Plan" listed three behaviors: depression, anxiety and paranoia. On 1/12/12 the administrator showed surveyors Resident #1's updated behavior plan. The plan had a hand-written note, dated 1/11/12, that said "Behavior: Using Cane when upset. (1). Res will need to be escorted from room to common areas then staff will keep cane at the med cart."  On 1/12/12 at 10:35 AM, the administrator stated she did not have documentation that Resident #1 threatened or had used his cane as a weapon while at the facility.  There was no documentation found in Resident #1's record that he had been informed of and agreed to having his cane taken away or being confined to his room.  On 1/13/12 at 9:40 AM, Resident #1 stated he did not agree with having his cane taken away or being confined to his room. He stated he felt "it was not fair." He further stated, the administrator had asked him to sign a paper agreeing to have his cane taken away. He stated he refused to sign the paper.  The facility failed to protect Resident #1's rights when he was subject to an arbitrary punishment of having his cane taken away from him and being confined to his room without his agreement.  II. ADMISSION/RETENTION	R 008		

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R 008	Continued From page 15  a. 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.  1. Resident #2 was admitted to the facility on 12/9/11, with diagnoses which included schizoaffective disorder/bipolar type, personality disorder, PTSD and polysubstance dependence.  A psychiatric evaluation dated 11/22/11, documented Resident #2 had a history of violent behaviors and made statements that he wanted to "beat up" or "kill" his neighbor for coughing too loud. The evaluation report documented, Resident #2 had hallucinations of seeing himself "stabbing other people."  Interviews were conducted with eight residents from 1/11/12 through 1/19/12. All eight residents stated that Resident #2's behaviors caused them distress. They stated the administrator had been informed of Resident #2's behaviors, but ignored the situation. During the survey, there was no documentation found in the facility, or in Resident #2's record referring to residents' complaints.  Nine caregivers were interviewed throughout the survey from 1/11/12 through 1/20/12, and stated Resident #2 exhibited threatening behaviors that included yelling profanities, making threatening remarks and throwing objects at residents. All caregivers stated Resident #2 was explosive when he became angry and was "out of control." Six caregivers said, Resident #2 would tell them he wanted to stab other residents and told them what residents were on his "shit list." They said, Resident #2 would tell them and other residents he had grudges against them because they said or did things that irritated him.	R 008	As listed for correction in R006 before the admission of a resident, each will be interviewed by the administrator to insure that the resident is appropriate for admission or retention in the facility. Upon interview by administrator and our behavior management specialist all residents will be evaluated for appropriateness with regards to level of care and cohesiveness with the other residents.	

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R 008	<p>Continued From page 16</p> <p>The police reports documented they were called to the facility twice, because Resident #2 was "out of control and causing damage to the property, throwing things and breaking things." The first police report dated 12/18/11, documented the administrator wanted the police to remove Resident #2 after the incident but then allowed him to stay. The police came to the facility again on 1/7/12, because Resident #2 threw a chair at another resident.</p> <p>On 1/11/12 at 9:50 AM, the administrator stated she allowed Resident #2 to remain at the facility because after the incident on 1/7/12, Resident #2 and Resident #1 "had worked out their differences and everything was okay now." The administrator denied knowing about any other incidents Resident #2 had been involved in.</p> <p>On 1/11/12, an immediate danger was called by the survey team because Resident #2 was retained after he had been violent and was a danger to others. Resident #2 was transferred to another facility operated by the same owner the evening of 1/11/12.</p> <p>2. Resident #3 was admitted to the facility on 9/11/11, from a psychiatric facility. He was discharged on 1/3/12 to a psychiatric facility and re-admitted again to the facility on 1/9/12. His diagnoses included alcoholism/substance abuse, anxiety, bipolar and schizoaffective disorder.</p> <p>A "Resident Communication Log" for Resident #3 contained the following documentation;</p> <p>On 9/9/11 at 8 PM: "Resident was acting aggitated (sic). He kept paceing (sic). Resident stated that he felt like 'blowing something up' and also stated that he 'felt like hurting someone.' He</p>	R 008		

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R 008	<p>Continued From page 17</p> <p>also told another resident that if he had a gun he would kill himself. Administrator came by and he told her the same thing."</p> <p>On 10/8/11 during the evening: "[Resident #3's name] was talking about hurting people..."</p> <p>There was no documentation in Resident #3's record regarding what the facility did to address him wanting to hurt himself or others.</p> <p>An Ombudsman report, dated 1/3/12 at 1:30 PM, documented Resident #3 stated he had urges and thoughts to kill someone and cut them up into pieces. He said he had gone to the administrator on several occasions about his feelings, but she did not get him help. The report further documented, he stated he was frightened of what he may do. The report documented the Ombudsman immediately reported to the administrator what she heard from the resident. The administrator stated to the Ombudsman, Resident #3 had expressed the same thoughts before and she would speak to the resident. After speaking to Resident #3, the administrator told the Ombudsman she would take the resident to the hospital right away.</p> <p>On 1/3/12 at 6:07 PM, the facility administrator documented "...he (Resident #3) said that he felt like he was going crazy and felt out of control. He said he needed help because he was scared that he was going to do something bad. He also said that he felt like he needed to cut someone up. ...I advised him of the procedure to go through the ER and then we would get him to the psychiatric hospital to get help."</p> <p>An incident report, dated 1/3/12, documented Resident #3 was sent to a psychiatric hospital at</p>	R 008		

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R 008	<p>Continued From page 18</p> <p>approximately 7:30 PM, for "review."</p> <p>A piece of paper in the book containing the "Resident Communication Log" documented, on 1/11/12 (no time) "Resident let [administrator's name] and I know that [Resident #3's name] was feeling bad and was having bad thoughts about cutting people up."</p> <p>During an interview, on 1/13/11 at 8:30 AM, Resident #1 stated the previous evening Resident #3 told him he was having thoughts and urges to cut other residents up with a knife and he "really wanted to see what their flesh looked like on the inside."</p> <p>Resident #3 was interviewed on 1/13/12 at 8:55 AM. He stated that he was not feeling well and having very morbid thoughts and feelings. He said he wanted to do "horrible things" to someone and wanted to go to [psychiatric hospital's name]. When asked what specifically he was having thoughts and feelings about, he stated, "I want to cut open other residents to see what their insides look like." He added that during his last stay at the psychiatric hospital he was not helped at all with his feelings or thoughts of hurting himself or others.</p> <p>During an interview with the administrator and owner, on 1/13/12 at 9:00 AM, the administrator stated that when Resident #3 made statements of wanting to hurt himself and others, she had the caregiver follow Resident #3's PSR plan. She stated the plan included calling the PSR worker and the PSR crisis hotline. She stated, the caregiver called that evening and no one answered. When the caregiver was asked if she tried to call more than once, the caregiver told her she only tried to call one time. The administrator</p>	R 008		

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R 008	<p>Continued From page 19</p> <p>and owner also stated there was confusion about which crisis line was to be called.</p> <p>Resident #3's outside agency staff, stated, on 1/13/12 at 10:15 AM, that he was not called regarding Resident #3's statements of wanting to hurt himself and others. He also stated, he received no messages and also had the crisis phone, which also was not called.</p> <p>During an interview, on 1/17/12 at 10:53 AM, Caregiver B stated Resident #3 had verbalized that he wanted to hurt himself and had thoughts of hurting others over the weekend of 1/14 and 1/15/12.</p> <p>During an interview, on 1/17/12 at 10:16 AM, Caregiver H stated that on 1/12/12, Resident #3 told her that "he wanted to cut peoples feet to see their flesh." Caregiver H stated she informed the administrator and was directed to "keep an eye on him and make sure he didn't do anything."</p> <p>During an interview, on 1/17/12 at 1:22 PM, Caregiver G stated Resident #3 had been making statements about wanting to hurt people and blow things up since he returned to the facility on 1/9/12. She stated the administrator was aware of the statements.</p> <p>On 1/12/12, an immediate danger was called by the survey team for retaining Resident #3 when he had been a danger to himself and others. Resident #3 was transferred to a psychiatric hospital for evaluation.</p> <p>Resident #3 was retained after he made numerous statements to the administrator, caregivers and outside agency staff, that he had continuing thoughts, feelings and urges to hurt</p>	R 008		

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R 008	<p>Continued From page 20</p> <p>himself and to stab and cut-up other residents. This resulted in inadequate care.</p> <p>III. Supervision</p> <p>IDAPA 16.03.22.011.08 defines Inadequate Care as: "When a facility...fails to provide the services required to meet the terms of the Negotiated Service Agreement or provided....supervision...."</p> <p>IDAPA 16.03.22.012.25 Supervision - A critical watching and directing activity which provides protection, guidance, knowledge of the resident's general whereabouts, and assistance with activities of daily living. The facility is responsible for providing appropriate supervision based on each resident's Negotiated Service Agreement or other legal requirements.</p> <p>Resident #2 was admitted to the facility on 12/9/11, with diagnoses which included, schizoaffective disorder/bipolar type, personality disorder, PTSD and polysubstance dependence.</p> <p>A discharge summary from a psychiatric hospital, dated 11/14/11, documented Resident #2 was considered "high risk for assault" and had a history of assaultive behaviors when "irritated by other patients."</p> <p>A "Psychiatric Evaluation," dated 11/22/11, documented Resident #2 had "suicidal and homicidal ideation" such as wanting to "beat up" or "kill" his neighbor for coughing too loud. The evaluation further documented, the resident had hallucinations of seeing himself "stabbing other people."</p> <p>Resident #2's NSA, dated 12/9/11, documented under the supervision section: "Resident requires</p>	R 008	<p>In the event a resident's behaviors become a danger to themselves or other residents in the facility staffing will be adjusted to fulfill appropriate supervision for the safety of all up to one to one staffing to meet requirements. This level of intense oversight will be continued until arrangements can be made insure the safety of self and others. This has been implemented as of February 6th 2012. The resident NSAs have also been implemented in the ADL binder as to insure that staff are constantly aware of the resident's agreement within the facility, this was accomplished January 31st 2012. Any resident of potential admit that is not appropriate will not be admitted or retained. This was implemented as of January 20th 2012.</p>	

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R 008	<p>Continued From page 21</p> <p>supervision for managing his behaviors and also the resistance [sic] of going to buy glue...needs supervision on his drinking and will only be able to have 2 beers per day." There was no written plan for staff to follow regarding what safety precautions needed to be implemented. A check mark in the "yes" box indicated there was a behavior management plan in place.</p> <p>Resident #2's BMP documented that he had the following behaviors: "Depression, Anxiety and Agitation."</p> <p>The BMP did not address Resident #2's behaviors such as: Huffing glue, drinking or leaving the facility to get high on drugs and alcohol. The listed interventions did not direct caregivers on how to provide supervision to prevent him from huffing glue and getting drunk at the facility. There was no written plan for staff to follow regarding what safety precautions needed to be implemented.</p> <p>The administrator sent a fax to the physician, on 12/19/11 (ten days after Resident #2's admission), requesting an order for a PRN anti-anxiety medication. The administrator wrote a note on the fax to inform the physician that, "[Resident #2's name] has been having more anxiety in between times he has the Diazepam. We are needing a PRN for those times so that he doesn't try to resort to other things he has used in the past..."</p> <p>The facility had not documented or tracked any of Resident #2's behaviors. There was no documentation found about what was going on when Resident #2 was having increased anxiety and needed more anti-anxiety medication.</p>	R 008	<p>to ensure that the planned interventions are working he/she will also ensure that behavior tracking/updates are sent to the physician at least every six months or more often if necessary so that the MD can determine that the medication and dose are appropriate. The facility nurse will review and delegate any new medications for residents. Nurse will also ensure that staff are assisting with medications according to the MD orders. A check list on when to call the nurse will be developed and posted to assist staff in determining when to call the nurse for medications, health issues, safety issues etc. Which fall under the nurses scope or delegable tasks to staff. This has been completed by March 2nd 2012.</p>	

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R 008	<p>Continued From page 22</p> <p>On 1/17/12 at 3:40 PM, Caregiver C stated, she called the police when Resident #2 was throwing an item at an elderly resident. He also punched a door and went outside and threw picnic table across the back yard. She said the administrator did not put a plan in place to ensure Resident #2 was supervised to protect residents or prevent reoccurrences after the incident.</p> <p>There was no incident report found regarding the 12/18/11 incident with Resident #2. The administrator denied knowledge of the incident. Resident #2's record did not contain a plan to ensure Resident #2 was supervised to protect residents or prevent reoccurrence after the incident.</p> <p>An incident report, written by the administrator on 12/30/11, documented Resident #2 left the facility without permission and unsupervised on that day. The report documented the following conversation between the administrator and Resident #2; "You need to come back... you are under court order or you will be placed first in jail then in the psych hospital..." She further documented, "I advised him he couldn't leave the facility over night because he was under court order to be at our facility. He said he was upset that I had cut him down to two beers a day and that he needed to get a buzz. He also said he was getting agitated by some of the residents and how they were acting. I advised him that staying overnight was not an option... [Resident #2's name] contacted me at 12:00 AM and said that he was in [name of town] and wanted to come back. He said that he was in a place that was dirty and cold and that he was freezing. He advised me he had been sniffing glue and drinking beer...I called Adult Mental Health...and was told it was going to be my decision whether I</p>	R-008		

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R 008	<p>Continued From page 23</p> <p>felt he would be safe coming back to [name of facility]..." The administrator documented Resident #2 arrived back at the facility the next morning at 4:30 AM. The administrator did not document how the facility would provide supervision to Resident #2 to prevent him from leaving again to use drugs, alcohol and sniff glue.</p> <p>A caregiver's note, dated 1/2/12 (untimed), documented the resident was "huffing glue to loose (sic) weight..."</p> <p>There was no documentation from the administrator on an investigation of how he obtained the glue or what was done to supervise Resident #2 and prevent him from continuing to huff glue.</p> <p>A police report dated 1/7/12, documented they had been called to the facility by Resident #1 because Resident #2 threw a chair at him during an altercation.</p> <p>On 1/11/12 at 9:50 AM, the administrator stated a police officer told her to keep the residents apart. She said, Resident #2 went outside to "cool off" after the incident and was not allowed to go near Resident #1. The administrator stated, "I took [Resident #2's name], his beer and his medications to stay the night with a caregiver so he could cool down." She said, "I didn't call a caregiver to come to the facility to provide 1 to 1 supervision because I thought having him go to the caregiver's house for the night was a good idea." The administrator stated when Resident #2 came back the next day he seemed okay and both residents were working things out. She denied knowing of any other incidents that Resident #2 was involved. She confirmed a plan to supervise Resident #2 was not in place.</p>	R 008		

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R 008	<p>Continued From page 24</p> <p>On 1/18/12 at 1:18 PM, Caregiver G stated, "I was off work the day the fight broke out. The administrator called and asked if I could take care of the resident over night." She stated, "I said it would be okay so she brought [Resident #2's name] over to my house along with his medication and beer for the night."</p> <p>On 1/12/12 at 9:45 AM, Resident #4 said that Resident #2 had a list of grudges that included "stabbing the piss out of us, starting with [Resident #1's name]." He further stated, he was not comfortable sleeping at night because Resident #2 was not supervised.</p> <p>During interviews from 1/11 through 1/19/12, nine of nine caregivers stated nothing had been put in place to supervise Resident #2 to prevent a recurrence or protect the other residents from Resident #2.</p> <p>On 1/11/12 at 3:40 PM, Caregiver A stated, that Resident #2 wanted to drink beer a lot. She said, "When he drinks he gets obsessive and can't get over something a resident may have said or done and he gets more agitated." She stated, "When this happens he has a lot of anxiety. We call the administrator because we have already given him every anti-anxiety medication ordered; we are told, if the meds don't work, give him beer." She further stated, "He gets set off easy and fast, a resident may say or do something and he gets angry."</p> <p>On 1/11/11 at 3:55 PM, Caregiver D stated, the resident was allowed to drink in his room unsupervised. She further stated, she had not received training from the facility regarding mental illness or how to intervene during physical</p>	R 008		

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R 008	<p>Continued From page 25</p> <p>altercations involving residents.</p> <p>Resident #2's record contained no interventions or plans on how to supervise him while he was drunk, threatening other residents, or verbally abusing other residents.</p> <p>On 1/11/12 at 5:30 PM, the administrator stated that Resident #2 had a "potty mouth" but she was not aware he cursed at other residents. She stated, "I was not aware [Resident #2's name] had been telling caregivers and residents that he was going to stab residents." She stated, "I have noticed residents have been isolating in their rooms lately but I did not know why." The administrator did not investigate the reasons why residents were isolating, so a plan could be developed to supervise Resident #2.</p> <p>On 1/11/12 at 6:18 PM, Caregiver I stated, Resident #2 got drunk the first time approximately one week after being admitted to the facility. She stated when he was drinking he would swear at residents and make gestures to intimidate them. The caregiver stated, "He would do things like raise his arms out and above his head and lunge at them." The caregiver did not know how to intervene or supervise the resident when he was drunk and intimidating other residents.</p> <p>On 1/12/12 at 1:45 PM, Caregiver A stated, "I gave [Resident #2's name] everything medication wise to help decrease his agitation. The day after the altercation, the administrator and I took [Resident #2's name] to buy beer to help keep him calm. Without beer he acts up and gets very angry if he doesn't have beer." She stated, "When we got back to the facility, he picked up a rock and told us he was going to go in and kill that [SOB]." Caregiver A said, "I took the rock away</p>	R 008		

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R 008	<p>Continued From page 26</p> <p>from him while the administrator just stood there and didn't say anything to the resident or try to intervene. She said the administrator did not put a plan in place to ensure Resident #2 was supervised to protect residents after the incident.</p> <p>On 1/13/12 at 10:35 AM, a female resident stated, [Resident #2's name] had a filthy mouth. She stated, "I saw him take a fork out of the kitchen drawer and say out loud that he was going to stab [Resident #1's name] in the back with the fork." She stated, "[Administrator's name] is aware of everything going on, but she won't do anything about it."</p> <p>On 1/17/12 at 11:49 AM, Caregiver B stated, "The facility was peaceful before [Resident #2's name] moved in." She said, "We call the administrator and tell her what was going on with the resident and that he was saying things to start arguments with residents by yelling and swearing to provoke them into a fight." Caregiver B further stated: "[Administrator's name] would tell us that it is just part of [Resident #2's name] behaviors." The caregiver concluded by saying the residents stay in their rooms most of the time to avoid Resident #2, as facility staff are unable to adequately supervise him.</p> <p>On 1/18/12 at 9:27 AM, Caregiver F stated, Resident #2 had lived at the facility for approximately a week when he started to say things like, "I want to stab all the residents and cut them up, or blow up the facility." She stated, Resident #2 would say things to provoke or make gestures to intimidate residents. She stated, "I could tell what he said bothered residents." She said, "When we told the administrator what the resident was saying or doing, the administrator's answer to us would be; if the medications aren't</p>	R 008		

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R 008	Continued From page 27 working give him beer."  The facility failed to provide adequate supervision by not properly training staff or putting appropriate interventions into place to address Resident #2's behaviors. First, the facility requested medications to manage the resident's behaviors. When that was unsuccessful, staff gave and encouraged him to drink beer. During the 33 days Resident #2 resided at the facility, he was drunk on numerous occasions and was verbally and physically assaultive to other residents. Although eight of eight residents residing at the facility were afraid of him, he was allowed the freedom to come and go as he pleased. This lack of supervision resulted in inadequate care.  Interviews were conducted from 1/11/12 through 1/19/12, with caregivers. Eight of nine caregivers interviewed stated they had not received training from the administrator or from any staff member on providing care to residents with mental illness. They stated at times they were afraid of Resident #2 because he was explosive and unpredictable.  The facility failed to protect Resident #1's rights when he was restricted to his room and had his mobility device taken away. The facility failed to protect residents when the facility accepted, re-admitted and retained residents (Resident #2 and #3) when they were violent or a danger to themselves or others. Additionally, the facility failed to provide supervision for Resident #2 when they did not ensure appropriate supervision was provided. These failures resulted in inadequate care.	R 008		

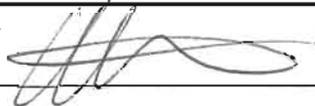


**ASSISTED LIVING**  
**Non-Core Issues**  
**Punch List**

Facility Name Carefix - Safe Haven of Burley	Physical Address 1703 Almo Avenue	Phone Number (208) 678-2955
Administrator Cathy Rupe	City Burley	Zip Code 83318
Team Leader Karen Anderson	Survey Type Complaint	Survey Date 01/20/12

**NON-CORE ISSUES**

Item #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	L&C USE
1	225.01	The facility did not update Resident #1, 2 & 3's BMP when they had increased or changes in behaviors that were distressing to themselves and other residents.	4/5/12	KA
2	225.02	The facility restricted Resident #1's use of his cane and required him to use a call light and have staff escort him to and from his room. The intervention used was not the least restrictive nor was it listed on the BMP. Resident #2 was given beer to calm him down, however the intervention was not listed on the BMP.	3/8/12	KA
3	300.01	The facility nurse was not notified after Resident #1 fell and complained of head and neck pain. Resident #2 was not assessed after he had increased behaviors and the administrator instructed staff to give him beer with his medications to decrease his agitation. Additionally, Resident #3 complained that he had increased pain and the administrator instructed staff to increase his dose of pain medications without notifying the nurse.	3/8/12	KA
4	300.02	The nurse was not contacted to assess Resident #'s 1, 2 & 3 when they had a change in health and mental status. ....REPEAT PUNCH.....	3/8/12	KA
5	305.07	The nurse was not contacted to review Resident #2's increased anti-anxiety medication or assess for adverse side effects when mixing prescription medications, narcotics and alcohol.	3/8/12	KA
6	310.01.f	The medication aide did not observe Resident #2 take his medication.	3/8/12	KA
7	350.02	The administrator did not complete an investigation or written report when Resident #2 had violent behaviors and the police were called.	3/8/12	KA

Response Required Date 02/19/12	Signature of Facility Representative 	Date Signed 4/10/12
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IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

C.L. "BUTCH" OTTER – GOVERNOR  
RICHARD M. ARMSTRONG – DIRECTOR

LESLIE M. CLEMENT – DEPUTY DIRECTOR  
LICENSING AND CERTIFICATION  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE 208-334-6626  
FAX 208-364-1888

February 2, 2012

Louis Adamson, Administrator  
Carefix-Safe Haven Homes Of Burley  
1703 Almo Avenue  
Burley, ID 83318

**FILE COPY**

Dear Mr. Adamson:

An unannounced, on-site complaint investigation survey was conducted at Carefix Management & Consulting Inc, Dba Safe Haven Homes Of Burley from January 11, 2012, to January 20, 2012. During that time, observations, interviews or record reviews were conducted with the following results:

**Complaint # ID00005360**

- Allegation #1: Residents did not receive their medications as ordered by the physician.
- Findings #1: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.305.02 for not ensuring residents' medications were given as ordered by the physician. The facility was required to submit evidence of resolution within 30 days.
- Allegation #2: An identified resident was given the wrong medications in December.
- Findings #2: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.305.02 for not ensuring the identified resident's medications were given as ordered by the physician. The facility was required to submit evidence of resolution within 30 days.
- Allegation #3: The facility retained an identified resident who was a danger to others.
- Findings #3: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.152.05.e for admitting and retaining an identified resident who was a danger to other residents. The facility was required to submit a plan of correction.

Allegation #4: Staff were not trained appropriately to assist residents with mental illness.

Findings #4: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.630.02 for not providing staff with specialized training regarding residents with mental illness. The facility was required to submit evidence of resolution within 30 days.

Allegation #5: The facility did not report an elopement to Licensing and Certification.

Findings #5: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.350.07 for not notifying Licensing and Certification of reportable incidents within 24 hours. The facility was required to submit evidence of resolution within 30 days.

Allegation #6: Resident records were not maintained by the facility.

Findings #6: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.711.08.c for not maintaining care notes regarding reportable incidents, altercations and the facility's response to the incidents and altercations. The facility was required to submit evidence of resolution within 30 days.

Allegation #7: The facility was not maintained in a clean manner.

Findings #7: The facility was observed to be maintained in a clean manner on 1/11, 1/12, and 1/13/12. Resident rooms, common areas, and common bathrooms were observed to be clean, neat and no odors were noted.

All residents were interviewed and stated the facility was generally very clean. When asked if the facility was ever dirty, all residents stated the facility was kept clean.

Nine of nine staff interviewed stated the facility was maintained in a clean manner at all times.

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

Allegation #8: The facility did not follow the menu.

Findings #8: From 1/11/12 through 1/13/12, five meals were observed. All meal items were listed on the approved menu.

All residents were interviewed and stated the meals were good and were always

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consistent with the posted menu.

A caregiver, who was observed to prepare four of the five meals, was questioned regarding following the posted menu. She responded that at times one vegetable or fruit would be substituted for another like vegetable or fruit. Documentation showed food substitutions were appropriate.

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

A core issue deficiency was identified during the complaint investigation. Please review the cover letter, which outlines how develop a Plan of Correction. The Plan of Correction must be submitted to our office within 10 (ten) calendar days of receiving the Statement of Deficiencies.

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, on **01/20/2012**. The completed punch list form and accompanying evidence of resolution (e.g., receipts, pictures, policy updates, etc) are to be submitted to this office within thirty (30) days from the exit date.

If you have questions or concerns regarding our visit, please call us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,



for

Karen Anderson  
Health Facility Surveyor  
Residential Assisted Living Facility Program

KA/mh

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



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

C.L. "BUTCH" OTTER – GOVERNOR  
RICHARD M. ARMSTRONG – DIRECTOR

LESLIE M. CLEMENT—DEPUTY DIRECTOR  
LICENSING AND CERTIFICATION  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE 208-334-6626  
FAX 208-364-1888

January 31, 2012

Louis Adamson, Administrator  
Carefix-Safe Haven Homes Of Burley  
1703 Almo Avenue  
Burley, ID 83318

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Dear Mr. Adamson:

An unannounced, on-site complaint investigation survey was conducted at Carefix Management & Consulting Inc, Dba Safe Haven Homes Of Burley from January 11, 2012, to January 20, 2012. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00005370

Allegation #1: The facility did not report resident to resident abuse to Adult Protection.

Findings #1: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.350.05 for failing to notify the Idaho Commission on Aging/Adult Protection in accordance with Section 39-5303, Idaho Code. The facility was required to submit evidence of resolution within 30 days.

Allegation #2: The facility did not take steps to protect residents from abuse.

Findings #2: Substantiated. The facility was issued a core level deficiency at IDAPA 16.03.22.510 for failing to ensure residents were protected after an identified resident made verbal and physical threats towards residents. The facility was required to submit a plan of correction.

Allegation #3: The facility did not investigate allegations of resident to resident abuse.

Findings #3: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.350.02 for not conducting an investigation within 30 days. The facility was required to submit evidence of resolution within 30 days.

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- Allegation #4: The facility did not report a resident to resident incident that caused injury to a resident to Licensing and Certification.
- Findings #4: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.350.07 for not reporting the incident to Licensing and Certification within 24 hours of the incident. The facility was required to submit evidence of resolution within 30 days.
- Allegation #5: The facility did not have sufficient personnel to safely care for the residents they admitted.
- Findings #5: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.600.06.a for not having sufficient staff to supervise residents at all times. The facility was required to submit evidence of resolution within 30 days.
- Allegation #6: The facility did not have personnel with appropriate knowledge and skills to safely care for the residents.
- Findings #6: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.630.02 for not training staff on mental illness. The facility was required to submit evidence of resolution within 30 days.

A core issue deficiencies were identified during the complaint investigation. Please review the cover letter, which outlines how develop a Plan of Correction. The Plan of Correction must be submitted to our office within 10 (ten) calendar days of receiving the Statement of Deficiencies.

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, on **01/20/2012**. The completed punch list form and accompanying evidence of resolution (e.g., receipts, pictures, policy updates, etc) are to be submitted to this office within thirty (30) days from the exit date.

If you have questions or concerns regarding our visit, please call us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,

  
Karen Anderson  
Health Facility Surveyor  
Residential Assisted Living Facility Program



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

C.L. "BUTCH" OTTER – GOVERNOR  
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LICENSING AND CERTIFICATION  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE 208-334-6626  
FAX 208-364-1888

January 31, 2012

*bill*  
**FILE COPY**

Louis Adamson, Administrator  
Carefix-Safe Haven Homes of Burley  
1703 Almo Avenue  
Burley, ID 83318

Dear Mr. Adamson:

An unannounced, on-site complaint investigation survey was conducted at Carefix Management & Consulting Inc, Dba Safe Haven Homes Of Burley from January 11, 2012, to January 20, 2012. During that time, observations, interviews, and record reviews were conducted with the following results:

**Complaint # ID00005373**

Allegation #1: The administrator failed to document an identified resident's behaviors.

Findings #1: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.225.01 and 16.03.22.225.02 and 16.03.22.711.01 for failing to document resident's behaviors and care notes regarding resident altercations. The facility was required to submit evidence of resolution within 30 days.

Allegation #2: The administrator failed to take steps to protect residents from harm.

Findings #2: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.510 for failing to ensure residents were protected after an identified resident assaulted other residents with large objects and made verbal and physical threats of violence towards other residents. The facility was required to submit a plan of correction.

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Allegation #3: Staff do not wear gloves when they prepare ready to eat foods.

Findings #3: From 1/11/12 through 1/13/12, five meals were observed being prepared in the kitchen. At no time were caregivers observed to touch ready-to-eat foods with their bare hands or not wear gloves when gloves were appropriate.

A caregiver who was observed to prepare four of the five meals observed, was questioned regarding the use of gloves. She responded that gloves were required whenever she needed to touch any ready-to-eat foods.

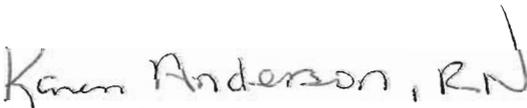
Unsubstantiated. This does not mean the incident did not take place; it only means that the allegation could not be proven.

Core issue deficiencies were identified during the complaint investigation. Please review the cover letter, which outlines how develop a Plan of Correction. The Plan of Correction must be submitted to our office within 10 (ten) calendar days of receiving the Statement of Deficiencies.

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, on **01/20/2012**. The completed punch list form and accompanying evidence of resolution (e.g., receipts, pictures, policy updates, etc) are to be submitted to this office within thirty (30) days from the exit date.

If you have questions or concerns regarding our visit, please call us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,

  
Karen Anderson, RN  
Health Facility Surveyor  
Residential Assisted Living Facility Program

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