



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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April 22, 2013

Marie Humphreys, Administrator
Carefix-Safe Haven Homes Of Bellevue
314 South 7th
Bellevue, ID 83313

License #: Rc-927

Dear Ms. Humphreys:

On February 28, 2013, a Complaint Investigation survey was conducted at Carefix Management & Consulting Inc, Dba Safe Haven Homes Of Bellevue. 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.

Should you have questions, please contact Rachel Corey, RN, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 334-6626.

Sincerely,

Rachel Corey, RN
Team Leader
Health Facility Surveyor
Residential Assisted Living Facility Program

rc/rc

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



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March 18, 2013

Marie Humphreys, Administrator
Carefix-Safe Haven Homes Of Bellevue
314 South 7th
Bellevue, ID 83313

Dear Ms. Humphreys:

An unannounced, on-site complaint investigation survey was conducted at Carefix Management & Consulting Inc, Dba Safe Haven Homes Of Bellevue from February 26, 2013, to February 28, 2013. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00005642

Allegation #1: The facility administrator gave residents other residents' medications which were not ordered for them.

Findings #1: From 2/26/13 through 2/28/13, four medication aides and the RN were interviewed separately. All stated they were unaware of a time when residents were given other residents' medications, which were not ordered for them. During this time, two residents, who were aware of their medications, stated they had never received medications which were not ordered for them.

During the survey, four current resident records and two closed records were reviewed. June 2012 medication assistance records (MARs) through current MARs were reviewed and were consistent with physician orders. There was no documentation indicating the medications were given without orders. Faxes to each resident's physician requesting as-needed (PRN) medication orders were present when each resident had symptoms requiring additional PRN medications.

On 2/27/13 at 2:15 PM, the administrator stated medications would not be given to a resident without written orders from the physician.

Unsubstantiated. Although the allegation may have occurred, it could not be

determined during the complaint investigation.

Allegation #2: Residents who had changes of condition did not receive medical treatment.

Findings #2: From 2/26/13 through 2/28/13, six interviewable residents were interviewed. The residents stated they received prompt medical attention when they were ill. One resident stated the facility was insistent she be medically evaluated after a fall, even when she had no symptoms. Four family members, stated the facility provided timely medical treatment when their loved ones experienced changes of condition. During this time frame, four caregivers were also interviewed. They were unaware of a time when residents did not receive medical treatment in a timely manner. They stated, the administrator and RN were timely when following up on medical concerns with residents and ensured residents were seen by their physician when abnormal symptoms were observed.

On 2/26/13 at 2:10 PM, the facility RN stated staff either called her when changes of condition were observed, or called 911 for emergencies. She was unaware of a time when medical treatment was delayed or not sought for changes of condition.

On 2/27/13 at 2:30 PM, the administrator stated that when in doubt, residents were evaluated by their medical doctors to rule out significant underlying problems, when changes of condition were observed or when residents fell.

During the survey, incident reports were reviewed from June 2012, through the present time. All incident reports documented residents received medical attention, when changes of condition were present. Six sampled resident records were reviewed. There was no documentation in the records indicating changes of condition were not medically treated. Faxes to residents' physicians for changes of condition were present, in addition to doctor or hospital note reports, which documented the follow-up on residents' changes of condition.

Unsubstantiated; however, the facility was issued a deficiency at 16.03.22.711.08.e for not documenting notification of the facility RN for all observed changes of condition.

Allegation #3: Between 4/28/12 through 6/20/12, the evening shift did not have a caregiver who was certified to assist with medications. Therefore, the facility gave the noon medications and the 6:00 PM medications at the same time.

Findings #3: On 2/27/13, April through June 2012 medication assistance records (MARs) were reviewed. Staff members' records, who signed as giving the 6:00 PM

medications during that time frame, were also reviewed. The staff members had the appropriate medication certification, which was documented as completed prior to evidence of them assisting with medications. Additionally, the current medication aides, during the time of the survey, had documentation of the necessary medication certification in their records.

From 2/26/13 through 2/28/13, four medication aides, the administrator, and the facility nurse were interviewed. They stated medication aides were always present to assist with medications and they were unaware of a time when a certified medication aide was not present to assist with medications at the ordered time.

During the survey, two residents, who were familiar with their medication routine, stated they always received their evening medications and did not recall a time frame when they received their evening medications at a different time. They both stated they would have noticed if their medications were given at the wrong time.

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

Allegation #4: Facility caregivers were told not to contact the facility nurse when there were changes of condition.

Findings #4: On 2/26/13 through 2/28/13, four caregivers, including one newly hired caregiver, were interviewed individually and privately. They all denied being instructed not to call the facility nurse for changes of condition. They stated the facility nurse was available by phone whenever they needed to contact her for changes of condition and was responsive to their concerns.

On 2/26/13 at 2:00 PM, the facility nurse stated she received calls from staff when they observed changes of condition. She was unaware if there were changes of condition that did not get reported to her.

On 2/27/13 at 2:10 PM, the administrator stated whenever staff called her to report changes of condition, she would question staff as to whether they had notified the facility RN. If they had not, she would call the nurse herself or instruct staff to. She acknowledged that staff did not always document calls to the facility RN for changes of condition.

Incident reports, from June 2012 until the survey date, were reviewed and included the date and time when the facility RN was notified. A nurse

notification book documented the date and time when the administrator notified the facility RN.

Unsubstantiated; however the facility was issued a deficiency at 16.03.22.711.08.c and 711.08.e, for caregivers not documenting all unusual events and notification of the facility RN.

Allegation #5: Reportable incidents were not reported to Licensing and Certification.

Findings #5: From 2/26/13 through 2/27/13, incident reports were reviewed from June 2012 until the date of the survey. Additionally, the communication log and care notes were reviewed for unusual events. There was no documentation of any reportable incidents during that time frame. During the survey, four caregivers, the administrator and the nurse were interviewed. They did not recall any reportable incidents occurring.

Unsubstantiated; however the facility was issued a deficiency at 16.03.22.711.08.c and 711.08.e, for caregivers not documenting all unusual events.

Allegation #6: Residents were not treated with dignity and respect by facility caregivers.

Findings #6: On 2/26/13 through 2/28/13, observations and interviews were conducted. Different shifts were observed and interactions with three different staff members and residents were observed. During this time, staff members were observed to treat residents in a courteous manner. Six residents were interviewed and stated caregivers were kind and treated them in a respectful manner. Four family members stated they had never witnessed staff members mistreat residents, nor had their loved ones complained of being mistreated. All four family members stated staff were responsive to residents' needs and were patient and caring when assisting residents. Four caregivers, the administrator and facility RN were interviewed privately and separately. All stated they had not witnessed, or heard of, staff mistreating residents at any time.

On 2/26/13 at 10:10 AM, the facility ombudsman stated he had never witnessed staff mistreating residents, nor had he received any complaints regarding staff mistreating residents.

Three behavior management plans were reviewed and documented appropriate interventions to manage residents' behaviors.

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

Allegation #7: Facility caregivers were instructed not to document residents' behaviors.

Findings #7: From 2/26/13 through 2/28/13, four caregivers were interviewed privately and separately. They stated they were instructed to document behaviors on behavior tracking sheets and in the communication log. They denied being instructed not to document behaviors.

On 2/27/13 at 2:00 PM, the administrator stated the current residents did not have behaviors, but the facility utilized behavior tracking sheets to document behaviors on past residents.

During the survey, two closed records of residents who had behaviors were reviewed. Behavior tracking sheets documented daily observations from caregivers of the residents' behaviors. One current resident's record was reviewed who had a history of behaviors. A behavior management plan was in the record and tracking sheets, which documented behaviors were not observed by the facility caregivers.

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

Allegation #8: The facility did not provide a secure environment for wandering residents.

Findings #8: During the survey, from 2/26/13 through 2/28/13, observations of all current residents were conducted. Residents were not observed to attempt to leave the facility. During this time, six staff members stated they currently did not have any residents who were at risk for elopement, but a "Wanderguard" system was in place if the facility were to admit or retain any residents at risk for elopement. Surveyors observed the inactivated "Wanderguard" system. During the survey, four family members stated they did not recall seeing any residents try to leave the building and had observed staff providing adequate supervision to residents.

Six sampled resident's records were reviewed, including two closed records. None of the documentation indicated the residents were at risk for elopement or had tried to leave the facility without staff's knowledge. Additionally, incident and accident reports, and shift communication logs for the past year were reviewed. There was no documentation that elopements or wandering behaviors had occurred.

On 2/26/13 at 10:14 AM, the ombudsman stated he had not observed any residents trying to elope during his visits to the facility.

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

Allegation #9: The facility did not monitor residents for side-effects of medications.

Findings #9: On 2/26/13 through 2/8/13, four caregivers were interviewed and stated they were aware of what side effects to monitor residents for, as each resident's MAR documented the side effects which were associated with each medication. They further stated, the pharmacy sent medication information sheets, which they were expected to read, when residents were started new medications; if they noticed any side effects they were to report the information to the facility RN and/or the resident's doctor.

On 2/26/13 at 2:00 PM, the facility RN stated the current residents were stable on their medications and had not experienced side effects to her knowledge. However, when she assessed the residents monthly, she monitored them for potential side effects of their medications. If she had concerns, she would report the information to the physician.

On 2/26/13 at 2:35 PM, a family member of a resident stated her loved one experienced side effects from a medication and the facility reported the concerns promptly to her physician.

On 2/27/13 at 8:15 AM, a resident stated the administrator was quick to report to her physician when she experience medication side effects.

On 2/27/13 at 2:25 PM, the administrator stated staff were expected to be aware of each medication's side effects and report any unusual symptoms to the facility nurse, so it could be followed up on.

During the survey, six sampled resident records were reviewed. One record contained documentation indicating the facility observed a resident expressing side effects from a medication. The physician was notified and the medication was adjusted. Additionally, each resident's MAR documented possible side effects below each medication.

During the survey, all residents were observed during different time periods through the day. They were observed alert and in no acute distress.

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

Allegation #10: The resident rights poster was not posted so that it was visible to residents.

Findings #10: On 2/27/13 through 2/28/13, the resident rights poster was observed clearly visible to residents and was posted outside of the administrator's office on a bulletin board. Additionally, six sampled resident's records contained resident rights forms signed by the residents, indicating they had been informed of their rights.

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

Allegation #11: The facility was not maintained in a safe manner.

Findings #11: On 2/26/13 at 10:15 AM, a tour of the facility interior and exterior was conducted. The facility was observed to be maintained in a clean, and safe manner. Between 2/16/13 and 2/28/13, six residents, six staff members and four family members were interviewed. All stated they were unaware of a time when maintenance issues were not quickly resolved or when the facility was not maintained in a clean and safe manner.

On 2/26/13 at 10:06 AM, the ombudsman stated during one visit, the facility was in the process of replacing a common bathroom toilet and the bathroom was "tore up," but during the next visit the facility was observed "safe and orderly."

During the survey, the facility complaint book was reviewed. There was no documentation indicating that complaints regarding the facility environment were received.

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

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 **03/28/2013**. 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.

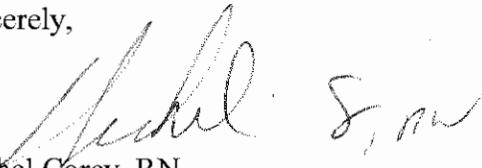
If you have questions or concerns regarding our visit, please call us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Marie Humphreys, Administrator

March 18, 2013

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Sincerely,

A handwritten signature in cursive script, appearing to read "Rachel Corey".

Rachel Corey, RN

Health Facility Surveyor

Residential Assisted Living Facility Program

rc/rc

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