



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

JUDY A. CORDENIZ – ADMINISTRATOR
LICENSING AND CERTIFICATION
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

June 25, 2012

Lisa Oakes, Administrator
Carefix-Safe Haven Homes Of Burley
1703 Almo Avenue
Burley, ID 83318

License #: Rc-931

Dear Ms. Oakes:

On April 11, 2012, a follow up survey and complaint investigation survey was conducted at Carefix Management & Consulting Inc, DbA Safe Haven Homes Of Burley. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level(s):

- Core issues, which are described on the Statement of Deficiencies, and for which you have submitted a Plan of Correction.
- 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 plan of correction and evidence of resolution.

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

Sincerely,

Karen Anderson, RN

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

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

May 15, 2012

CERTIFIED MAIL #: 70073020000140507640

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

Dear Mr. Adamson:

Based on the Follow-Up survey and complaint investigation conducted by Department staff at Carefix Management & Consulting Inc, dba Safe Haven Homes of Burley on **April 11, 2012**, we have determined that the facility failed to protect residents from inadequate care.

This core issue deficiency substantially limits the capacity of Carefix Management & Consulting Inc, dba 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 provisional license, issued on February 3, 2012, remains in effect. The following administrative rule for Residential Care or Assisted Living Facilities in Idaho (IDAPA 16.03.22) give 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 will maintain, on an ongoing basis, the deficient area in a state of compliance in accordance with the submitted Plan of Correction;**
- 2. The provisional license shall be prominently displayed in the facility.**

3. Limit on all new admissions to the facility. Re-admissions from the hospital may be permitted after consultation with the Department.

The following administrative rule for Residential Care or Assisted Living Facilities in Idaho (IDAPA 16.03.22) gives the Department the authority to limit admissions to the facility:

920.ENFORCEMENT REMEDY OF LIMIT ON ADMISSIONS.

02. Reasons for Limit on Admissions. The Department may limit admissions for the following reasons: c. Enforcement Action "B" or "C" is taken as described in Sections 900.04 and 900.05, of these rules. (3-30-06)

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
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009**

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

You have an opportunity to make corrections and thus avoid further enforcement action. Correction of this deficiency must be achieved by May 31, 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?

March 15, 2012

Louis Adamson

Page 3 of 3

Return the **signed** and **dated** Plan of Correction to us by **May 24, 2012**, 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 (**May 28, 2012**). 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 after **May 28, 2012**, 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 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.) were due to our office by **May 11, 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 an enforcement action against the license held by Carefix Management & Consulting Inc, dba Safe Haven Homes of Burley.

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/TFP

Enclosure

c: Melanie Belnap, Program Manager, Regional Medicaid Services, Region V - DHW

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 R-C 04/11/2012
NAME OF PROVIDER OR SUPPLIER CAREFIX-SAFE HAVEN HOMES OF BURLEY		STREET ADDRESS, CITY, STATE, ZIP CODE 1703 ALMO AVENUE BURLEY, ID 83318		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{R 000}	Initial Comments The following deficiencies were cited during a follow up and complaint investigation survey conducted on 4/9/12 through 4/11/12, at your residential care/assisted living facility. The surveyors conducting the survey were: Karen Anderson, RN Team Leader Health Facility Surveyor Donna Henscheid, LSW Health Facility Surveyor Abbreviations used in this report: @ = at ct. = client ER = Emergency Room MARs = Medication Assistance Record MD = physician meds = medications PSR = Psychosocial Rehabilitation Specialist RN = Registered Nurse UAI = Uniform Assessment Instrument	{R 000}		
{R 008}	16.03.22.520 Protect Residents from Inadequate Care. The administrator must assure that policies and procedures are implemented to assure that all residents are free from inadequate care. This Rule is not met as evidenced by: Based on observation, interview and record review it was determined the facility did not provide appropriate monitoring of medications for 1 of 3 diabetic residents (#3) who received insulin. Further, the facility did not protect	{R 008}		

RECEIVED
JUN - 7 2012
FACILITY STANDARDS

Bureau of Facility Standards

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



TITLE

Administrative

(X8) DATE

6/1/12

Bureau of Facility Standards

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{R 008}	<p>Continued From page 1</p> <p>residents' rights when 1 of 7 sampled residents (#7) was inappropriately discharged without honoring a 30 day discharge notice. The findings include:</p> <p>I. Assistance and Monitoring of Medications</p> <p>Resident #3 was admitted to the facility on 6/1/08 with diagnoses which included insulin dependent diabetes and dementia.</p> <p>A UAI, dated 12/8/11, documented "staff to assist with her medications as she doesn't remember to take them, ct is able to do her own insulin injections when cued."</p> <p>A Humalog sliding scale insulin order, dated 8/12/11, documented the following:</p> <p>Breakfast and Bedtime: Blood sugars less than 80 = no insulin less than 150 = 12 units 150-200 = 14 201-250 = 16 251-300 = 18 301-400 = 20 401-450 = 22 451-500 = 24 If over 500 = call MD</p> <p>Lunch: Blood sugars less than 80 = no insulin Less than 150 = 18 units 150-200 = 20 201-250 = 22 251-300 = 24 301-400 = 26 401-450 = 28 451-500 = 30 If over 500 = call MD</p>	{R 008}	<p>R 008 Diabetic Management</p> <p>1. Resident #3's chart was reviewed by RN on 4/19/12 and again on 5/4/12. Self-medication assessment was completed by RN on 4/19/12. Dr. Consultation and follow-up appointment made for Resident #3 regarding insulin. BG to be reviewed for adjustments at Dr. appointment also. Resident #3 will be visually observed by Facility RN on a weekly basis while administering insulin to ensure resident displays the ability to self-inject safely and has the correct interpretation of the sliding scale. Continuing observation for all insulin dependent resident's will be monitored once/weekly by the facility nurse. Any changes observed by Medication assistance's will be reported to facility RN for immediate review. RN will continue to review orders and self-medication assessment Q weekly / Q 90 days and with change of condition.</p> <p>2. The facility RN completed another self-medication assessment for these residents on 4/19/12. RN Consultant was contracted. Review of resident records and monitored self BG and injections on 5/31/12. Diets were submitted to attending</p>	

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{R 008}	<p>Continued From page 2</p> <p>Dinner:</p> <p>Blood sugars less than 80 = no insulin Less than 150 = 24 units 150-200 = 26 201-250 = 28 251-300 = 29 301-400 = 31 401-450 = 32 451-500 = 33 If over 500 = call MD</p> <p>On 4/10/12, a laminated sliding scale insulin chart was observed in the resident's room. The above sliding scale was the chart the resident used to ensure she took the right amounts of Humalog (insulin). The chart and physician's order, dated 8/12/11 were congruent.</p> <p>A March "Blood Glucose Monitoring Record" documented the following:</p> <p>*On 3/3/12 at 10:00 PM (bedtime), the resident's blood glucose level was 246. According to the sliding scale, the resident should have received 16 units of Humalog but 18 units were documented as given.</p> <p>There were other 5 other instances, during March, where Resident #3 received too much insulin.</p> <p>*On 3/1/12 at 11:00 AM (lunch), the resident's blood glucose level was 190. According to the above sliding scale, the resident should have received 20 units but instead was given 14.</p> <p>There were 25 other instances, during March, where Resident #3 did not receive enough insulin.</p>	{R 008}	<p>Physicians for review. Insulin orders have been re-written with clarifications and submitted to Physicians for review.</p> <p>3. Blood sugars will be reviewed by facility nurse weekly and faxed to Physicians if needed.</p> <p>4. RN will continue to review orders and self-medication assessment as stated above. Facility has implemented and will continue to implement a required additional 3 hour in-house diabetic training guide with documentation for each individual medication aide. Understanding diabetes, monitoring symptoms/medication dosages/actions and notifications for emergency response procedures. Staff will be tested and signed off that they understand and exhibit the skills needed to provide above adequate care for our diabetic population by facility RN. Implemented to current staff and new hires.</p> <p>5. Facility has contracted an RN Consultant, Sherri Rogers, RN to assist with the plan of correction.</p> <p>6. Correction date: June 21, 2012</p>	

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{R 008}	<p>Continued From page 3</p> <p>*From 3/3/12 to 3/28/12, there were no blood glucose levels or insulin units documented for breakfast 15 times, lunch 7 times, dinner 5 times and bedtime 6 times.</p> <p>A Humalog sliding scale insulin order from the discharging hospital, dated 3/28/12, documented the following:</p> <p>DO NOT USE SLIDING SCALE AT BEDTIME 61-120 = Do Nothing 121-150 = 1 unit 151-200 = 2 units 201-250 = 4 units 251-300 = 7 units 301-350 = 10 units 351-400 = 13 units 401-450 = 16 units Greater than 450 = Call MD</p> <p>On 4/10/12 a laminated sliding scale insulin chart was observed in the resident's room. The chart for the sliding scale was from a previous physician's order dated 8/12/11, and was not congruent with the current physician's order, dated 3/28/12, as listed above.</p> <p>March (3/28 - 3/31/12) and April "Blood Glucose Monitoring Records" documented the following:</p> <p>*On 3/30/12 at 5:00 PM (dinner), the resident's blood glucose level was 139. According to the above new sliding scale, the resident should have received 1 unit of Humalog but 12 units were documented as given.</p> <p>There were 18 other instances, during the end of March and beginning of April, where Resident #3 received too much insulin.</p>	{R 008}		

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{R 008}	<p>Continued From page 4</p> <p>*On 4/1/12 at 12:00 PM (lunch), the resident's blood glucose level was 131. According to the above new sliding scale, the resident should have received 1 unit of Humalog but 0 (zero) was documented as given.</p> <p>There were two other instances, during the end of March and beginning of April, where Resident #3 did not receive enough insulin.</p> <p>* On 3/30/12 at 10:00 PM (bedtime), the resident received 14 units of Humalog, although the above order instructed staff not to use a sliding scale for bedtime.</p> <p>There were 5 other instances where insulin was documented as given when it was not ordered.</p> <p>A Humalog sliding scale for "10:00 PM (bedtime) schedule only," dated 4/6/12, documented the following:</p> <p>61-120 = Do Nothing 121-150 = 1 unit 151-200 = 2 units 201-250 = 4 units 251-300 = 7 units 301-350 = 10 units 351-400 = 13 units 401-450 = 16 units</p> <p>On 4/10/12 a laminated sliding scale chart was observed in the resident's room. It was not congruent with the above order.</p> <p>An April "Blood Glucose Monitoring" record documented the following:</p> <p>*On 4/6/12 at 10:00 PM, the resident's blood glucose level was 266. According to the new</p>	{R 008}		

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{R 008}	<p>Continued From page 5</p> <p>"bedtime" sliding scale the resident should have received 7 units of insulin but 15 units were documented as given.</p> <p>There were 3 other instances where the resident received more insulin at bedtime than what was ordered.</p> <p>On 4/10/12 at approximately 11:30 AM, the facility faxed all the insulin orders to the RN for clarification. At 1:00 PM, the facility RN faxed back a handwritten sliding scale for caregivers to use.</p> <p>On 4/10/12 at 1:10 PM, the resident was observed in her room. The house manager stated she had just taken her blood glucose reading which was 164. When asked by a surveyor how many units she would take for a reading of 164, the resident replied, "15." After she was shown the handwritten sliding scale chart, the resident guessed "22" or maybe "20." The resident was then observed to put the needle on the pen, dial the insulin pen to 20 units. The resident was observed to stick the needle in at a couple of inches above her knee. She was observed to rock back and forth with her thumb on top of the pen. This continued for a few seconds and then the resident pulled the needle out from her leg and insulin was observed squirting from the pen. During the process, it could not be determined the resident had actually pushed the plunger to inject the insulin or to determine how many units she had received.</p> <p>On 4/10/12 at 2:50 PM, the facility RN stated he was not aware Resident #3 had a problem with her medications. The RN stated, "The staff never told me there was a problem." The RN also stated he was new to assisted living and was</p>	{R 008}		

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{R 008}	<p>Continued From page 6</p> <p>unclear what his role or responsibilities were as the facility nurse. Further, the RN stated he had not assessed the resident to determine she was competent to interpret the sliding scale and self-administer insulin.</p> <p>The facility RN did not monitor Resident #3's ability to self-inject insulin or safely interpret the sliding insulin scale. Consequently, from 3/1/12 to 4/9/12, the resident received incorrect doses of insulin approximately 64 times.</p> <p>II. Resident Rights</p> <p>IDAPA 16.03.22.011.08 defines Inadequate Care as: "When a facility...engages in violations of resident rights...."</p> <p>According to IDAPA 16.03.22.550.20 "Each resident must have the right to be transferred or discharged only for medical reasons, or for his welfare or that of other residents...In non-emergency conditions, the resident must be given at least thirty (30) calendar days notice of discharge...."</p> <p>Resident #7 was admitted to the facility on 9/13/11, with diagnoses which included severe depression, chronic headaches, and a history of seizures.</p> <p>On 1/7/12, Resident #7 was given a 30 day discharge notice for non payment of rent and care charges.</p> <p>On 1/20/12, the resident was given a 24 hour "Notice of Emergency Discharge." The notice documented an "Emergency discharge is necessary as the facility can no longer provide you with safe and effective care due to your</p>	{R 008}	<p>R 008 Resident Rights</p> <ol style="list-style-type: none"> 1. We are seeking consultation from LMC to clarify 30 day notice and non-payment requirements 2. We will comply with IDAPA 16.03.22.011.08 as we understand the rules and regulations at this time. 3. Systemic measures to prevent recurrence-BMP have been re-addressed to help assist with resident's who's behaviors can be re-directed and to identify behaviors before they escalate to create an adverse reaction and outcome. Facility policies for discharge notices were reviewed and revised. Residents who are exhibiting evidence of potential for injury to self or others will be assessed by the RN, behavior specialist and Administrator. Appropriate documentation will be entered into the resident record. Written notice will be given for both immediate as well as 30 day discharges. 	

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{R 008}	<p>Continued From page 7</p> <p>increasing mental health care needs and the limited staff available in the building. You need to immediately find placement elsewhere."</p> <p>Caregiver notes documented the following:</p> <p>* 1/18/12, evening shift, "[Resident #7's name] stated that his head was hurting and felt stressed out about all the things in the facility and stated he get [sic] really worried about his meds."</p> <p>* 1/18/12, night shift, "[Resident #7's name] got up at around 5 PM. Resident was not feeling well... Stated his legs felt tingling in both legs also his head was hurting, he felt dizzy. No other changes to report."</p> <p>*1/18/12, untimed, "[Resident #7's name] was taken to the ER @ 10:00 AM. He's wearing a monitor for his heart. He is to take it to his doctors his next visit."</p> <p>*1/19/12, during the evening shift, a caregiver documented the resident had been in the dining room visiting with a resident and was in a "great mood all night."</p> <p>*1/19/12, during the night shift, a caregiver documented the resident was up after 1:00 AM, "talking with residents in a good mood."</p> <p>*1/20/12, during the night shift, a caregiver documented the resident stayed in his room most of the day and "did not eat lunch or dinner." It further documented the resident was up most of the night.</p> <p>*1/21/12, on the evening shift, the house manager documented, "Resident moved out @ 3:30 PM. Made him copies of his MARs and gave</p>	{R 008}	<p>4. Administrator will review decision to issue discharge notice with corporate office to ensure policies are followed.</p> <p>5. Completion Date: June 21, 2012</p>	

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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 008}	Continued From page 8 him his meds." According to the caregiver notes, Resident #7 had not exhibited any behaviors. There was no further documentation by the administrator or caregivers to specify what behaviors the resident had exhibited to verify the resident had "increasing mental health care needs" related to why he was given an emergency discharge. An Ombudsman report, dated 1/30/12, documented "[Resident #7's name] received an emergency 24 hour discharge notice..." The Ombudsman's report further documented, "I tried to get documentation on why the emergency 24 hour discharge notice was given...I called him [owner's name] that day and he refused to give me any more documentation or provide any specific information on why [Resident #7's name] was given this short discharge notice..." On 4/10/12 at 10:30 AM, the administrator stated the resident was given an immediate discharge for "stirring up problems" such as telling other residents things staff were doing. The administrator stated, Resident #7 was "agitating the other residents" but stated Resident #7 was not a danger to himself or to the other residents. On 4/10/12 at 12:45 PM, the house manager stated, that prior to Resident #7 receiving his emergency discharge notice, he was causing problems by telling other residents to watch out for staff. The house manager stated, Resident #7 caused problems by getting the other residents "all stirred up." The house manager said, Resident #7 had refused to take his medications but stated, he was not a danger to himself or others.	{R 008}		

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 R-C 04/11/2012
NAME OF PROVIDER OR SUPPLIER CAREFIX-SAFE HAVEN HOMES OF BURLEY		STREET ADDRESS, CITY, STATE, ZIP CODE 1703 ALMO AVENUE BURLEY, ID 83318		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{R 008}	<p>Continued From page 9</p> <p>There was no documented evidence found in Resident #7's record or at the facility to verify what Resident #7 had been saying about staff members to the other residents. There was no documentation regarding the resident not being compliant with his medication or refusing care.</p> <p>On 4/10/11 at 3:50 PM, the resident's PSR worker stated, "I was there when [Resident #7's name] was asked to leave the facility by the owner and the administrator." The PSR worker stated, "[Resident #7's name] had not been feeling well so it wasn't the best time to have him immediately discharged from the facility."</p> <p>The facility gave Resident #7, a thirty day discharge notice on 1/6/12. However, the discharge notice was not honored and the resident was given an immediate discharge notice on 1/20/12, to vacate the facility within 24 hours. This violated Resident #7's rights and resulted in inadequate care.</p> <p>The facility did not provide appropriate assisting and monitoring of medications for Resident #3 who received insulin according to a sliding scale. Further, the facility did not protect residents' rights when Resident #7 was inappropriately discharged without honoring a 30 day notice. These failures resulted in inadequate care.</p> <p>THIS IS A REPEAT CORE VIOLATION</p>	{R 008}		



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

April 25, 2012

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

Dear Mr. Adamson:

An unannounced, on-site follow-up survey and complaint investigation survey were conducted at Carefix Management & Consulting Inc, Dba Safe Haven Homes Of Burley from April 9, 2012, to April 11, 2012. During that time, observations, interviews and record reviews were conducted with the following results:

Complaint # ID00005396

Allegation #1: The facility inappropriately discharged an identified resident.

Findings #1: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.550 for violating an identified resident's right to a 30 day discharge. The facility was required to submit a plan of correction within 10 days.

A core issue deficiency was identified during the complaint investigation. Please review the cover letter, which outlines how to 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.

Louis Adamson, Administrator

April 25, 2012

Page 2 of 2

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 **04/11/2012**. A "Repeat" non-core deficiency was cited at IDAPA 16.03.22.300.01, as well as, a twice "Repeated " non-core deficiency at IDAPA 16.03.22.300.02 both related to lack of facility's nurse involvement. The completed punch list form and accompanying evidence of resolution (e.g., assessments, 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

Karen Anderson, RN

Health Facility Surveyor

Residential Assisted Living Facility Program

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



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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April 25, 2012

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 April 9, 2012, to April 11, 2012. During that time, observations, interviews, and record reviews were conducted with the following results:

Complaint # ID00005402

Allegation #1: Three identified residents' bills from the facility were not accurate.

Findings #1: On 4/09/12, two of the three residents were interviewed and both stated they had no further concerns with the billing. One resident said he would like more social security income but expressed understanding the facility could not provide that for him.

One of the residents no longer resided at the facility. A copy of his billing was provided prior to the complaint investigation. A review of the billing by surveyors indicated the facility had appropriately accounted for the resident's funds and the resident actually owed the facility \$5.00.

Louis Adamson, Administrator

April 25, 2012

Page 2 of 2

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

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

Sincerely,

Karen Anderson, RN

Karen Anderson, RN

Health Facility Surveyor

Residential Assisted Living Facility Program

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



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April 25, 2012

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 April 9, 2012, to April 11, 2012. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00005469

Allegation #1: The facility house manager changed the times Adderal was given to an identified resident without an MD order. This resulted in the resident getting 20 mg. (milligrams) twice a day instead of 40 mg. once a day.

Findings #1: On 4/10/12, the identified resident's record was reviewed.

On 1/30/12 a physician's order documented Adderal 20 mg. was to be given twice a day. The January and February 2012 MARs documented the medication was given as ordered.

On 3/5/12 a physician's order documented Adderal 20mg., 1/2 tablet was to be given twice a day. This was a reduction in the dose of the medication. The March 2012 MAR reflected the order change and documented the medication was given as ordered.

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

Louis Adamson, Administrator
April 25, 2012
Page 2 of 2

Allegation #2. An identified resident's medication changed on 3/8/12, but the change was not implemented.

Findings #2: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.520 for not providing adequate assistance and monitoring of medications. The facility was required to submit a plan of correction within 10 days.

Allegation #3. The facility nurse was not available to assist with the implementation of new orders.

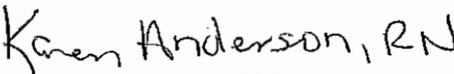
Findings #3: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.520 for not providing adequate assistance and monitoring of medications. The facility was required to submit a plan of correction within 10 days.

A core issue deficiency was identified during the complaint investigation. Please review the cover letter, which outlines how to 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 **04/11/2012**. A "Repeat" non-core deficiency was cited at IDAPA 16.03.22300.01, as well as, a twice "Repeated" non-core deficiency was cited at 16.03.22.300.02, both related to lack of the facility's nurse involvement. The completed punch list form and accompanying evidence of resolution (e.g., assessments, 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