



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

LESLIE M. CLEMENT - Administrator
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (206) 364-1888

June 27, 2011

Carissa Bullets, Administrator
185 Constellations Rd
Idaho Falls, ID 83402

License #: Rc-977

Dear Ms. Bullets:

On May 12, 2011, a Complaint Investigation survey was conducted at Friends & Family Living Center - Tierragold Assisted Living Center, Llc. 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 Donna Henscheid, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 334-6626.

Sincerely,

Donna Henscheid, LSW
Team Leader
Health Facility Surveyor
Residential Assisted Living Facility Program

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



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May 20, 2011

CERTIFIED MAIL #: 7009 0820 0000 2807 1804

Carissa Bulletts, Administrator
Friends & Family Living Center
185 Constellations
Idaho Falls, ID 83402

Dear Ms. Bulletts:

Based on the Complaint Investigation survey conducted by our staff at Friends & Family Living Center - Lbd Investments Llc on **May 12, 2011**, we have determined that the facility failed to protect residents from abuse and inadequate care.

This core issue deficiency substantially limits the capacity of Friends & Family Living Center - Lbd Investments Llc 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 May 23, 2011, through November 23, 2011. 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. A registered nurse or administrator consultant, with experience working for a residential care assisted living facility in Idaho and experience working with persons with severe and persistent mental illness will be obtained and paid for by the facility, and approved by the Department. This consultant must possess either an Idaho nursing license or an Idaho residential care administrator license, and may not also be employed by the facility or company that operates the facility. The consultant must be allowed unlimited access to the**

facility and its systems for the provision of care to residents. The name of the consultant with the person's qualifications will be submitted to the Department for approval no later than June 1, 2011

2. The Department approved consultant will submit a weekly written report to the Department commencing on June 3, 2011 and every Friday thereafter. The reports will address progress on correcting the deficiencies on the Statements of Deficiencies and Non-Core Issues Punch Lists.
3. The facility will maintain, on an ongoing basis, the deficient area in a state of compliance in accordance with the submitted Plan of Correction;
4. 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.
5. 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:

Randy May
Deputy Administrator
Division of Medicaid-DHW
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036

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 **June 26, 2011**. **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 by **June 2, 2011**, 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 (**June 2, 2011**). 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 **June 2, 2011**, 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.) are to be submitted to this office by **June 11, 2011**.

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 Friends & Family Living Center - Lbd Investments Llc.

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/js

Enclosure

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

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R977	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/12/2011
NAME OF PROVIDER OR SUPPLIER FRIENDS & FAMILY LIVING CENTER - LBD IN\		STREET ADDRESS, CITY, STATE, ZIP CODE 165 + 175 + 185 + 195 CONSTELLATIONS ROAD IDAHO FALLS, ID 83402		
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R 000	<p>Initial Comments</p> <p>The following deficiencies were cited during the complaint investigation survey conducted 5/11/11 through 5/12/11 at your residential care/assisted living facility. The surveyors conducting the survey were:</p> <p>Donna Henscheld, LSW Team Coordinator Health Facility Surveyor</p> <p>Gloria Keathley, LSW Health Facility Surveyor</p> <p>Rae Jean McPhillips, RN, BSN Health Facility Surveyor</p> <p>Definitions: @ = at & = and AV = Arterial Venous bldg - building BS and B/S = blood sugar carbs = carbohydrates DEC = decanoate DR = doctor D/T = due to Flex = flexible hrs = hours hx = history IM = intramuscular LPN = Licensed Practical Nurse MAR = Medication Assistance Record meds = medications mg = milligram msg. = message NSA = Negotiated Service Agreement OJ = orange juice Oxy's = oxycontin PSR = Psychosocial Rehabilitation</p>	R 000		

Bureau of Facility Standards

TITLE

(X6) DATE

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

STATE FORM

6829

UGS111

If continuation sheet 1 of 27

Bureau of Facility Standards

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R 000	Continued From page 1 q = every qd = every day Res = Resident RN = Registered Nurse SmI = small UAI = Uniform Assessment Instrument w/ = with X's = times	R 000	<u>R006</u> Facility failed to report and investigate an allegation of sexual abuse (Res #4) What corrective actions will be accomplished for the specific resident affected?	
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 and interview, it was determined the facility failed to report and investigate an allegation of abuse when 1 of 1 sampled residents (#4) reported she had been sexually abused. The findings include: Resident #4 was admitted to the facility on 3/4/11 with diagnoses which included bipolar disorder, schizoaffective disorder and developmental disabilities. The facility's abuse policy and procedure documented, "...The facility administrator shall report the incident to the proper authorities within hours of the incident...the facility must report such information within (4) hours to the appropriate law enforcement agency. The administrator will investigate and make a determination on further action within five (5) days." There was no mention in the facility's abuse policy to contact Adult Protective Services (APS) as mandated by Idaho Statutes 39-5303.	R 006	1) Police were notified on 6/7/11. Police investigation conducted on 6/7/11. 2) PSR worker was notified on 3-21-11. 3) Facility nurse conducted a head to toe physical exam of resident on 5-19-11. 4) Administrator is conducting an investigation related to the alleged abuse. How will you identify other residents that may be affected by the same deficient practice and what corrective action will be taken? 1) All residents could be affected. Staff will be informed of need to report any allegations or	

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R 006	<p>Continued From page 2</p> <p>The facility's resident rights policy documented, "...guarantees the following rights to our residents... freedom from abuse"</p> <p>The resident's UAI, dated 2/08/11, documented under the "Self-Preservation/Victimization" section, "D/T mental illnesses could be vulnerable to victimization/manipulation by others if not protected."</p> <p>A "Psychological History Report" documented the resident had "impaired decision making skills and impaired ability to comprehend."</p> <p>A "Resident Care Note," dated 3/17/11, documented the resident told a caregiver an acquaintance touched her inappropriately. The caregiver told the administrator and the resident's case manager from an outside agency about the incident.</p> <p>An incident report, dated 3/20/11, documented Resident #4 told staff she had been sexually abused by a male acquaintance. The report did not document whether the facility reported the allegation of sexual abuse to APS or local law enforcement. Additionally, there was no evidence an investigation had been initiated to protect the resident from abuse.</p> <p>On 5/12/11 at 9:15 AM, the facility administrator stated she did not report the incident to APS or law enforcement. Additionally, she stated she had not conducted an investigation of the incident.</p> <p>On 5/12/11 at 2:20 PM, a caregiver stated she told the administrator and case manager about the allegations made by Resident #4.</p> <p>The facility failed to report an allegation of sexual</p>	R 006	<p>Actual abuse to the Administrator immediately. If any allegations are received the Abuse Policy will be implemented by the Administrator and reviewed by the RA/ADM Consultant for completion.</p> <p>What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur?</p> <p>1) The abuse policy has been modified to include the directive to contact Protective Services (APS) as mandated by Idaho Statutes 39-5303.</p> <p>2) Staff will be inserviced on the Abuse Policies 6-2-11, including what constitutes abuse, who needs to be notified, and what needs to be done to protect residents from further abuse during the investigation as well as how to do a thorough investigation. This in-service will be provided by the facility nurse LPN/RN over-site and Administrator.</p> <p>How will the corrective action be monitored and how often will monitoring occur to ensure the deficient practice will not recur?</p>	6/2/11

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R 006	Continued From page 3 abuse to the appropriate agencies. The facility's policies and procedures, regarding abuse, were not implemented to ensure the proper authorities were notified, an investigation was conducted and Resident #4 was protected from further abuse. The facility failed to protect Resident #4 from abuse.	R 006	1) Contracted Nurse/ADM. Consultant will review staff communication system and care giver notes and formulate a system with the Administrator by which any noted allegations of abuse will be identified, communicated and follow up on within the required time frame. Staff education will be provided on the communication reporting expectations. In-services for staff will be held on 6-2-11 and 6-7-11.	
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 record review and interview, It was determined the facility admitted and retained 1 of 4 sampled residents (#3) who the facility did not have the capability, capacity and services to provide an appropriate level of care. The facility retained 1 of 1 sampled residents (#2) and 7 Random Residents who were a danger to themselves or others. Additionally, the facility did not provide assistance and monitoring of medications for 2 of 4 sampled residents (#2 and #3). Finally, the facility did not coordinate care for 1 of 1 sampled residents (#3) who had end stage renal disease and required dialysis. The findings include: I. ADMISSION AND RETENTION A. IDAPA rule 16.03.22.52.05.a states "A resident will be admitted or retained only when the facility has the capability, capacity, and services to provide appropriate care, or the resident does not require a type of service for which the facility is not licensed to provide or	R 008	2) Contracted Nurse/ADM consultant will review any allegations of abuse via phone, fax, email within the Administrator through the period of the follow up survey to ensure that all steps are followed. What date will the corrective actions be completed by? Corrective actions will be completed by June 24, 2011. R008 The facility admitted and retained Resident #3, who the facility did not have the capability, capacity and services to provide an appropriate level of care. The facility retained resident #2 and 7 others who were a danger to themselves or others.	

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R 008	Continued From page 4 which the facility does not provide or arrange for, or if the facility does not have the personnel, appropriate in numbers and with appropriate knowledge and skill to provide such services;" 1. Resident #3 was admitted to the facility on 11/6/10 with diagnoses that included Type I diabetes mellitus, diabetic neuropathy, diabetic retinopathy, end-stage renal disease and hypertension. The resident received hemodialysis three days a week. A nursing assessment, dated 11/6/10, documented the resident had "impaired judgement and confusion" related to diabetes. It further documented, the resident's "functional limitations" included hemodialysis three times a week, Type I diabetes with history of poor glucose control. i. Diet According to KT/DA at http://ms11.mit.edu/ESD10/kidneys/HndbkHTML/ch17.htm and http://www.drugs.com/cg/dialysis-diet.html . A dialysis diet is an important part of an individual's overall medical care. A dialysis diet controls the amount of potassium, phosphorus, sodium and liquid in an individual's diet. Dialysis machines remove the waste from the blood. These wastes come from foods that have been eaten and build up in the blood between dialysis. Therefore, it is very important to follow the meal planning suggestions received, as well as all other suggestions from your doctor or other team members. A dialysis diet "can and should change" as the individual's medical and nutritional needs change.	R 008	The facility did not provide assistance with medications for residents #2 and #3. The facility did not coordinate care for resident #3 with Dialysis Center. What corrective actions will be accomplished for the specific residents affected? Resident #3 no longer resides at the facility as of 6-2-11. Staff will be educated on diabetic diet, counting carbs and the documentation system on 6-14-11. Resident #2 no longer resides at the facility, and will not be accepted back. How will you identify other residents that may be affected by the same deficient practice and what corrective actions will be taken? There currently are not any residents residing in the facility that receive dialysis treatments.	

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R 008	<p>Continued From page 5</p> <p>An NSA, dated 11/6/10, documented Resident #3 was "diabetic and his diet is closely monitored for his dialysis treatment." It further documented the resident received dialysis three times a week.</p> <p>A nursing assessment, dated 11/6/10, documented the resident had renal failure and was on a diabetic and "dialysis" diet. There was no further documentation of any training or instruction to staff regarding what was included in a "dialysis diet." From 11/7/10 through 6/12/11, the facility nurse had not assessed Resident #3 to ensure his diabetic and renal diets were being implemented.</p> <p>There were no diet restrictions or guidelines from the dialysis center available in the facility to guide staff on how to meet the resident's nutritional needs.</p> <p>On 5/12/11 at 8:30 AM, the administrator confirmed the facility was not monitoring the resident's diet.</p> <p>On 5/12/11 at 11:08 AM, the LPN stated the resident was on a 1800 calorie diabetic diet and a renal diet but was not aware what was being provided.</p> <p>On 5/12/11 at 4:30 PM, the facility cook, stated there was no one in the facility on a therapeutic or renal diet.</p> <p>The facility did not ensure the facility nurse, dialysis center, or registered dietician coordinated a food plan to meet the resident's nutritional needs for a renal diet. Additionally, there was no documented evidence that training or education had been provided to staff by the facility or dialysis center regarding the resident's diet.</p>	R 008	<p>All potential residents will be assessed for appropriateness of level of care for the facility before being admitted.</p> <p>All residents in the facility will be assessed for risk of danger to themselves or others. Those with psychiatric diagnosis will be assessed by a Mental Health Professional to determine risk of danger to self or others.</p> <p>All residents in the facility will have a complete medication order review. All will have self administration assessments completed and reassessed by at least every 90 days.</p> <p>Supply of ordered medications will be validated. Pharmacy consultant will be asked to participate in this review.</p> <p>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</p> <p>Behavior management, mental health and crisis intervention training for</p>	

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R 008	Continued From page 6 ii. Nepro According to the website for Abbott Nutrition, 2011, Nepro is a "therapeutic nutrition specifically designed to help meet the nutritional needs of patients on dialysis (Stage 5 chronic kidney disease)." A physician's order, dated 3/28/11, documented Resident #3 was to receive "Nepro nutritional supplement, one can with carb study every day." An April 2011 MAR, documented the Nepro was not available from 4/1/11 until 4/26/11. For 25 days, the resident did not receive the supplement as ordered to meet his nutritional needs while receiving dialysis. There was no documented evidence the physician was notified the resident was not receiving the supplement. iii. Carbohydrate to Insulin Ratio Resident #3's NSA, dated 11/6/10, documented the staff would "monitor and control all medication." It further documented the resident received dialysis three times a week and his medication "must be monitored closely." A UAI, dated 11/6/10, documented the resident "cannot remember to take meds. Must have them set up and handed to him in order to take them." A nursing assessment, dated 11/6/10, documented the resident required "total" assistance with medication management. Further it documented the resident had a "hx of non-compliance."	R 008	Staff will be provided by Nurse Administrator Consultant and/or Mental Health Professional and Completed by 6-24-11. Preadmission screening will be completed by to ensure all residents are appropriate for admission. How will the corrective action be monitored and how often will monitoring occur to ensure the deficient practice will not recur? The UAI/USA will be reviewed with each 90 day assessment by the R.W. MARs will be reviewed weekly for three months then every 14 to 30 days to ensure staff have documented all medications appropriately. Any missed doses or refusals that are consistent or can affect the health or well being of the resident will be reported to the MD.	

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R 008	Continued From page 7 A physician order, undated, documented the resident was to receive "Novolog Flex pen 100 units. Take 1:15 carbs 1:40 target 100 approximately 30 units qd 3 times a day subcutaneously." It was signed off by the facility RN on 11/23/10. A "Carbohydrate to Insulin Ratio Guideline" provided by the facility LPN, documented the following: "Units of insulin to cover carbohydrate intake = Total grams of carbohydrate consumed divided by ratio factor. Example: *1 Unit for every 15 grams of carbohydrate *15 would be the ratio factor *If a patient consumed 60 grams of carbohydrate the total dose of rapid insulin would be 4 units because 60 divided by 15 = 4. If the patient was given 15 grams of carbohydrate before the meal to treat hypoglycemia, this 15 grams would not be included in the insulin coverage. The total carbohydrates used for calculation would still be 60 not 75." On 5/12/11 at 9:15 AM, when asked about the resident's carbohydrate to insulin guidelines, the administrator stated, "We aren't counting carbs. To be honest I don't think anyone fully understands what the order is." On 5/12/11 at 11:08 AM, the LPN stated the resident determined the amount of insulin (Novolog) depending on what he had eaten. She confirmed there was no documentation of what the resident had eaten to "clarify the amount of insulin he was taking."	R 008	Pharmacy consultant will provide quarterly review of medication orders/supplies for facility. Administrator and nurse will review daily logs to identify need for intervention/assessment by mental health professional. Referrals will be made as needed. What date will the corrective actions be completed by? Corrective actions will be completed by June 24, 2011.	

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R 008	<p>Continued From page 8</p> <p>Resident #3 had an order to receive Humalog insulin according to the amount of carbohydrates he had consumed. Although assessed as being totally dependent on staff for medication management, the facility allowed the resident to determine the amount of Novalog insulin to take. The facility had no way to verify the amount of carbohydrates he consumed to ensure he was taking the correct amount of insulin.</p> <p>iv. Medical Condition</p> <p>"Resident Case Notes" documented the following:</p> <p>*11/7/10 - (3 - 11 shift) Resident #3 "moved in on 11/6/10 at 7:00 PM. [Former administrator's name] will get all his meds squared away on Monday...His BS was 561 when he moved in...There is a booklet that [Former administrator's name] printed off for all of us to read. I am checking his meds out so he will have them for the day."</p> <p>*11/8/10 - (3 - 11 shift) The current administrator was picking up the resident's medications at 8:30 - 9:00 AM the next morning. (Three days after admission.)</p> <p>*11/13/10 - (7 - 3 shift) The resident "had bad incident with B/S - walked to [grocery store's name]. Did incident report." (The report for this incident was not found in the resident's record.)</p> <p>*11/16/10 - (7 - 3 shift) The resident had a "bout of extreme fatigue."</p> <p>*11/16/10 - (3 - 11 shift) Resident #3 "has been sick this evening. I checked B/S @ dinner it was 490. He took both shots. He then asked for Oxy's.</p>	R 008		

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R 008	Continued From page 9 After he took them he wanted nausea pill. He got sick. I assisted him. I checked B/S again it was 416. I called [former administrator's name] and she referred me to [RN's name]. He said have him take his Lantus and have him go to Dr. in the morning." *11/17/10 - (3 - 11 shift) "Went to dialysis came home w/blood all over his arm & hand, I cleaned him up and called [RN's name] left msg. Then I called [administrator's name]. She came over with guaze to fix his arm. He is having surgery in the morning to have it fixed." *11/18/10 - (3 - 11 shift) "Very tired. He got back from his appointment, his blood sugar level was 543. I called [former administrator's and RN's names]." *11/24/10 - (7 - 3 shift) The resident refused morning medications because he had to go to dialysis earlier than he had planned. The resident was "very upset. Blood sugar up again." *11/27/10 - (7 - 3 shift) "...he ate dinner, couple hrs after dinner he vomited 2 x's, he stated not to worry that he's fine..." *11/28/10 - (7 - 3 shift) "...Vomited twice today." *11/28/10 - (3 - 11 shift) The resident "bottomed out @ 8 PM, B/S got to 70, had glass OJ, cheese-n-crackers, chicken noodle soup, he went to bed fell asleep hard, didn't take his Lantus." *11/30/10 - (3 - 11 shift) The resident "got sick, throwing up." *12/1/10 - (3 - 11 shift) Resident #3 "has been vomiting since last night." The administrator and	R 008		

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R 008	<p>Continued From page 10</p> <p>nurse were notified and caregiver was advised to send the resident to urgent care but "he refused." At approximately 7:25 PM, the resident was found on the floor saying "God help me." The resident was sent to the hospital by ambulance.</p> <p>*12/7/10 - (11 - 7 shift) The resident was "still in a great deal of pain. B/S at 11:35 PM was 85 & at 12:15 he stated that his B/S was going down lower, checked it and it was at 76, gave him OJ. The resident was offered cheese and crackers or peanut butter and jelly sandwich but he refused." The resident stated "he could hardly keep food down." It further documented a family member had witnessed and reported the resident had a "very short seizure at 11:35 PM."</p> <p>*12/16/10 - (3 - 11 shift) The resident had been "moaning a lot...He also threw his dinner up."</p> <p>*1/8/11/11 - (11 - 7 shift) The resident returned from the hospital at 9:45 PM. At 10:55 PM the resident's blood glucose level was 463 and a family member gave him 12 units of Lantus and 5 units of Novolog. He was rechecked at 1:55 AM and his blood glucose level was 429. He was given 7 more units of Novolog.</p> <p>*1/10/11 - (3 - 11 shift) Resident #3 "woke up screaming in pain."</p> <p>*1/10/11 - (11 - 7 shift) The resident "seems to be in a lot of pain, but he slept during most of the night. He just seems to look a little pail [sic]."</p> <p>*1/22/11 - (11 - 7 shift) The resident's blood glucose level was 29 at 4:00 AM. He was given orange juice. He was "unresponsive" so 911 was called. The paramedics gave the resident a "shot to help bring his B/S back up."</p>	R 008		

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R 008	Continued From page 11 *1/23/11 - (11 - 7 shift) The resident's blood glucose levels were "up and down last night, continually checked and monitored B/S." *1/24/11 - (11 - 7 shift) Resident #3's blood glucose level was "very low 26, called paramedics, they were able to get it up after 2 hours." *1/26/11 - One hour checks were initiated. At 11:00 PM, the resident went to bed and checks through 3:00 AM found him sleeping. At 4:30 AM, the resident "wasn't ok, felt cold and clammy [sic] sweating bad." His blood glucose levels were checked and were below 20. After being rechecked and still below 20, the paramedics were called and he was taken to the hospital. *2/10/11 - (3 - 11 shift) The resident "was not feeling well, slept most shift, did not eat very much." *2/12/11 - (11 - 7 shift) Resident #3 had "2 hour blood sugar checks." *2/16/11 - (7 - 3 shift) The resident's blood pressure "sky rocked [sic]" during dialysis. *2/20/11 - (7 - 3 shift) The resident's "B/S has been elevated today, he has been in room all shift. Found 3 meds in his room." *2/21/11 - (7 - 3 shift) "[Resident's nickname] hemraged [sic] @ dialysis [sic], please keep eye on him." *2/22/11 - (7 - 3 shift) Resident #3 went in for a stress test but was not feeling well so was unable to complete test. The resident "came back really	R 008		

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R 008	Continued From page 12 sick, has been in room ever since." *3/4/11 - (3 - 11 shift) The resident's B/S "was high & he is hurting from dialysis." *3/6/11 - (7 - 3 shift) The resident stayed in is room "most of the day, not feeling to [sic] good, really tired." The resident was nauseated and was not eating well. *3/8/11 - (no shift noted) The resident was out of Lantus. *3/18/11- (11 - 7 shift) The resident's blood glucose was "high" and his back was "hurting really bad." *3/23/11 - (7 - 3 shift) The resident's "sugar was high! Keep eye on him!" *3/30/11 - (11 - 7 shift) The resident's "BS were high. Contacted the [RN's name and former administrator's name], gave Novolog a couple of times." *3/31/11 - (3 - 11 shift) The resident's "blood sugar spiked verry [sic] high. Res refuses to take insulin." The staff checked him every hour until he finally took insulin at 10:20 PM. *4/3/11 - (11 - 7 shift) The resident's "B/S was high through the night, finally went down." *4/4/11 - (7 - 3 shift) Resident 3's blood pressure was "supposedly high at dialysis and they treated him." *4/22/11 - (11 - 7 shift) "See incident report & MARs for BS checks." An Incident/Accident report for this incident was not found so there was	R 008		

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R 008	Continued From page 13 no documentation what was going on with the resident's blood glucose levels. *4/26/11 - (11 - 7 shift) "B/S concern." *5/5/11 - (11 - 7 shift) The resident's "B/S up and down all night." *5/6/11 - (7 - 3 shift) The resident's "B/S up and down." *5/12/11 - (3 - 11 shift) The resident's "B/S up and down tonight as well as pain." A hospital report, dated 11/18/10, documented the resident's AV fistula was not functioning and required "endovascular intervention." A hospital "Discharge Summary," dated 12/1/10, documented the resident was "carefully hydrated, and blood sugars brought under better control." An "Incident/Accident Report" form, dated 12/31/10, documented Resident #3's "B/S was high. Was instructed to call 911." The resident was transported to the hospital due to high blood glucose levels. An "Emergency Room" report, dated 12/31/10, documented the resident was admitted for "abnormal glucose." It further documented the patient reported "ongoing pain in his right arm and ribcage after sustaining an injury several days ago from a fall. Other than that he is uncertain why he is here." An "Incident/Accident Report" form, dated 1/1/11, documented the resident's blood glucose level was at 26 and "he was not responsive." The caregiver gave him orange juice and took his	R 008		

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R 008	<p>Continued From page 14</p> <p>blood sugars every 15 minutes.</p> <p>An "Incident/Accident Report" form, dated 1/2/11 at 7:15 PM, documented the caregiver checked his blood glucose level and it was "maxed" over 600. The caregiver called 911 and the resident was admitted to the hospital.</p> <p>The facility staff were not properly trained and did not have the knowledge to provide and monitor a renal diet for Resident #3. The facility staff also lacked the capability, knowledge and skill to monitor the resident's carbohydrate intake to ensure he received the correct dose of insulin. Because Resident #3's blood glucose levels varied dramatically, his medical condition was unstable and he required medical intervention which the facility did not have the capacity to provide.</p> <p>B. No resident will be admitted or retained who requires ongoing skilled nursing or care not within the legally licensed authority of the facility. Such residents include:</p> <p>... "A resident that is violent or a danger to himself or others."</p> <p>1. Resident #2 was readmitted to the facility on 11/1/10 with diagnoses that included schizoaffective and bipolar disorder.</p> <p>A "Resident Case Note," dated 1/19/11, documented Resident #2 and another resident left the facility. When the resident arrived back to the facility, he told the caregiver he had two beers. In the afternoon, the resident came back out of his room with "bloodshot eyes" and his skin "was turning red." The report documented the resident would not say what was wrong. An</p>	R 008		

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R 008	<p>Continued From page 15</p> <p>employee searched the dumpster and found empty cold medicine packages. The facility nurse and administrator were called. Resident #2 was taken to the hospital via paramedics. Another resident told caregivers Resident #2 had taken 42 cold tablets. Resident #2 was admitted to the in the hospital overnight.</p> <p>A "Resident Case Note," dated 2/25/11, documented Resident #2 and another resident took pills.</p> <p>A "Resident Case Note," dated 3/31/11, documented, "...he is kinda [sic] acting weird watch him and (another resident's name) around each other."</p> <p>A "Resident Case Note," dated 4/1/11, documented, "Res ran out of his room nude, ran to the road and, then again, he actually ran into the road almost getting hit by the cars. He later was taken to (behavioral hospital's name) for a re-evaluation."</p> <p>The facility continued to retain Resident #2, even though he was a danger to himself on two separate occasions.</p> <p>2. The following incidents were found during a review of the facilities accident and incident reports. The incidents involved seven random residents who were exhibiting behaviors that endangered themselves or others.</p> <p>i. An "Incident/Accident Report," dated 1/27/11, documented Random Resident #1 "...used a pocket knife to cut a small area on her wrist. She was moved to safe room and 15 min checks for 24 hours..."</p>	R 008		

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R 008	Continued From page 16 An "Incident/Accident Report," dated 2/24/11, documented Random Resident #1, "walked out of room asking for a bandaid. She had cut her left arm w/razor 2 sml scratches...proceeded w/ first aid....Had [Random Resident's name] stay in safe area until she calmed down and appeared to doing better...." An "Incident/Accident Report," dated 3/8/11, documented Random Resident #1, "cut the top of her hand in an X pattern because she was upset about life. Kept stating she was tired of life & this continued till shift change. Contacted administrator & sat and talked to [Random Resident's Name] for a bit...." Although Random Resident #1 had harmed herself on three separate occasions, the facility continued to retain her. There was no documentation the resident had been assessed by a mental health professional to determine she was no longer a danger to herself or others. ii. An "Incident/Accident Report," dated 1/28/11, documented Random Resident #2, "Had an ongoing behavior all night @ 10:45 she came out of her room holding her wrist. She had broke a piece of plastic off her stereo and scratched her wrist. She was told she would be moved to a safe room & be put on 24 hour watch." The resident left the facility and was later located by the police and arrested. An "Incident/Accident Report," dated 2/27/11, documented Random Resident #2, "stated she was going to harm herself. She called [agency's name]. They came out & suggested journaling...." The report documented the resident refused the "journaling" and walked to a gas station and returned later to another building on the property.	R 008		

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R 008	<p>Continued From page 17</p> <p>An "Incident/Accident Report," dated 2/27/11, documented Random Resident #2, "came out of her room and stated she wanted to call 911 because she was going to hurt herself. Redirected her & explained her she didn't need to call. She then walked in her room and called 911 from her cell phone...." She was "removed" from the facility by the police and admitted to a psychiatric hospital.</p> <p>An "Incident/Accident Report," dated 3/8/11, documentec Random Resident #2, "cut herself on her wrist when caregiver left bldg to go to another bldg to get dinner. Behavior kept up until 9:30 PM" The resident was put on 15 minute checks and staff were not to leave her alone. The staff "tried to distract and not play along with her." There was no documentation regarding what interventions were used to address the self-injurious behavior.</p> <p>Although Random Resident #2 no longer resided at the facility, the facility readmitted her after three separate incidents of harming herself. Prior to returning to the facility, there was no documentatlon the resident had been assessed by a mental health professional to determine she was no longer a danger to herself or others.</p> <p>iii. An "Incident/Accident Report," dated 1/30/11, documentec Random Resident #3, " ..was pounding his head on the walls...." The staff talked to the resident and "let him express his feelings."</p> <p>An "Incident/Accident Report," dated 2/13/11, documentec Random Resident #3, "broke into the kitchen and broke knife drawer trying to cut himself. I wrestled the knife away from him...he</p>	R 008		

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R 008	Continued From page 18 laid [sic] down...." The staff checked him frequently and "talked to him about his feelings." An "Incident/Accident Report," dated 2/26/11, documented Random Resident #3 "...was upset refusing meds. Went into his room & broke a coffee cup all over his floor. Picked up a piece & said he was going to cut his arm....cops called. Came out & talked to him, he decided to take meds & turn his night around." An "Incident/Accident Report," dated 3/26/11, documented Random Resident #3 was heard yelling from his room. It documented the "resident had multiple..." The report did not document what had occurred "multiple" times. The staff member "sat down and asked [Random Resident #3's name] why he had cut himself..." The facility was to conduct frequent room checks for "sharp objects and more attentiveness" to the resident's demeanor. After four separate incidents of harming or attempting to harm himself, Random Resident #3 was retained at the facility. There was no documentation the resident had been assessed by a mental health professional to determine he was no longer a danger to himself or others. iv. An "Incident/Accident Report," dated 2/7/11, documented Random Resident #4, "...was agitated most of shift...She slapped at my hands, grabbing my coat telling me she was going to bash my head in...." The PSR worker had taken the resident's cigarettes away from the resident became "agitated." The police were called, talked to her and had her go to her room. The current administrator came and gave her a cigarette and told her to stay in her room and "be calm."	R 008		

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R 008	<p>Continued From page 19</p> <p>Random Resident #4, continued to reside at the facility. There was no documentation the resident had been assessed by a mental health professional to determine she was no longer a danger to herself or others.</p> <p>v. An "Incident/Accident Report," dated 2/21/11, documented Random Resident #5, "had a phone conversation with his mom that upset him....He got upset and broke the handrail off the wall & threatened to hit [residents' names].... I talked [random resident's name] into giving me the handrail. I felt the situation was calm so I did not call the police...."</p> <p>An "Incident/Accident Report," dated 2/25/11, documented Random Resident #5 took "32 cough pills and was unresponsive." The resident was transported to hospital and the plan was to keep him away from the other resident who had also taken the "cough pills."</p> <p>After two incidents of attempting to harm himself or others, Random Resident #5 remained at the facility. There was no documentation the resident had been assessed by a mental health professional to determine he was no longer a danger to himself or others.</p> <p>vi. An "Incident/Accident Report," dated 3/16/11, documented Random Resident #6, "actually intentionally [sic] scratched her wrist because she stated she wanted to go be w/another resident...."</p> <p>After one incident of attempting to harm herself, Random Resident #6 remained at the facility. There was no documentation the resident had been assessed by a mental health professional to determine she was no longer a danger to herself or others.</p>	R 008		

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R 008	Continued From page 20 vii. An "Incident/Accident Report," dated 5/7/11, documented Random Resident #7 punched another resident in the face. The resident then fled the facility and went into one of the other buildings on the property. The police were called but did not remove the resident. Random Resident #7 was moved to another building. After an incident of harming another resident, Random Resident #7 remained at the facility. There was no documentation the resident had been assessed by a mental health professional to determine he was no longer a danger to himself or others. On 5/12/11 at 2:00 PM, a caregiver stated she had worked for the facility for one year. She stated she had behavioral training from her previous employer, but not from the current facility. On 5/12/11 at 2:15 PM, a caregiver stated she had worked at the facility for one year and received behavioral training "a week ago" through a PSR agency. On 5/12/11 at 2:20 PM, a caregiver stated she had worked at the facility for 11 months and had not been trained. She stated she had no orientation, no mental health training, or training on how to intervene during a crisis. The facility continued to retain residents who were a danger to themselves or others. Residents were cutting themselves, hitting walls, overdosing, making suicidal threats and hitting and threatening harm to others. The staff did not have the training and knowledge to provide appropriate supervision during violent or crisis	R 008		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R977	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/12/2011
NAME OF PROVIDER OR SUPPLIER FRIENDS & FAMILY LIVING CENTER - LBD IN		STREET ADDRESS, CITY, STATE, ZIP CODE 165 + 175 + 185 + 195 CONSTELLATIONS ROAD IDAHO FALLS, ID 83402		
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R 008	<p>Continued From page 21</p> <p>situations.</p> <p>II. ASSISTANCE & MONITORING OF MEDICATIONS</p> <p>1. Resident #3 was admitted to the facility on 11/6/10 with diagnoses which included Type I diabetes mellitus, diabetic neuropathy, diabetic retinopathy, end-stage renal disease and hypertension. The resident received hemodialysis three days a week.</p> <p>An NSA, dated 11/6/10, documented the staff would "monitor and control all medication." It further documented the resident received dialysis three times a week and his medication "must be monitored closely."</p> <p>A UAI, dated 11/6/10, documented the resident "cannot remember to take meds. Must have them set up and handed to him in order to take them."</p> <p>A nursing assessment, dated 11/6/10, documented the resident required "total" assistance with medication management. Further it documented the resident had a "hx of non-compliance."</p> <p>A "Case Note," dated 11/7/10, documented the resident "moved in on 11/6/10 at 7:00 PM. [Former administrator's name] will get all his meds squared away on Monday." There were no orders for medications found for the day of admission.</p> <p>A physician order, dated 12/6/10, documented the resident was to receive Lantus insulin, 12 units, once daily at bedtime.</p> <p>A March 2011 MAR, documented the resident did</p>	R 008		

Bureau of Facility Standards

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R 008	<p>Continued From page 22</p> <p>not receive Lantus insulin on 3/7, 3/8, and 3/29. The reason the medication was not given was not documented.</p> <p>A "Case Note," dated 3/8/11, documented the resident was "out of Lantus."</p> <p>An April 2011 MAR, documented Resident #3 refused to take 12 units of Lantus on 4/22/11 and 4/30/11. It documented on 4/30/11 the resident stated, "I only take 11 units." It did not document the physician was notified of the refusals.</p> <p>"Blood Sugar Log" sheets documented Lantus was taken as follows:</p> <ul style="list-style-type: none"> *12/13 - 10 units *12/20 - 10 units *12/21 - 10 units *1/22 - 10 units *1/24 - 10 units *4/14 - 11 units *4/24 - 11 units *4/26 - 11 units *4/27 - 11 units *4/30 - 7 units *5/1 - 11 units *5/2 - 11 units *5/3 - 11 units *5/4 - 11 units *5/9 - 11 units <p>On 5/12/11 at 8:30 AM, the administrator stated, Resident #3's Lantus was not available for three days.</p> <p>On 5/12/11 at 11:08 AM, the LPN stated she had been "working hard at getting medication errors under control." Further, she stated she had not assessed the resident's ability to self-administer</p>	R 008		

Bureau of Facility Standards

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R 008	<p>Continued From page 23</p> <p>medications but the RN was scheduled to do that his next visit.</p> <p>Resident #3 had an order to receive 12 units of Lantus daily at 8:00 PM. Not only was it unclear how many days the resident went without Lantus, fifteen times the staff documented he received the incorrect dose. Further, the physician was not notified of the resident's refusal to take the prescribed dose of insulin.</p> <p>2. Resident #2 was admitted to the facility with diagnoses that included schizoaffective and bipolar disorder.</p> <p>Resident #2's NSA, dated 11/1/10, documented the facility would control all medications.</p> <p>Resident #2's UAI, dated 11/8/10, documented the facility would manage his medications.</p> <p>A physician's order, dated 3/1/10, documented the resident was to receive "Fluphenazine 50 mg. IM, q 2 weeks."</p> <p>An "Incident Report," dated 1/19/11, documented "the resident came out of his room his face was red & eyes were bloodshot, he was breathing heavy. I took him back in room to ask what he had done. He said he had 2 beers. His whole body started to turn red. I called the nurse, (administrator's name) then the ambulance. He was taken to the hospital."</p> <p>A "History and Physical," from a behavioral hospital dated 1/31/11, documented the resident was admitted to the hospital due to an increase in auditory hallucinations and suicidal ideations.</p> <p>A "Medication Error," dated 2/2/11, by the facility</p>	R 008		

Bureau of Facility Standards

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R 008	Continued From page 24 RN documented the resident did not receive multiple bi-weekly doses of IM Fluphenazine DEC (which is a psychotropic medication). It further documented, the resident was transported to a behavioral hospital, on 1/30/11, and released back to the facility on 2/1/11. A "Medication Assistance Record," dated 1/11, did not document the IM Fluphenazine DEC was given. A "Medication Assistance Record," dated 2/11, did not document the IM Fluphenazine DEC was given. A "Medication Assistance Record," dated 3/11, did not document the IM Fluphenazine DEC was given. An "Incident/Accident Report," dated 4/1/11, documented the resident ran from his room naked and then ran outside to the road. The resident proceeded to run into the middle of the road and was almost hit by traffic. The incident report further documented, the resident would stared blankly and did not respond to caregivers. A "Discharge And After Care Plan," from a behavioral hospital dated 5/3/11, documented Resident #2 "decompensates quickly without his medications and becomes gravely disabled and a danger to himself or others." On 5/12/11 at 9:25 AM, the administrator stated the resident was released after being incarcerated at the end of March. Resident #2 was placed on Haldol (which is a psychotropic medication) while incarcerated. When the resident was released, the facility did not confirm the resident's medications with the agency. She	R 008		

Bureau of Facility Standards

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R 008	Continued From page 25 further stated, the facility did not have orders for Haldol, so they resumed his old medication regime. Resident #2 did not receive the required behavioral medication injection for three months. III. COORDINATION OF CARE Resident #3 was admitted to the facility on 11/6/10 with diagnoses that included Type I diabetes mellitus, diabetic neuropathy, diabetic retinopathy, end-stage renal disease and hypertension. The resident received hemodialysis three days a week at a renal dialysis center. There was no documentation found in Resident #3's record that the administrator or RN had done the following: *contacted the dialysis center for updates on his condition *provided instruction to staff and followed-up on those instructions *educated staff regarding assistance and monitoring of a carbohydrate to insulin ratio *educated staff on a renal diet *assessed the resident following a change of condition *conducted a 90 day assessment of the resident's ability to self-administer medications and follow a carbohydrate to insulin ratio. There was no documentation found in the resident's record regarding the coordination of care between the end stage renal dialysis center and the facility. The facility failed to provide coordination of services for Resident #3.	R 008		

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R 008	Continued From page 26 The facility admitted and retained Resident #3 whom the facility did not have the capability, capacity and services to provide an appropriate care. The facility retained Resident #2 and 7 Random Residents who were a danger to themselves or others. Additionally, the facility did not provide assistance and monitoring of medications for Residents #2 and #3. Finally, the facility did not coordinate care for Resident #3 who had end stage renal disease and required dialysis. These failures resulted in inadequate care.	R 008		



ASSISTED LIVING
Non-Core Issues
Punch List

Facility Name Friends and Family Living Center	Physical Address 185 Constellations	Phone Number 208-227-0801
Administrator Carissa Bullets	City Idaho Falls	Zip Code 83402
Team Leader Donna Henscheid	Survey Type Complaint	Survey Date 05/12/11

RECEIVED

JUN - 9 2011

FACILITY STANDARDS

NON-CORE ISSUES

Item #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	L&C USE
1	300.01	The facility licensed professional nurse did not conduct a nursing assessment every 90 days for 5 of 5 reviewed records.	5/31/11	6/10/11 DAH
2	305.03	The nurse did not document when residents (5 of 5 records reviewed) had a change in medical or mental condition.	6-1-11	6/10/11 DAH
3	305.06	Residents #1 and 3 were not assessed to determine if they could safely inject their medications.	6-2-11	6/12/11 DAH
4	320	Residents #3 and 5's NSA were not developed within 14 days of admission. Additionally, Resident #s 1 and 3's records did not contain interim plans of care.	ongoing 6-1-11	6/10/11 DAH
5	320.03	Resident #6's NSA was not signed by all parties.	resident deceased	6/10/11 DAH
6	335.02	Facility staff were allowed to work when they had an infectious disease.	6-1-11	6/15/11 DAH
7	350.04	The administrator did not provide complainants with a written response within 30 days.	ongoing 6-1-11	6/10/11 DAH
8	550.02	A former employee talked about residents' health and behavioral needs in front of other residents.	6-2-11	6/10/11 DAH
9	600.03	Residents are left unsupervised when facility staff leave the buildings.	6-1-11	6/10/11 DAH

Response Required Date 06/11/11	Signature of Facility Representative <i>Carissa Bullets</i>	Date Signed
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IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER - Governor
RICHARD M. ARMSTRONG - Director

LESLIE M. CLEMENT - Administrator
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888

May 19, 2011

Carissa Bullets, Administrator
Friends & Family Living Center
Po Box 50540
Idaho Falls, ID 83405

Dear Ms. Bullets:

An unannounced, on-site complaint investigation survey was conducted at Friends & Family Living Center - Lbd Investments Llc from May 11, 2011, to May 12, 2011. During that time, observations, interviews, and record reviews were conducted with the following results:

Complaint # ID00004956

- Allegation #1:** Facility staff left residents unsupervised.
- Findings #1:** Substantiated. The facility was cited at IDAPA 16.03.22.600.03 for not ensuring staff were present in the buildings when residents were present. The facility was required to submit evidence of resolution within 30 days.
- Allegation #2:** The facility did not protect an identified resident's privacy when a lock on her door was not repaired in a timely manner.
- Findings #2:** Substantiated. However, the facility was not cited as they acted appropriately by moving the resident to a room that had a lock on the door.
- Allegation #3:** The administrator did not respond in writing to a complainant within 30 days.
- Findings #3:** Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.350.04 for not responding to complainants in writing within 30 days. The facility was required to submit evidence of resolution within 30 days.

Carissa Bullets, Administrator
May 19, 2011
Page 2 of 2

Allegation #4: The facility did not follow the Idaho Food Code when they prepare meals.

Findings #4: An inspection of the facility's kitchen was conducted on 5/12/11. The food preparation surfaces were observed to be clean. The facility cook was observed to obtain temperatures on the hamburger patties prior to transferring them to hot holding. The hamburger patties were cooked to 155 degrees Fahrenheit and were held at 146 degrees. The cooks were observed to wash their hands prior to putting on gloves and when they took them off. Additionally, no bare hand contact of ready to eat foods was observed during the survey. Kitchen practices were observed to meet the Idaho Food Code.

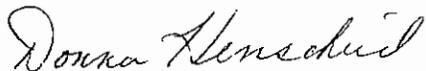
Unsubstantiated. This does not mean the incident did not take place; it only means that the allegation could not be proven.

Allegation #5: A caregiver was allowed to worked while ill.

Findings #5: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.335.02 for allowing an employee to work while ill with an infectious disease. The facility was required to submit evidence of resolution within 30 days.

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,



Donna Henscheid, LSW
Health Facility Surveyor
Residential Assisted Living Facility Program

DH/rm

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



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May 19, 2011

Carissa Bullets, Administrator
Friends & Family Living Center
P.O. Box 50540
Idaho Falls, ID 83405

Dear Ms. Bullets:

An unannounced, on-site complaint investigation survey was conducted at Friends & Family Living Center - Lbd Investments Llc from May 11, 2011 to May 12, 2011. During that time, observations, interviews, and record reviews were conducted with the following results:

Complaint # ID00005005

Allegation #1: Two identified residents did not receive medications as ordered.

Findings #1: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.520 for not ensuring residents received their medications as ordered. The facility was required to submit a plan of correction.

Allegation #2: Facility staff left residents unsupervised.

Findings #2: Substantiated. The facility was cited at IDAPA 16.03.22.600.03 for not ensuring staff were present. The facility was required to submit evidence of resolution within 30 days.

Allegation #3: The telephone in Building #2 could not receive incoming calls.

Findings #3: Substantiated. However, the facility was not cited as they acted appropriately by having the telephone repaired prior to the complaint investigation.

Allegation #4: Staff did not participate in fire drills.

Carissa Bullets, Administrator
May 19, 2011
Page 2 of 2

Findings #4: Substantiated. However, the facility had received a citation, at IDAPA 16.03.22.410.02, during a previous survey, on 3/3/11, and had corrected the citation prior to the complaint investigation.

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,



Donna Henscheid, LSW
Health Facility Surveyor
Residential Assisted Living Facility Program

DH/rm

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