



IDAHO DEPARTMENT OF  

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HEALTH & WELFARE

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P.O. Box 83720  
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PHONE 208-334-6626  
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July 11, 2012

Larue Gunter, Administrator  
Crystal Springs Living Center  
8284 South Crystal Springs Road  
Mc Cammon, ID 83250

License #: Rc-510

Dear Ms. Gunter:

On May 14, 2012, a Complaint Investigation survey was conducted at Crystal Springs Living Center. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level:

- Non-core issues, which are described on the Punch List, and for which you have submitted evidence of resolution.

This office is accepting your submitted evidence of resolution.

Should you have questions, please contact Karen Anderson, 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



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May 21, 2012

Larue Gunter, Administrator  
Crystal Springs Living Center  
8284 South Crystal Springs Road  
McCammon, ID 83250

Dear Ms. Gunter:

An unannounced, on-site complaint investigation survey was conducted at Crystal Springs Living Center from May 10, 2012 to May 14, 2012. During that time, observations, interviews or record reviews were conducted with the following results:

**Complaint # ID00005473**

Allegation #1: Residents were left unsupervised on 3/13/12.

Findings #1: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.600.06.a for the administrator not scheduling sufficient staff to provide supervision when caregivers had to leave the building. The facility was required to submit evidence of resolution within 30 days.

Allegation #2: Medications were left unsecured.

Findings #2: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.310.01.a for caregivers not ensuring medications were secured. The facility was required to submit evidence of resolution within 30 days.

Allegation #3: Caregivers pre-poured the residents' medications.

Findings #3: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.310.01.e and 16.03.22.310.01.f for caregivers pre-pouring medications and not observing residents take their medications. The facility was required to submit evidence of resolution within 30 days.

Allegation #4: Residents did not have phone access which was a violation of their rights.

Findings #4: On 5/10/12 at 7:25 PM, a caregiver stated a wind storm came through the area and knocked a huge tree over and when it fell, the phone line was cut. The caregiver stated the facility did not have phone service for 3 days.

On 5/11/12 at 9:00 AM, the house manager stated, when the phone line was damaged, there was a cell phone available for use until the phone line was repaired. He further stated, most of the residents had their own cell phones.

Substantiated. However, the facility was not cited as they acted appropriately by having the phone line repaired as soon as possible.

Allegation #5: Residents did not receive assistance with meals.

Findings #5: On 5/10/11 at 7:15 PM, a caregiver stated residents were served a home cooked breakfast every other day and cold cereal was provided on alternate mornings. He stated all of the residents were capable of getting their own cereal or making sandwiches. He said some of the residents also helped cook.

On 5/11/12 from 8:30 AM until 9:45 AM, residents were observed in the kitchen getting their own juice and cereal. All six residents stated they did not have any difficulty preparing their own breakfast or making sandwiches. Three residents stated they liked helping with meals and enjoyed cooking.

On 5/11/12 at 9:30 AM, the house manager stated he took the residents grocery shopping because they like to be involved in the food choices and cooking. He stated the residents participated in meal prep and served themselves because it helped build their confidence and helped them work towards independence.

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

Allegation #6: The facility did not follow an approved menu.

Findings #6: On 5/10/12 and 5/11/12, observations were made of the facility's food supply. The refrigerator, pantry and freezer were observed to contain food items necessary to meet the daily menu requirements.

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

Allegation #7: Residents did not have current Negotiated Service Agreements (NSAs).

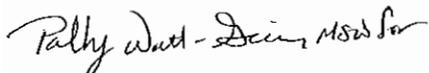
Larue Gunter, Administrator  
May 21, 2012  
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Findings #7: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.320.03 for not being able to determine if the NSAs were current because they were not signed or dated by the administrator. The facility was required to submit evidence of resolution within 30 days.

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 **05/14/2012**. The completed punch list form and accompanying evidence of resolution (e.g., receipts, pictures, policy updates, etc) are to be submitted to this office within thirty (30) days from the exit date.

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

Sincerely,



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

KA/pwg

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

