



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

August 22, 2012

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

Dear Ms. Oakes:

On August 16, 2012, a follow-up survey and complaint investigation survey was conducted at Carefix Management & Consulting Inc, dba Safe Haven Homes of Burley. The core issue deficiency issued as a result of the April 11, 2012, survey have been corrected.

- The conditions of your provisional license have been met. Your full license has been restored effective August 16, 2012, and is enclosed.
- The limit on all new admissions is lifted. You may resume admitting new residents to the facility.

The non-core issue deficiencies on the Punch List, dated April 11, 2012, have also been corrected.

Should you have questions, please contact me at (208) 334-6626.

Sincerely,

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

JS/TFP

Enclosure



IDAHO DEPARTMENT OF  
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August 21, 2012

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

Dear Ms. Oakes:

An unannounced, on-site complaint investigation survey was conducted at Carefix Management & Consulting Inc, Dba Safe Haven Homes Of Burley on August 16, 2012. During that time, observations, interviews, and record reviews were conducted with the following results:

**Complaint # ID00005516**

**Allegation #1:** Staff were not treating residents with dignity and respect.

**Findings #1:** On 8/16/12 from 9:30 AM through 1:00 PM, observations and interviews were conducted with all seven residents residing in the facility. The residents stated they were treated well by the staff. One resident stated things had really improved since the new administrator had taken over. He stated when residents had complaints or concerns the administrator responded back to them both verbally and in writing. Additionally, during this time frame, residents were observed being treated in a courteous manner by staff.

The complaint log was reviewed and included an investigation into each complaint. There were no complaints documented, regarding staff mistreatment of residents.

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

Allegation #2: Management shredded documents and instructed caregivers to change their documentation.

Findings #2: On 8/16/12, four current residents records and three closed record were reviewed. All seven records were complete and had documented care notes, nursing notes, medication administration records and incident reports.

On 8/16/12, at 9:35 AM, a caregiver stated she was trained to document the cares that she had provided and if there was an incident during her shift to document what had occurred. She further stated, she was trained to leave notes for the administrator or nurse alerting them of any changes during her shift. She denied being instructed to change documentation.

On 8/16/12 at 11:40 AM, the administrator stated when she first started as the administrator for the facility the previous administrator was looking for some paper work. She stated the paper work that he had been looking for did turn up later. She stated she was not aware of any caregivers being instructed to change their documentation and it wouldn't be a practice she would allow.

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

Allegation #3: Snacks were not being offered three times per day.

Findings #3: On 8/16/12 from 9:30 AM through 1:00 PM, four residents who had resided at the facility during the last eight months stated snacks were not offered three times a day. They stated that things had really improved with the new crew of staff members and snacks were now being offered and were available throughout the day and before going to bed. Observations were made of a caregiver providing snacks to all seven residents. One resident who preferred to sleep was observed to have a plate of crackers and peanut butter in her room.

On 8/16/12 at 11:30 AM, the administrator stated residents had complained about not receiving snacks previously to her being hired. She stated she had corrected that problem and had not received any further complaints from the residents regarding food or snacks.

Substantiated. However, the facility was not cited as they acted appropriately by correcting the situation and providing snacks three times a day and more if requested.

Allegation #4: The facility was not maintained in a clean and sanitary manner.

Findings #4: On 8/16/12 from 9:30 AM through 1:00 PM, the facility was observed to be clean, tidy and odor free. All residents' rooms were vacuumed and clutter free. Bathroom toilets, showers and sinks were clean and individual trash containers had been emptied. Residents stated staff had been keeping the facility neat and clean.

A cleaning schedule documented what cleaning duties staff were to have completed on each shift.

On 8/16/12 at 11:36 AM, the administrator stated when she took over as the administrator, the facility had not been kept in a clean manner. She stated she had in-service with staff on daily cleaning requirements for each shift. She also stated she implemented a housecleaning schedule that staff were to follow.

Substantiated. However, the facility was not cited as they acted appropriately by providing supervision and staff training to ensure the facility was kept clean, sanitary and odor free.

Lisa Oakes, Administrator

August 21, 2012

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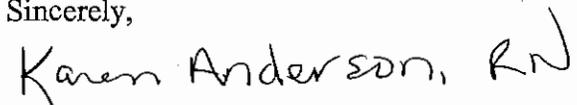
Allegation #5: Caregivers' cardiac pulmonary resuscitation (CPR) training was not current.

Findings #5: On 8/16/12 at 11:55 PM, the administrator confirmed one staff member had an expired CPR certification. She stated, when she discovered the expired date on the CPR card, she had the caregiver obtain the recertification training. Four staff members CPR cards were observed and all CPR cards were up to date.

Substantiated. However, the facility was not cited as they acted appropriately by having the caregiver take a CPR training course to renew her certification.

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

Health Facility Surveyor

Residential Assisted Living Facility Program

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