



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DIVISION OF LICENSING & CERTIFICATION
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

September 21, 2012

CERTIFIED MAIL: 7012 1010 0002 0836 0065

Rebecca Dean, Administrator
Panorama Hills Living Center - RC-320
6488 Panorama Drive
Idaho Falls, ID 83401

**Re: Revocation of Residential or Assisted Living Facility License # RC-320
Panorama Hills Living Center**

Dear Ms. Dean

Please accept this notice that the Residential Care Facility License RC-320 for Panorama Hills Living Center, located at 6488 Panorama Drive, Idaho Falls, Idaho 83401, is being **revoked** effective October 21, 2012, based on Department findings from the complaint investigation survey conducted September 20, 2012. This action is being taken pursuant to Idaho Code Section 39-3345 and IDAPA 16.03.22.940.01, 16.03.22.940.02.b, 16.03.22.940.02.c, and 16.03.22.940.02.h.

You are also hereby notified that effective immediately, the following enforcement actions are imposed:

- 1. A ban on all new admissions pursuant to IDAPA 16.03.22.920. The ban on all admissions shall be in effect upon receipt of this notice and shall remain in effect until removed by the Department.**
- 2. Should you choose not to abide by this condition, the Department will take action to summarily suspend the facility's license and transfer residents under IDAPA 16.03.22.900.01.**

The following is an explanation of the basis for the Department's action.

On September 20, 2012, a complaint investigation regarding the treatment of residents at Panorama Hills Living Center was concluded. It was determined during that survey the facility was not in substantial compliance with the provisions of the Idaho Residential Care or Assisted Living Act, Idaho Code Section 39-3301 *et seq.*, and the rules governing licensed residential or assisted living facilities, IDAPA 16.03.22. Specifically, the facility was issued a core issue deficiency for abuse. The complaint

alleged, and our investigation substantiated, that you had behaved verbally and mentally abusive toward at least one of your residents.

A detailed report of the finding leading to the determination of noncompliance is enclosed.

You may contest this decision to revoke the facility's license 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:

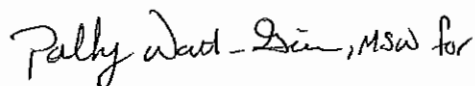
**Debby Ransom, Bureau Chief
Division of Licensing and Certification - DHW
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036**

Upon receipt of the written request, an administrative review conference will be scheduled and conducted. The purpose of the conference is to clarify and attempt to resolve the issues. A written review decision will be sent to you within thirty (30) days of the date of the conclusion of the administrative review conference.

If the facility fails to file a request for administrative review within the time period, this decision shall become final.

Should you elect to voluntarily relinquish your facility license, please contact me at (208) 334-6626 to coordinate an orderly transfer of the residents.

Sincerely,



JAMIE SIMPSON, MBA, QMRP
Program Supervisor
Residential Assisted Living Facility Program
Division of Licensing & Certification

cc: Whit Riggs, Deputy Attorney General
Cathy Hart, Idaho State Ombudsman, Idaho Commission on Aging
Debby Ransom, Bureau Chief, Licensing and Certification
Deedra Hunt, Program Specialist, Idaho Commission on Aging
Lynda Armstrong, Adult Protection Supervisor, Area Agency on Aging VI
L&C Revocation Group

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R320	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/20/2012
NAME OF PROVIDER OR SUPPLIER PANORAMA HILLS LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 6488 PANORAMA DRIVE IDAHO FALLS, ID 83401		
(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 deficiency was cited during a complaint investigation conducted between 9/11/12 and 9/20/12, by phone, mail and in-person interview for your residential care/assisted living facility. The surveyors conducting the survey were: Polly Watt-Geier, MSW Team Leader Health Facility Surveyor Rachel Corey, RN Health Facility Surveyor Donna Henscheid, LSW Health Facility Surveyor Gloria Keathley, LSW Health Facility Surveyor Abbreviations: d/t= due to UAI = Uniform Assessment Instrument	R 000		
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 protect 1 of 1 sampled residents (Residents #1) and potentially all of the residents from abuse. The findings include:	R 006		

Bureau of Facility Standards

TITLE

(X6) DATE

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

Bureau of Facility Standards

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R 006	<p>Continued From page 1</p> <p>IDAPA 16.03.22.520 states, "The administrator must assure that policies and procedures are implemented to ensure that all residents are free from abuse."</p> <p>IDAPA 16.03.22.010.01 defines abuse as, "The non-accidental act of sexual, physical or mental mistreatment, or injury of a resident through the action or inaction of another individual. "</p> <p>The McGraw-Hill Concise Dictionary of Modern Medicine (2002) defines verbal abuse as, "...A form of emotional abuse consisting of the use of abusive and demeaning language with a spouse, child, or elder, often by a caregiver or other person in a position of power."</p> <p>Resident #1, a 22 year-old female, was admitted to the facility on 1/12/12 with diagnoses of developmental delay, schizoaffective disorder and anxiety.</p> <p>The facility's "Behavior Management Policy" documented, "Our policy is designed so that the interventions are positive, the least restrictive and the least aversive means of obtaining the desired results."</p> <p>Resident #1's record contained a behavior management program documenting Resident #1 had outbursts, would leave supervised areas, and would "run in buildings."</p> <p>Resident #1's UAI, dated 6/19/12, documented "Very vulnerable d/t being a people pleaser, easily influenced by others ..."</p> <p>A written statement, dated 8/19/12, documented an observation from a witness of an interaction</p>	R 006		

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R 006	Continued From page 2 that occurred between Resident #1 and the administrator while attending church on 8/19/12. Witness #1 documented, "...At about 9:30 A.M., I was in the hall and noticed a girl sitting on the floor in the hall. Sitting in the very back of the meeting I saw this same girl being pulled by her arm out of the front doors by another lady about 30 minutes later." The statement further documented, the witness left the church service when it was reported to her that the woman was "yelling at her child." She documented, "The tone of the voice was very ugly and the words were hateful, so I went outside to stop it. As I walked out of the doors the woman must have heard me and changed her tone and verbal insults immediately, but didn't stay nice for long. Her comments went from, 'You're a child of God and need to learn to behave. There's a meeting in there that we should be listening to.' To, 'You can't steal other people's food. You need to learn to control yourself better. You have a beautiful body and need to learn to take care of it so people will like you. Your own parents can't stand being around you. Nobody can be around you. You want to make it to heaven don't you?' This little girl was cornered between the building and a fence with the woman inches from her face blocking her into the corner." A written statement from Witness #2 (no date) documented, "I was at church today and had to step out because my son was having a hard time being quiet. While I was in the hall a girl walked passed [sic] looking very distressed, I asked her what was wrong and she replied, 'I'm just having a hard time breathing.' ...A couple minutes later I saw a woman taking her outside...I heard someone begin to yell. I walked into the room closer to the window and heard someone yelling and someone crying. I overheard the girl say, 'I	R 006		

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R 006	<p>Continued From page 3</p> <p>wish I were dead' or something to that extent which was followed by the women saying, 'I wouldn't care if you were dead.'...The yelling and the derogative comments just kept going on and on. One comment was directed at not getting to heaven and another was that her mother didn't love her or want her." The written statement further documented, Witness #1 also observed the interaction with Resident #1 and the administrator. They both went outside and observed, "The girl was in the corner with the woman in front of her so she couldn't go anywhere. The young girl was just weeping." When the witness approached the administrator she was told, "the reason she got so mad was because the girl wouldn't sit and listen to the speaker. She was working on this with her and was mad that she needed to go to the bathroom while someone was speaking. She said she was an adult and she needed to act like one."</p> <p>An "Adult Protective Services Report to Law Enforcement," dated 9/6/2012, documented Resident #1 functioned at a "2-3 year-old level" and had difficulty answering questions. Resident #1 did not recall the 8/19/2012 incident, but stated, "[Administrator's name] yells at me because she loves me." The report further documented Adult Protection substantiated that abuse had occurred on 8/19/2012.</p> <p>On 9/11/12 at 1:12 PM, Witness #2 was interviewed. She stated while at church, she left the services to attend to her young child. While in the hall, she observed a "young girl" leave and a few minutes later a woman followed after her. Witness #2 stated she heard the woman "screaming." She further stated, "As a mother, the things she said made me sick." She stated the administrator said things like, "I don't care if</p>	R 006		

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R 006	<p>Continued From page 4</p> <p>you die. Your mom does not love you. The way you are acting, you will not go to heaven." Witness #2 stated when she confronted the administrator, the administrator replied that she was the authoritative figure and Resident #1 needed to have someone talk to her in a harsh manner. She was trying to teach Resident #1 to sit through church services and she was upset because Resident #1 needed to go to the bathroom. Witness #2 further stated, after confronting the administrator, "she did not express remorse for what she had done."</p> <p>On 9/11/12 at 2:20 PM, Witness #1 was interviewed. She stated she was in the hallway at church with her young niece when she observed Resident #1 in the hall and her caregiver "race" into the hall behind her. She took her out of the building and was heard yelling at Resident #1. "The tone of her voice was very angry. She was very mad. I went outside to make her stop by my presence. As soon as I opened the door, the tone of her voice changed. Although, within minutes, she changed back to her ugly tone. She stated the administrator told the girl, "Your parents don't want to be around you. No one wants to be around you." Witness #1 also stated the administrator was "maybe an inch from the girl's face and was so intimidating." Witness #1 further stated, Resident #1 was observed crying, with her head down. Witness #1 stated she tried to get the administrator's attention, but "she wanted me to mind my own business, but I told her that what she was saying was abusive." Witness #1 stated the administrator said she had been "dealing with this for weeks." Witness #1 further stated, she followed the administrator into the parking lot, because she was "really scared for the girl and I was afraid she was going to get hit."</p>	R 006		

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R 006	<p>Continued From page 5</p> <p>On 9/12/12 at 9:50 AM, the administrator was interviewed regarding Resident #1 and the incident on 8/19/12. She stated Resident #1 left the church service, because she needed to use the restroom. When she didn't return, she went into the hall and saw the resident "running up and down." She took Resident #1 outside of the church to "talk to her about how to behave." During this time, Resident #1 "kept saying she wanted to go home and she wanted to die." The administrator stated she told Resident #1, "he won't take you." Resident #1 also stated she wanted to see her mother and she told her that her mother would not take her until her behaviors were "under control." The administrator acknowledged that during her interaction with Resident #1, that she had raised her voice and was "right in her face." She further stated, "that is how [Resident #1's name] responds" and learns. She stated, she felt her interactions were appropriate for what Resident #1 was doing, but were not appropriate in the church setting.</p> <p>On 9/12/12 at 2:25 PM, five residents were interviewed. Three residents stated the administrator had yelled at residents when she was angry. One random resident stated, "When [administrator's name] gets mad it is scary. I turn my lights out when this happens."</p> <p>After Resident #1, who had the mental capacity of a 2-3 year-old, was unable to remain seated during church, the administrator took her outside, cornered her, raised her voice and used demeaning language.</p> <p>The administrator used her tone of voice, body position and authority to scare and intimidate Resident #1 and caused her to cry. This lead to the mental mistreatment and abuse of Resident</p>	R 006		

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R 006	Continued From page 6 #1. The administrator's anger and verbal attacks had the potential to result in mental mistreatment and abuse for all residents.	R 006		



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DIVISION OF LICENSING & CERTIFICATION
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September 21, 2012

Rebecca Dean, Administrator
Panorama Hills Living Center
6488 Panorama Drive
Idaho Falls, ID 83401

Dear Ms. Dean:

An unannounced, complaint investigation survey was conducted for Panorama Hills Living Center between September 11, 2012 and September 20, 2012. During that time, interviews and record reviews were conducted with the following results:

Complaint # ID00005726

Allegation #1: The administrator verbally abused an identified resident.

Findings #1: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.510 for the administrator verbally abusing an identified resident. The facility was required to submit a plan of correction.

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.

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,

Polly Watt-Geier, MSW
Health Facility Surveyor
Residential Assisted Living Facility Program

PWG

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