



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 83720-0099  
PHONE 208-334-6626  
FAX 208-364-1888

November 23, 2011

Melissa Fustos, Administrator  
Divine Living Centers At Curry Retirement Estate  
3805 North 2538 East  
Twin Falls, ID 83301

License #: Rc-924

Dear Ms. Fustos:

On October 20, 2011, a Complaint Investigation and State Licensure survey was conducted at Divine Living Centers At Curry Retirement Estate. 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 Rae Jean McPhillips, RN, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 334-6626.

Sincerely,

Rae Jean McPhillips, RN  
Team Leader  
Health Facility Surveyor  
Residential Assisted Living Facility Program

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

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13R924	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  10/20/2011
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NAME OF PROVIDER OR SUPPLIER  DIVINE LIVING CENTERS AT CURRY RETIREM	STREET ADDRESS, CITY, STATE, ZIP CODE 3805 NORTH 2538 EAST TWIN FALLS, ID 83301
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R 000	<p>Initial Comments</p> <p>The following deficiency was cited during the licensure, follow-up and complaint survey conducted on October 19, 2011 through October 20, 2011 at your residential care/assisted living facility. The surveyors conducting the survey were:</p> <p>Rae Jean McPhillips, RN Team Leader Health Facility Surveyor</p> <p>Rachel Gorey, RN Health Facility Surveyor</p> <p>Survey Definitions:</p> <p>bm = bowel movement crepitus = the sound made from pressure on tissues from an abnormal amount of air. cont = continued d/t = due to EMS = Emergency Medical Services ER = Emergency room eve = evening HS = at bedtime md = medical doctor meds = medications NOC = night pneumothorax = A collection of air in the chest, which causes the lung to collapse PRN = As Needed PT = Patient Q2 = every two hours QID = four times a day ROM = Range Of Motion RN = Registered nurse sat = blood oxygen saturation sepsis = a life-threatening condition that occurs</p>	R 000	<p><i>CURRY RETIREMENT ESTATES</i> on Assisted Living Home</p> <p>Although I respectfully disagree with the findings of the state survey team, I have provided the following informational response as required by the state rules and regulations for licensure. Any information provided is not to be construed as an admission of guilt or that the facility in any way agrees with the findings of the survey team.</p> <p>Plan of Correction for Identified Deficiency #16.03.22.525</p> <p>*What corrective action(s) will be accomplished for those specific residents / personnel / areas found to have been affected by the deficient practice?</p> <p>Neither resident specifically identified as being affected by the deficient practice (Resident #4 and Resident #5) are currently</p>	<p>Info was mailed on 11/10/2011 and was faxed on 11/10/2011 MJ</p>

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE <i>Melissa Justos</i> (Administrator)	(X6) DATE 11-10-2011
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STATE FORM 6899 JLKF11 If continuation sheet 1 of 17 amended sent 11/23/11

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R 000	Continued From page 1  when an infecting agent - such as bacteria, virus, or fungus - gets into the bloodstream and requires immediate medical care. subq = subcutaneous vs = vital signs	R 000	residing at this assisted living home therefore no immediate corrective actions to the specifically identified residents need be accomplished.	
R 009	16.03.22.525 Protect Residents from Neglect.  The administrator must assure that policies and procedures are implemented to assure that all residents are free from neglect.  This Rule is not met as evidenced by: Based on interview and record review it was determined the facility did not protect 2 of 7 sampled residents (#4 & #5) from neglect when they failed to respond in an appropriate and timely manner when the residents had a significant change in condition. The findings include:  IDAPA 16.03.22.011.24 defines neglect as "Failure to provide ...medical care necessary to sustain the life and health of a resident."  1. Resident #4 was admitted to the facility on 12/19/10 with a diagnosis of dementia. Resident #4 was deceased at the time of the survey.  Resident #4's record contained an incident report, dated 8/27/11, documenting "[Resident's name] had been sleeping well for the previous 2 hours in his bed. I came in the room at 9 PM to help his wife lay down in bed. Found [Resident's name] sitting up on the bathroom floor in a puddle of urine. His pants were down to his knees. Looks like he went to the bathroom on the floor and then slipped in it." The incident report further documented the resident was helped off the floor	R 009	*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?  All resident have the potential for being affected by the identified deficit. The corrective actions being taken are the development of new measures and instituted changes delineated in the answer to the next question, including revamping of current paperwork, staff education, improved documentation, elimination and modifications in some facility roles and responsibilities and the position of management and Facility RN.	

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R 009	Continued From page 2  and no bruises or open wounds were found. The incident report documented the facility RN was notified on 8/27/11 at 9:15 PM. The incident report did not document if the facility RN determined if it was safe to assist Resident #4 off of the floor, prior to the caregiver assisting him.  The facility RN/administrator documented the following under a section titled "Results of Notification," within the 8/27/11 incident report, "RN notified of fall with no injuries night of fall. I called into the facility at about 10 AM to check on [Resident's name], aide said he seemed good at that time was actually less active than previous day (has a history of wandering and being very 'busy') I informed her of his fall and to watch for bruising or pain. She said NOC shift had gotten him up and dressed for the day and had not said anything about any injuries but she would check him out thoroughly with his next toileting. I received a call about 130 PM (sic) from the same aide who said when she had him up walking with him he was grimacing while moving and seemed like it was maybe his ribs. She said he was currently sleeping, vitals were done 116/70, 68, 18, sat 95. We discussed the possibility of fractured ribs and really no treatment other than stronger pain medication but I asked her to monitor him closely and medicate him as allowed with PRN medication while awake (and to pass this on to the eve shift due in at 2 PM). At 330 (sic) I received a call from the eve shift aide (who had been on duty for his fall the night before). She was worried about his increasing pain that there was now crackling when she touched his ribs/sides to feel for broken ribs (he was last medicated at 11am). I asked her to medicate him for pain, perform vital signs and ensure his breathing was normal - not labored, fast, etc and she said he looked "normal" except he grimaced	R 009	The corrective actions and instituted changes implemented include improved overall communication within the facility. This entails, increased facility RN presence at the facility, improved information and assessment gathering by the facility RN (through newly developed tools previously detailed), and improved communication and notification from staff to facility RN (through educational process previously detailed). These systemic changes will allow the facility RN to be made aware of any resident status deviations from their norm, will ensure the facility RN will physically assess any resident who exhibits any status deviations from their norm or is involved in any type of incident (fall, behavior outbursts, etc). The facility RN will notify the resident's primary care physician, Home Health RN, Hospice RN and/or appropriate health care provider for <u>any</u> change of status from their norm. The facility RN will determine the need for further care or	

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R 009	<p>Continued From page 3</p> <p>when he moved. I decided to call the family and spoke with his daughter at about 430 PM." The facility RN did not physically assess the resident when it was reported to her that Resident #4 was showing signs of significant pain and abnormal physical findings such as "crackling" over his ribs; nor did the facility RN ensure Resident #4 was assessed by a medical professional to determine the required medical care, when the resident began showing abnormal symptoms.</p> <p>The 8/27/11 incident report, documented under the sections titled "Follow up and Plan of Prevention," "Resident was transported to the ER by ambulance per daughters request d/t his pain with movement. He was admitted with a diagnosis of 2 broken ribs and a collapsed lung. Treatment included a chest tube, oxygen and pain management...A plan of prevention is to not allow time passing before realizing something worse than first thought has happened is to send all fall residents to the ER for thorough exam to ensure there are no major or significant injuries." The incident report documented, the facility RN/administrator acknowledged Resident #4 should have been assessed in a timely manner when abnormal signs were observed; Resident #4 was not taken to the ER until the evening of 8/28/11.</p> <p>A "Shift Change Note," dated 8/28/11 at 9:05 PM, documented "In a lot of pain, [Resident's daughter's name] decided to have him go to the ambulance. Off at 5 PM. Not back today." Only when the daughter arrived to observe the resident, was further medical treatment sought. The facility RN/administrator did not observe the resident to determine if further evaluation was necessary.</p>	R 009	<p>medical treatment through her physical assessment of residents at the time of resident status change or incident. The facility RN will require transport to the emergency department at the hospital for any resident who exhibits a change in status from their norm that does not improve with measures taken within her scope of practice as the facility RN.</p> <p>I sincerely hope this has fully answered the specific question of how I will evaluate the need for medical treatment. I am having some difficulty determining the exact written response expectations for how I, as the facility RN will evaluate the need for additional care and/or medical treatment. The bottom line is that I am now doing everything I can to be 100% involved in the daily assessment and care of my residents. I have done away with a "middle man" to prevent missing and/or inaccurate information. I am out at the facility every day checking on every resident. I am doing everything I can to ensure I</p>	

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R 009	<p>Continued From page 4</p> <p>A "Shift Change Note," dated 9/2/11, documented Resident #4 returned to the facility on 9/2/11 with hospice services "after a few days stay at the hospital in which his lung did re-inflate but the md still believes he would not fully recover." The note further documented the resident passed away.</p> <p>On 10/21/11, the ambulance records were received at Licensing and Certification. Ambulance records documented the following on 8/29/11.</p> <p>*At 5:21 PM, "PT is found lying in bed. PT is in the fetal position on his bed. PT is lying on his right side. PT is in what appears to be obvious pain. PT actes like he can not get comfortable on the bed. EMS started to talk to the PT. He has a very hard time speaking."</p> <p>*At 5:22 PM, "...EMS palpates the PT's left shoulder and scapula. EMS immediately feels subcutaneous air. Further palpation shows Subq (subcutaneous) air all the way into the PT's lower back and left side..."</p> <p>*At 5:23 PM, "PT advises that he is having trouble breathing by nodding his head when asked and saying yes. PT had obvious labored breathing..."</p> <p>*At 5:30 PM, "PT's shirt is removed. The left side of the PT's chest is twice as big as the right as it is full of subcutaneous air..."</p> <p>*At 5:31 PM, "...PT has a hard time laying still on the stretcher and can not get comfortable."</p> <p>Resident #4 exhibited abnormal physical findings, which the facility RN/administrator had not assessed for and evaluated.</p>	R 009	<p>improve my documentation to show that I am involved with each resident, his or her status, health and happiness. I am continually educating and reminding the staff of the importance of notifying me for everything occurring within the facility, most especially with the residents. I am physically in to assess each resident if there is a concern or change in his or her status or an incident. I am notifying appropriate agencies (HH RN's and Dr.'s) for any changes in residents. I will follow all orders given but if I believe there is even a chance that the identified change of status in a resident needs care beyond my scope of practice or beyond what I know as a registered nurse to be 'normal', I will seek further medical evaluation and treatment.</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>	

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R 009	Continued From page 5  Hospital records received at Licensing and Certification, dated 8/28/11, documented the resident was diagnosed with a left pneumothorax secondary to a fall. "...he fell, and when his daughter arrived to evaluate him he had some shortness of breath and crepitus in his chest." The records documented the resident was observed to be "somnolent, agitated, and unaware...." The records further documented the resident would be discharged for comfort care.  On 10/20/11 at 8:49 AM, Caregiver A stated she was not on duty the time Resident #4 fell, but took care of him the next day. She stated around lunch time (on 8/28/11) she noticed he was "cringing" and seemed to be guarding his rib area. She felt the rib area and it felt like "crunching glass." She further stated, "you could tell something was off. I felt like he should be further evaluated. He wouldn't eat." She stated she called the facility RN/administrator who instructed her to keep an eye on him. After lunch she "laid him down in his bed and he slept...I passed it on to the other shift."  On 10/20/11 at 10:35 AM, Caregiver B stated she was on shift when the resident fell. At the time, the resident had not shown any signs of pain. The next day when she was back on for the afternoon shift, the day-shift caregiver reported to her the resident had been up for breakfast, but had been guarding his chest. She further stated, the day-shift caregiver reported to her that the facility RN/administrator had been notified and thought the resident had broken ribs and to watch the resident. She stated she called the facility RN/administrator again because "something was wrong." The RN told her to call Resident #4's daughter. When the daughter came, the	R 009	To ensure this deficient practice does not reoccur, the following corrective actions and instituted changes being taken are: 1.) Development of individual blank weekly calendar for Facility RN to document pertinent resident issues and status changes daily. *(see attachments #1a and 1b)* 2.) Development of individual monthly calendar for Resident Aides to document pertinent resident issues. *(see attachment #2)* 3.) Termination of current 'House Manager' in the management position. *(This occurred on October 3 <sup>rd</sup> , 2011)* 4.) Elimination of House Manager position. *(This occurred on October 3 <sup>rd</sup> , 2011)* 5.) Development of a Facility Manager job description role and	10/21/11 WJY  error to WJY 11-1-11 WJY  10-3-11 WJY  10-3-11 WJY  on-going WJY

*WJY*

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R 009	<p>Continued From page 6</p> <p>caregiver sat the resident up for dinner and he started crying. "He was not answering questions coherently." She stated Resident #4's daughter instructed her to call the ambulance.</p> <p>On 10/20/11 at 12:05 PM, the facility RN/Administrator stated she was notified when Resident #4 fell, but at the time there was "nothing out of the ordinary." She further stated "you could not rely on the resident to tell you if he was in pain unless he was asked." She stated the morning after the fall, she called the caregiver on duty to check on the resident and no concerns were voiced. However, later in the afternoon the caregiver called her to report that she had noticed some "guarding." She then received another call from the afternoon caregiver who reported the resident was moaning while being assisted to the toilet and reported his ribs felt funny. "I was thinking if he had a cracked rib, I was wondering what they would do for him. I called [resident's daughter's name] and told her there was nothing they would do about a cracked rib, but he may need pain meds, which would make him more of a fall risk. I was trying to think in my mind what was a better scenario." She further stated the daughter came in to see the resident and decided an ambulance should be called. She stated, she had not visited the facility to assess the resident, but was relying on the caregivers to reports their observations to her.</p> <p>The facility RN/administrator did not physically assess or observe Resident #4 when abnormal findings were reported to her, or recommend Resident #4 be further evaluated.</p> <p>According to the the facility RN/administrator's documentation, she was informed on 8/28/11 at 1:30 PM, that Resident #4 was grimacing and</p>	R 009	<p>responsibilities. This position will not include resident care but facility specific tasks - ie: supply ordering. *(This is currently being developed)*</p> <p>6.) Staff education, re-education and reinforcement of Facility RN notification expectations for resident issues and status changes. *(This has occurred on several occasions in formal staff meetings (10/07/2011 &amp; 11/4/2011) as well as a 'communication log' book developed for the purpose of relaying information between everyone working at the facility. Information in the communication log is for all facility employees. Each entry is dated &amp; signed by the 'author' and</p>	<i>on-going</i> <i>my</i>

*my*

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R 009	<p>Continued From page 7</p> <p>having rib pain. At this time, she determined over the phone that the resident may have a rib fracture, but medical attention was not required. Then at 3:30 PM, the caregiver on duty reported "crackling" over the ribs; medical attention was not sought and an hour later at 4:30 PM, the daughter was notified. Only when the daughter visited the facility was emergency services sought. Assessment by a qualified medical professional was delayed for more than 20 hours, and treatment was not sought when the resident demonstrated obvious signes of distress; this resulted in neglect.</p> <p>2. Resident #5 was admitted to facility on 6/29/10 with diagnoses that included multiple sclerosis. The resident was deceased at the time of the survey.</p> <p>The facility's "Intra Mail," "Shift Change Notes," "Q2 Checks" and "Incident Reports" provided the following documentation:</p> <p>5/18/11 at 2:04 PM - an incident report documented the resident fell at 9:00 AM and sustained two skin tears on her right arm, a bruise on the underside of her right arm, a red spot on her left shoulder blade and a bruise on her right leg. The report further documented, "House manager was on site and did Head-to-Toe check and ROM. Resident had no complaints of pain and no loss of ROM. Left a message for [Resident's physician] about her fall and her statement that muscle spasms in her legs had led to it. Asked if he would like to see her or if he would like to increase her Baclofen. I am waiting for a call back." The facility's house manager was not a licensed medical</p>	R 009	<p>then initialed by all staff who had read &amp; reviewed the entry. The communication log is reviewed by myself on a daily basis so staff who have not initialed the entry can be contacted and updated appropriately.)*</p> <p>7.) Staff education, re-education and reinforcement of essential and correct documentation of resident issues.</p> <p>*(Again, this has occurred on several occasions in formal staff meetings (10/07/2011 &amp; 11/4/2011) as well as a 'communication log' book. Incident and Behavior Reporting specific education was distributed and reviewed at a staff meeting on February 4<sup>th</sup>, 2011 and again October 7<sup>th</sup>, 2011 with sample/example</p>	<p><i>on-going</i> <i>my</i></p>

*my*

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R 009	<p>Continued From page 8</p> <p>professional.</p> <p>The 5/18/11 incident report also documented under the "7 Day Follow Up" section, "Resident screamed out for the next two nights (due to spasms). Was fine during the days, vs good, denied any other symptoms." The report documented the RN/administrator was notified of the fall on 5/19/11 at 4:53 PM. The report was not electronically signed by the RN/administrator until 6/6/11 at 4:27 PM. There was no evidence the RN/administrator assessed the resident after she fell or "screamed out for the next two nights" due to her muscle spasms.</p> <p>5/18/11 at 7:22 PM - the house manager documented, "Was notified that the resident was calling out and was complaining of full body muscle spasms. Asked her to give her the HS dose of Baclofen (just ordered today). When I called back, the resident had settled down and was sleeping." There was no evidence the house manager, who was unlicensed, contacted the RN/administrator prior to telling the caregiver to give the resident the Baclofen, which was a new order. Additionally, there was no evidence the RN/administrator was aware the resident's Baclofen order had been increased.</p> <p>5/19/11 at 5:42 AM - a caregiver documented, "Watched tv most of the night. Legs didn't want to work last night when I got here. When I told her I would notify [the house manager's name], she had no difficulty standing and transferring. Called out throughout the night. Said she was having full body muscle spasms."</p> <p>5/19/11 at 4:53 PM - the house manager documented in an email to the RN/administrator, "...had more muscle spasms. They were severe</p>	R 009	<p>reports and documentations with detailed instructions for thorough and accurate completion of each left in the communication log for staff review. Again, information in the communication log is for all facility employees. Each entry is dated &amp; signed by the 'author' and then initialed by all staff who had read &amp; reviewed the entry. The communication log is reviewed by myself on a daily basis so staff who have not initialed the entry can be contacted and updated appropriately.)*</p> <p>8.) Increased RN presence at the facility with daily check in with residents and staff. *(Previously I had been on site at least 3 days a week, M/W/F and PRN. Currently I</p>	<p><i>on-going</i> <i>my</i></p>

*my*

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NAME OF PROVIDER OR SUPPLIER  DIVINE LIVING CENTERS AT CURRY RETIREM	STREET ADDRESS, CITY, STATE, ZIP CODE 3805 NORTH 2538 EAST TWIN FALLS, ID 83301
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R 009	<p>Continued From page 9</p> <p>enough that they jerked her feet out from underneath her and she had a fall yesterday. Has a couple of skin tears on her right forearm but otherwise is uninjured...Notified [Resident's physician] and he added another dose of Baclofen (she now takes 10 mg QID). She has been milking it for all that she can get."</p> <p>5/19/11 at 8:35 PM - the house manager documented, "Was notified at 7:30 pm that [Resident's name] was calling out again. I could hear her in the background yelling. The aide had already given her her (sic) HS dose of Baclofen....Was called again at 8 pm and there was no improvement. Came in to the facility and stood outside the door to observe what the resident was doing. When I walked in the room, the resident stopped what she was doing and said 'Oh [house manager's name], what are we going to do about this?' I did her vs and asked again about any other symptoms, she denied any other symptoms. Asked the aide to call for an ambulance. Notified her daughter. When the paramedics got here, I left the room to give them a report. When we went back into the room, she acted like she was unresponsive (she had been alert and answering my questions coherently just a couple minutes before). Then when the paramedic asked me a question, she all the sudden was responsive and coherent again and answered the question herself. She was taken to the ER." There was no evidence the RN/administrator was consulted by the caregiver about the resident's condition prior to contacting the house manager for assistance.</p> <p>5/20/11 at 8:37 PM - the house manager documented in an email to the RN/administrator, "Ended up sending [Resident's name] to the ER and she was admitted with a UTI and dehydration</p>	R 009	<p>am in daily, including weekends to evaluate the facility and 'check-in' with residents and staff. This allows me to physically see every resident. This time also allows me to assess any changes in condition or status of each resident, investigate any concerns, issues or complaints in order to ensure each resident is safe, healthy and content.)*</p> <p>9.) Improved gathering of essential information through my daily visits and contact with residents; through my review of the facility communication log, which was previously explained in #6 &amp; #7; and through my thorough review of staff's BlueStep computerized documentation system entails review of</p>	<p><i>Program on 10/21/11 on-going</i></p>

*My*

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER  <b>DIVINE LIVING CENTERS AT CURRY RETIREM</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3805 NORTH 2538 EAST TWIN FALLS, ID 83301</b>
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R 009	<p>Continued From page 10 (?)."</p> <p>Notes further documented the resident was hospitalized from 5/20/11 to 5/23/11. There was no evidence in the record the RN/administrator had assessed the resident when she was complaining of pain and full body muscle spasm prior to her admission to hospital or when she returned to the facility.</p> <p>5/23/11 at 5:00 PM - the house manager documented the resident returned to the facility from the hospital.</p> <p>5/24/11 through 5/27/11 - caregivers document the resident was doing well.</p> <p>5/28/11 at 3:00 AM - a caregiver documented, "yelling 'help me, help me.' I got in there, she says she's in a lot of pain, she was given 2 Tylenol for body aches." There was no evidence in the record the RN/administrator was notified of the resident yelling out in pain.</p> <p>5/28/11 at 8:20 AM - a caregiver documented the resident needed total assistance to transfer from her wheelchair to the toilet due to weakness. She also documented the resident was in her room moaning &amp; begging for 'Jesus to help her' all night. The caregiver documented she gave the resident two Tylenol for pain. The note further documented, the resident called for assistance at 5:15 AM because she had a "bowel accident in bed." The caregiver documented, "I started to get her cleaned up &amp; she cont to have diarrhea (sic). I got things ready for a shower to get her cleaned up. She cont to have diarrhea (sic) in her wheelchair on the way to the shower. She was very weak &amp; unable to transfer into the shower. Still cont to have diareah (sic) &amp; was unable to sit</p>	R 009	<p>i.) 'Shift Change Notes', which is a summary of each resident's activities for each shift completed by the resident aide on duty.</p> <p>ii.) 'Incident and Behavior Reporting', which is where staff document any issues such as resident falls and/or inappropriate behavior – again through numerous staff education encounters (staff meetings, communication log, phone calls and daily 'check ins') such incidents are to now IMMEDIATELY reported to me as both the Administrator and Facility RN. *(Staff education for the appropriate documentation expectation has occurred as listed in #6 &amp; #7 above)*</p>	<p><i>Began on 10/21/11 on-going</i></p>

*My*

Bureau of Facility Standards

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R 009	Continued From page 11  up or do any moving at all." The note documented the RN/administrator instructed caregivers to hold all stool softeners and to "monitor" the resident. The "Shift Change Note" contained an untimed "RN NOTE" which documented she was notified by phone of the resident's physical condition. The "RN NOTE" also documented she "Asked staff on duty to leave a note for all weekend staff" of what interventions they were to do for the resident if she continued to have diarrhea or pain.  5/28/11 at 8:29 PM - a caregiver documented the resident "Had diarhera (sic), wanted me to do a full transfer, but she did it herself with assistance. Soiled her clothes with bm, changed and washed up. Ice x 3, no grapes they went right through her. Was in bed by 8:00 pm."  5/29/11 at 2:02 PM - a caregiver documented the resident "Said she didn't feel up to eating this morning, ended up making her toast and she threw it away. [House manager's name] had me get her some crackers and cheese, she also threw that away." The caregiver also documented when the resident went outside to smoke she ran her wheelchair into the building and then "what looked like she threw herself" out of her wheelchair. She documented the house manager came to the facility to deal with the "issue." She further documented that "moments after [house manager's name] left [Resident's name] messed all over herself, her pants, the bathroom!" There was no evidence the RN/administrator came to facility to assess the resident. Additionally, there was no evidence the RN/administrator contacted the unlicensed caregivers over the weekend to check on the resident's medical condition.  5/30/11 at 3:24 PM - the house manager documented, "...continues to have diarrhea	R 009	*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)?  The corrective actions will be monitored daily by myself, the owner/administrator/and facility RN, to ensure a consistent, complete and comprehensive coverage of all areas. The corrective actions include the newly created documentation forms which are completed daily to keep myself updated on each residents condition. My physical presence at the facility allows for more interaction with the residents, the staff, the family members and any outside service providers or visitors to ensure compliance with new documentation. The elimination of a 'House Manager' role will help prevent missed or inaccurate information being passed onto	

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R 009	<p>Continued From page 12 although it is lessening..."</p> <p>5/31/11 at 12:03 AM - a caregiver documented, "Vomiting. House Manager offered to send her in for nausea medication if it continues. Try to get her to keep down some tea and toast."</p> <p>5/31/11 at 2:03 AM - a caregiver documented, "Sleeping on and off. Continues to have some dry heaves and nausea. No more vomitting since 1:20 am. Keeps on crying."</p> <p>5/31/11 at 4:11 AM - a caregiver documented, "Dry heaves, nausea. Gave her mint tea and soda crackers."</p> <p>5/31/11 at 7:38 AM - a caregiver documented the resident, "threw up almost all night. not eating this morning, refused breakfast. Tried to play me hard tonight."</p> <p>5/31/11 at 2:06 PM - the house manager documented, "Gave her two pieces of toast and a cup of mint tea when I got here this morning. There had been no more vomitting (sic) and no complaints of nausea."</p> <p>5/31/11 at 3:48 PM - the house manager documented in an email to the RN/administrator, "...She wanted to go to the hospital." There was no documentation the resident was taken to hospital or evaluated by a medical professional.</p> <p>6/1/11 at 2:01 PM - the house manager documented, "...When I went in to assist her at 10 am, I found her sitting on the toilet with her pants up, she had had a bowel accident. I assisted her to stand and got her on the toilet. Went to the closet to get her some clean clothes and when I was returning, I saw her stand up and</p>	R 009	<p>myself. Physically being present at the facility daily and increasing communication with all staff and residents, I will be aware of any changes in condition of residents.</p> <p><i>*What date will the corrective action(s) be completed by?</i></p> <p>Many changes were started in August 2011. There have been many changes instituted, beginning in August 2011. The most necessary change is elimination of a house manager, who acted as a decision-maker or filter as to information passed onto administration and the RN, was on October 3<sup>rd</sup>, 2011. Although many changes were in the process at the time of the survey, several additional changes were instituted immediately upon the state survey and finally all of the above-mentioned corrective actions are all currently instituted as of November 1<sup>st</sup>, 2011. Some changes have required minor adjustments here and there as well as continued staff re-education</p>	<p><i>Begin on 10/21/11 on-going MJ</i></p>
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*MJ*

Bureau of Facility Standards

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R 009	<p>Continued From page 13</p> <p>then let go of the toilet arms and fall."</p> <p>6/1/11 at 2:18 PM - the house manager documented in an email to the RN/administrator, "...Made her come out and sit in recliner. Was fine until it was time to go to the doctors. Then she had diarrhea, so I put her on the toilet to change her and went to get pants and she threw herself off of the toilet and peed on the the floor..."</p> <p>The RN/administrator documented on a "Monthly/Quarterly Nursing Assessment," dated 6/1/11, that she saw the resident "on the 23rd, 25th, and 30th and each time she was in her automatic wheelchair..."</p> <p>6/2/11 at 8:32 AM - a caregiver documented, "When I came in her daughter was here. [Resident's name] was sick and her daughter asked to keep an extra eye on her, so I did q2s on her all night every hour. She seemed fine throughout the night, she slept. Her daughter returned this morning and requested that she go to the hospital about 7:30 AM."</p> <p>Resident #5 was admitted to the hospital on 6/2/11 with diagnoses that included sepsis and dehydration. She passed away on 6/10/11 from severe sepsis with septic shock.</p> <p>There was no evidence the RN/administrator had physically assessed the resident after she fell on 5/18/11, when she "screamed out" for two days after that due to full body spasms, when she returned to the facility after being hospitalized for sepsis due to a urinary tract infection, and when she had continued diarrhea and vomiting which led to her hospitalization on 6/2/11.</p>	R 009	<p>and/or reiteration. Therefore, although the comprehensive corrective actions have all currently been implemented, working with the resident aides and a management consultant, we have set the target date for overall completion with successful and comprehensive corrective changes to be fully implemented as December 1<sup>st</sup>, 2011.</p>	<p><i>Began on 10/21/11</i></p> <p><i>On-going</i></p> <p><i>WJ</i></p>
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*WJ*

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R 009	<p>Continued From page 14</p> <p>On 10/20/11 at 8:49 AM, a caregiver stated the house manager was usually on call. Staff were instructed to call the designated "on call" person for emergencies or when residents were observed with changes of condition. She further stated, Resident #5 had many changes of condition, "towards the end, she began having a lot of spasms and when they would occur she would curse, "god please take me." She stated during this time, the RN/administrator was on vacation, so the house manager would come in and "assess" her. She further stated, she remembered an instance when, "I knew something was wrong." She stated she had observed the resident sticking her fingers down her throat, pouring water in her lap, and purposely sliding out of her wheelchair. After she slid out of her wheelchair, she struggled to get her back up. The caregiver said that she called the house manager who 'was tired from working 16 hour shifts." The caregiver stated she was instructed by the house manager to call Resident #5's daughter and "see what she wanted to do." She stated, at some point, the daughter made the decision to call an ambulance. To her knowledge, the RN had not been notified of the resident's changes of condition or provided direction to staff.</p> <p>On 10/20/11 at 9:57 AM, another caregiver stated the house manger was "on call" and staff were instructed to call her for changes of condition or "when a resident needed a pill." When Resident #5 "got sick," the RN and house manager told her "it was just a show. I did not think it was a show. She was throwing up green." She further stated, the next day resident #5's daughter came in to see the resident and had non-emergent transport called for her to be further evaluated.</p> <p>On 10/20/11 at 10:17 AM, the house manager</p>	R 009		
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R 009	<p>Continued From page 15</p> <p>stated it was her responsibility to be on call 24/7 and to deal with "family, physicians and changes of condition." She further stated staff were instructed to call her for unusual occurrences and if she thought it was serious enough, she would call the facility nurse/administrator. She stated, Resident #5 had many changes of condition, "many were honest issues and some were manipulative behaviors." She stated Resident #5 had gone to the hospital for a UTI and pneumonia and when she got back, she wanted to go back to the hospital, because "they waited on her hand and foot." She stated Resident #5 began dumping her water and food, sticking her finger down her throat and "throwing herself down" out of her wheelchair. She instructed staff to keep her in a common area so they could watch her. She notified the facility RN/administrator through email and "she was okay with what I was doing." She stated the facility RN had not physically assessed the resident, nor had she instructed staff to have her further evaluated.</p> <p>On 10/20/11 at 12:15, the RN/administrator stated she had not physically assessed Resident #5 when she had changes of condition. She stated a home health nurse assessed the resident, on 5/31/11, and gave a verbal report to the house manager, who then reported the information to her. She further stated she was not notified when the resident had reportedly been making herself vomit until "after the fact." She stated had she been notified, she would have told the house manager to call the family and discuss the issue with them.</p> <p>The facility failed to protect Resident #4 and Resident #5 from neglect. The facility's RN/administrator did not assess Resident #4 and Resident #5 when they had substantial changes</p>	R 009			

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R 009	Continued From page 16  in their physical conditions to determine the required medical care. Additionally, the RN/administrator did not protect residents from neglect when she allowed the unlicensed house manager to assess residents and make determinations as to whether or not they needed medications or medical interventions. These system failures delayed medical care for Resident #4 and #5. This system failure had the potential to impact 100% of the facility's residents.	R 009		



Facility Name Divine Living Centers at Curry Retirement Estates	Physical Address 3805 N. 2538-A East	Phone Number 208-724-0626 734-0626
Administrator Melissa Fustos	City Twin Falls	Zip Code 83301
Team Leader RaeJean McPhillips	Survey Type Licensure, Follow-up and Complaint	Survey Date 10/20/11

**NON-CORE ISSUES**

Item #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	L&C USE
1	009.03	Employees were allowed to work unsupervised prior to completing a criminal history and background check.	11-15-2011	RM 11/22/11
2	152.05.iii	Side rails were observed in room #2. ***REPEAT VIOLATION***	10-20-2011	RM 11/22/11
3	250.10	Water temperatures exceeded 120 degrees.	10-21-2011	RM 11/22/11
4	300.02	The facility nurse did not evaluate residents when they had changes in condition such as: nausea, vomiting, falls, skin changes due to radiation therapy and changes in behaviors (Residents #1 & 5). Additionally, Resident #3's mechanical diet was not implemented.	Began 10/21	RM 11/22/11
		***REPEAT VIOLATION***	11/11/11	RM 11/22/11
5	305.07	The nurse did not evaluate the side effect of Resident #5's medication or report the side effects to the resident's physician.	11-12-11	RM 11/22/11
6	310.01.d	A caregiver, without medication certification, assisted with medications. Also, unlicensed caregivers assessed residents and made the decision to assist them with PRN medications without the direction of the facility nurse.	11-4-11	RM 11/22/11
7	310.04.a	Interventions were not documented prior to assisting residents with behavioral modifying medications.	11-4-11	RM 11/22/11
8	310.04.e	Behavioral updates were not provided to residents' physicians who were conducting six month psychotropic medication reviews.	11-18-11	RM 11/22/11
9	350.02	The administrator did not conduct an investigation into missing narcotics or report the incident to local law enforcement.	11-18-11	RM 11/22/11
10	350.04	The administrator did not provide a written report to a complainant.	11-18-11	RM 11/22/11
<del>11</del>	<del>350.07</del>	<del>The facility did not report an incident which resulted in a resident's death to Licensing and Certification. ***REPEAT VIOLATION***</del>	N/A	

Response Required Date 11/19/11	Signature of Facility Representative <i>Melissa Fustos</i>	Date Signed 10-20-2011
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RECEIVED  
NOV 21 2011



# Food Establishment Inspection Report

Establishment Name <u>Divine Living Center</u>		Operator <u>Melissa Fustos</u>	
Address <u>3405 N. 2538 N. EAST</u>		City <u>Twin Falls</u>	Zip <u>83301</u>
County Estab #	EHS/SUR.#	Inspection time:	Travel time:
Inspection Type:	Risk Category: <u>High</u>	Follow-Up Report: OR	On-Site Follow-Up:
Date: _____		Date: _____	

Items marked are violations of Idaho's Food Code, IDAPA 16.02.19, and require correction as noted.

Critical Violations	Good Retail Practices
# of Risk Factor Violations <u>0</u>	# of Retail Practice Violations <u>0</u>
# of Repeat Violations <u>1</u>	# of Repeat Violations <u>0</u>
Score <u>0</u>	Score <u>0</u>
A score greater than 3 Med or 5 High-risk = mandatory on-site reinspection	A score greater than 6 Med or 8 High-risk = mandatory on-site reinspection

### RISK FACTORS AND INTERVENTIONS (Idaho Food Code applicable sections in parentheses)

The letter to the left of each item indicates that item's status at the inspection

	Demonstration of Knowledge (2-102)	COS	R
<u>Y</u> _N	1. Certification by Accredited Program or Approved Course; or correct responses; or compliance with Code	<input type="checkbox"/>	<input type="checkbox"/>
<b>Employee Health (2-201)</b>			
<u>Y</u> _N	2. Exclusion, restriction and reporting	<input type="checkbox"/>	<input type="checkbox"/>
<b>Good Hygienic Practices</b>			
<u>Y</u> _N	3. Eating, tasting, drinking, or tobacco use (2-401)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> _N	4. Discharge from eyes, nose and mouth (2-401)	<input type="checkbox"/>	<input type="checkbox"/>
<b>Control of Hands as a Vehicle of Contamination</b>			
<u>Y</u> _N	5. Clean hands, properly washed (2-301)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> _N	6. Bare hand contact with ready-to-eat foods/exemption (3-301)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> _N	7. Handwashing Facilities (5-203 & 6-301)	<input type="checkbox"/>	<input type="checkbox"/>
<b>Approved Sources</b>			
<u>Y</u> _N	8. Food obtained from approved source (3-101 & 3-201)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> _N	9. Receiving temperature / condition (3-202)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> _N (N/A)	10. Records: shellstock tags, parasite destruction, required HACCP plan (3-202 & 3-203)	<input type="checkbox"/>	<input type="checkbox"/>
<b>Protection from Contamination</b>			
<u>Y</u> _N (N/A)	11. Food segregated, separated and protected (3-302)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> _N (N/A)	12. Food contact surfaces clean and sanitized (4-5, 4-6, 4-7)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> _N	13. Returned / reservice of food (3-306 & 3-801)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> _N	14. Discarding / reconditioning unsafe food (3-701)	<input type="checkbox"/>	<input type="checkbox"/>

	Potentially Hazardous Food Time/Temperature	COS	R
<u>Y</u> _N (N/O) (N/A)	15. Proper cooking, time and temperature (3-401)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> _N (N/O) (N/A)	16. Reheating for hot holding (3-403)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> _N (N/O) (N/A)	17. Cooling (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> _N (N/O) (N/A)	18. Hot Holding (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> _N (N/O) (N/A)	19. Cold Holding (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> _N (N/O) (N/A)	20. Date marking and disposition (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> _N (N/O) (N/A)	21. Time as a public health control (procedures/records) (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
<b>Consumer Advisory</b>			
<u>Y</u> _N (N/A)	22. Consumer advisory for raw or undercooked food (3-603)	<input type="checkbox"/>	<input type="checkbox"/>
<b>Highly Susceptible Populations</b>			
<u>Y</u> _N (N/O) (N/A)	23. Pasteurized foods used, avoidance of prohibited foods (3-801)	<input type="checkbox"/>	<input type="checkbox"/>
<b>Chemical</b>			
<u>Y</u> _N (N/A)	24. Additives / approved, unapproved (3-207)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> _N	25. Toxic substances properly identified, stored, used (7-101 through 7-301)	<input type="checkbox"/>	<input type="checkbox"/>
<b>Conformance with Approval Procedures</b>			
<u>Y</u> _N (N/A)	26. Compliance with variance and HACCP plan (8-201)	<input type="checkbox"/>	<input type="checkbox"/>

Y = yes, in compliance      N = no, not in compliance  
 N/O = not observed      N/A = not applicable  
 COS = Corrected on-site      R = Repeat violation  
 = COS or R

Item/Location	Temp	Item/Location	Temp	Item/Location	Temp	Item/Location	Temp
<u>COOK-OVEN</u>	<u>175</u>	<u>WATER HEAT-FRIG</u>	<u>111.9</u>				
<u>JUST ING. COOKTOP</u>	<u>160</u>	<u>COOLAMBERG-FRIG</u>	<u>40.8</u>				

### GOOD RETAIL PRACTICES ( = not in compliance)

	COS	R		COS	R		COS	R
<input type="checkbox"/> 27. Use of ice and pasteurized eggs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 34. Food contamination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 42. Food utensils/in-use	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 28. Water source and quantity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 35. Equipment for temp. control	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 43. Thermometers/Test strips	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 29. Insects/rodents/animals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 36. Personal cleanliness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 44. Warewashing facility	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 30. Food and non-food contact surfaces: constructed, cleanable, use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 37. Food labeled/condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 45. Wiping cloths	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 31. Plumbing installed; cross-connection; back flow prevention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 38. Plant food cooking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 46. Utensils & single-service storage	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 32. Sewage and waste water disposal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 39. Thawing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 47. Physical facilities	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 33. Sinks contaminated from cleaning maintenance tools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 40. Toilet facilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 48. Specialized processing methods	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/> 41. Garbage and refuse disposal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 49. Other	<input type="checkbox"/>	<input type="checkbox"/>

### OBSERVATIONS AND CORRECTIVE ACTIONS (CONTINUED ON NEXT PAGE)

Person in Charge (Signature) <u>Melissa Fustos</u>	(Print) <u>Melissa Fustos</u>	Title <u>Assistant Director</u>	Date <u>10-20-2011</u>
Inspector (Signature) <u>[Signature]</u>	(Print) <u>[Print]</u>	Date <u>[Date]</u>	Follow-up: Yes/No (Circle One)



Food Protection Program, Office of Epidemiology  
450 West State Street, Boise, Idaho 83702  
208-334-5938

Page 2 of 2  
Date 10/20/11

Establishment Name <i>Divine Living Center</i>			Operator <i>Melissa Eustos</i>		
Address <i>3805 N. 2538 N. East</i>			City/Zip <i>Twin Falls 83310</i>		
County	Estab #	EHS/SUR.#	License Permit #		

OBSERVATIONS AND CORRECTIVE ACTIONS (Continuation Sheet)

#11 saw hamburger was stored above RTE foods

COA: staff educated + hamburger was moved below RTE foods

Person in Charge <i>Melissa Eustos</i>	Date <i>10/26/2011</i>	Inspector <i>Debra [unclear]</i>	Date <i>10/20/11</i>
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IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

LESLIE M. CLEMENT – DEPUTY DIRECTOR  
RANDY MAY – DEPUTY ADMINISTRATOR  
LICENSING AND CERTIFICATION  
P.O. Box 83720  
Boise, Idaho 83720-0036  
PHONE 208-334-6626  
FAX 208-364-1888

October 28, 2011

Melissa Fustos, Administrator  
Divine Living Centers At Curry Retirement Estate  
3805 North 2538 East  
Twin Falls, ID 83301

Dear Ms. Fustos:

An unannounced, on-site complaint investigation survey was conducted at Divine Living Centers At Curry Retirement Estate from October 19, 2011, to October 20, 2011. During that time, observations, interviews, and record reviews were conducted with the following results:

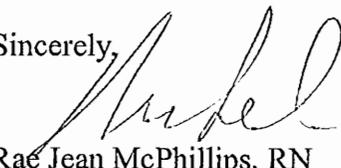
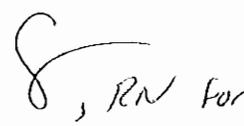
Complaint # ID00005280

Allegation #1: The facility did not seek medical treatment in a timely manner after a resident fell.

Findings #1: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.525 for neglect. The facility was required to submit a plan of correction.

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,

   
Rae Jean McPhillips, RN  
Health Facility Surveyor  
Residential Assisted Living Facility Program

rj/rc

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



IDAHO DEPARTMENT OF  
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October 28, 2011

Melissa Fustos, Administrator  
Divine Living Centers At Curry Retirement Estate  
3805 North 2538 East  
Twin Falls, ID 83301

Dear Ms. Fustos:

An unannounced, on-site complaint investigation survey was conducted at Divine Living Centers At Curry Retirement Estate from October 19, 2011, to October 20, 2011. During that time, observations, interviews, and record reviews were conducted with the following results:

Complaint # ID00005106

- Allegation #1:** The facility RN did not monitor side effects of a resident's medications and report concerns to the physician.
- Findings #1:** Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.305.07 for not monitoring the side effects of a resident's medications and reporting concerns to the physician. The facility was required to submit evidence of resolution within 30 days.
- Allegation #2:** The facility did not ensure medical treatment was provided to an identified resident in a timely manner.
- Findings #2:** Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.525 for neglect. The facility was required to submit a plan of correction.
- Allegation #3:** An identified resident was not assisted with activities of daily living ( ADLs) when she became ill.
- Findings #3:** On 10/19/11 through 10/20/11, observations, interviews and record reviews were conducted. During this time, the identified resident was deceased. Four caregivers interviewed, stated they assisted the identified resident with mobility,

showering and dressing when required. They stated she was able to make her needs known and some days required more cares than other days. They were never instructed not to assist her with cares, which she requested. During the survey, residents were observed receiving assistance with activities of daily living and two interviewable resident stated they were satisfied with the care they received.

On 10/18/11 at 2:00 PM, the ombudsman stated she had interviewed the resident two weeks prior to her becoming ill, and the resident had no complaints and was able to make her needs known. The ombudsman further stated, she had no concerns with residents not receiving the necessary assistance with activities of daily living.

The identified resident's record was reviewed, on 10/20/11, and care notes documented the resident was assisted with transferring, toileting, bathing, and grooming while ill.

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

Allegation #4: The identified resident was not assisted with eating.

Findings #4: On 10/19/11 through 10/20/11, observations, interviews and record reviews were conducted. During this time, the identified resident was deceased. Four caregivers interviewed, stating the identified resident was able to eat independently, but she often requested alternative meals, such as chili, which was provided to her. They further stated, at one time, when ill, they encouraged the resident to eat lighter meals such as toast.

On 10/19/11 through 10/20/11, two meal times were observed. Residents were observed receiving the necessary assistance with eating and staff were observed cueing residents to eat when appropriate.

On 10/18/11 at 2:00 PM, the ombudsman stated she had no concerns with residents not receiving assistance with eating.

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

Allegation #5: The appropriate criminal history background checks were not completed on all staff.

Findings #5: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.009.03

Melissa Fustos, Administrator  
October 28, 2011  
Page 3 of 3

for allowing a caregiver to work unsupervised prior to the completion of the appropriate criminal history check. The facility was required to submit evidence of resolution within 30 days.

Allegation #6: The facility did not respond appropriately to an allegation of missing narcotics.

Findings #6: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.350.02 for not investigating and reporting to law enforcement an allegation of narcotic theft. 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,

A handwritten signature in cursive script, appearing to read "Rae Jean McPhillips, RN for".

Rae Jean McPhillips, RN  
Health Facility Surveyor  
Residential Assisted Living Facility Program

rjm/rc

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