



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK – ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
JAMIE SIMPSON – PROGRAM SUPERVISOR
RESIDENTIAL ASSISTED LIVING FACILITY PROGRAM
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: 208-334-6626
FAX: 208-364-1888

February 5, 2013

FILE COPY

Kathy Adams, Administrator
Safe Haven Homes Of Wendell
Po Box 306
Wendell, ID 83355

License #: Rc-932

Dear Ms. Adams:

On November 9, 2012, a Complaint Investigation survey was conducted at Carefix Management & Consulting Inc, Dba Safe Haven Homes Of Wendell-Magic Valley Manor. 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 MATT HAUSER , Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 334-6626.

Sincerely,

MATT HAUSER
Team Leader
Health Facility Surveyor
Residential Assisted Living Facility Program

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



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DUPLICATE

TAMARA PRISOCK – ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
JAMIE SIMPSON – PROGRAM SUPERVISOR
RESIDENTIAL ASSISTED LIVING FACILITY PROGRAM
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: 208-334-6626
FAX: 208-364-1888

November 20, 2012

CERTIFIED MAIL #: 7007 3020 0001 4050 7954

Kathy Adams
Safe Haven Homes Of Wendell
Po Box 306
Wendell, ID 83355

Dear Ms. Adams:

Based on the Complaint Investig. conducted by our staff at Carefix Management & Consulting Inc, Dba Safe Haven Homes Of Wendell-Magic Valley on November 9, 2012, we have determined that the facility failed to seek timely medical treatment for an identified resident which resulted in neglect.

This core issue deficiency substantially limits the capacity of Carefix Management & Consulting Inc, Dba Safe Haven Homes Of Wendell-Magic Valley 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.

You have an opportunity to make corrections and thus avoid a potential enforcement action. Correction of this deficiency must be achieved by **December 24, 2012**. **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 **December 3, 2012**, and keep a copy for your records. Your license depends upon the corrections made and the evaluation of the Plan of Correction you

Kathy Adams
November 20, 2012
Page 2 of 2

develop.

In accordance with Informational Letter #2002-16 INFORMAL DISPUTE RESOLUTION (IDR) PROCESS, 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. See the IDR policy and directions on our website at www.assistedliving.dhw.idaho.gov. If your request for informal dispute resolution is not received within the appropriate time-frame, your request will not be granted.

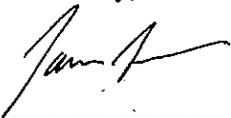
Please bear in mind that non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference. The completed punch list form and accompanying evidence of resolution (e.g., receipts, pictures, policy updates, etc.) are to be submitted to this office by **December 9, 2012**.

Also, be aware that any variance allowing the administrator to serve over other facilities is revoked as of the date of the exit conference. The facility must now employ a single, licensed administrator who is not serving as administrator over any other facilities. Failure to do so within thirty (30) days of the date of the exit conference will result in a core issue deficiency.

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 in Idaho, the Department will have no alternative but to initiate an enforcement action against the license held by Carefix Management & Consulting Inc, Dba Safe Haven Homes Of Wendell-Magic Valley.

Should you have any questions, or if we may be of assistance, please call our office at (208) 334-6626 and ask for the RALF program.

Sincerely,



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

DUPLICATE

MH/mh

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R932	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/09/2012
--	---	--	--

NAME OF PROVIDER OR SUPPLIER CAREFIX-SAFE HAVEN HOMES OF WENDELL	STREET ADDRESS, CITY, STATE, ZIP CODE 210 NORTH IDAHO WENDELL, ID 83355
--	---

(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

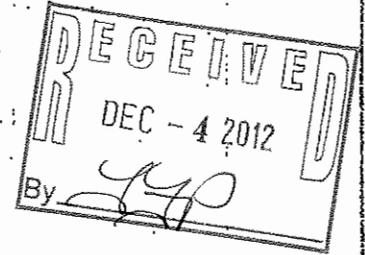
The following deficiency was cited during a complaint investigation survey conducted on 11/07/2012 through 11/09/2012 at your residential care/assisted living facility. The surveyors conducting the survey were:

Matt Hauser, QMRP
Team Leader
Health Facility Surveyor

Karen Anderson, RN
Health Facility Surveyor

Survey Abbreviations:
cm = centimeter

R 000



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 observation, interview and record review, it was determined the facility did not seek timely medical treatment for 1 of 6 sampled residents (Resident #1). This failure constituted neglect and the facility's practice of not involving the nurse had the potential to affect 100% of the facility's residents.

IDAPA 16.03.22.001.3 documents, "The facility must have an administrator and staff who have the knowledge and experience required to provide safe and appropriate services to all residents of the facility."

IDAPA 16.03.22.011.24 defines neglect as

R 009

The following are new policies put in place

- ① Incident-Event Policy
- ② Change of Condition Policy
- ③ Abuse & Neglect Policy
- ④ Resident Behavior Support
- ⑤ Intermittent Nursing Services

11/29/12 - In Service given going over reading above policies.
New RN went over Nurse

Bureau of Facility Standards	TITLE	(X6) DATE
------------------------------	-------	-----------

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

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R932	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/09/2012
NAME OF PROVIDER OR SUPPLIER CAREFIX-SAFE HAVEN HOMES OF WENDELL		STREET ADDRESS, CITY, STATE, ZIP CODE 210 NORTH IDAHO WENDELL, ID 83366	
(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 009	<p>Continued From page 1</p> <p>"Failure to provide...medical care necessary to sustain the life and health of a resident."</p> <p>Resident #1 was a 93 year old female admitted to the facility on 5/31/07 with a diagnosis of dementia.</p> <p>On 11/7/12 at 10:10 AM, Resident #1 was observed self propelling her wheelchair down the hallway and into her room. The resident stated things were not going well for her because "something hurt" on her thigh. The resident lowered her pants to show a surveyor a wound on her upper left thigh. A large red, open wound was observed just below the leg band of her incontinent brief. The wound was not covered by a protective dressing. Therefore, her clothing and her brief rubbed directly against the wound. The wound measured approximately 6 inches in length by approximately 2 inches in width. The center of the wound was black in color and the top layers of skin were not intact. The resident could not remember how she obtained the wound. She stated, each time a caregiver changed her pants or removed her brief the wound would be rubbed by the material which caused her more pain.</p> <p>On 11/7/12 at 10:25 AM, the administrator stated the resident's wound was caused by hot coffee spilling on her lap. She stated she received a call on the morning of 10/27/12, around 4:00 AM, from a caregiver reporting that Resident #1 had spilled a cup of hot coffee on her lap. The administrator stated, "I instructed the caregiver to apply a cold compress and then to get the burn cream from the kitchen and put some on the burn." The administrator further stated, "I called the nurse after talking to the caregiver and described to the nurse what the caregiver told me</p>	R 009	<p>Delegations. Nurse went over expectations to follow policies that were read. Went over why & when to file out incident report or change of condition. Documentation discussed & the importance of doing it appropriately. New RN will provide monthly and PRN training to all staff. Corrective actions were started immediately & will be ongoing to assure compliance. 11/09/12 - completed. 12/4/12 - Kathy Adams. Copies attached.</p>

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R932	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/09/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CAREFIX-SAFE HAVEN HOMES OF WENDELL	STREET ADDRESS, CITY, STATE, ZIP CODE 210 NORTH IDAHO WENDELL, ID 83356
--	---

(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 009: Continued From page 2

about the incident." She stated, "I told the nurse what I had instructed the caregiver to do and that I didn't think she needed to come to the facility." The administrator stated, "This happened on a Saturday (10/27/12). I observed the burn on Monday (10/29/12), and then again on Monday (11/5/12), and it did not look bad."

On 11/7/12 at 10:30 AM, a cup of coffee was poured from the facility's coffee maker into a cup. The temperature of the coffee measured 134.7 degrees Fahrenheit.

According to an article dated "Spring of 2012" by The Burn Foundation, "Hot liquids can cause life-threatening burn injuries." The article further documented that "Hot Water Causes Third Degree Burns...in 15 seconds at 133 degrees."

On 11/7/12 at 3:15 PM, Caregiver A stated, "I was working the night shift when the resident was burned." She stated on 10/27/12 around 3:30 AM, the resident was "upset and yelling for her mother." She said, "I brought her to the dining room table and served her a cup of coffee. I left the resident in the dining room alone while I completed other tasks." The caregiver stated she heard the resident screaming and went back to the dining room and observed the resident had spilled hot coffee on her lap. Caregiver A stated, "it took me a few minutes to get back to the dining room." She said she observed most of the coffee had pooled on the left side of the resident's lap. She stated she called the administrator and was instructed to get the burn cream from the kitchen and put it on the resident's burn. Caregiver A stated the resident refused to let her or the other caregiver put the burn cream on because it was "too painful." The caregiver stated, "at first the burn was very red and the resident said it was

R 009

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R932	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/09/2012
NAME OF PROVIDER OR SUPPLIER CAREFIX-SAFE HAVEN HOMES OF WENDELL.		STREET ADDRESS, CITY, STATE, ZIP CODE 210 NORTH IDAHO WENDELL, ID 83355		
(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 009	<p>Continued From page 3</p> <p>painful." The reddened area covered her upper thigh, just below the elastic leg band on her brief. The caregiver stated that a day or so later, the burn blistered and it continued to look worse. She stated she asked other caregivers if they had put burn cream on her thigh or was something else suppose to be done, such as covering the burn. She stated she had asked the house manager and administrator about the burn, and was told by them that nothing had been changed on how to treat the burn.</p> <p>On 11/8/12 at 11:20 AM, Caregiver B stated she was working when Resident #1 burned her thigh with hot coffee. She stated the administrator was called and informed the resident was in a lot of pain. The caregiver stated they were instructed to put a cold compress and burn cream on her thigh. However, the resident refused because she said it hurt too much. She further stated, the resident had Tylenol that she received daily, but there was nothing further ordered for pain control after she sustained the burn.</p> <p>Between 11/7/12 and 11/8/12, eight caregivers stated they had not put anything on Resident #1's burn, because the resident would not let them touch it. They also stated the resident complained of pain from the burn. They said the nurse had not been in to assess the resident after being burned. Two caregivers stated the administrator did not see the resident's leg until Monday, two days after the resident was burned.</p> <p>The administrator confirmed the nurse did not come assess the resident's burn or address her pain issues.</p> <p>A fax, sent to a physician, dated 10/29/12, documented an incident occurred on 10/27/12,</p>	R 009		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R932	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/09/2012
NAME OF PROVIDER OR SUPPLIER CAREFIX-SAFE HAVEN HOMES OF WENDELL.		STREET ADDRESS, CITY, STATE, ZIP CODE 210 NORTH IDAHO WENDELL, ID 83355		
(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 009	<p>Continued From page 4</p> <p>when the resident "poured hot coffee on her left thigh at 4:00 AM." The administrator documented, she had directed caregivers to apply "Cold compresses and burn ointment." The physician's response was to "Monitor for blister formation or sign of infection."</p> <p>There was no documented evidence the physician was notified when Resident #1's burn blistered, nor was the physician informed the resident had been complaining of pain related to the burn.</p> <p>There was no documented evidence the facility nurse assessed Resident #1's burn to ensure the resident received appropriate pain management and wound care.</p> <p>On 11/7/12, eleven days after the incident, Resident #1 was seen by her physician. The physician's report documented the resident had an "8 x 2 cm area of a partial thickness burn" on her left thigh. The report further documented the burn's "center portion is partial thickness, dry and starting to granulate...." The physician ordered an antibiotic cream to be applied twice daily and the burn was to be covered with a dressing.</p> <p>The facility did not ensure Resident #1 received timely medical treatment when she sustained a serious burn from hot coffee. The resident did not receive medical attention until 11/7/12, eleven days after sustaining a burn. The resident's burn was not protected from abrasions caused by clothing, nor was it protected from urine leakage. Additionally, Resident #1 experienced significant pain for which she did not receive pain medication. This failure to provide medical care resulted in neglect.</p>	R 009		



ASSISTED LIVING
Non-Core Issues
Punch List

Facility Name Carefix-Safe Haven of Wendell- Magic Valley Manor	Physical Address 210 North Idaho	Phone Number 208-536-5570
Administrator Kathy Adams	City Wendell	Zip Code 83355
Team Leader Matt Hauser	Survey Type Complaint and Follow-up	Survey Date 11/09/12

NON-CORE ISSUES

Item #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	L&C USE
1	225.01	The facility did not document an evaluation of Residents #1 and #2's behaviors (aggression, sexual inappropriateness).	1/7/13	
2	225.02	The facility did not develop interventions for each behavior for Residents #1 and #2.	1/7/13	
3	300	The administrator performed acts that required a nursing license for example; determined an ointment treatment for Resident #1's burn, requested medications without the knowledge of the nurse, and directed medication aides when to give PRN medications to residents.	1/7/13	
4	300.01	The facility nurse did not visit the facility when Resident #1 was burned and when Resident #3 fell and broke her hip and had blood clots and red fluid in her catheter, and when Resident #2 had severe itching all over his body.	1/7/13	
5	300.02	The facility nurse did not document reviews and implementation of new orders by the resident's physicians and did not document that she addressed resident's changes in health or mental status (see above).	1/7/13	
6	305.02	The facility nurse did not document assessments when Residents #1 and #2 had changes in condition (a burn, itching, aggression, broken hip and blood clots in her catheter).	1/7/13	
7	305.04	The facility nurse did not make recommendations to the administrator regarding Resident #3's pressure ulcer.	1/7/13	
8	310.01.d	Medication aides did not contact the facility nurse for PRN medications, and there were no written parameters for their use.	1/7/13	
9	310.04.a	Psychotropic medications were implemented prior to documenting non-drug interventions for Residents #1 and #2.	1/7/13	
10	310.04.e	Six month psychotropic medication reviews did not contain behavior updates to the physician and were not done every 6 months.	1/7/13	

Response Required Date 12/08/12	Signature of Facility Representative 	Date Signed 11/9/12
------------------------------------	--	------------------------



ASSISTED LIVING
Non-Core Issues
Punch List

Facility Name Carefix-Safe Haven of Wendell- Magic Valley Manor	Physical Address 210 North Idaho	Phone Number 208-536-5570
Administrator Kathy Adams	City Wendell	Zip Code 83355
Team Leader Matt Hauser	Survey Type Complaint and Follow-up	Survey Date 11/09/12

NON-CORE ISSUES

Item #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	L&C USE
11	320.01	Resident #1 and #3's NSA's were not updated to reflect their current needs, such as, Resident #3's home health services and pressure ulcer preventive measures and Resident #1's burn treatment. **Previously cited on 12/13/2011**	1/7/13 ml	
12	350.02	The administrator did not document an investigation of each accident and incident, for example, Resident #1 sustained a burn, and Resident #3 fell and sustained a skin tear on her left forearm.	1/7/13 ml	
13	350.07	The facility did not notify Licensing and Survey within 24 hours when Resident #3 fell and broke her hip.	1/7/13 ml	
14	711.01	The facility did not track Resident #1 and #2's behaviors.	1/7/13 ml	
15	711.08.b	There were no care notes by the person providing the care for delegated nursing tasks, such as catheter care and wound care.	1/7/13 ml	
16	711.08.c	There were no care notes for unusual events and incidents, accidents and altercations.	1/7/13 ml	
17	711.08.e	There were no care notes documenting when or if the facility nurse was notified of changes in residents' condition (see item #4).	1/7/13 ml	
18	711.12	Caregivers documented Residents #1 & #2 requested PRN medications when the resident did not request them.	1/7/13 ml	
19	730.02.a	Work records did not document personnel on duty at any given time.	1/7/13 ml	

Response Required Date 12/08/12	Signature of Facility Representative <i>Kathy Adams</i>	Date Signed 11/9/12
------------------------------------	--	------------------------



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK – ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
JAMIE SIMPSON – PROGRAM SUPERVISOR
RESIDENTIAL ASSISTED LIVING FACILITY PROGRAM
- P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: 208-334-6626
FAX: 208-364-1888

FILE COPY

November 20, 2012

Kathy Adams, Administrator
Safe Haven Homes Of Wendell
Po Box 306
Wendell, ID 83355

Dear Ms. Adams:

An unannounced, on-site complaint investigation survey was conducted at Carefix Management & Consulting Inc, Db a Safe Haven Homes Of Wendell-Magic Valle from November 7, 2012, to November 9, 2012. During that time, observations, interviews, and record reviews were conducted with the following results:

Complaint # ID00005651

Allegation #1: An identified resident did not have a working call light.

Findings #1: The identified resident was observed in her room on 11/8/12 at 9:45 AM. Her call light was observed to be a pendent type of call button, which she wore around her neck. The resident was asked to push the call button and did so. Staff responded to the resident's call within 2 minutes. Additionally, two other random resident's call lights were tested on 11/7/12, and both worked properly.

Between 11/7/12 and 11/8/12, eight caregivers stated the identified resident used her call light daily. None of the caregivers were aware of a time when the identified resident's call light was not working.

Conclusion #1: Unsubstantiated. This does not mean the incident did not take place; it only means that the allegation could not be proven.

Allegation #2: An identified resident was not assisted with toileting as needed.

Findings #2: The facility's "Behavior Plans, ADLs and Care Notes" book was reviewed for the identified resident. The identified resident's ADL record documented she

received assistance with toileting 3-4 times daily and as needed. This was congruent with the identified resident's care plan and negotiated service agreement.

Between 11/7/12 and 11/8/12, eight caregivers stated the identified resident was assisted with toileting whenever she required assistance. Two of the eight caregivers stated that in the mornings, the identified resident was sometimes wet, but was always assisted with toileting or changing when wet. All of the caregivers stated the identified resident used her call light if she needed assistance with toileting or was wet.

On 11/8/12 at 9:55 AM, the identified resident indicated that she was happy with the assistance and cares she received from the facility and had no complaints. She was observed to be clean, well groomed and had no foul odors.

Conclusion #2: Unsubstantiated. Although the allegation may have occurred, it could not be determined during the complaint investigation.

Allegation #3: Non-ambulatory residents were placed at the table during meals and their wheelchairs were taken away from them so they could not leave the table.

Findings #3: Between 11/7/12 and 11/8/12, three meals were observed. All residents who used wheelchairs were observed to be in their wheelchairs during the meal, at the table.

Three resident who used wheelchairs were interviewed on 11/7/12. All three stated their wheelchairs were never taken from them during meals. All three stated they were always allowed to leave the table when they wanted.

Between 11/7/12 and 11/8/12, eight caregivers stated they worked during meals and had not observed residents' wheelchairs being taken from them at any time.

Conclusion #3: Unsubstantiated. This does not mean the incident did not take place; it only means that the allegation could not be proven.

Allegation #4: An identified staff member did not treat residents with dignity and respect.

Findings #4: On 11/7/12 from 8:40 AM - 9:40 AM, eighteen residents were interviewed. All eighteen stated that staff members treated them respectfully and did not raise their voices at them. All of the residents interviewed stated they had not witnessed staff treat any other residents poorly.

Kathy Adams, Administrator

November 20, 2012

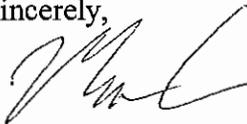
Page 3 of 3

Between 11/7/12 and 11/8/12, eight caregivers stated all staff members treated residents with dignity and respect. None of the caregivers interviewed stated they had ever had concerns about any staff treating the residents poorly.

Conclusion #4: Unsubstantiated. Although the allegation may have occurred, it could not be determined during the complaint investigation.

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,



FILE COPY

MATT HAUSER
Health Facility Surveyor
Residential Assisted Living Facility Program

MH/mh

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



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK – ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
JAMIE SIMPSON – PROGRAM SUPERVISOR
RESIDENTIAL ASSISTED LIVING FACILITY PROGRAM
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: 208-334-6626
FAX: 208-364-1888

November 20, 2012

Kathy Adams, Administrator
Safe Haven Homes Of Wendell
Po Box 306
Wendell, ID 83355

FILE COPY

Dear Ms. Adams:

An unannounced, on-site complaint investigation survey was conducted at Carefix Management & Consulting Inc, Db a Safe Haven Homes Of Wendell-Magic Valle from November 7, 2012, to November 9, 2012. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00005775

Allegation #1: The administrator instructed staff to give an identified resident PRN medication.

Findings #1: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.310.01.d for medication aides not contacting the facility nurse to obtain permission for PRN medications. The facility was issued an additional deficiency at IDAPA 16.03.22.300 for the administrator performing acts requiring a nursing license. The facility was required to submit evidence of resolution within 30 days.

Allegation #2: Staff documented residents requested PRN medications when residents were not able to request them.

Findings #2: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.711.12, because medication aides documented residents requested PRN medications when the residents did not request them. The facility was required to submit evidence of resolution within 30 days.

Allegation #3: An identified resident fell and the fall was not documented.

Findings #3: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.711.08.c for not documenting in care notes all incidents, accidents, altercations and unusual events. The facility was required to submit evidence of resolution within 30 days.

Findings #3: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.711.08.c for not documenting in care notes all incidents, accidents, altercations and unusual events. The facility was required to submit evidence of resolution within 30 days.

Allegation #4: The facility nurse was not notified when residents had changes in condition.

Findings #4: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.711.08.e for not documenting when or if the facility nurse was notified of changes in residents' condition. The facility was required to submit evidence of resolution within 30 days.

Allegation #5: The administrator did not document investigations of incidents and accidents.

Findings #5: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.350.02 for the administrator not documenting an investigation of each accident and incident. The facility was required to submit evidence of resolution within 30 days.

Allegation #6: An identified resident was not assessed after a change in physical condition.

Findings #6: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.305.02 for not documenting assessments after residents had changes in condition. The facility was required to submit evidence of resolution within 30 days.

Allegation #7: The administrator did not schedule sufficient staff to care for the residents.

Findings #7: On 11/7/12 through 11/9/12, between 8:00 AM and 4:30 PM, observations were made of caregivers assisting residents with their care needs. Two caregivers on the day shift and two caregivers on the evening shift were observed assisting thirty-three residents. During this time, it was observed residents received the assistance they required with their care needs.

On 11/7/12 through 11/8/12, between 8:00 AM and 4:30 PM, interviews were conducted with twenty-four residents who had a variety of care needs. All

FILE COPY

residents stated they felt there were sufficient staff to meet their care needs. Residents stated call lights were answered timely, and if a caregiver could not accomplish what they needed, one caregiver would get the other caregiver to help. Residents additionally stated, the caregivers were proficient and had no complaints.

Six resident records were reviewed and their needs were described in their care plans. The facility's "Behavior Plans, ADLs and Care Notes" book was reviewed for the six residents. The six residents ADL (activity of daily living) records documented they received assistance with their ADLs according to their care plans.

The September and October 2012 work schedule documented the following:

- *Day shift had 2 caregivers scheduled from 6:00 AM until 2:00 PM
- *Evening shift had 2 caregivers scheduled from 2:00 PM until 10:00 PM
- *Night shift had 2 caregivers scheduled from 10:00 PM until 6:00 AM

Between 11/7/12 and 11/9/12, twelve caregivers were interviewed. Caregivers that worked the night shift stated at times it was difficult to "get everything done." They stated during those times they would call the house manager or administrator to come in and help. They also stated the house manager or administrator arrived at the facility within five minutes. Caregivers stated the residents' needs were being met. The caregivers stated staffing was adequate to meet the needs of the residents.

Conclusion #7: Unsubstantiated. This does not mean the incident did not take place; it only means that the allegation could not be proven.

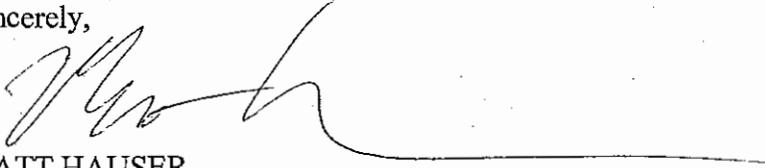
A core issue deficiency was identified during the complaint investigation. Please review the cover letter, which outlines how to develop a Plan of Correction. The Plan of Correction must be submitted to our office within 10 (ten) calendar days of receiving the Statement of Deficiencies.

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 11/09/2012. 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.

Kathy Adams, Administrator
November 20, 2012
Page 4 of 4

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,



MATT HAUSER
Health Facility Surveyor
Residential Assisted Living Facility Program

FILE COPY

MH/mh

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



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK - ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
JAMIE SIMPSON - PROGRAM SUPERVISOR
RESIDENTIAL ASSISTED LIVING FACILITY PROGRAM
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: 208-334-6626
FAX: 208-364-1888

November 20, 2012

FILE COPY

Kathy Adams, Administrator
Safe Haven Homes Of Wendell
Po Box 306
Wendell, ID 83355

Dear Ms. Adams:

An unannounced, on-site complaint investigation survey was conducted at Carefix Management & Consulting Inc, DbA Safe Haven Homes Of Wendell-Magic Valle from November 7, 2012, to November 9, 2012. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00005786

Allegation #1: The facility did not have enough staff to meet all residents' needs.

Findings #1: On 11/7/12 through 11/9/12, between 8:00 AM and 4:30 PM, observations were made of caregivers assisting residents with their care needs. Two caregivers on the day shift and two caregivers on the evening shift were observed assisting thirty-three residents. During this time, it was observed residents received the assistance they required with their care needs.

On 11/7/12 through 11/8/12, between 8:00 AM and 4:30 PM, interviews were conducted with twenty-four residents who had a variety of care needs. All residents stated they felt there were sufficient staff to meet their care needs. Residents stated call lights were answered timely, and if a caregiver could not accomplish what they needed, one caregiver would get the other caregiver to help. Residents additionally stated, the caregivers were proficient and had no complaints.

Six resident records were reviewed and their needs were described in their care plans. The facility's "Behavior Plans, ADLs and Care Notes" book was reviewed for the six residents. The six residents ADL (activity of daily living) records documented they received assistance with their ADLs according to their care

FILE COPY

Kathy Adams, Administrator
November 20, 2012
Page 2 of 4

plans.

The September and October 2012 work schedule documented the following:

- *Day shift had 2 caregivers scheduled from 6:00 AM until 2:00 PM
- *Evening shift had 2 caregivers scheduled from 2:00 PM until 10:00 PM
- *Night shift had 2 caregivers scheduled from 10:00 PM until 6:00 AM

Between 11/7/12 and 11/9/12, twelve caregivers were interviewed. Caregivers that worked the night shift stated at times it was difficult to "get everything done." They stated during those times they would call the house manager or administrator to come in and help. They also stated the house manager or administrator arrived at the facility within five minutes. Caregivers stated the residents' needs were being met. The caregivers stated staffing was adequate to meet the needs of the residents.

Conclusion #1: Unsubstantiated. This does not mean the incident did not take place; it only means that the allegation could not be proven.

Allegation #2: The facility was cold.

Findings #2: On 11/7/12 at 10:35 AM, the facility's temperature was 74.2 degrees, as measured in a hallway near two windows and an exit door. Two residents' rooms located in opposite hallways had temperatures of 75.1 and 74.9 degrees. One resident's room was noted to be cold, however the resident's window was observed to be open and the resident stated he preferred his room to be a "little chilly."

On 11/7/12 from 8:40 to 9:40 AM, eighteen residents were interviewed. All eighteen residents stated the facility did get cold at night occasionally, but they could turn up their own heat if it did. Two of the residents stated that staff had assisted them to turn up their heating units when asked.

Between 11/7/12 and 11/8/12, eight caregivers stated they generally felt the facility was too warm. All of the caregivers stated each resident room had individual heating units and could be adjusted by the residents. When asked about residents who were not able to adjust their own heating units, the caregivers stated they would assist the resident if the resident seemed cold.

Conclusion #2: Unsubstantiated. This does not mean the incident did not take place; it only means that the allegation could not be proven.

FILE COPY

Allegation #3: Caregivers and medication assistants called the administrator instead of calling the nurse for medication questions.

Findings #3: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.310.01.d for medication aides not contacting the facility nurse to obtain permission to assist with PRN medications. The facility was issued an additional deficiency at IDAPA 16.03.22.300 for the administrator performing acts requiring a nursing license. The facility was required to submit evidence of resolution within 30 days.

Allegation #4: The facility's carpet was not being kept clean because the vacuum cleaner was broken.

Findings #4: On 11/7/12 at 8:30 AM, during an unannounced onsite investigation, the facility's carpet was observed to be clean and free of debris or dirt. All residents' rooms were also observed to have clean carpeting with no debris.

On 11/7/12 from 8:40 to 9:40 AM, eighteen residents were interviewed regarding the carpet being kept clean. All residents stated the carpet was always kept clean and regularly vacuumed.

Between 11/7/12 and 11/8/12, eight caregivers stated the facility had two vacuum cleaners. They stated the newer and better one had been broken twice in the last 2 or 3 months, but another vacuum cleaner was always available to use. Two of the caregivers did state the secondary vacuum cleaner was not as nice as the newer one, but it worked functional. All of the caregivers stated that at no time was the facility carpeting not regularly vacuumed.

Conclusion #4: Unsubstantiated. This does not mean the incident did not take place; it only means that the allegation could not be proven.

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.

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 **11/09/2012**. The completed punch list form and accompanying evidence of resolution (e.g., receipts, pictures, policy updates, etc) are to be

Kathy Adams, Administrator
November 20, 2012
Page 4 of 4

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,



FILE COPY

Matt Hauser
Health Facility Surveyor
Residential Assisted Living Facility Program

MH/mh

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