



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: 208-364-1962
FAX: 208-364-1888

April 21, 2014

Jerry Bowlin, Administrator
Wedgewood Terrace, Provident Foundation
2114 Vineyard Avenue
Lewiston, Idaho 83501

License #: RC-588

Ms. Bowlin:

On February 4, 2014, a follow-up/revisit survey was conducted at Wedgewood Terrace-Provident Resources Group, Inc. 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.

Your submitted plan of correction is being accepted by this office. Please ensure the corrections you identified are implemented for all residents and situations, and implement a monitoring system to make certain the deficient practices do not recur.

Thank you for your work to correct these deficiencies. Should you have questions, please contact Karen Anderson, RN, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 364-1962.

Sincerely,

KAREN ANDERSON, RN
Team Leader
Health Facility Surveyor

KA/sc

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



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P.O. Box 83720
Boise, Idaho 83720-0009
EMAIL: ralf@dhw.idaho.gov
PHONE: 208-364-1962
FAX: 208-364-1888

February 18, 2014

CERTIFIED MAIL #: 7007 3020 0001 4051 2545

Jerry Bowlin, Administrator
Wedgewood Terrace, Provident Foundation
2114 Vineyard Avenue
Lewiston, Idaho 83501

Provider ID: RC-588

Dear Ms. Bowlin:

On February 4, 2014, a follow-up survey to the complaint investigation conducted on October 22, 2013 was conducted by our staff at Wedgewood Terrace-Provident Resources Group, Inc. The facility was cited with a repeat core issue deficiency for failing to protect a resident from sexual abuse after an allegation of abuse was made known.

This core issue deficiency substantially limits the capacity of Wedgewood Terrace-Provident Resources Group, Inc to provide for residents' basic health and safety needs. The deficiency is described on the enclosed Statement of Deficiencies.

PROVISIONAL LICENSE:

As a result of the survey findings, a provisional license is being issued effective February 18, 2014 and will remain in effect for a period of six months or until revoked. The facility is required to return the full license previously issued to the facility January 1, 2014. A full license will be restored when it is determined the facility is back in compliance. The following administrative rule for Residential Care or Assisted Living Facilities in Idaho (IDAPA 16.03.22) gives the Department the authority to issue a provisional license:

935. ENFORCEMENT REMEDY OF PROVISIONAL LICENSE.

A provisional license may be issued when a facility is cited with one (1) or more core issue deficiencies, or when non-core issues have not been corrected or become repeat deficiencies. The provisional license will state the conditions the facility must follow to continue to operate. See Subsections 900.04, 900.05 and 910.02 of these rules.

The conditions 1- 3 of the provisional license are as follows:

CONSULTANT:

1. A licensed residential care administrator consultant or RN Consultant, with at least three years' experience working as an administrator or RN for a residential care or assisted living facility in Idaho, shall be obtained and paid for by the facility, and approved by the Department. This consultant must be fully credentialed in the State of Idaho and may not also be employed by the facility or the company that operates the facility. The purpose of the consultant is to assist the facility in identifying and implementing appropriate corrections for the deficiencies. Please provide a copy of the enclosed consultant report content requirements to the consultant. The consultant shall be allowed unlimited access to the facility's administrative, business and resident records and to the facility staff, residents, their families and representatives. The name of the consultant with the person's qualifications shall be submitted to the Department for **approval no later than February 27, 2014.**

2. A weekly written report must be submitted by the Department-approved consultant to the Department commencing on March 7, 2014. The reports will address progress on correcting the core deficiency identified on the Statement of Deficiencies as well as the non-core deficiencies identified on the punch list. When the consultant and the administrator agree the facility is in full compliance, they will notify the Department and request a follow-up survey be scheduled.

PLAN OF CORRECTION:

3. 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)?
- ◆ By what date will the corrective action(s) be completed?

An acceptable, **signed** and **dated** Plan of Correction must be submitted to the Division of Licensing and Certification within **ten (10) calendar days of your receipt of the Statement of Deficiencies.** You are encouraged to immediately develop and submit this plan so any adjustments or corrections to the plan can be completed prior to the deadline.

ADMINISTRATIVE REVIEW

You may contest this decision to issue a provisional license and impose enforcement action of requiring a consultant by filing a written request for administrative review pursuant to IDAPA 16.05.03.300,

which states: **the request must be signed by the licensed administrator of the facility, identify the challenged decision, and state specifically the grounds for your contention that this decision is erroneous.** The request must be received **no later than twenty-eight (28) days after this notice was mailed.** Any such request should be addressed to:

**Tamara Prisock, Administrator
Division of Licensing and Certification - DHW
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036**

Upon receipt of a written request that meets the requirements specified in IDAPA 16.05.03.300, an administrative review conference will be scheduled and conducted. The purpose of the conference is to clarify and attempt to resolve the issues. A written review decision will be sent to you within thirty (30) days of the date of the conclusion of the administrative review conference.

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

INFORMAL DISPUTE RESOLUTION

Pursuant to IDAPA 16.03.22.003.02, you have available the opportunity to question the core issue deficiency 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 Assisted Living Facility Program for an IDR meeting. The request for the meeting must be in writing and must be made within ten (10) business days of receipt of the Statement of Deficiencies. The facility's request must include sufficient information for Licensing and Certification to determine the basis for the provider's appeal, including reference to the specific deficiency to be reconsidered and the basis for the reconsideration request. If your request for informal dispute resolution is received more than ten (10) days after you receive the Statement of Deficiencies, your request will not be granted. Your IDR request must be made in accordance with the Informal Dispute Resolution Process. The IDR request form and the process for submitting a complete request can be found at www.assistedliving.dhw.idaho.gov under the heading of Forms and Information.

FOLLOW-UP SURVEY

An on-site, follow-up survey will be scheduled after the administrator and consultant submit a letter stating that all deficiencies have been corrected and systems are in place to assure the deficient practices remain corrected. If at the follow-up survey, the core issue deficiency still exists, a new core issue deficiency is identified, non-core deficiencies have not been corrected, or the facility has failed to abide by the conditions of the provisional license, including achieving full compliance with IDAPA 16.03.22 the Department will take further enforcement action against the license held by Wedgewood Terrace, Provident Foundation. Those enforcement actions will include one or more of the following:

- Revocation of the Facility License
- Summary Suspension of the Facility License
- Imposition of Temporary Management
- Limit on Admissions
- Civil Monetary Penalties

Division of Licensing and Certification staff is available to assist you in determining appropriate corrections and avoiding further enforcement actions. Please contact our office at (208) 364-1962 if we may be of assistance, or if you have any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Jamie Simpson', written in a cursive style.

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

JS/sc

Enclosure

PRINTED: 02/13/2014
FORM APPROVED

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R588	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 02/04/2014
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NAME OF PROVIDER OR SUPPLIER WEDGEWOOD TERRACE, PROVIDENT FOUND	STREET ADDRESS, CITY, STATE, ZIP CODE 2114 VINEYARD AVENUE LEWISTON, ID 83501
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(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
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R 000

Initial Comments

The following deficiencies were cited during the follow-up survey to a complaint investigation conducted between February 03, 2014 and February 04, 2014 at your residential care/assisted living facility. The surveyors conducting the survey were:

Karen Anderson, RN
Team Leader
Health Facility Surveyor

Maureen McCann, RN
Health Facility Surveyor

Survey Definitions:

@ = at
NSA = Negotiated Service Agreement
rm = room
RN = Registered Nurse

(R 006)

16.03.22.510 Protect Residents from Abuse.

The administrator must assure that policies and procedures are implemented to assure that all residents are free from abuse.

This Rule is not met as evidenced by:
Based on observation, interview and record review it was determined the facility failed to protect 1 of 6 sampled Residents (#1) from sexual abuse. This failure resulted in a repeat deficiency of not protecting a resident after an allegation of abuse was made known.

Licensing and Certification conducted a complaint investigation at the facility between 10/21/13 and

R 000

(R 006)

Bureau of Facility Standards

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

TITLE

(X6) DATE

[Signature]

Executive Director

3-4-14

STATE FORM

6552

YHEG12

If continuation sheet 1 of 9



Wedgewood Terrace
 2114 Vineyard Avenue
 Lewiston, Idaho 83501
 Phone: 208-743-4545
 Fax: 208-743-2268

To: Karen Anderson. From: Jerry Bowlin.
 Fax: 208-364-1888 Date: ~~3~~ '4-7-14.
 Phone: _____ Pages: _____
 Re: _____ CC: _____

- Urgent For Review Please Comment Please Reply Please Recycle

Comments:

Karen.

Here is a copy of the plan of correction.

Thanks

Jerry.

Note: The information contained in this message may be privileged, confidential and protected from disclosure. If the reader of this message is not the intended recipient, or an employee or agent responsible for delivering this message to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this in error, please notify us immediately at 208-743-4545.

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{R 006}	<p>Continued From page 1</p> <p>10/22/13. At that time, the facility received a deficiency for the failure to protect several residents from sexual abuse.</p> <p>The facility submitted a plan of correction in response to the deficiency they received on 10/22/13 survey. This plan included staff were to report allegations of abuse to the administrator and facility nurse, who would then report the allegations to the appropriate authorities. Further, the facility would assure protection to the victim such as providing 1:1 care.</p> <p>Between 2/3/14 and 2/4/14, a follow-up survey, was conducted. The findings include:</p> <p>Idaho Statute 39-5303 requires that a residential care facility serving vulnerable adults, must immediately report information to the Idaho Commission on Aging (Adult Protection/APS) when there is reasonable cause to believe that a resident had been abused.</p> <p>IDAPA 16.03.22.153.01 documents, "The facility must develop policies and procedures to assure that allegations of abuse, neglect and exploitation are identified, reported, investigated, followed-up with interventions to prevent reoccurrence and assure protection, and documented."</p> <p>IDAPA 16.03.22.520 documents, "The administrator must assure that policies and procedures are implemented to ensure that all residents are free from abuse."</p> <p>The facility's Abuse Policy, was reviewed on 2/4/14, and documented if an employee witnessed or had knowledge of abuse, they were required to immediately report it to their supervisor. The policy further documented, the</p>	{R 006}	<p>State of Disclaimer Preparation and/or execution of this plan of correction does not constitute the providers admission of or agreement with the facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared and executed solely because it is required by the provision of Idaho State law.</p> <p>Corrective actions for this specific incident are ensuring RN reports any allegations of abuse/neglect to Adult Protection and facility administrator so a formal investigation can be completed and to ensure interventions to protect residents are put into place. Also, a nurse consultant will be assisting in identifying and implementing appropriate corrections.</p> <p>In order to identify other residents/personnel/ areas that may be affected by the same deficient practice there will be proper reporting done by caregivers who observe such behaviors. The RN and/or facility administrator will then properly report to adult protection/correct agencies and corrective interventions will be implemented to ensure said resident(s) are free from abuse to self and others. NSA will be updated accordingly and personnel will be notified of changes that need to be made immediately. Provide one on one care 24 hours a day. If deemed necessary, said resident(s) will be given an immediate discharge notice/30 day notice and assistance will be provided to find different placement.</p> <p>Measures that are being put into place that will ensure the deficient practice does not recur:</p> <ul style="list-style-type: none"> - Extensive training was provided by Richard from Adult Protection in December; this training will be mandatory for all employees every six months and as deemed necessary. The administrator is working on setting up another training session that will take place by April 1, 2014 - Facility RN is completing daily chart audits to monitor for any inappropriate behaviors that may have been documented on, but not reported to the correct authority of further investigated by RN and/or administrator. 	

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{R 006}	Continued From page 2 administrator was to then report the incident to the proper authorities immediately. 1. According to her record, Resident #1 was an 80 year-old female, admitted to the facility's memory unit, on 7/10/13, with a diagnosis of dementia. Resident #1's NSA, dated 7/9/13, documented she was "excessively worried" at times, but usually the resident was "Pleasant, cooperative, and friendly." A progress note, dated 1/17/14 at 2:30 PM, documented Resident #1 rang her call light. When a caregiver went to answer her call light, Resident #1 told the caregiver that "something felt wrong." The progress noted further documented, Resident #1 told the caregiver she was "raped." The progress note documented, the caregiver notified the RN of the allegation. The caregiver documented she would continue to monitor the resident. A progress note, dated 1/23/14 at 8:00 AM, documented the RN notified the resident's family member and her physician of the resident receiving a skin tear. The progress note, further documented Resident #1 told the RN, the skin tear was caused when "A big man came in and was hitting me." There was no documentation the allegation of rape had been reported to Adult Protection. Further, there was no documentation the administrator was informed of Resident #1's allegation of being raped or physically abused so that an investigation could be conducted. On 2/3/14 and 2/4/14, Resident #1 was observed	{R 006}	- Employees will undergo training on how to properly document behaviors - The administrator will follow policies and procedures to identify, investigate and communicate to the commission on Aging Adult Protection any time the facility has reasonable cause to suspect abuse. The corrective actions will be monitored by all staff filling out work sheets for their shift, including behaviors. These will be turned in to the RN at the end of each shift. The RN will audit these worksheets daily and will report all behaviors to the administrator and proper authorities as deemed necessary. RN will continue to monitor all charts daily to ensure proper charting. RN will do inspections periodically on all shifts to ensure staff is doing their job properly. All employees are aware that they are mandated to report any suspicion of neglect/abuse. This will be reinforced by the training of the facility's current abuse policy and the training that has and will be done by Adult Protection every six months and/or as needed. All corrected actions will be put in place prior to April 1, 2014.	

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{R 006}	<p>Continued From page 3</p> <p>in the memory unit, ambulating independently and talking and interacting with other residents. The resident stated caregivers were good to her and helped her when she requested help.</p> <p>On 2/4/14 at 10:00 AM, the RN stated she interviewed Resident #1 about her statement of being raped. The RN stated, the resident was not able to remember the incident or that she had even said it. The RN stated, she also interviewed caregivers about Resident #1's allegation of rape. She said after interviewing the resident and the caregivers, she had ruled out "sexual abuse" and did not think it needed to be reported to Adult Protection. The RN further stated, she had not documented her investigation or informed the administrator about the allegation because she thought it was a behavior.</p> <p>On 2/4/14 at 10:10 AM, the administrator stated she was not aware Resident #1 had reported to a caregiver that she had been raped. Further, the administrator stated the RN did not inform her of the allegation of rape or that the RN had conducted her own investigation. She stated, the RN did not inform her when Resident #1 stated she was assaulted by a large man. The administrator stated, all staff had been trained to report any allegation of abuse to Adult Protection and to her. The administrator stated staff did not follow the facility's abuse policy when Adult Protection was not notified after an allegation of sexual abuse and an allegation of physical assault were made known.</p> <p>From 1/17/14 until 2/4/14, the facility failed to protect Resident #1 from potential sexual and physical abuse by not identifying, reporting, investigating and ensuring interventions to protect the residents were put in place.</p>	{R 006}		

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R 008	<p>Continued From page 5</p> <p>as needed.</p> <p>Between 2/3/14 and 2/4/14, a follow-up survey, was conducted. The findings include:</p> <p>According to IDAPA 16.03.22.152.05.e, a resident will not be admitted or retained who is violent or a danger to himself or others.</p> <p>1. According to her records, Resident #3, was an 89 year-old female, admitted to the facility on 6/25/07, with a diagnosis of Alzheimer's type dementia. Resident #3 no longer resided in the facility at the time of the survey and was not available for observation or interview.</p> <p>An NSA, dated 11/2013, documented the resident could "have periods of anxiety and resistance to cares... She can get more agitated the more staff attempts to calm her down. When this happens, walk away and allow her to calm down." There was no further documentation regarding the resident's behaviors or how the resident displayed, "anxiety," "resistive to cares" or "agitation." The NSA had not been updated to reflect the resident's aggressive behaviors as outlined in the facility's plan of correction.</p> <p>The following progress notes were found in Resident #3's record:</p> <p>*12/4/13 at 5:45 AM, Resident #3 "hit" another resident on the arm and was yelling at the other resident.</p> <p>*12/13/13 at 2:15. Resident #3 "hit" a female resident "in mouth with closed fist."</p> <p>1/17/14 at 9:00 PM. The resident was "very resistive to being changed. Took 2 staff to</p>	R 008	<p>The corrective action for this incident has been taken care of as stated above; resident #3 no longer resides in the facility. The corrective actions will be monitored by all staff filling out work sheets for their shift, including behaviors. These will be turned in to the RN at the end of each shift. The RN will audit these worksheets daily and will report all behaviors to the administrator and proper authorities as deemed necessary. RN will continue to monitor all charts daily to ensure proper charting. RN will do inspections periodically on all shifts to ensure staff is doing their job properly.</p> <p>All corrected actions will be put in place prior to April 1, 2014.</p>	
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R 008	Continued From page 6 change" her clothing and she "hit staff numerous times." *1/21/14 at 9:30 AM. Resident #3 displayed increased behaviors and "hit" staff. *1/21/14 at 8:00 PM. The resident was "very agltated @ dinner...Wandered around the dining rm and started getting aggressive towards other" residents. *1/22/14 at 5:00 PM, Resident #3 hit another resident "repeatedly in the head." *1/22/14 at 8:00 PM. Resident #3 "was found on floor bleeding from the nose and complaining of pain" on her right side. *1/23/14 at 4:00 PM. The facility received a call from the emergency department. Resident #3 had been diagnosed with a fractured nose and fractured hip. On 2/4/14 at 9:03 AM, the facility nurse stated Resident #3 and another resident were found in the other resident's room on 1/22/14. She stated, Resident #3 was on the floor "bleeding from the nose and complaining of pain." On 2/4/14 at 10:30 AM, the administrator and facility nurse stated they did not know how Resident #3 sustained her injuries. They confirmed a thorough investigation had not been completed regarding the two incidents Resident #3 was involved in on 1/22/14. A "Behavior/mood symptom monitoring record," found in Resident #3's record, documented the following behavior occurrences:	R 008			

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R 008	<p>Continued From page 7</p> <ul style="list-style-type: none"> *12/4/13 "Hitting and yelling." *12/9/13 Resistive to cares. *12/13/13 "Hitting another [resident]." *12/16/13 "Hitting staff." *12/26/13 "Slapping @ staff, yelling." *1/8/14 "Very resistive to shower yelling, hitting." *1/10/14 "Threw meds on floor." *1/19/14 Resistive to cares. *1/21/14 at 9:00 AM. "Hitting" resisting cares. *1/21/14 at 6:00 PM. "Aggressive towards staff and [residents]." *1/22/14 "Hitting other [resident]." <p>There was no further documentation which explained what was meant by "aggressive" or "resistive" to cares.</p> <p>Further, there was no documentation the facility had followed the plan of correction they had submltted to Licensing and Certification regarding bi-weekly chart monitoring or other interventions to ensure an aggressive resident was not retained by the facility.</p> <p>On 2/4/14 at 10:30 AM, the above documentation was reviewed with the facility administrator and nurse. They confirmed Resident #3 had been verbally and physically aggressive toward other residents and staff. They further confirmed Resident #3 was retained by the facility despite</p>	R 008		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R588	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 02/04/2014
NAME OF PROVIDER OR SUPPLIER WEDGEWOOD TERRACE, PROVIDENT FOUND			STREET ADDRESS, CITY, STATE, ZIP CODE 2114 VINEYARD AVENUE LEWISTON, ID 83501		
(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 008	Continued From page 8 her aggressive behaviors. The facility failed to implement their plan of correction. They retained Resident #3 for forty-five days while she was being aggressive towards residents and staff, and failed to implement their plan of correction including updating NSAs, providing 1:1 care and issuing a discharge notice. THIS IS A REPEAT CORE DEFICIENCY. During a follow-up survey completed on 2/4/13, it was determined the facility failed to correct the deficiencies they received on 10/22/13. The facility received repeat core deficiencies when they failed to protect resident #1 and potentially 100% of the residents from abuse and retained Resident #3, who was a danger to others.	R 008			