



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 22, 2014

Kara Reese, Administrator  
Carefix-Safe Haven's Mount Vernon/monticello  
3620 Potomac Way  
Idaho Falls, Idaho 83404

License #: RC-1034

Ms. Reese:

On March 20, 2014, a follow-up/revisit to the initial state licensure survey and complaint investigation of 6/27/2013 was conducted at Carefix Management & Consulting dba Safe Haven's Mount Vernon/monticello. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level(s):

- Non-core issues, which are described on the Punch List, and for which you have submitted evidence of resolution.

Your submitted evidence of resolution 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 Maureen McCann, RN, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 364-1962.

Sincerely,

MAUREEN MCCANN, RN  
Team Leader  
Health Facility Surveyor

MM/sc

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



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April 1, 2014

Kara Reese, Administrator  
Carefix-Safe Haven's Mount Vernon/monticello  
3620 Potomac Way  
Idaho Falls, Idaho 83404

Provider ID: RC-1034

Ms. Reese:

A follow-up/revisit to the initial state licensure survey of June 27, 2013 and a complaint investigation were conducted at Carefix-Safe Haven's Mount Vernon/monticello between March 17, 2014 and March 20, 2014. The facility was found to be in substantial compliance with the rules for Residential Care or Assisted Living Facilities in Idaho. No core issue deficiencies were identified.

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 **March 20, 2014**. 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.

Our staff is available to answer questions and to assist you in identifying appropriate corrections. Should you require assistance or have any questions about our visit, please contact us at (208) 364-1962. Thank you for your continued participation in the Idaho Residential Care Assisted Living Facility program.

Sincerely,

MAUREEN MCCANN, RN  
Health Facility Surveyor  
Residential Assisted Living Facility Program

MM/sc



Facility Safe Haven's Mount Vernon/Monticello	License # RC-1034	Physical Address 3620 Potomac Wy	Phone Number (208) 528-0467
Administrator Kara Reese	City Idaho Falls	ZIP Code 83404	Survey Date March 20, 2014
Survey Team Leader Maureen McCann, RN	Survey Type Complaint Investigation and Follow-up	RESPONSE DUE: April 19, 2014	
Administrator Signature 	Date Signed 3-20-14		

**NON-CORE ISSUES**

Item #	IDAPA Rule #	Description	Department Use Only	
			EOR Accepted	Initials
1	210	The facility did not provide an on-going activity program that encouraged and promoted Residents to maintain and develop their highest potential. ****Previously cited on 6/27/2013****	4/21/14	MM
2	305.03	The facility RN did not assess changes of conditions such as: When Resident #1's anti-diarrhea medication was discontinued and the resident experienced diarrhea for several days. When Resident #10 experienced diarrhea between 3/5/14 - 3/10/14. Bi-weekly assessments of Resident #3's and #6's wounds. Resident #10's swollen feet, trouble walking and knee pain and a follow-up on Resident #4's fractured shoulder. ****Previously cited on 6/27/2013****	4/21/14	MM
3	305.04	The facility RN did not make recommendations such as: Skin breakdown interventions for Resident #3's and #6's wounds. Resident #1's and #10's diarrhea. ****Previously cited on 6/27/13****	4/21/14	MM
4	310.03	Resident #2's and #4's substance control tracking sheets were not accurate. ****Previously cited on 6/27/13****	4/21/14	MM
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April 1, 2014

Kara Reese, Administrator  
Carefix-Safe Haven's Mount Vernon/monticello  
3620 Potomac Way  
Idaho Falls, Idaho 83404

Dear Ms. Reese:

An unannounced, on-site complaint investigation survey was conducted at Carefix Management & Consulting DbA Safe Haven's Mount Vernon/monticello between March 17, 2014 and March 20, 2014. During that time, observations, interviews or record reviews were conducted with the following results:

**Complaint # ID00006424**

**Allegation #1:** The facility did not assist residents with their medications per physicians' orders.

**Findings:** Between 3/17/14 and 3/20/14, ten residents' records including their physicians' orders, and their medication assistance records (MARs) were reviewed. During the survey and complaint investigation, observations were made of 5 medication aides assisting resident with their medications, during this process, no medication concerns were identified. Interviews were conducted with caregivers, house managers, the administrator, the facility nurse, and the director of nursing for a home health agency, regarding the system the facility used to monitor and assist residents with their medications.

An identified resident was admitted to the facility on 2/11/14, and left the facility to live independently on 2/21/14.

Physician orders, dated 2/5/14 through 2/19/14, were contained in the resident's closed record.

The MAR, dated 2/11/14 through 2/21/14, documented the resident was assisted with medications as ordered.

There was documentation of a complaint in the identified resident's closed record, pertaining to the resident not having medications available as ordered by her physician.

The administrator's response to the complainant, dated 2/19/14, documented, "(###) moved in with only 2 doctor's orders. She brought many other medications with her, some OTC, and I explained to her multiple

Kara Reese, Administrator

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times that we had to have doctor's orders." The administrator further stated, "Over the 11 days she was at the facility, we received multiple orders and added all of them to the MAR. The nurse delegated, bubble packed as appropriate."

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

Allegation #2: The facility did not provide activities for residents per state rules.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.210 when the facility did not provide an on-going activity program that encouraged and promoted residents to maintain and develop their highest potential. The facility was required to submit evidence of resolution within 30 days.

Allegation #3: The facility did not provide supervision to confused residents.

Findings: Between 3/17/14 and 3/20/14, observations were made of both buildings. There was a total of 29 residents residing in the facility.

Interviews were conducted with residents between 3/17/14 and 3/19/14. Ten interviewable residents stated caregivers had been able to supervise confused residents and meet their needs.

The staff schedule, dated December 2013 through March 20, 2014, was reviewed.. The schedule documented the facility had 2 caregivers in each building for the day and evening shifts; the night shift had 1 caregiver in each building. A third caregiver was hired for night shift, to float between buildings, depending on residents' needs.

Between 3/17/14 and 3/19/14, interviews were conducted with 8 caregivers, 2 house managers and the administrator. The caregivers, the house managers and the administrator stated having an extra caregiver on duty, who was able to float between buildings, helped provide additional care and supervision for residents in both buildings.

Incident and accident reports were reviewed from 12/18/13 through 3/18/14. There was no documented evidence the facility had any other incidents related to residents who were confused and not provided adequate supervision.

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

Allegation #4: The facility's administrator did not address a resident's concerns regarding being woke up during the night shift.

Findings: Substantiated. However, the facility was not cited as they acted appropriately by implementing frequent night checks for newly admitted residents, after a resident eloped during the early hours of the morning.

On 3/17/14 through 3/20/14, interviews were conducted with caregivers and the house managers. They stated after a former resident eloped from the facility during the night shift, the administrator instructed

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caregivers to visually check on newly admitted residents and confused residents throughout the night shift.

On 3/19/14 at 9:27 AM, the administrator stated a resident was admitted to the facility on 2/11/14, just days after another resident had eloped. She stated the facility implemented nightly checks on newly admitted residents or confused residents as a preventive measure, to ensure all residents were accounted for. The administrator stated she received a complaint on 2/12/14, from a resident when caregivers woke her up several times during the night shift. The administrator stated she documented the complaint and had provided the resident with a written response explaining the reason for all the checks and why they were being done.

Allegation #5: The facility lost residents' personal laundry.

Findings: Substantiated. However, the facility was not cited as they acted appropriately by staff members actively helping to locate the residents' personal laundry, and returning their clean laundry to them as soon as possible.

Allegation #6: The facility frequently ran out of hot water for showers during the evening hours.

Findings: On 3/17/14 at 2:30 PM, a tour was conducted of the facility's buildings. Twelve residents stated they had not experienced running out of hot water during their showers.

Between 3/17/14 and 3/20/14, hot water temperatures were taken at various times in both buildings and the hot water was maintained between 105 degrees and 120 degrees Fahrenheit.

There was no documentation found in the complaint log that residents had complained of not having hot water for showers during the evening hours.

On 3/18/14 at 2:45 PM, an interview was conducted with the corporate fire life safety manager. She stated hot waters temperatures were routinely monitor to maintain compliance with the assisted living rules.

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

Allegation #7: The facility did not thoroughly remove offensive odors from residents' rooms between when one resident left and another resident occupied the room.

Findings: Between 3/17/14 and 3/20/14, observations were made of both buildings. Every resident room, including all empty rooms, were inspected for cleanliness. During the survey, observations were made of staff vacuuming, steam cleaning carpets, cleaning bathrooms and emptying trash cans throughout out the day.

Interviews were conducted with residents on 3/17/14 and 3/18/14. Ten interviewable residents, stated when they moved into the facility their rooms had been cleaned and were odor free.

A random resident, who resided in the identified room, stated when he moved in to the facility, his room was very clean and odor free. There was an empty room across the hall from the identified room. The room was inspected and was found to be clean and odor free.

Kara Reese, Administrator

April 1, 2014

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Between 3/17/14 and 3/19/14, interviews were conducted with 8 caregivers and 2 house managers. They stated all rooms were cleaned prior to new admissions.

On 3/19/14 at 9:45 AM, the administrator stated when residents move out of the facility, the room would be cleaned, painted and repairs would be made before another resident occupied the room.

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

Allegation #8: The facility night shift staff were loud when completing their tasks, which frequently woke up residents.

Findings: Substantiated. However, the facility was not cited as they acted appropriately by identifying the problem and changing cleaning assignments for each shift.

On 3/19/14 at 9:25 AM, the administrator stated the night shift were responsible to perform tasks that could be completed in a quiet fashion such as, deep clean living areas, folding laundry, dusting living areas, wiping down door frames or cleaning windows that were away from the residents' rooms. The administrator stated there was a time when she received a complaint that the night shift caregivers were noisy while working in the kitchen. She stated when caregivers opened and closed the cabinet doors, the noise would keep the resident awake because the resident's room shared the same wall as the cabinets. She stated the resident was given the option to move to a room across the hallway. Further, the administrator stated she spoke to the night shift about the situation and explained that she expected them to work quietly so that they would not disturb the sleeping residents.

If you have questions or concerns regarding our visit, please call us at (208) 364-1962. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,



MAUREEN MCCANN, RN  
Health Facility Surveyor  
Residential Assisted Living Facility Program

MM/sc

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