



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

June 17, 2013

Owen Snead, Administrator
Bridge Assisted Living At Sandpoint, Sandpoint Med
1123 North Division Street
Sandpoint, ID 83864

License #: RC-610

Dear Mr. Snead:

On May 2, 2013, a Follow-Up survey was conducted at Bridge Assisted Living At Sandpoint, Sandpoint Medical Investors. 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.

Your submitted plan of correction and evidence of resolution are 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 no recur.

Thank you for your work to correct these deficiencies. Should you have questions, please contact Donna Henscheid, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 334-6626.

Sincerely,

Donna Henscheid
Team Leader
Health Facility Surveyor

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



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May 17, 2013

CERTIFIED MAIL #: 7012 1010 0002 0836 0515

Owen Snead, Administrator
Bridge Assisted Living at Sandpoint
1123 North Division Street
Sandpoint, ID 83864

Dear Mr. Snead:

Based on the follow-up/revisit, state licensure survey conducted by our staff at Bridge Assisted Living at Sandpoint, Sandpoint Medical Investors, on May 2, 2013, we have determined that while the facility corrected the previous core deficiencies for failure to maintain a licensed administrator and failure to protect residents from inadequate care, the facility failed to protect residents from abuse.

This core issue deficiency substantially limits the capacity of Bridge Assisted Living at Sandpoint, Sandpoint Medical Investors, 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.

As a result of the survey findings, the Department is issuing the facility a provisional license, effective May 20, 2013 through November 20, 2013. The following administrative rule for Residential Care or Assisted Living Facilities in Idaho (IDAPA 16.03.22) give 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 noncore 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 of the provisional license are as follows:

- 1. The facility will correct all core and non-core deficiencies and implement a quality assurance system to ensure they remain corrected.**
- 2. A provisional license is issued which is to be prominently displayed in the facility. Upon receipt of this provisional license return the full license, currently held by the facility.**
- 3. The administrator will notify the Department when the facility is in full compliance and systems to ensure ongoing compliance are functioning.**

Please be advised that you may contest this decision by filing a written request for administrative review pursuant to IDAPA 16.05.03.300. **no later than twenty-eight (28) days after this notice was mailed.** Any such request should be addressed to:

**Tamara Prisock, Administrator
Licensing and Certification
Department of Health and Welfare
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009**

If you fail to file a request for administrative review within the time allowed, this decision shall become final.

You have an opportunity to make corrections and thus avoid further enforcement action. Correction of this deficiency must be achieved by **June 16, 2013**. **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)?
- ◆ By what date will the corrective action(s) be completed?

Return the **signed** and **dated** Plan of Correction to us within 10 days of receipt of this letter, and keep a copy for your records. Your license depends upon the corrections made and the evaluation of the Plan of Correction you 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 nine (9) non-core issue deficiencies were identified on the punch list and six (6) were identified as repeat punches. Civil monetary penalties will be imposed if any of these six repeat punches are found out of compliance on a subsequent survey.

Owen Snead
May 17, 2013
Page 3 of 3

As explained during the exit conference, the completed punch list form and accompanying evidence of resolution (e.g., receipts, photographs, policy updates, etc.) needs to be submitted to our office no later than **June 1, 2013**.

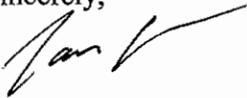
If, at the follow-up survey, it is found that the facility is not in compliance with the rules and standards for residential care or assisted living facilities in Idaho, the Department will have no alternative but to initiate an enforcement action against the license held by Bridge Assisted Living at Sandpoint, Sandpoint Medical Investors.

Enforcement actions may include:

- limitation on admission to the facility;
- requirement that the facility hire a consultant who submits periodic reports to Licensing and Certification
- imposition of civil monetary penalties;

Our staff is available to answer questions and to assist you in identifying appropriate corrections to avoid further enforcement actions. Should you have any questions, or if we may be of assistance, please contact us at (208) 334-6626 and ask for the Residential Assisted Living Facility program. Thank you for your continued participation in the Idaho Residential Care Assisted Living Facility program.

Sincerely,



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

DH/ftp

Bureau of Facility Standards

RECEIVED
JUN - 3 2013
By RALF

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R610	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 05/02/2013
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NAME OF PROVIDER OR SUPPLIER BRIDGE ASSISTED LIVING AT SANDPOINT, SA	STREET ADDRESS, CITY, STATE, ZIP CODE 1123 NORTH DIVISION STREET SANDPOINT, ID 83864
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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}	<p>Initial Comments</p> <p>The following deficiency was cited during the follow-up survey conducted on 5/2/2013 at your residential care/assisted living facility. The surveyors conducting the survey were:</p> <p>Donna Henscheid, LSW Team Leader Health Facility Surveyor</p> <p>Rae Jean McPhillips, RN Health Facility Surveyor</p> <p>Survey Definitions: RN = Registered Nurse w/ = with</p>	{R 000}	<p><i>Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law.</i></p> <p>16.03.22.510 Protect Residents from Abuse</p> <p>With Respect to the Specific Residents Cited:</p>	
R 006	<p>16.03.22.510 Protect Residents from Abuse.</p> <p>The administrator must assure that policies and procedures are implemented to assure that all residents are free from abuse.</p> <p>This Rule is not met as evidenced by: Based on record review and interview, it was determined the facility failed to implement policies and procedures to protect 2 of 2 sampled Residents (#4 & #8) and potentially 100% of the residents from the possibility of abuse. The findings include:</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>IDAPA 16.03.22.010.01 documents, "Abuse. The</p>	R 006	<p>Residents #4, #8 and their responsible parties were informed of the response plan. The employee was scheduled for 1:1 review of regulatory resident rights, the employee handbook resident rights review with signature acknowledgement of understanding. The employee is scheduled to work on the day or evening shift to receive more supervision. The employee is scheduled to make a presentation to the resident care team on Abuse Prevention and resident rights enforcement. Review of the Abuse Prevention Policy was conducted with the Resident Care Director and Administrator.</p>	

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE
Administrator

(X6) DATE
5/30/13

Bureau of Facility Standards

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R 006	<p>Continued From page 1</p> <p>non-accidental act of sexual, physical, or mental mistreatment, or injury of a resident through the action or inaction of another individual."</p> <p>The facility's "Resident Protection and Abuse Prohibition" policy, dated 11/10/10, documented that "Immediate action will be taken to investigate any alleged resident neglect, mistreatment, misappropriation of funds, and/or physical, verbal, sexual, emotional/psychological abuse....General Manager and/or Resident Care Director investigate promptly, confidentially and thoroughly via private interviews with residents, witness and staff...."</p> <p>Resident #4, an 89 year-old female, was admitted to the facility on 10/3/12 with a diagnosis of dementia.</p> <p>Resident #8, an 88 year-old female, was admitted to the facility on 4/4/2011 with diagnoses including diabetes and hip repair.</p> <p>The general manager documented the following on two "Grievance/Concern" forms:</p> <p>*Resident #8's allegation - On 2/27/13 at 9:30 PM, the resident's "complaint" was that Resident #8 was treated in a "rough, unkind manner." The caregiver "threw" the resident's feet into the bed and after being told the resident's "legs were bad," the caregiver responded, "well my back hurts." The "resolution" to the allegation was to speak with the resident and inform the resident that the caregiver would be counseled prior to starting her next shift.</p> <p>*Resident #4's allegation - On 2/27/13 at 4:30 AM - "It was brought to my attention this morning in 'stand up' that [caregiver's name] has been</p>	R 006	<p>The Administrator met with Resident #4 #8 and their responsible parties to ensure residents/responsible parties were free from complaints or issues related to abuse.</p> <p>With Respect to How the Facility will Identify Residents with the Potential for the Identified Concern and Take Corrective Action:</p> <p>A Resident Council meeting has been scheduled to review the community's enforcement of resident rights, abuse prevention and communication and follow up by the Administrator and Resident Care Director. The Local Ombudsman was contacted to request staff and resident training on resident rights and abuse prevention. Incident Reports will document allegation of complaints. The resident record will reflect the complaint follow up and notification of responsible party, healthcare provider, Resident Care Director, Administrator and regulatory agency. Documented counseling was conducted with the</p>	

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R 006	<p>Continued From page 2</p> <p>charged w/treating [Resident #4's name] in a rough and uncaring manner." The "resolution" to the allegation was to speak with the caregiver prior to starting her shift and to give the caregiver "her second written notice" and to speak with Resident #4's family member. The family member said the caregiver failed to give "adequate assistance" to Resident #4, was "insensitive and rough in her care over a 3 day period." The family member stated he felt the issue had been resolved.</p> <p>Both allegations identified the same caregiver on the same day. The caregiver was described as "rough, unkind, insensitive and uncaring." There was no documentation that Adult Protective Services was called or that a thorough investigation was completed to include interviews with other staff, witnesses or residents. Further, there was no documentation the caregiver was prevented from working with residents to protect them from potential abuse until the investigation was completed.</p> <p>A corrective action form, signed and dated by the caregiver and RN on 3/1/13 (three days after the allegation occurred), documented the caregiver had been informed Residents' Rights had been violated because of "lack of hospitality." The "Associate's Comment" section documented, "Thank you for advising me of the situation."</p> <p>On 5/2/13 between 12:27 PM and 3:13 PM the following interviews were conducted:</p> <p>On 5/2/13 at 12:27 PM, the administrator confirmed she had not contacted Adult Protective Services. The administrator stated she did not conduct an investigation because the allegation was brought to the general manager and he did</p>	R 006	<p>Administrator and Resident Care Director to review communication and required reporting expectations. The Resident Care Director and Administrator will review Incident Reports during Daily Stand up, including documentation and communication of regulatory required reporting. The Administrator or Resident Care Director will document and ensure required reporting compliance within twenty-four hours of the occurrence. Future allegations of abuse will result in employee "suspension" until and investigation and conclusion has been conducted and communicated to the Administrator, resident, responsible party and regulatory agency.</p> <p>With Respect to What Systemic Measures have been put in place to Address the Stated Concern:</p> <p>In-service training has been scheduled for community associates to review resident rights, abuse prevention, communication, follow up expectations and the community Abuse Prevention Policy. A calendar and Agenda outline for Resident</p>	

Bureau of Facility Standards

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R 006	<p>Continued From page 3</p> <p>the investigation.</p> <p>On 5/2/13 at 12:47 PM, a caregiver stated a resident had told him that a night shift employee had put her to bed "roughly." The caregiver stated he told the RN.</p> <p>On 5/2/13 at 12:51 PM, the RN stated she and the general manager met with the caregiver. She stated she did not feel the resident was "really being abused." She stated, she had spoken to other staff members, but had not documented the interviews because the staff had no concerns. Further, she stated, the caregiver was never removed from the schedule and continued to work at the facility.</p> <p>On 5/2/13 at 3:13 PM, the general manager stated the two allegations occurred on the same day and were brought to his attention by the RN at a meeting. He stated, they had talked to the caregiver and told her it was her second warning. Further he stated, Adult Protection was not called because "it wasn't alarming."</p> <p>The facility failed to report allegations of abuse to Adult Protection, failed to conduct a thorough investigation and failed to protect residents from the potential of abuse by allowing the staff member to continue working with residents. These failures led to abuse.</p>	R 006	<p>Council meetings has been established, to include review or Resident Rights and Abuse Prevention during each meeting.</p> <p>With Respect to How the Plan of Corrective Measures will be Monitored:</p> <p>The Resident Care Director will provide a summary of Incidents and resident complaints with resolution during weekly meetings with the Administrator.</p> <p>Date the corrective action will be completed:</p> <p>This will be completed by June 14, 2013.</p>	



Facility Name Bridge Assisted Living at Sandpoint	Physical Address 1123 N. Division St.	Phone Number 208-263-1524
Administrator Rosemary Ann Dutson-Sater	City Sandpoint	Zip Code 83864
Team Leader Donna Henscheid	Survey Type Follow-up	Survey Date 05/02/13

NON-CORE ISSUES

Item #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	L&C USE
1	220.02	The facility had not implemented the admission agreements which reflected the correction required from a survey conducted on 1/30/13. ***Previously cited on 1/30/13***	5/6/13 <i>Copies attached</i>	
2	225.01	The facility did not evaluate Resident #3's behaviors, such as her refusals of cares and aggression towards staffs when they attempted to provides cares. ***Previously cited on 1/30/13***	5/3/13	
3	225.02	The facility did not develop interventions for Resident #3's behaviors. ***Previously cited on 1/30/13***	5/3/13	
4	320	Resident #5 and #8's records did not contain Negotiated Service Agreements.	COS 5/3/13 RH	
5	350.01	The facility's administrator was not notified of all incidents and accidents. ***Previously cited on 1/30/13***	5/3/13	
6	350.02	The administrator did not complete an investigation of incidents, accidents and complaints. ***Previously cited on 1/30/13***	5/20/13	
7	350.04	The administrator did not respond to complainants in writing within 30 days. ***Previously cited on 1/30/13***	5/8/13	
8	350.07	The facility did not report Resident #2's elopement to Licensing and Certification.	Reported 5/2/13	

Response Required Date 06/01/13	Signature of Facility Representative <i>Ann Dutson-Sater</i>	Date Signed 5/2/2013
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