



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 24, 2013

Cecilia Wilkerson, Administrator
Post Falls Ops Llc Dba: Guardian Angel Homes
1050 East Mullan
Post Falls, ID 83854

License #: RC-643

Dear Ms. Wilkerson:

On May 8, 2013, a State Licensure, Follow-up and Complaint Investigation survey was conducted at Post Falls Ops Llc, Dba-Guardian Angel Homes. As a result of that survey, deficient practices were found. The deficiencies were cited at the following levels:

- 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 Rae Jean McPhillips, RN, BSN, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 364-1962.

Sincerely,

Rae Jean McPhillips, RN, BSN
Team Leader
Health Facility Surveyor

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



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May 22, 2013

CERTIFIED MAIL #: 7007 3020 0001 4050 8050

Cecilia Wilkerson
Post Falls Ops LLC dba: Guardian Angel Homes
1050 East Mullan
Post Falls, ID 83854

Dear Ms. Wilkerson:

Based on the Complaint Investigation, State Licensure/follow-up survey conducted by our staff at Post Falls Ops LLC, dba-Guardian Angel Homes, between May 6, 2013 and May 8, 2013, we have determined that the facility failed to protect resident from sexual abuse, retained a resident who was a danger to others, and retained residents who either had a wound that was not improving bi-weekly or had pressure ulcers that were a Stage III or greater.

This core issue deficiency substantially limits the capacity of Post Falls Ops Llc, Dba-Guardian Angel Homes 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 **June 22, 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?

Cecilia Wilkerson

May 22, 2013

Page 2 of 2

Return the **signed** and **dated** Plan of Correction to us by **June 4, 2013**, 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 I 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 **June 7, 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 Post Falls Ops LLC, dba-Guardian Angel Homes.

Enforcement actions may include:

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

We received your letter of May 10, 2013. Please refer to the Frequently Asked Questions on our website at: www.assistedliving.dhw.idaho.gov for information that may apply.

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

RM/rm

PRINTED: 05/22/2013
FORM APPROVED

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R643	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/08/2013
NAME OF PROVIDER OR SUPPLIER POST FALLS OPS LLC, DBA-GUARDIAN ANGE		STREET ADDRESS, CITY, STATE, ZIP CODE 1070 EAST MULLAN AVENUE POST FALLS, ID 83854		
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R 000	<p>Initial Comments</p> <p>The following deficiencies were cited during the licensure and follow-up survey conducted May 6, 2013 through May 8, 2013 at your residential care/assisted living facility. The surveyors conducting the survey were:</p> <p>Rae Jean McPhillips, RN, BSN Team Leader Health Facility Surveyor</p> <p>Donna Henscheid, LSW Health Facility Surveyor</p> <p>Maureen McCann, RN Health Facility Surveyor</p> <p>Rachel Corey, RN, BSN Health Facility Surveyor</p> <p>Gloria Keathley, LSW Health Facility Surveyor</p> <p>Matt Hauser, GMRP Health Facility Surveyor</p> <p>Abbreviations used in the report:</p> <p>ABD = abdominal (a larger-type wound dressing) AP = Adult Protection BID = twice a day bm = bowel movement BMP = Behavior Management Plan Dr. = physician drs = dressing EMT = emergency medical technician ER = emergency room HA = hospice aid L = left LPN = Licensed Practical Nurse</p>	R 000		

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE Administrator (X6) DATE 5/28/13

STATE FORM

0499

YN7211

If continuation sheet 1 of 40

Bureau of Facility Standards

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Bureau of Facility Standards

TITLE

(X8) DATE

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

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R 000	Continued From page 1 meds = medication mm = millimeter MD = Physician NSA = Negotiated Service Agreement PRN = as needed RN = Registered Nurse UA = urine analysis & = and 2X = twice	R 000		
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, record review and interview it was determined the facility did not protect 2 of 11 sampled female residents (#6 and #12) from abuse. This had the potential to place 100% of the female population at risk for abuse. The findings include: The facility campus was comprised of 5 separate buildings. One building was a two-story building which was licensed for 62 residents. Four smaller single-story buildings were each licensed for 16 residents. At the time of the survey, there were 84 residents residing in the 5 buildings, 49 of which the facility identified as having dementia. Victims: 1. Resident #6 was a 63 year-old female, admitted to the facility on 9/1/12 with a diagnosis of dementia. The resident was non-verbal and did not write or have an alternate method to effectively communicate with staff or others.	R 006	R006 16.03.22.510 Protect Residents from Abuse. • Resident #16 was discharged from the facility on January 31st, 2013 due to sexual inappropriateness. • The facility nursing staff has received continued education on the updated facility policy regarding pre-screening potential residents, prior to the resident's admission to the facility. The facility nurse will review the potential resident's current History and Physical, recent nursing/progress notes if applicable, and interview family and/or appropriate personnel regarding a history of sexual inappropriateness, beginning May 30th 2013. If the potential resident has a positive history of sexual inappropriateness the resident will not be admitted to the facility.	

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R 006	<p>Continued From page 2</p> <p>Between 5/6/13 and 5/8/13, Resident #6 was observed three times. The resident was able to track the surveyor with her eyes, but did not respond verbally to any questions asked. Throughout each visit, the resident's face remained expressionless.</p> <p>2. Resident #12 was a 104 year-old female, admitted to the facility on 9/1/12 with a primary diagnosis of dementia.</p> <p>On 5/6/13, Resident #12 was observed to be a frail, thin female who was in a wheelchair. The resident answered yes or no questions, but did not engage in conversation with the surveyor.</p> <p>Perpetrator:</p> <p>Resident #16 was a 95 year-old male, admitted to the facility on 9/1/12 with a diagnosis of dementia.</p> <p>A history and physical, dated 5/17/12, documented the resident had "some aggressive behaviors both sexually and physically though better than before..."</p> <p>A behavior management plan, dated 9/1/12, documented the resident had "sexual inappropriateness" and would "enter female residents' rooms and solicit sexual favors, touches female residents in sexual manner." It further documented the resident required a 24 hour caregiver to be by his side at all times.</p> <p>The plan included the following two interventions to use to deal with his behaviors:</p> <p>1. "Staff will monitor resident when approaching female to assure that no contact is made, staff will redirect to different area or to his room"</p>	R 006	<ul style="list-style-type: none"> • All staff will undergo in-service and training regarding the facilities Treatment & Referral for Sexual Assault Victims, Consensual Sexual Relations & Prevention Policy, and Mandatory Reporting policies. Training will be completed during the 16 hours of orientation, upon hire, and periodically throughout their employment. A Mandatory Abuse Reporting easy reference flyer will be posted in each of the 5 homes on the facility campus in the medication rooms. • Continued education for all staff will provide for highly knowledgeable and competent employees. In the event that a sexually inappropriate behavior is reported an immediate internal investigation will started by the administrator or designee and Adult Protective Services will be notified. The administrator will notify the perpetrators family of the findings, if substantiated, will require the perpetrators family to immediately provide a 24 hour caregiver to remain with the resident until discharge. A 24 hour emergency discharge notice will be given to the resident and/or their responsible party. • A mandatory all staff meeting will be held on June 7th 2013, to review the Treatment & Referral for Sexual Assault Victims, Consensual Sexual Relations & Prevention Policy, and Mandatory Reporting policies. All new employees will review the above listed policies during their 16 hours of orientation, beginning June 1st 2013. <p>Attachment:</p> <ol style="list-style-type: none"> 1. Treatment & Referral for Sexual Assault Victims Policy 2. Consensual Sexual Relations & Prevention Policy 3. Mandatory Reporting Policy 4. Quick guide Mandatory Reporting flyer 	

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R 006	Continued From page 3 2. "Staff will monitor that resident does not enter any female residents' rooms alone, they will approach immediately and direct to common area or his room, staff will notify nurse immediately of any incidents. "Behavior Plan" notes documented the following: 9/16/12 at 6:25 AM - The resident was "up early and twice was found walking Resident #6 towards her room." Interventions #2 & #3 were attempted. (According to the behavior plan there was not a #3 intervention.) 9/20/12 at 10:04 PM - Staff found a female resident in his room and were "able to redirect with no behaviors." 9/22/12 at 9:03 AM - Resident was found 2 times leading another female resident by the hand to her room. Intervention #2 was "attempted." 9/22/12 at 2:15 PM - The resident "tried to go into Resident #6's room several times today" *9/24/12 - Resident #16 was found in Resident #6's room. Staff "attempted" interventions #2 & #3. *9/26/12 at 9:32 PM - Staff found Resident #16 in Resident #6's room and were able to redirect. *9/30/12 at 1:24 PM - Resident #16 was "caught making out" with Resident #6 and was "whispering" in another resident's ear. The caregiver "kept monitoring him after that and redirecting" him. *10/4/12 at 2:14 PM - The staff saw Resident #16	R 006		

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R 006	<p>Continued From page 4</p> <p>and Resident #6 walking towards her room early in the morning. The staff redirected the female resident back to her room and Resident #16 to the living room.</p> <p>*10/8/12 at 1:48 PM - Staff saw Resident #16 trying to get Resident #6 to go to her room with him. "Redirected them."</p> <p>*10/10/12 at 2:47 PM - Resident made sexual comments to staff in the morning. Intervention #2 was "attempted."</p> <p>A fax to the nurse practitioner (NP) from the staff, dated 1/10/13, documented, "Please address recent sexual aggression. May we consider medication to decrease his testosterone." The NP ordered an antidepressant and antipsychotic medications.</p> <p>"Behavior Plan" notes documented the following:</p> <p>*10/13/12 at 9:00 PM - Resident was trying to get into Resident #6's room. Intervention #3 was "attempted."</p> <p>*10/14/12 at 1:25 PM - Staff caught him kissing Resident #6 in the hallway.</p> <p>*10/16/12 at 9:06 PM - The staff found Resident #16 in Resident #6's room. The staff redirected him back to the living room.</p> <p>*10/20/12 at 8:48 PM - Resident #16 was trying to go into Resident #6's room and he was "redirected."</p> <p>*10/22/13 at 2:13 PM - Staff went to find Resident #16, but he was not in the living room or in his room. The caregiver checked Resident #6's room</p>	R 006		

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R 006	<p>Continued From page 5</p> <p>because of "previous behaviors" and found them "touching with clothes on." Resident #16 was told to "get out of her room" and Resident #6 was told to stay in her room.</p> <p>An NSA, dated 10/29/12, documented the resident was "sexually aggressive with female residents and staff and may be sexually inappropriate with other residents. Resident will be monitored at all times to assure he is in common area and not in female residents' rooms. If he approaches a female resident staff will intercede and redirect resident away. Staff will let resident know that touching or speaking in a sexual nature with anyone is not acceptable."</p> <p>"Behavior Plan" notes documented the following:</p> <p>*11/17/12 at 7:51 PM - Resident #16 was going up to female residents and "stroking their hair." Interventions #2 & #3 were "attempted."</p> <p>*11/27/12 at 1:46 PM - The resident was found in Resident #6's room trying to pull his pants down while she was sitting in the chair watching television. Intervention #2 was "attempted."</p> <p>*11/17/12 at 8:26 PM - The resident was trying to get another resident into an empty room, but the door was locked. Intervention #2 was "attempted."</p> <p>*12/9/12 at 10:13 PM - Resident #16 attempted to take another resident into a room. He tried to get into another two rooms with "his zipper down."</p> <p>An incident report, dated 1/4/13 at 7:15 PM, documented Resident #16 was told by a caregiver to stop pushing Resident #12 in her wheelchair. When the caregiver went upstairs</p>	R 006		

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R 006	<p>Continued From page 6</p> <p>and looked over the banister, Resident #16 had Resident #12 sitting in front of him with his hand up her shirt. The caregiver called out his name from upstairs and when she came downstairs, he stopped. The resident then approached another resident and was holding her hand and whispering in her ear. Again, the resident was told to stop. The report further documented, the resident was removed from the area and was separated from the female resident. (Unclear which female resident he was separated from) Staff were directed to call the administrator immediately if another sexual incident occurred. The report also documented, the resident did attempt to approach another female resident that same evening. The resident was placed on short-term monitoring to "accurately evaluate his behaviors and frequency of those behaviors."</p> <p>Nursing notes documented the following on 1/5/13:</p> <p>*An LPN spoke to the resident about his "alleged sexual aggression" towards female residents. The resident had "no recollection" of such incidents.</p> <p>*Adult Protective Services and the Ombudsman were notified of incident where the resident "fondled and pursued" two different female residents. A short-term monitor was put into place. All staff were educated to know his whereabouts at all times and instructed to lock all female residents' doors when they were laying down or in bed for the evening. (By locking the doors, the facility focused on the victims rather than the perpetrator's behavior.)</p> <p>A short-term monitoring note, dated 1/5/13 at</p>	R 006		

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R 006	<p>Continued From page 7</p> <p>8:46 PM, documented the "Resident stayed in the living room most of the night. Redirected him away from females all night long."</p> <p>A "Behavior Plan" note, dated 1/5/13 at 9:14 PM, documented Resident #16 wanted to talk or stand near "all female residents all night." Staff redirected several times and did not leave him alone with female residents.</p> <p>Short-term monitoring notes, documented the following:</p> <p>*1/6/12 at 8:42 PM - "Resident was redirected from female residents."</p> <p>*1/7/13 at 7:20 AM - "Bugging a couple of ladies just annoying them."</p> <p>An incident report, dated 1/8/13 at 8:05 AM, documented Resident #16 was "touching and bothering other residents. One resident asked him to leave her alone so he started to head back to his room." While watching him walk to his room, a caregiver saw him grab Resident #6's breast as she was walking by him. Staff "redirected" him and told him that it was not appropriate. The report documented, Resident #16, "smiled and did it again." Staff removed the female resident from the situation and returned Resident #16 to his room. The report further documented, "Then the same thing happened again except this time, he grabbed the same resident's groin area." The staff "redirected" him and he returned to the dining room table. The report documented, a short-term monitor was put into place to evaluate Resident #16's behaviors. The plan was to move the resident to a smaller building on 1/10/13 and to start two medications to reduce libido and testosterone.</p>	R 006		

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R 006	Continued From page 8 A nursing note, dated 1/8/13, documented the resident grabbed Resident #6's breast and groin. Staff were notified to continue to keep a very close eye on him at all times. AP was notified. A short-term monitoring note, dated 1/8/13 at 10:11 AM, documented, the resident was out in the dining room "touching and bothering" other residents. "One resident asked him to leave her alone so he headed back to his room." The resident then grabbed the breast and groin of Resident #6, who was walking down the hall. Staff redirected him and told him that "it was not okay and he smiled and did it again." Staff removed the other resident from the situation. A short-term monitoring note, date 1/9/13 at 2:05 PM, documented Resident #16 was in the great room with pants unbuttoned and unzipped...." A nursing note, dated 1/9/13, documented, the administrator talked to Resident #16's family regarding the resident's behaviors and the possibility of moving him into one of the facility's smaller buildings "so there would be more oversight..." A "Behavior Plan" note, dated 1/10/13 at 9:36 PM, documented the resident "needs to be on constant watch. He goes into other residents' rooms particular [sic] females. He tries to sit very close to female residents on couch and will follow female residents until redirected which only seems to work if you don't leave him alone for a second....He was very loud and crude at dinner which had the other male residents staring him down." A short-term monitoring note, dated 1/10/13 at	R 006		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R643	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/08/2013
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R 006	<p>Continued From page 9</p> <p>10:23 PM, documented the "Resident needs to be on constant watch, he goes into other residents' rooms particularly females. He tries to sit very close to female residents on couch and will follow female resident until redirected which only seems to work if you don't leave him alone for a second."</p> <p>A nursing note, dated 1/10/13, documented Resident #16 had been moved to one of the facility's smaller buildings at 11:00 AM.</p> <p>An NSA, dated 1/11/13, documented the resident was "sexually aggressive with female residents and staff and may be sexually inappropriate with other residents. Resident will be monitored at all times to assure he is in common area and not in female residents' rooms. If he approaches a female resident staff will intercede and redirect resident away. Staff will let resident know that touching or speaking in a sexual nature with anyone is not acceptable. Staff will watch for changes in behaviors and report them to administration immediately."</p> <p>"Behavior Plan" notes documented the following:</p> <p>*1/11/13 at 6:46 AM - "All female rooms had to remain locked once he got up this morning. He did not appreciate being redirected.</p> <p>*1/11/13 at 1:25 PM - "Wandered into one female's room this morning. Redirected him to picking out a movie and he happily complied...during movie started wandering a little bit...after lunch, he started wandering towards a female room...took him to his room."</p> <p>*1/12/13 at 4:20 AM - documented the "Resident was in the common area most of the night. No behaviors to report with all female resident doors</p>	R 006		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R643	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/08/2013
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R 006	Continued From page 10 locked and everyone in bed. He did wander a little bit and checked a few doors." A short-term monitoring note, dated 1/12/13 at 12:31 PM, documented the resident grabbed at caregiver's breast when being assisted with cares. "Behavior Plan" notes documented the following: *1/12/13 at 12:41 PM - "No behaviors with other residents, only grabbed at staff's chest when toileting/changing brief after lunch. Reminded him to be a gentleman and let him know we do not touch women there..." *1/14/13 at 9:16 PM - "Resident attempted to sneak a feel while staff was assisting him to get ready for his shower. Staff told him it was inappropriate behavior & he stopped trying to sneak a feel..." A short-term monitoring note, dated 1/15/13 at 10:42 PM, documented, the resident asked a female caregiver to "play with him" when giving him a shower. A "Behavior Plan" note, dated 1/18/13 at 9:58 AM, documented, "I was getting pants out of his closet while he was sitting on his bed getting a clean brief on. He stood up and came up behind me rubbing me and wrapping his arms around me....He kept trying to push me against his closet door and trying to rub me." The caregiver went to get a male caregiver to finish assisting the resident with dressing. When they got back to the resident's room, he was not there. Resident #16 was found in the dining room with his pants on, but unbuttoned, "getting a female resident to fondle him." The staff notified the administrator	R 006		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R643	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/08/2013
NAME OF PROVIDER OR SUPPLIER POST FALLS OPS LLC, DBA-GUARDIAN ANGE		STREET ADDRESS, CITY, STATE, ZIP CODE 1070 EAST MULLAN AVENUE POST FALLS, ID 83854		
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R 006	<p>Continued From page 11</p> <p>who "had another caregiver come over to do one to one cares" with him.</p> <p>An incident report, dated 1/19/13 at 7:40 PM, documented that Resident #16 and two other residents were sitting in the living room watching television. The caregiver heard the resident "mutter something" then heard a female resident say "No." The caregiver went around the corner a "few seconds later" and found Resident #16 pulling up his brief and pants from below his knees. The report documented the caregiver took the female resident to her room to "calm down." The caregiver called the administrator and sat with the residents in the living room. It also documented, Resident #16 "started to play with himself" and was told to go to his room. The report further documented, the staff were told to lock all the female residents' doors, "if they were already lying down for bed." Staff were directed to provide "complete oversight" for Resident #16 and to "know his whereabouts at all times."</p> <p>"Behavior Plan" notes documented the following:</p> <p>*1/19/13 at 8:02 PM - "pulled pants and brief down in front of another resident and was playing with himself in great room."</p> <p>*1/20/13 at 1:25 PM - Staff had to redirect the resident away from other female residents several times in the morning. "He kept trying with two in particular. He eventually got tired when his daughter came in to sit with him..."</p> <p>*1/20/13 at 9:29 PM - The resident was "playing with himself in the living room and showed staff his genitals and invited other residents to go to bed with him. Resident was monitored by a one-on-one, and the behaviors were addressed</p>	R 006		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R643	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/08/2013
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R 006	<p>Continued From page 12</p> <p>immediately."</p> <p>A short-term monitoring note, dated 1/20/13, documented the resident had "No behaviors this evening due to 1 to 1 supervision."</p> <p>An incident report, dated 1/21/13 at 9:50 PM, documented that a resident from another room came out "frantically" stating that Resident #16 was in a female resident's room. The staff "ran" into the room and found Resident #16 holding his penis in his left hand and the female resident's head in his right hand pulling the resident's head towards his genitals. The report documented, the resident was redirected from the female's room and all of the female residents' doors were locked. The administrator contacted the family and implemented a 24 hour caregiver to be with the resident until he could be discharged. The report further documented, the resident had been moved to a smaller home for more oversight.</p> <p>Short-term monitoring notes documented the following:</p> <p>A short-term monitoring note, dated 1/21/13 at 10:12 PM, documented the resident continually asked staff to "look at" his genital area. He "continued to exit his room without trousers on and was redirected back."</p> <p>"Behavior Plan" notes documented the following:</p> <p>*1/22/13 at 6:47 AM - The resident came out of his room in his underwear and pulled them down in front of another resident. The caregiver came out of another resident's room and redirected him back to his room. "We did this 3 times. I asked him to put pants on twice and told him not to come out without pants on the third time...The</p>	R 006		

Bureau of Facility Standards

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R 006	<p>Continued From page 13</p> <p>resident he approached would call for me as soon as she seen [sic] him after the first time he approached..."</p> <p>*1/22/13 at 10:06 PM - The resident "made a few attempts" to approach a female resident and get her to go with him. The caregiver and agency sitter "intervened immediately and he was easily redirected."</p> <p>*1/23/13 at 9:31 PM - The resident tried to kiss the agency sitter and also exposed himself on several occasions in public areas. When told it was his bath time, the resident stated the reason the caregiver wanted to bathe him was because she "wanted to hold it and clean it." At the same time the resident made "very lewd hand gestures."</p> <p>A short-term monitoring note, dated 1/23/13 at 1:59 PM, documented when the resident came out of his room, staff overheard the agency sitter who was sitting outside his room, tell him to pull up his pants and to put his penis inside his brief.</p> <p>"Behavior Plan" notes documented the following:</p> <p>*1/24/13 at 9:49 PM - The resident asked the agency sitter and facility caregivers "if they would like to come in and see it." The resident was "successfully redirected," but it was "a constant thing."</p> <p>*1/25/13 at 9:49 PM - "Had some comments and started to wander into female residents' rooms, but was easily redirected" by the caregivers and agency sitter.</p> <p>*1/28/13 at 10:56 PM - "As it got later in the evening he kept asking staff to assist him in his</p>	R 006		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R643	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/08/2013
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R 006	<p>Continued From page 14</p> <p>room & play with him."</p> <p>*1/29/13 at 4:38 AM - The resident was "asking the agency sitter to join him in his room...as well as trying to exit his room without appropriate attire. She (agency sitter) redirected him several times."</p> <p>*1/30/13 at 10:09 PM - The agency sitter reported there was no "show and tell" during the night. The resident "persistently tried to get physical" with her and she had to "repeatedly" remind him of boundaries. "Earlier in shift" staff witnessed Resident #16 trying to touch another resident and was told to "keep his hands to himself."</p> <p>Between 5/6/13 and 5/8/13, caregiver interviews were conducted.</p> <p>On 5/7/13 at 9:17 AM, a caregiver stated Resident #16 "was sexual" and "they moved him to the other side, but that didn't work and he had to leave."</p> <p>On 5/7/13 at 9:55 AM, a caregiver stated, Resident #6 did not speak except at times to repeat what "I said". She confirmed the resident was very limited in her ability to communicate verbally or non-verbally. She stated, Resident #6 would not understand if another resident made sexual advances toward her. The caregiver further stated, when Resident #16 had sexually inappropriate behavior with other residents, the staff redirected him or separated the residents by taking them to their rooms.</p> <p>On 5/7/13 at 10:10 AM, a caregiver stated, Resident #8 was essentially non-verbal, although at times "she would repeat what you said." She stated after the January 2013 incident between</p>	R 006		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R643	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/08/2013
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R 006	<p>Continued From page 15</p> <p>Resident #16 and #6, the staff were to make sure they knew where both residents were at all times.</p> <p>On 5/7/13 at 10:40 AM, a caregiver stated, staff were instructed to separate residents right away if one resident was displaying inappropriate sexual behavior towards another resident. She further stated, they were to "keep a close eye on" Resident #16.</p> <p>On 5/8/13 at 9:50 AM, the administrator stated before she was the administrator over the building the residents resided in, she thought there was a consensual relationship between Resident #6 and #16. She confirmed there was nothing documented or care-planned regarding a consensual relationship between the two residents.</p> <p>Resident #16 exhibited sexually aggressive behaviors for over five months. There were at least 10 incidents where the resident "touched" female residents or exposed himself that were not reported to Adult Protection. The behavior management plan directed staff to "monitor" the resident to ensure that no contact was made with female residents, which was not effective.</p> <p>In January, Resident #16 assaulted female residents and was moved to a smaller building where he assaulted another female resident in that building. Even though the facility put 1 to 1 supervision in place on 1/22/13, Resident #16 exposed himself to female residents and made crude comments.</p> <p>The facility did not protect Resident #6 and #12 from Resident #16's repetitive, sexual behaviors and sexual assaults. The failure to develop or implement effective interventions to prevent</p>	R 006		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R643	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/08/2013
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R 006	Continued From page 16 Resident #16's repeated sexual aggression and voyeurism, left 100% of the female population at risk for abuse. This failure resulted in abuse.	R 006		
R 008	16.03.22.520 Protect Residents from Inadequate Care. The administrator must assure that policies and procedures are implemented to assure that all residents are free from inadequate care. This Rule is not met as evidenced by: Based on record review and interview, it was determined the facility retained 2 of 5 sampled residents (#14 and #18) who had disruptive and violent behaviors and were a danger to others. Consequently, Resident #14 and #18 were not compatible with other residents at the facility. Additionally, it was determined the facility retained 3 of 5 sampled residents (#1, #9 and #10) who either had wounds that were not improving bi-weekly, had drainage from wounds that could not be contained, or had pressure ulcers that were a Stage III or greater. A. Behaviors IDAPA 16.03.22.152.05.d states that, "A resident will not be admitted or retained who has physical, emotional, or social needs that are not compatible with other residents in the facility; and 152.05.e, "A resident that is violent or a danger to himself or others." 1. Resident #18 was an 82 year-old male admitted on 10/11/12 with a diagnosis of Alzheimer's dementia with a history of increased behavioral problems at home. The resident no longer resided at the facility.	R 008	R008 16.03.22.520 Protect Residents from Inadequate Care. A. Behaviors • Resident # 18 with the diagnosis of Alzheimer's dementia passed away at the facility on May 4th, 2013. • All of the facilities currently residing residents, resident to resident altercations, progress notes, and behaviors plans, which involve an act of violence within the past 12 months, will be reviewed by the nursing team and administrator. The facilities Specialized Alzheimer's/Dementia Behavioral Management policy and procedures will be referenced in order to determine the continued retention of the resident. All staff will be trained on the facilities Behavior Management Policy and Procedures, Dealing with Aggressive/Assault Person, and Uncontrollable Behavior Plan of Action. If an act of violence occurs, the administrator will complete an investigation within 24 hours of the incident. An investigation regarding the retention of the perpetrator will be determined by the administrator. At no time will a resident be admitted or retained in the facility if they are deemed violent or a danger to himself or others. • All nursing staff will be trained on the following admission intake process; prior to a potential resident's admittance to the facility, the facility nurse will: review their current History and Physical, progress/nursing notes if applicable, and verbally interview family members and/or appropriate personnel regarding a history of violence, aggression, or combative behaviors. The nursing staff will then discuss their findings with the administrator and make a decision about the appropriateness of the admission. Additionally, if a residing resident has physical, emotional or social needs that are not compatible with other residents or proves violent or danger to himself or others an emergency discharge will be issued to the resident.	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R643	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/08/2013
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R 008	<p>Continued From page 17</p> <p>An NSA, dated 4/24/13, documented the resident required "2 person assistance for all cares due to striking out at caregivers...Resident may become anxious about his surroundings...Staff will refer to the behavior plan. Nurse will monitor behaviors and medications for anxiety, and will notify of any changes."</p> <p>Resident #18 had two BMPs in his record. Each BMP tracked different behaviors exhibited by the resident. The first BMP, dated 11/16/12, tracked "Language, wanders, defecates." The second BMP, dated 11/29/12, tracked "Aggression-Altercation with other resident [sic] or staff. May display combativeness, aggression toward others."</p> <p>The following is a summary of the documented aggressive behaviors Resident #18 exhibited by month:</p> <p>*Between 11/16 - 11/30/2012, staff documented, Resident #18 pushed a resident once, urinated on a resident once and was aggressive and/or combative with staff 10 times.</p> <p>*In December of 2012, staff documented, Resident #18 was aggressive and/or combative with staff 15 times.</p> <p>*In January of 2013, staff documented Resident #18 was combative with other residents once and was aggressive and/or combative with staff 24 times.</p> <p>*In February of 2013, staff documented Resident #18 hit a resident once and was aggressive and/or combative with staff 14 times.</p>	R 008	<ul style="list-style-type: none"> • The nursing team will review all unstable behaviors weekly and additionally as needed. Appropriate behavior management oversight and modification will be implemented as needed. Training will be completed during the 16 hours of orientation, upon hire, and periodically throughout their employment, to include: Behavior Management, Dealing with Aggressive/Assault Person, and Uncontrollable Behavior Plan of Action. A quick guide flyer on Mandatory Reporting will be placed in each of the 5 homes medication room. • All quick guide flyers on Mandatory Reporting will be place in each of the 5 homes by May 31st, 2013. All staff will review the Specialized Alzheimer's/Dementia Behavior Management Policy and Procedures, Dealing with Aggressive/Assault Person, and Uncontrollable Behavior Plan of Action by June 22nd, 2013. All new hires will be receiving the training beginning June 1st, 2013. The nursing team will begin the comprehensive behavior management reviews weekly on May 12th, 2013. Attachment: 1. Specialized Alzheimer's/Dementia Behavioral Management 2. Dealing with Aggressive/Assault Person 3. Uncontrollable Behavior Plan of Action 4. Quick guide Mandatory Reporting flyer 	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R643	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/08/2013
NAME OF PROVIDER OR SUPPLIER POST FALLS OPS LLC, DBA-GUARDIAN ANGI		STREET ADDRESS, CITY, STATE, ZIP CODE 1070 EAST MULLAN AVENUE POST FALLS, ID 83854		
(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	<p>Continued From page 18</p> <p>*In March of 2013, staff documented Resident #18 was aggressive and/or combative with staff 32 times.</p> <p>*Between 4/1 through 4/26/2013, staff documented Resident #18, was aggressive and/or combative with staff 14 times.</p> <p>The following are examples of the entries documented on Resident #18's behavior plans between 11/16/12 through 4/25/13:</p> <p>*11/18/12 at 8:19 PM - Resident wandered into other residents' rooms. "...using inappropriate language toward staff, threatening to hit staff, very confused..."</p> <p>*12/6/12 at 9:44 PM - The resident "grabbed" a caregiver's hand, bent her thumb back towards her wrist and pushed her. The altercation caused a resident to say she was "scared." He was in and out of other residents' room and used inappropriate language.</p> <p>*12/21/12 at 10:59 PM - The resident became very agitated with staff and hit them in twice in the face.</p> <p>*1/4/13 at 1:30 PM - The resident "attacked caregiver."</p> <p>*1/13/13 at 9:35 PM - Resident was "combative" with caregivers and residents.</p> <p>*1/29/13 at 7:04 PM - Resident hit a caregiver in the face when they tried to redirect him.</p> <p>*2/6/13 at 10:54 PM - The resident "pushed" another resident and "hit her in the ear."</p>	R 008		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R643	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/08/2013
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R 008	Continued From page 19 *2/23/13 at 3:48 PM - The resident "scared" caregivers with his behaviors. *2/26/13 at 9:51 PM - The resident grabbed a caregiver's arm and twisted it. He also grabbed a caregiver's finger and twisted it as well. *2/28/13 at 9:51 PM - Resident tried to "punch" a caregiver in the face. *3/2/13 at 8:54 PM - The resident grabbed a caregiver's hand, which was holding a razor, and violently shook and knocked it against a chair. *3/3/13 at 8:49 PM - Resident became very violent when being showered. *3/6/13 at 9:18 PM - The resident tried to urinate on another resident. *3/16/13 at 9:45 PM - The resident was aggressive at dinner when caregivers tried to redirect him away from other residents. *3/18/13 at 1:42 PM - Resident swore at caregivers, kicking one caregiver, and biting the other. *3/22/13 at 9:31 PM - Resident threw a chair at a caregiver and attempted to "break" one of her fingers. *3/22/13 at 9:32 PM - Resident called me a "worthless cocksucker" and stated he should "kill himself today." *3/26/13 at 1:28 PM - Resident was extremely aggressive and agitated in the morning. He punched a nightshift caregiver in the chest and squeezed two caregivers' arms very aggressively.	R 008		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R643	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/08/2013
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R 008	Continued From page 20 *3/27/13 at 10:40 PM - Resident was "very verbally aggressive today, cursed many times at staff while attempting to change out of soiled clothing. Wandered into other residents' rooms, several times, staff had to lock doors." *3/29/13 at 10:16 PM - Resident "...hit caregiver in the jaw when trying to shower him and also grabbed right arm and twisted it violently." *4/1/13 at 1:34 PM - The resident "punched staff member in the face today extremely hard after staff member showed him to his room." *4/1/13 at 10:08 PM - The resident became very aggressive and pushed a caregiver and repeatedly tried to punch them. *4/2/13 at 10:28 PM - The resident "...bit me and was aggressive during shower...." *4/4/13 at 10:24 PM - Resident "...was very violent when trying to toilet him both times and also later in the evening when staff was trying to get him out of another resident's bed." *4/8/13 at 1:59 PM - "Resident became very aggressive while trying to toilet him." *4/13/13 at 9:54 PM - The resident "...punched caregiver while we were putting him to bed." *4/15/13 at 1:44 PM - "Resident punched me in the face today while toileting him." *4/19/13 at 10:14 PM - "...punched staff while doing shower." "Progress Notes" signed by the licensed facility	R 008		

Bureau of Facility Standards

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R 008	Continued From page 21 nurses documented the following entries regarding Resident #18's aggressive behaviors: *11/27/12 at 2:14 PM - "...resident was found in another resident's room and there had been a physical altercation between the two...The resident stated, "he just punched me." *11/30/12 at 4:35 PM - Caregivers notified the nurse that Resident #18 was combative with care. *12/27/12 at 11:43 AM - Caregivers notified the nurse that Resident #18 had struck a caregiver with a closed fist, striking her outer eye. *1/4/13 at 12:47 PM - The resident attempted to strike a caregiver which resulted in a skin tear on his left elbow. *1/15/13 at 6:10 PM - Staff called for assistance with getting resident onto the bus for a doctor's visit, he become combative and resistive to care. *1/17/13 at 4:59 PM - The resident became "very combative," striking the RN twice on her arm. *1/19/13 at 4:46 PM - Caregivers notified the nurse that Resident #18 grabbed another resident, one hand on each side of her face and was "shaking" her. *1/30/13 at 12:00 PM - Caregivers reported to nurse, that while attempting to redirect Resident #18, "staff got swung at and he connected slightly" with the caregivers. The nurse educated staff on proper approach and keeping other residents "rooms locked when applicable." On 3/5/13 at 10:58 PM, a facility nurse documented the "increased agitation" monitoring	R 008		

Bureau of Facility Standards

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R 008	<p>Continued From page 22 ended on 3/4/13.</p> <p>On 4/10/13 at 11:35 AM, the administrator documented an NSA was completed due to a level of care increase. Further, she documented, "No concerns with his care at this time."</p> <p>For 51 days there were no "Progress Notes," signed by a licensed nurse, regarding Resident #18's aggressive behaviors. However, during those 51 days, caregivers documented 38 incidents where Resident #18 was verbally and physically aggressive. They documented he bit, punched, kicked, twisted caregivers' fingers, threw a chair, threatened to kill himself and tried to urinate on another resident. Additionally, caregivers documented they had to lock other residents' doors to keep them safe.</p> <p>On 5/6/13 at 8:56 AM, a resident stated, "...we couldn't leave our door open because he was always in here." The resident further stated, the resident was very mean and some of the caregivers quit because of his behaviors. They stated, "...he would kick them in the leg, but they weren't allowed to say anything" about him.</p> <p>On 5/8/12 at 9:50 AM, the administrator stated the facility tried to address Resident #18's aggression by having the nurse evaluate him, taking him to his physician, keeping the resident's family member involved and implementing non-pharmacological approaches. However, Resident #18 continued to display violent behavior toward caregivers and other residents for at least 5 months. The facility retained Resident #18 who was beyond the facility's capability to handle and who was not compatible with other residents.</p>	R 008		

Bureau of Facility Standards

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R 008	<p>Continued From page 23</p> <p>2. Resident #14 was a 91 year-old male, admitted to the facility on 9/1/12 with diagnoses that included dementia/behaviors and anxiety/agitation.</p> <p>An NSA, dated 12/14/12, documented the resident's behaviors included "anxiety, due to level of confusion, will wander within the facility, confused, verbally inappropriate, yells at staff in the dining room at meal times, makes comments about other residents and requires redirection. Staff will refer to behavior plan and the interventions that have been placed by the nurse. Staff will notify nurse if interventions are not effective."</p> <p>Another NSA, not signed or dated, documented the resident's behaviors included "anxiety, due to level of confusion....If he becomes aggressive, staff will assure his needs have been met, step away and monitor for safety, offer something to drink. He will often calm down if left alone for several minutes. Staff to assure other residents are not in his direct line of sight during these times of agitation. Staff will refer to behavior plan and the interventions that have been placed by the nurses. Staff will notify nurse if interventions are not effective."</p> <p>A "Behavior Plan" for "confusion" and "agitation," dated 9/30/12, documented the resident "may raise voice, argue or resist cares. Resident may display inappropriate physical contact with female care staff."</p> <p>The behavior interventions included the following:</p> <ol style="list-style-type: none"> "1. Rule out the three P's (Pee, Poop and Pain) 2. Be firm with boundaries, redirect attention 3. If interventions 1 and 2 are not successful, staff 	R 008		

Bureau of Facility Standards

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R 008	Continued From page 24 will notify nurse" The following is a summary of the documented aggressive behaviors Resident #14 exhibited: *10/24 to 10/30/12 - The resident was "confused," had urinated in a closet, and "demanded" staff give him food. *11/1/12 at 12:01 AM - The resident became violent with staff. *11/02/12 at 1:40 PM - The resident was naked sitting in the common area upstairs and yelling for someone to help him get dressed. *10/1/12 to 10/4/12 - The resident was confused, yelled downstairs at other residents, and became "very agitated" when staff would not let him urinate in the elevator. *10/7/12 at 1:35 PM - The resident "fondled" a caregiver and a female visitor. *10/8/12 to 10/22/12 - The resident was "confused," was out in public either nude or only in his briefs, or had urinated in inappropriate places. *11/3/12 to 11/19/13 - The resident was "agitated and confused," had inappropriately touched staff and other residents, had urinated in the dining area, and was found asleep in another resident's bed. *11/24/12 at 10:12 PM - The resident told caregivers he "wanted us out of his house. Yelling at the caregivers about it." *11/25/12 at 4:17 AM - The resident came down	R 008	R008 16.03.22.520 Protect Residents from Inadequate Care. B. Behaviors • Resident # 14 with the diagnosis of dementia was discharged from the facility on May 13th, 2013. • All of the facilities currently residing residents, resident to resident altercations, progress notes, and behaviors plans, which involve an act of violence within the past 12 months, will be reviewed by the nursing team and administrator. The facilities Specialized Alzheimer's/Dementia Behavioral Management policy and procedures will be referenced in order to determine the continued retention of the resident. All staff will be trained on the facilities Behavior Management Policy and Procedures, Dealing with Aggressive/Assault Person, and Uncontrollable Behavior Plan of Action. If an act of violence occurs, the administrator will complete an investigation within 24 hours of the incident. An investigation regarding the retention of the perpetrator will be determined by the administrator. At no time will a resident be admitted or retained in the facility if they are deemed violent or a danger to himself or others.	

Bureau of Facility Standards

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R 008	Continued From page 25 "only in a brief." *12/17/12 to 1/27/13 - The resident would not redirect, "got nasty," was confused, thought he was at the airport or on a train, thought he was moving out, and was exit-seeking." *12/1/12 at 10:39 PM - The resident pulled another resident's hair and threatened to "shoot the caregivers." *12/10/12 at 6:22 PM - The resident was downstairs and into other residents rooms. After being redirected to the kitchen he "tried to slam" his walker into a caregiver twice. *12/22/12 at 8:12 PM - The resident was "verbally aggressive" to another resident. *12/23/12 at 7:25 PM - "Came behind nurses station tried redirecting him. He got agitated and verbally abusive threatening staff." *1/28/13 to 2/10/12 - The resident was "extremely confused," was out in the common area wearing only a brief, yelled at his wife, repeatedly asked for a car or bus schedule, cursed at caregivers, swung at caregivers and threatened to tear the place down. *2/14/13 at 2:24 PM - Resident #14 had been "very violent and verbally abusive." The resident was found by the elevator yelling and completely nude. When staff assisted him back to his room, he yelled and attempted to hit them. The resident refused medications and was "verbally rude" to caregivers. When a nurse came to assist, the resident "yelled and poked fingers into the nurse's chest and was throwing his arms around."	R 008	<ul style="list-style-type: none"> • All nursing staff will be trained on the following admission intake process; prior to a potential resident's admittance to the facility, the facility nurse will: review their current History and Physical, progress/nursing notes if applicable, and verbally interview family members and/or appropriate personnel regarding a history of violence, aggression, or combative behaviors. The nursing staff will then discuss their findings with the administrator and make a decision about the appropriateness of the admission. Additionally, if a residing resident has physical, emotional or social needs that are not compatible with other residents or proves violent or danger to himself or others an emergency discharge will be issued to the resident. • The nursing team will review all unstable behaviors weekly and additionally as needed. Appropriate behavior management oversight and modification will be implemented as needed. Training will be completed during the 16 hours of orientation, upon hire, and periodically throughout their employment, to include: Behavior Management, Dealing with Aggressive/Assault Person, and Uncontrollable Behavior Plan of Action. A quick guide flyer on Mandatory Reporting will be placed in each of the 5 homes medication room. • All quick guide flyers on Mandatory Reporting will be place in each of the 5 homes by May 31st, 2013. All staff will review the Specialized Alzheimer's/Dementia Behavior Management Policy and Procedures, Dealing with Aggressive/Assault Person, and Uncontrollable Behavior Plan of Action by June 22nd, 2013. All new hires will be receiving the training beginning June 1st, 2013. The nursing team will begin the comprehensive behavior management reviews weekly on May 12th, 2013. Attachment: <ol style="list-style-type: none"> 1. Specialized Alzheimer's/Dementia Behavioral Management 2. Dealing with Aggressive/Assault Person 3. Uncontrollable Behavior Plan of Action 4. Quick guide Mandatory Reporting flyer 	

Bureau of Facility Standards

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R 008	<p>Continued From page 27</p> <p>evening, tried to pull his pants down and take a BM all the way from the couch to his room and was extremely upset at the staff redirecting him to his room, he made a couple of attempts at hitting staff before we got him into his bathroom..."</p> <p>*3/31/13 at 9:19 PM - "Lots of agitation this evening despite meds was extremely combative."</p> <p>*4/2/12 at 9:32 PM - The resident was "highly confused thinking he was the boss." The resident was "redirectable at times but other times he was swinging and threatening. Tried to let him alone and let him calm down but wife was also continuously antagonizing him."</p> <p>*4/2/13 at 9:58 PM - "Agitated a lot, especially at wife antagonizing him. Was taking swings at staff also"</p> <p>*4/9/13 at 3:40 AM - "Resident needed to have a BM and was very combative with staff. It took 3 caregivers to toilet and clean him up. He hit and kicked staff along with cursing and yelling at us."</p> <p>During this time, the only interventions documented as attempted by staff was to "check the three Ps, be firm with boundaries, redirect his attention and notify the nurse." None of these interventions were effective and no other interventions were identified.</p> <p>An incident report, dated 2/14/13, documented Resident #14 approached two women and rammed his walker into the walker of one of them and yelled at her. The female resident told him to leave her alone and Resident #14 pushed her shoulder and walked away. A short-term monitor was put into place "in order to effectively track his behaviors on each shift." The administrator sent a</p>	R 008		

Bureau of Facility Standards

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R 008	Continued From page 26 *2/15/13 at 5:02 AM - The resident was in his wife's closet and staff told him it was the wrong closet and staff would help him find what he was looking for. The resident told staff it was none of their "damn business." The resident tried swinging at staff and blocked them in the bathroom while they were assisting his wife. *2/17/13 at 9:52 PM - The resident became "extremely agitated" and rammed his walker into the other caregiver. *2/18/13 at 9:21 PM - "Resident went into another resident's room and scared her." *2/25/13 at 9:11 PM - "...highly agitated. Asked staff to take him to bathroom and when staff went to get gloves he yelled and swore and became angry." *2/26/13 at 2:16 PM - The resident had "agitation with confusion" and was yelling and hitting staff while they gave him a shower. *2/28/13 at 9:21 PM, "Some Agitation. Did take a swing at me this evening..." *3/1/13 at 9:01 PM - "...combative and refused to be changed out of clothes or brief." *3/17/13 at 4:15 AM - The resident was "agitated most of the night," was "exit seeking and being loud...disruptive to other residents as well as physically violent with staff." *3/25/13 at 8:51 PM - "...agitated resident resistive to care toiling, yelling at staff, two staff toileted him." *3/26/13 at 9:53 PM - "...was very agitated this	R 008		

Bureau of Facility Standards

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R 008	<p>Continued From page 28</p> <p>letter to family informing them the resident "must" be moved in one week to a "smaller more conducive home."</p> <p>An incident report, dated 2/16/13, documented Resident #14 "ran his walker on purpose [sic] in agitation into another resident and used profanity to demean her." A "prn was administered and resident was removed from the area....Provided close oversight to his behaviors."</p> <p>An incident report, dated 2/25/13, documented Resident #14's spouse called staff to the room. The resident yelled at staff that they had "no right" to be there and he threatened to call the police and threatened he was going to "hit, shoot, kill" the staff. The resident left the room "ranting and yelling." The resident threatened and pushed his wheelchair into a male resident's legs as he walked by. The staff "allowed resident to walk around house, shut and locked all residents' doors." A PRN medication was given for agitation.</p> <p>"Progress Notes" signed by the licensed facility nurses documented the following entries regarding Resident #14's behaviors:</p> <p>*9/16/12 at 2:48 PM - The resident had "multiple incidents of taking off his pants in common areas as well as in the dining room."</p> <p>*10/24/12 at 12:31 PM - The resident had been "refusing and combative" with his cares in the morning. The resident was combative and staff were unable to obtain a blood pressure. The paramedics were called and transported the resident to the hospital. Later the LPN spoke to physician at the hospital and the physician stated there was no medical reason to keep resident at the hospital.</p>	R 008			

Bureau of Facility Standards

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R 008	Continued From page 29 *11/03/12 at 3:54 PM - The resident became "very loud verbally demanding he get something to eat" even though he had just left the table. During one incident, the resident hit a nurse on the shoulder as she walked by him. The resident was given yogurt, but continued "food seeking behavior with loud verbal demands." The RN directed staff to give him PRN anxiety medication. *12/02/12 at 8:16 AM - The resident verbally threatened to "shoot" staff. The nurse attempted to talk to him to calm him down, but he also threatened to shoot her. The staff moved away from him to "observe for safety." The resident "swatted" at another staff member as she walked by. *12/04/12 at 5:08 PM - The physician increased the resident's Zyprexa. *1/12/13 at 4:56 PM - Resident #14 was found in another resident's room on the second floor. The resident had opened the window and pushed the screen out. Staff were directed to ensure that all of the residents' windows were locked and the doors to residents' apartments "if they agreed." Further, staff were directed to monitor the resident's whereabouts "every shift." *2/15/13 at 12:05 PM - Resident #14 had an altercation with another resident where he pushed her in the chest "with two fingers." Since Resident #14's increase in Zyprexa, the resident continued with "physical aggression, increased anxiety...leaving his room without clothes and refusing assistance with cares." *2/15/13 at 3:21 PM - The decision was made to move the resident to a "one level, smaller home	R 008		

Bureau of Facility Standards

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R 008	<p>Continued From page 30</p> <p>in order to be able to meet his needs, assure safety, and provide adequate oversight."</p> <p>*2/18/12 at 1:44 PM - Order received from the physician to increase the resident's Zyprexa "for agitation and aggression."</p> <p>*2/26/13 at 12:22 PM - Resident #14 was moved from the 62 bed building to one of the facility's smaller 16 bed buildings. The resident had "frequent verbally aggressive outbursts since the move and had one incident with another male resident..." The physician was notified and an immediate response and medication review was requested.</p> <p>After 2/26/13, there was no further documentation by the facility's nurses regarding the resident's behaviors, other than the increases in his Zyprexa and antianxiety medication. The Zyprexa was increased an additional 3 times within two months.</p> <p>Resident #14 was moved to a smaller home on 2/23/13, in order to "be able to meet his needs, assure safety, and provide adequate oversight." However, the resident continued to be physically and verbally abusive to staff and other residents. Other than to increase his behavioral medications 5 times, there was no further nursing documentation to address the resident's behaviors after 2/26/12. The facility retained Resident #14 who was beyond the facility's capability to handle and who was not compatible with other residents.</p> <p>B. Non-Improving and draining wound</p> <p>IDAPA 16.03.22.152.05 documents that residents with "open, draining wounds for which the</p>	R 008		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R643	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/08/2013
NAME OF PROVIDER OR SUPPLIER POST FALLS OPS LLC, DBA-GUARDIAN ANGI		STREET ADDRESS, CITY, STATE, ZIP CODE 1070 EAST MULLAN AVENUE POST FALLS, ID 83854		
(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	<p>Continued From page 31</p> <p>drainage cannot be contained," and open wounds that are not "improving bi-weekly" cannot be retained.</p> <p>Resident #1 was an 87 year-old female who was admitted to the facility on 6/28/04 with diagnoses that included a malignant neoplasm of the breast.</p> <p>The resident's record contained the following:</p> <p>A facility nursing note, dated 11/26/12, documented the resident had a small amount of blood on the left armpit of her pajamas.</p> <p>A facility nursing note, dated 12/5/12, documented the resident had active bleeding around a lump in the left armpit. The note documented the "bleeding was a constant ooze."</p> <p>A facility "Quarterly Nursing Review," dated 1/30/13 and signed by the RN, documented the "Resident has a tumor in her left armpit that had started draining red serosanguinous fluid this was dressed and kept covered, changing PRN until resolved."</p> <p>A facility nursing note, dated 2/25/13, documented the resident was sitting on a shower chair and had "...a steady flow of red serosanguineous fluid..." from the tumor site. The nurse documented that she applied "firm pressure" to the site but was unable to stop the bleeding, so the resident was transported to the hospital.</p> <p>A facility nursing note, dated 3/4/13, documented an "Assessment of the axilla tumor reveals it is clean and dry. The area of the tumor has multiple surfaces and is approximately 45 mm and involved the upper aspect of the arm pit. There is</p>	R 008	<p>R008 16.03.22.152.05 Protect Residents from Inadequate Care.</p> <p>A. Non-improving and draining wound</p> <ul style="list-style-type: none"> A variance was granted on May 28th, 2013 allowing the facility to retain Resident # 1. Who has a protruding left axillary mass that is consistent with metastatic breast cancer. The facility RN reviewed each of the variance guidelines and implemented the following: updated the residents care plan, created a record for dressing changes which reflects the condition of the wound. The RN also reviewed the infection control policy, dressing change and care instructions, and changes in condition reporting with care staff and LPN's. Each residing resident with compromised skin integrity will be observed and assessed by the facility nurse bi-weekly and as needed. The facility RN will determine if the wound is non-improving or has uncontained drainage. The facility RN will immediately report any non-healing wounds or wound for which the drainage cannot be contained to the administrator. The administrator will send a discharge notice and if appropriate may attempt to obtain a variance. All nursing staff will be in-serviced on wound care management and staging by a wound care specialist. The nursing staff will reference the Wound Management policy and procedure for all skin integrity concerns and documentation guidelines. All contracted Home Health and Hospice providers were notified of the IDAPA regulations and the facilities expectations on immediate reporting for changes in wounds. The facility has adopted the National Pressure Ulcer Advisory Panel as a guideline for wound care staging and documentation. 	

Bureau of Facility Standards

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R 008	Continued From page 32 no sign of infection..." A hospice note, dated 3/6/13, documented the resident had an "open tumor to her left axilla..." A facility nursing note, dated 3/7/13, documented the resident's physician had evaluated the resident and ordered a "quick clot gauze" for the bleeding around the growth. Additionally, the note documented care staff were instructed to apply gauze "...to catch any of the bleeding for now." A hospice note, dated 3/7/13, documented, "... There is an open sore in her left under arm area." Additionally the note documented the wound was "draining." A facility nursing note, dated 3/11/13, documented, "Assessment of her axilla tumor shows that there has been an increase in size, it appears more swollen than previous. There isn't any draining currently. Will continue to monitor." A hospice note, dated 3/12/13, documented, "Tumor extruding under her L arm appears to be growing and is now golf ball size but extruding more. Area is without drainage." A facility nursing note, dated 3/18/13, documented the resident's tumor "continued to grow and fill." The note further documented there had been slight drainage periodically and gauze dressings were used "to catch any drainage." A hospice note, dated 3/19/13, documented there was no further bleeding from tumor site, however the "tumor continues to grow." A facility nursing note, dated 3/25/13, documented there were now "...some satellite	R 008	<ul style="list-style-type: none"> • The facility nurse will gather wound care data for each residing resident with skin integrity impairment bi-weekly and as needed. The facility nurses will receive continued education on wound care management and staging throughout their employment. • The variance requirements for the retention of Resident #1 were implemented on May 30th, 2013. The facility nurses will complete wound care management training by a wound care specialist on June 4th, 2013. The care staff drainage measurement guide and nursing delegation will be completed by June 22nd, 2013. Attachment: <ol style="list-style-type: none"> 1. Resident #1 variance compliance forms 2. Wound Care Management policy 3. Infection Control policy 4. Negotiated service agreement 5. Drainage measurement guide 6. Nursing Delegation assisting with dressing changes 	

Bureau of Facility Standards

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R 008	<p>Continued From page 33</p> <p>tumors..." on the resident's chest.</p> <p>A hospice note, dated 3/26/13, documented, "... tumor under her left arm continues to grow however, this is hard to measure accurately. It appears to extrude more." Additionally, another hospice note, dated 3/26/13, documented, "Drainage from her tumor under the left arm was noticed..."</p> <p>A facility nurse documented, on 4/1/13, the resident's tumor was "unchanged" from her last assessment. However, the hospice note, dated 3/26/13, documented the tumor had grown and there was drainage.</p> <p>A hospice note, dated 4/4/13, documented, the tumor continued to enlarge by "increased extrusion" and there was some drainage.</p> <p>A facility nurse documented, on 4/8/13, the resident's tumor was "unchanged" from her last assessment. However, the hospice note, dated 4/4/13, documented the tumor had grown and there was drainage.</p> <p>A hospice note, dated 4/9/13, documented the tumor had increased in size and "extrudes more." Additionally, the note documented there were numerous small "blebs" surrounding the tumor.</p> <p>A "Quarterly Nursing Review," dated 4/10/13 and signed by the facility RN, documented the resident was not a surgical candidate due to the "disease process & the extent of involvement to surgically remove it..."</p> <p>A facility nursing note, dated 4/15/13, documented, "Tumor remains unchanged from previous assessment. Continue current plan."</p>	R 008		

Bureau of Facility Standards

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R 008	Continued From page 34 A hospice note, dated 4/16/13, documented, "reddened area surrounding extruding tumor L armpit with multiple 'blister like' sites." A facility nurse documented, on 4/22/13, the resident's tumor was "unchanged" from her last assessment. However, the hospice note, dated 4/16/13, documented it the skin was red around the tumor and had multiple blister like sites. A hospice note, dated 4/23/13, documented there was increased drainage from the "extruding tumor..." Another hospice note, dated 4/23/13, documented the resident had "...blood-tinged clear fluid..." on her shirt from the tumor. A facility nurse documented, on 4/29/13, the resident's tumor was "unchanged" from her last assessment. However, the hospice note, dated 4/23/13, documented there was increased drainage from the tumor. A facility nursing note, dated 5/6/13, documented, "...Also noted that her tumor under her arm has continued to grow, satellite tumors noted on her chest just adjacent to her axilla..." There was no documentation in the record to indicate the resident's tumorous wound improved bi-weekly. Further, it was documented the tumor had increased in size and surface area and continued to drain. On 5/7/13 at 2:45 PM, the administrator and facility nurse were interviewed. They stated the resident had a wound caused by cancer and it "would never improve." From 5/7/13 through 5/8/13, three caregivers	R 008		

Bureau of Facility Standards

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R 008	<p>Continued From page 35</p> <p>were interviewed regarding Resident #1's tumorous wounds. All three caregivers stated Resident #1's wound had drainage that could not be contained for a few weeks. They stated in the past, the drainage would leak through the bandages and gauze and unto her clothing and furniture. They confirmed the wound continued to grow in size and surface area.</p> <p>The facility retained Resident #1 with a wound that was not improving bi-weekly and did not ensure the drainage was contained.</p> <p>C. Stage III or greater pressure ulcers</p> <p>IDAPA rule 16.03.22.152.05.b states that "No resident will be admitted or retained who requires ongoing skilled nursing care not within the legally licensed authority of the facility. Such residents include:</p> <p>ix. A resident with Stage III or IV pressure ulcer."</p> <p>The "National Pressure Ulcer Advisory Panel" described the following pressure ulcers:</p> <p>*Stage II pressure ulcer - a shallow open ulcer without slough</p> <p>*Stage III pressure ulcer - slough may be present but does not obscure the depth of tissue loss</p> <p>*Unstageable - Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) in the wound bed. Until enough slough is removed to expose the base of the wound, the true depth cannot be determined, but it will be either be a Stage III or IV.</p> <p>1. Resident #9 was a 78 year-old female, admitted to the facility on 4/4/13, with diagnoses</p>	R 008	<p>R008 16.03.22.152.05.b Protect Residents from Inadequate Care.</p> <ul style="list-style-type: none"> Resident # 9 was discharged from the facility on May 20th, 2013 due to the development of a stage 3 pressure ulcer, which developed while she was admitted to the hospital. 	

Bureau of Facility Standards

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R 008	<p>Continued From page 36</p> <p>of dementia and chronic kidney disease.</p> <p>On 4/4/13, a facility nurse documented the resident was admitted with two areas of skin breakdown on her buttocks. The note documented the wounds were similar in appearance and were open in the center. There was no documentation of the stages of the wounds.</p> <p>On 4/19/13, a facility nurse documented the resident "now" had a "few open reddened areas." The nurse documented the resident had 3 open wounds on the left side of the gluteal fold and 2 open wounds on the right. The nurse did not document the stages of the resident's wounds. Additionally, the nurse did not document if she had notified the resident's physician of the wounds, or documented what treatments the facility had done.</p> <p>A fax, dated 4/24/13 from a home health provider to the resident's physician, documented a request to provide wound care for Resident #9's "sacral ulcer."</p> <p>Home health nursing notes documented the following:</p> <p>*4/26/13 - The resident had 2 ulcers on her sacral area that were covered 100% by slough, the home health note did not contain the stage of the pressure ulcers.</p> <p>*4/29/13 - The ulcer continued to be 100% covered by slough. The home health note did not contain the stage of the pressure ulcer.</p> <p>*5/3/13 - The pressure ulcer was 50% covered by slough. The home health note did not contain the</p>	R 008	<ul style="list-style-type: none"> • Each residing resident with compromised skin integrity will be observed and assessed by the facility nurse bi-weekly and as needed. The facility RN will determine if the wound is a stage III or IV pressure ulcer in accordance with the National Pressure Ulcer Advisory Panel. The facility RN will immediately report any stage III or IV pressure ulcers to the administrator immediately. The administrator will send a discharge notice and if appropriate may attempt to obtain a variance. • All nursing staff will be in-serviced on wound care management and staging by a wound care specialist. Prior to re-admission to the facility every resident's skin integrity will be reassessed by the facility nurse to ensure regulatory compliance. The nursing staff will reference the Wound Management policy and procedure for all skin integrity concerns and documentation guidelines. All contracted Home Health and Hospice providers were notified of the IDAPA regulations and the facilities expectations on immediate reporting non-healing or stage III or IV wounds. The facility has adopted the National Pressure Ulcer Advisory Panel as a guideline for wound care staging and documentation. • The facility nurse will gather wound care data a minimum of bi-weekly and as needed; observing for non-healing and/or stage III or IV wounds for each residing resident with skin integrity impairment. The facility nurses will receive continued education on wound care management and staging throughout their employment. • The facility nurses will be in-serviced on wound care management and staging on June 4th, 2013. The facility nurses will review the National Pressure Ulcer Advisory Panel literature by June 22nd, 2013. 	

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R 008	<p>Continued From page 37</p> <p>stage of the pressure ulcer.</p> <p>*5/6/13 - The pressure ulcer continued to be 50% covered by slough. The home health note did not contain the stage of the pressure ulcer.</p> <p>*5/8/13 - The home health LPN documented the pressure ulcer was a Stage II with 50% coverage of "white tissue."</p> <p>On 5/7/13 at 2:50 PM, the facility RN stated she did not feel comfortable staging pressure ulcers and did not know what stage the resident's pressure ulcer was, or had been.</p> <p>On 5/7/13 at 4:07 PM, the home health LPN, stated the resident's pressure ulcer had never been more than a Stage II. However, when asked by surveyors if she had documented the pressure ulcer had been covered by slough, she stated yes. Additionally, she stated the pressure ulcer was, at one time, unstageable due the 100% coverage of slough.</p> <p>According to the "National Pressure Ulcer Advisory Panel" pressure ulcer staging criteria, Resident #9's pressure ulcer was at least a Stage III from 4/26 through 5/8/13. Additionally, the facility nurse did not assess Resident #9's wound, or verify its status, to ensure that she was appropriate to remain in an assisted living facility.</p> <p>2. Resident #10 was a 94 year-old female, admitted to the facility on 3/22/07, with diagnoses that included diabetes.</p> <p>Nursing notes documented the following:</p> <p>*12/28/11 - "Nurse applied an Allevyn dressing due to some redness to her coccyx area. There is</p>	R 008	<p>R008 16.03.22.152.05.b Protect Residents from Inadequate Care.</p> <ul style="list-style-type: none"> Resident # 10 does not currently have any skin integrity impairment. 	

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R 008	<p>Continued From page 38</p> <p>no open areas and dressing can stay on up to one week."</p> <p>*3/17/12 - "Care staff reported that dressing on coccyx had come loose, was soiled with stool, therefore removed. Nurse assessed and noted redness and sloughing over coccyx and between medial gluteal crease. Area cleansed, dried and large Allevyn dressing applied..."</p> <p>*3/31/12 - "Nurse removed dressing from coccyx, noted slough and brownish drainage on dressing. Area red, with sloughing present throughout. Area cleansed, and large Allevyn dressing applied..."</p> <p>On 5/8/13 at 8:00 AM, a caregiver stated Resident #10 had an open wound a year ago from "being sedentary and being in her wheelchair."</p> <p>On 5/8/13 at 8:30 AM, an LPN and RN stated the former facility nurse had documented on Resident #10's wound and they were unaware of the status of the wound during that time.</p> <p>There was no documentation in the record, the wound was staged to determine if Resident #10 was appropriate for assisted living. However, due to the slough present, the wound had characteristics indicating it was greater than a Stage II. Additionally, there was no documentation the physician was notified of the wound, so that wound care orders could be obtained. There was no further documentation of the wound.</p> <p>The facility retained Residents #9 and #10 when they had pressure ulcers that were, according to the "National Pressure Ulcer Advisory Panel" staging criteria, greater than Stage II.</p>	R 008	<ul style="list-style-type: none"> • Each residing resident with compromised skin integrity will be observed and assessed by the facility nurse bi-weekly and as needed. The facility RN will determine if the wound is a stage III or IV pressure ulcer in accordance with the National Pressure Ulcer Advisory Panel. The facility RN will immediately report any stage III or IV pressure ulcers to the administrator immediately. The administrator will send a discharge notice and if appropriate may attempt to obtain a variance. • All nursing staff will be in-serviced on wound care management and staging by a wound care specialist. The nursing staff will reference the Wound Management policy and procedure for all skin integrity concerns and documentation guidelines. All contracted Home Health and Hospice providers were notified of the IDAPA regulations and the facilities expectations on immediate reporting non-healing or stage III or IV wounds. The facility has adopted the National Pressure Ulcer Advisory Panel as a guideline for wound care staging and documentation. • The facility nurse will gather wound care data a minimum of bi-weekly and as needed; observing for non-healing and/or stage III or IV wounds for each residing resident with skin integrity impairment. The facility nurses will receive continued education on wound care management and staging throughout their employment. • The facility nurses will be in-serviced on wound care management and staging on June 4th, 2013. The facility nurses will review the National Pressure Ulcer Advisory Panel literature by June 4th, 2013. 	

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R 008	Continued From page 39 The facility retained Resident #14 and #18 whose behaviors were disruptive, violent and a danger to others, this had the potential to effect 100% of the facility's population. Additionally, the facility retained Resident #1, #9 and #10 whose wounds were not appropriate for assisted living. The retention of these residents resulted in inadequate care.	R 008		



ASSISTED LIVING
Non-Core Issues
Punch List

Facility Name Post Falls Ops LLC, DBA - Guardian Angel Home	Physical Address 1070 East Mullan Avenue	Phone Number 208-777-7797
Administrator Cecilia Wilkerson	City Post Falls	Zip Code 83854
Team Leader RaeJean McPhillips	Survey Type Licensure, Follow-up and Complaint	Survey Date 05/08/13

NON-CORE ISSUES

Item #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	L&C USE
1	220.03.e	The admission agreement did not include the assessment form used to determine levels.	6/17/13 Rm	
2	225.02.c	The facility did not document they had reviewed the behavior management plan for Resident #16. ***Previously cited on 5/19/10***	6/17/13 Rm	
3	300.01	Five of ten staff did not have delegation from the current RN.	6/17/13 Rm	
4	300.02	Mechanical soft and CCHO diets were not implemented for all residents requiring such a diet. Further, caregivers did not document they had taken a pulse and blood pressure as required before implementing Resident #11's heart medication.	6/17/13 Rm	
5	330.02	Caregiver notes were automatically deleted on the computer after 5 days and were not retained as part of the record for three years.	6/17/13 Rm	
6	350.02	The administrator did not investigate all complaints or concerns.	6/17/13 Rm	
7	350.04	The administrator did not provide a written response to complainants within 30 days.	6/17/13 Rm	
8	630.04	Five of ten staff did not have traumatic brain injury training.	6/17/13 Rm	
9	711.01.b	The facility did not document what interventions were used for Residents #8 and #13.	6/17/13 Rm	
10	711.01.c	The facility did not document the effectiveness of the interventions used for Residents #8 and #13.	6/17/13 Rm	
11	711.07	Resident #9 did not have a home health plan of care in the record.	6/17/13 Rm	
12	711.08	Caregiver notes were not maintained on the computer system. Such as: notification of the RN of changes in residents' condition.	6/17/13 Rm	
13	711.08.f	Resident #9 did not have all home health care notes available in the record.	6/17/13 Rm	

Response Required Date
06/07/13

Signature of Facility Representative

Date Signed

5/8/13



IDAHO DEPARTMENT OF

HEALTH & WELFARE Food Establishment Inspection Report

Food Protection Program, Division of Health
450 W. State Street, Boise, Idaho 83720-0036
208-334-5938

Establishment Name <u>Middleman's Home</u>		Operator <u>Erica Wilkerson</u>	
Address <u>1370 East Miller Ave</u>		<u>Post Falls, ID 83854</u>	
County <u>Boonville</u>	Estab #	EHS/SUR #	Inspection time: <u>5/7+5/8</u>
Inspection Type:		Risk Category: <u>High</u>	Follow-Up Report: OR On-Site Follow-Up: Date: _____ Date: _____

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

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

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

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

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

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

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

Item/Location	Temp	Item/Location	Temp	Item/Location	Temp	Item/Location	Temp
<u>Sliced dressing in fridge</u>	<u>37°</u>	<u>Hot hold - 200°</u>	<u>160°</u>				
<u>Hot hold - 140°</u>	<u>37°</u>						

GOOD RETAIL PRACTICES (= not in compliance)

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

OBSERVATIONS AND CORRECTIVE ACTIONS (CONTINUED ON NEXT PAGE)

Person in Charge (Signature) <u>[Signature]</u>	(Print) <u>Michelle Wilkerson</u>	Title <u>MDM</u>	Date <u>5/8/13</u>
Inspector (Signature) <u>[Signature]</u>	(Print) <u>[Name]</u>	Date <u>5/8/13</u>	Follow-up: (Circle One) <u>Yes</u> / <u>No</u>



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

May 22, 2013

Cecilia Wilkerson, Administrator
Post Falls Ops LLC dba: Guardian Angel Homes
1050 East Mullan
Post Falls, ID 83854

Dear Ms. Wilkerson:

An unannounced, on-site complaint investigation survey was conducted at Post Falls Ops LLC, dba-Guardian Angel Homes between May 5, 2013 and May 8, 2013. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00005895

Allegation #1: The facility retained an identified resident who was a sexually inappropriate with others.

Findings #1: Substantiated. The facility was issued a core deficiency at IDAPA 16.03.22.510 for not protecting residents from abuse. The facility was required to submit a plan of correction within 10 days.

Allegation #2: The facility did not protect residents from abuse.

Findings #2: Substantiated. The facility was issued a core deficiency at IDAPA 16.03.22.510 for not protecting residents from abuse. The facility was required to submit a plan of correction within 10 days.

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 **May 8, 2013**. 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.

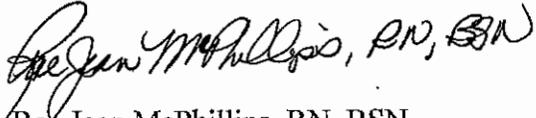
Cecilia Wilkerson, Administrator

May 22, 2013

Page 2 of 2

If you have questions or concerns regarding our visit, please call us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,

A handwritten signature in black ink, appearing to read "Rae Jean McPhillips, RN, BSN". The signature is written in a cursive style.

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

RJM/gk

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



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May 22, 2013

Cecilia Wilkerson, Administrator
Post Falls Ops LLC, dba Guardian Angel Homes
1050 East Mullan
Post Falls, ID 83854

Dear Ms. Wilkerson:

An unannounced, on-site complaint investigation survey was conducted at Post Falls Ops LLC, dba-Guardian Angel Homes between May 6, 2013 and May 8, 2013. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00005941

Allegation #1: The facility did not protect residents from abuse.

Findings #1: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.501 for not protecting residents from abuse. The facility was required to submit a plan of correction within 10 days.

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 **May 8, 2013**. 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.

If you have questions or concerns regarding our visit, please call us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,

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

RJM/gk

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



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May 22, 2013

Cecilia Wilkerson, Administrator
Post Falls Ops LLC, dba: Guardian Angel Homes
1050 East Mullan
Post Falls, ID 83854

Dear Ms. Wilkerson:

An unannounced, on-site complaint investigation survey was conducted at Post Falls Ops LLC, dba-Guardian Angel Homes between May 6, 2013 and May 8, 2013. During that time, observations, interviews, and record reviews were conducted with the following results:

Complaint # ID00005739

- Allegation #1:** A resident was left in a urine soaked bed and clothing for over 4 hours.
- Findings #1:** Unsubstantiated. This does not mean the incident did not take place; it only means that the allegation could not be proven during the investigation.
- Allegation #2:** Staff left residents unattended while they went outside to smoke.
- Findings #2:** Unsubstantiated. This does not mean the incident did not take place; it only means that the allegation could not be proven.
- Allegation #3:** Facility staff did not transfer residents appropriately.
- Findings #3:** Unsubstantiated. This does not mean the incident did not take place; it only means that the allegation could not be proven.
- Allegation #4:** Residents received assistance with showers late in the evenings due to insufficient staffing during the day.
- Findings #4:** Unsubstantiated. This does not mean the incident did not take place; it only means that the allegation could not be proven.

Cecilia Wilkerson, Administrator

May 22, 2013

Page 2 of 2

Allegation #5: Call lights were not answered in a timely manner due to insufficient staffing.

Findings #5: Unsubstantiated. This does not mean the incident did not take place; it only means that the allegation could not be proven.

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,



Rae Jean McPhillips, RN, BSN

Health Facility Surveyor

Residential Assisted Living Facility Program

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



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May 22, 2013

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Post Falls Ops LLC, dba: Guardian Angel Homes
1050 East Mullan
Post Falls, ID 83854

Dear Ms. Wilkerson:

An unannounced, on-site complaint investigation survey was conducted at Post Falls Ops LLC, dba-Guardian Angel Homes between May 6, 2013 and May 8, 2013. During that time, observations, interviews, and record reviews were conducted with the following results:

Complaint # ID00005889

Allegation #1: Staff did not wash their hands when using the restroom because the restroom did not have a hand washing sink.

Findings #1: On 5/6/13, the sinks in all 5 buildings were observed. Each building had a bathroom with a "hair dressing sink" and a toilet. Because of the flexible nozzle on the "hair dressing" sink, proper handwashing could be tricky, but properly accomplished. Between 5/6/13 and 5/8/13, caregivers from all 5 buildings were interviewed. Some stated they did not use the hair salon bathroom, because of the flexible nozzle. Others stated they did not have a problem using the sink and practicing proper handwashing. All staff interviewed stated they did not have a problem finding a bathroom where they could practice proper handwashing after toileting.

Unsubstantiated.

Allegation #2: Staff did not properly sanitize dishes when hand-washing them.

Findings #2: Between 5/6/13 and 5/8/13, staff from all 5 of the facility's buildings were interviewed. All staff denied dishes were hand-washed. During the survey, staff in each of the 5 buildings were observed to wash dishes in the automatic dishwashers.

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

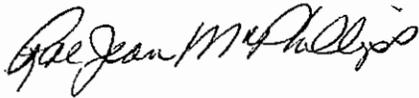
Cecilia Wilkerson, Administrator

May 22, 2013

Page 2 of 2

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,

A handwritten signature in cursive script that reads "Rae Jean McPhillips".

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

RJM/TFP

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