



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
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3232 Elder Street
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Boise, ID 83720-0009
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CERTIFIED MAIL: 7012 1010 0002 0836 1642

May 20, 2014

Steve Gannon, Administrator
Safe Haven Care Center of Pocatello
1200 Hospital Way
Pocatello, ID 83201-2708

Provider #: 135071

Dear Mr. Gannon:

On **May 9, 2014**, a Complaint Investigation survey was conducted at Safe Haven Care Center of Pocatello by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3.) **Please provide ONLY ONE completion date for each federal and state tag in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

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After each deficiency has been answered and dated, the administrator should sign both the Form CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **June 2, 2014**. Failure to submit an acceptable PoC by **June 2, 2014**, may result in the imposition of civil monetary penalties by **June 23, 2014**.

The components of a Plan of Correction, as required by CMS include:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put in place or what systemic change will you make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice does not recur, i.e., what quality assurance program will be put into place. This monitoring will be reviewed at the follow-up survey as part of the process to verify that the facility has corrected the deficient practice. Monitoring must be documented and retained for the follow-up survey. In your Plan of Correction, please be sure to include:
 - a. Specify by job title who will do the monitoring.
 - * It is important that the individual doing the monitoring have the appropriate experience and qualifications for the task.
 - * The monitoring cannot be completed by the individual(s) whose work is under review.
 - b. Frequency of the monitoring; i.e., weekly x 4, then q 2 weeks x 4, then monthly x 3.
 - * A plan for "random" audits will not be accepted.
 - * Initial audits must be more frequent than monthly to meet the requirement for the follow-up.
 - c. Start date of the audits;
- Include dates when corrective action will be completed in column (X5).

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If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567 and the state licensure survey report, State Form.

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

This agency is required to notify CMS Region X of the results of this survey. We are recommending that CMS impose the following remedy:

Denial of payment for new admissions effective as soon as notice requirements can be met. [42 CFR §488.417(a)]

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **November 9, 2014**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

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go to the middle of the page to **Information Letters** section and click on **State** and select the following:

- BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process
2001-10 IDR Request Form

This request must be received by **June 2, 2014**. If your request for informal dispute resolution is received after **June 2, 2014**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care at (208) 334-6626.

Sincerely,

A handwritten signature in black ink that reads "David Scott, R.N." The signature is written in a cursive style with a large initial "D" and "S".

DAVID SCOTT, R.N., Supervisor
Long Term Care

DS/dmj
Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/15/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/09/2014
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201	
(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) COMPLETION DATE
F 000	INITIAL COMMENTS The following deficiencies were cited during the complaint investigation survey of your facility conducted 5/8/14 - 5/9/14. The facility self-reported this incident as well. The surveyors conducting the survey were: Michael Case, LSW, QIDP, Team Coordinator Karen Marshall, MS, RD, LD Trish O'Hara, RN Common abbreviations used in this report are: BIMS - Brief Interview for Mental Status cm - centimeters CNA - Certified Nurse Aide CT - Computerized Tomography CVA - Cerebrovascular Accident DNS - Director Nursing Services MDS - Minimum Data Set assessment NEC - Not Elsewhere Classified NOS - Not Otherwise Specified	F 000	Preparation and execution of this Plan of Correction (PoC) is not an admission of guilt nor does the provider agree with the conclusions set forth in the Statement of Deficiencies rendered by the Bureau. The Plan of Correction is prepared and executed simply as a requirement of federal and state law. We maintain that the alleged deficiencies do not individually, or collectively, jeopardize the health and safety of our residents, nor are they of such character as to limit this provider's capacity to render adequate resident care. Furthermore, the provider asserts that it is in substantial compliance with regulations governing the operation and licensure of skilled nursing facilities, and this document, in its entirety, constitutes this providers claim of compliance. Completion dates are provided for the procedural procession purposes to comply with the state and federal regulations, and correlate with the most recent contemplated or accomplished corrective action. These dates do not necessarily correspond chronologically to the date the provider is under the opinion it was in compliance with the requirements of participation or that corrective actions was necessary.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law, or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property, and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.	F 225	F 225 Resident Specific 2 of 5 sampled residents (#1 and #2) were affected. Safe Haven has amended its incident investigation process / protocol. The investigation for the incident between resident #1 and resident #2 was reviewed again to identify the root cause of the incident, to find any questions that arose from the investigation data and statements, and to implement the necessary changes. Disciplinary actions were issued for those staff that did not follow current care plan for resident #2 that led to this incident.	5/14/2014

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

TITLE

(X6) DATE

Stella

ADMINISTRATOR

5/29/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	<p>Continued From page 1</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of the facility's Investigations, the facility's Resident-to-Resident Abuse policy, the facility's Abuse Investigations policy, and staff interview it was determined the facility failed to ensure all investigations were thorough for 2 of 5 residents (Residents #1 and #2) for whom resident-to-resident altercations had occurred. This resulted in a lack of comprehensive information being captured to ensure all concerns were addressed. Findings include:</p> <p>1. The facility's Resident-to-Resident Abuse policy, undated, stated procedures for</p>	F 225	<p>F 225 continued...</p> <p>Other Residents All residents involved in a facility investigation had the potential to be affected.</p> <p>Facility Systems POLICIES/PROCEDURES: Safe Haven will review, update, sign and date the res-res abuse policy and any other abuse related policies. Policy review meeting will be held regularly to ensure facility policies are current, updated and signed on a regular basis. INVESTIGATION PROCEDURES: Safe Haven has added the following to the investigation process/review: - Timeline of events in order to get a complete picture of what happened and when. - Evaluation of written witness statements during the investigation process to determine if an interview with the witness is necessary to gather more information or to clarify details of the written statement. - A separate summary conclusion section will be added to the investigation report. The summary conclusion will include the root cause of the incident, if determinable, and any information about other potential factors: i. Staff involvement cause: ii. Medical cause: iii. Behaviors for last week: iv. Relationship that the involved residents have. The facility plan of correction section will be separate from the investigation conclusion section to provide more detail to each section. - An audit tool has been created for review of witness statements to determine if further information or clarification is needed. Any necessary witness interviews will be documented and included in the investigation report. - If any resident injuries are sustained due to the incident, care and treatment of said injuries will be included in the investigation summary conclusion.</p>	

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F 225	<p>Continued From page 2</p> <p>investigating incidents of about were outlined in the Abuse Investigations policy. The facility's Abuse Investigations policy, undated, stated any witnesses to the event were to be interviewed, the witness reports were to be reduced to writing and signed by the witnesses. Additionally, the policy stated a written report of the results of the investigation and appropriate action taken was to be provided.</p> <p>On 5/8/14 at 4:00 p.m., the facility's Investigations were reviewed. One investigation, dated 4/26/14 at 8:15 a.m. and signed by the Administrator 5/5/14, documented Resident #2 became agitated and aggressive and "flipped" Resident #1 out of his wheelchair and onto the floor. The investigation included staff statements that documented the following:</p> <p>On 5/8/14 at 7:45 a.m., Resident #2 left his room and went to the dining area for breakfast. At that time, CNA #1 stated she wanted to take "advantage of the opportunity and went in his room and cleaned up." CNA #1, CNA #2 and Housekeeper #3 entered Resident #2's room and removed bedding and clothing to be laundered.</p> <p>Upon returning to his room, time unspecified, Resident #2 noticed his clothing had been removed and became angry and went looking for his clothing. Resident #2 was able to gain access to the basement laundry room. CNA #1 attempted to redirect Resident #2 upstairs, at which point he physically assaulted her and an unidentified nurse.</p> <p>After approximately 30 minutes, Resident #2 was redirected upstairs. When he returned to the unit, Resident #2 saw Resident #1 sitting in a</p>	F 225	<p>F 225 continued...</p> <p>Facility Systems continued...</p> <ul style="list-style-type: none"> - A 'personnel file review' section has been added to the investigation report process for analysis of previous potential issues of a similar nature. - The investigation report template has been updated to include the facility plan to protect other residents from future potential harm of a similar nature. <p>INSERVICE: All employees inserviced to ensure they understand how to write a complete and clear statement for investigations.</p> <p>Monitoring For any and all new incident investigations, an audit will be performed by the administrator / designee weekly X4 weeks then every other week X4 weeks then monthly X3 months to ensure the details of the investigation are brought to light and any underlying questions are answered as much as possible. Upon receiving information that requires an investigation, the admin team (Administrator, DNS, Social Service Director, Care Plan Coordinator, ADON, BCU director and any others deemed necessary) will review the incident within 1-3 business days to ensure as many accurate details about the incident are discovered and any unclear or misleading statements are clarified or corrected. The following list will be the starting point:</p> <ul style="list-style-type: none"> - Are the witness statements clear and concise? If no, which ones. - Do any witness statements require an interview for further clarification? Who will perform the interview? - Are there any holes in the timeline? If so, where? Is that information available to obtain? If so, who will obtain it? 		

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F 225	<p>Continued From page 3</p> <p>wheelchair in the hallway. Resident #2 ran towards Resident #1, took hold of the left side of Resident #1's wheelchair, then flipped the wheelchair, along with Resident #1, over. The staff statements included in the Investigation do not clearly document if Resident #1 hit the wall or floor first. However, the staff statements did indicate Resident #1 received injury to his head as a result of the incident.</p> <p>The investigation did not contain thorough or comprehensive information, as follows:</p> <p>a. Attached to the Investigation were multiple hand-written staff statements signed by the staff completing the forms. However, there was no information included in the investigation document indicating interviews with the staff had been completed as per the facility's policy. As a result, the investigation did not document information clarifying additional concerns that arose in the staff statements.</p> <p>For example, the investigation report documented Resident #2 had a 1:1 staff. However, the staff statements did not indicate which staff was Resident #2's 1:1 staff and no clarifying information was present in the Investigation. Additionally, during an interview on 5/9/14 at 10:15 a.m., the Administrator stated CNA #2 had been Resident #2's 1:1 staff on the date of the incident. However, CNA #2's statement documented she was one of the staff clearing out Resident #2's clothing while he was at breakfast. The Investigation did not include information related to why CNA #2 had left Resident #2 in the breakfast area while she was his 1:1 staff.</p> <p>Additionally, CNA #1's written statement</p>	F 225	<p>F225 continued...</p> <p>Monitoring continued...</p> <p>- Has the root cause been identified? What is the root cause? What will be implemented to prevent future incidents? What other potential factors are there?</p> <p>- Are there any injuries involved? What are the extent of the injuries? What care is necessary to treat the injuries?</p> <p>Safe Haven has created an audit tool to be used during the incident investigation audit that will analyze the witness statements to determine if further information or clarification is needed and that any questions arising from the witness statements regarding the incident are answered as much as possible.</p>	

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F 225	<p>Continued From page 4</p> <p>documented she initiated removing Resident #2's clothing from his room while he was at breakfast. However, there was no clarifying interview to determine why she had completed this action when Resident #2's behavior intervention guidelines clearly stated staff were not to touch Resident #2's belongings without his permission or knowledge. Refer to F323 for additional information.</p> <p>b. The Investigation included a section titled "Recreate the Event Summary." The section stated "Resident [Resident #2] was agitated and aggressive this morning. Staff unable to calm him down. Resident [Resident #2] saw resident [Resident #1] sitting in the hallway outside of resident [Resident #2's] room. Resident [Resident #2] ran away from his 1:1 staff, ran down the hall and flipped resident [Resident #1] out of his wheelchair and onto the floor. Resident [Resident #2] was escorted back to his room and Resident [Resident #1] was assessed by the nurse. Resident [Resident #1] was then sent to the ED for evaluation and treatment. Resident [Resident #2] was escorted by the police to the ED for psychiatric evaluation and then was admitted to [name of hospital] Psychiatric hospital."</p> <p>The Summary did not include information related to the cause of Resident #2's agitation and aggression (i.e., failure of staff to follow his written plan related to his belongings). Also, the investigation did not include information related to a review of other potential factors (medical issues, earlier behavioral issues, relation between Resident #1 and Resident #2 prior to the event, etc.) that may have impacted the event. Additionally, the Summary did not include additional information related to the nature and</p>	F 225		
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F 225	<p>Continued From page 5 care/treatment of Resident #1's injuries.</p> <p>c. The investigation did not include if personnel files had been reviewed to determine if staff involved had prior incidents of failing to follow residents treatment plans.</p> <p>d. The Investigation did not include information related to how other residents would be protected from failure to follow care plans during the course of the investigation.</p> <p>A lack of thorough information would inhibit the facility's ability to ensure appropriate corrective action was taken and to ensure other residents were protected for abuse or neglect.</p> <p>During an interview on 5/9/14 at 8:17 a.m., the facility's Owner stated he reviewed the 4/26/14 Investigation with the Administrator on 5/8/14. The Owner stated the Investigation did not include information documenting a thorough investigation had been completed.</p> <p>The facility failed to ensure all investigations contained complete and comprehensive information.</p>	F 225		
F 323 SS=G	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p>	F 323	<p>F 323 Resident Specific 2 of 5 residents (#1 and #2) were affected by this incident. Resident #2 was admitted to Safe Haven psychiatric hospital for evaluation and treatment. Resident #1 was sent to ED for evaluation and treatment. When resident #2 was re-admitted to the SNF, resident #1 was moved to a different hall to prevent further interactions between resident #1 and resident #2.</p>	5/14/2014

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F 323	<p>Continued From page 6</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, review of the facility's investigations, and staff interviews, it was determined the facility failed to follow a resident's care plan and Behavior Management Guidelines and failed to ensure residents environments remained as free from hazards as possible. This was true for 2 of 5 residents (#s 1 & 2) for whom a resident-to-resident altercation had occurred. Resident #2's care plan and Behavior Management Guidelines were not implemented as written. Resident #1 was harmed when Resident #2 flipped Resident #1 from his wheelchair causing injury to his head and required sutures at a local hospital. Findings included:</p> <p>Resident #1 was admitted to the facility on 11/14/11 with multiple diagnoses including dementia NOS, aphasia late effect of CVA, stroke ischemic with occlusion, and chronic pain NEC.</p> <p>Resident #1's 2/27/14 quarterly MDS coded: - Moderately cognitively impaired - Utilized wheelchair - Required two person physical assistance for transfers and one person assistance for locomotion on and off unit</p> <p>On 5/8/14 at 4:00 p.m., the facility's Investigations were reviewed. One investigation, dated 4/26/14 at 8:15 a.m. and signed by the Administrator 5/5/14, documented Resident #2 became agitated and aggressive and "flipped" Resident #1 out of his wheelchair and onto the floor. The investigation included staff statements that documented the following:</p>	F 323	<p>F 323 continued...</p> <p>Resident Specific Resident #2's care plan was updated to provided clarified instruction for caring for him, his behaviors, and de-escalation techniques as well as taking care of his laundry. - A written summary guide was created for resident #2 to further assist the staff interacting with the resident. - A written de-escalation procedure was provided to all staff regarding the proper protocol to follow to de-escalate resident #2 when he shows signs of agitation. - A new emergency code was created to assist in incidents in which resident #2 has increased behaviors and requires all other residents to be appropriately removed to a safe environment.</p> <p>Other Residents Any resident in the facility had the potential to be affected.</p> <p>Facility Systems - In-service provided to all staff regarding proper following of resident care plans. - In-service provided to all staff regarding ensuring secured areas remain secure (i.e.: doors are shut after walking through) - In-service provided to all staff regarding the Schizophrenia disease process and how we can appropriately interact with those with Schizophrenia. - In addition to the mandatory annual BCU training required for all staff working in this facility, an additional mandatory semi-annual BCU refresher course will be added to include methods of dealing with aggressive or agitated residents, de-escalation methods, resident safety, redirection methods, etc. - Staff who violated company policy and procedures were identified and provided proper disciplinary action and education as to the incident and what was the cause of the incident.</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/15/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/09/2014
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201	
(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) COMPLETION DATE
F 323	Continued From page 7 On 5/8/14 at 7:45 a.m., Resident #2 left his room and went to the dining area for breakfast. At that time, CNA #1 stated she wanted to take "advantage of the opportunity and went in his room and cleaned up." CNA #1 and CNA #2 entered Resident #2's room and removed bedding and clothing to be laundered. At this same time, CNA #1 asked Housekeeper #3 to clean the resident's room while Resident #2 was out of his room. Upon returning to his room, time unspecified, Resident #2 noticed his clothing had been removed and became angry and went looking for his clothing. The resident asked CNA #1 where his clothes were. The CNA told the resident his clothes were being washed because the CNA did not want the resident to have his soiled clothes under his bed. The resident then went looking for his clothes. The resident was able to gain access to the basement laundry room even though the door to the basement had a coded key pad for entry. As the resident was looking for his clothes in the laundry room area of the basement, CNA #1 placed herself in between the resident and the washing machine. CNA #1 attempted to redirect Resident #2 upstairs, at which point he physically assaulted her and an unidentified nurse. NOTE: Please refer to Resident #2's Care Plan intervention below of remaining at arms length from the resident and not touching his clothing without asking permission first. After approximately 30 minutes, Resident #2 was redirected upstairs. When he returned to the unit, Resident #2 saw Resident #1 sitting in a wheelchair in the hallway. Resident #2 ran	F 323	F323 continued... Facility Systems continued... - Staff who were involved in the incident with resident #2 were given debriefing and education as to the incident and what was the cause of the incident. - Resident #2's care plan was updated to provided clarified instruction for caring for him, his behaviors, and de-escalation techniques. - A written summary guide was created for resident #2 to further assist the staff interacting with the resident. - A written de-escalation procedure was provided to all staff regarding the proper protocol to follow to de-escalate this resident when he shows signs of agitation. - A written procedure was developed specifically for the licensed nursing staff regarding the proper steps to follow when using the de-escalation protocol for this resident. - A new emergency code was created to assist in incidents in which a resident has increased behaviors and requires all other residents to be appropriately removed to a safe environment. CODE PEACE. - In-service provided to all staff regarding all new procedures and information that have been created regarding resident #2's care. - In-service to RN's/LPN's regarding their role in the de-escalation of residents. - In-service provided to all staff regarding the creation and procedural implementation of the new Code Peace. - Resident behaviors are documented and reviewed daily to determine if any adjustments to their care plans are necessary. Those identified as having increased behaviors are discussed during the weekly behavior care unit meetings as well as the weekly psychotropic drug review meetings.	

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F 323	<p>Continued From page 8</p> <p>towards Resident #1, took hold of the left side of Resident #1's wheelchair, then flipped the wheelchair, along with Resident #1 over. The staff statements included in the investigation did not clearly document if Resident #1 hit the wall or floor first. However, the staff statements did indicate Resident #1 received injury to his head as a result of the incident.</p> <p>Resident #1's record documented he was seen at local hospital's Emergency Department on 4/26/14 at 9:37 a.m. due to being "Dumped forward out of wheelchair by another patient at [name of facility] this AM." A CT scan was completed and revealed a "Small right frontal/temporal bleed..." No intervention was documented as needed.</p> <p>Additionally, the record documented Resident #1 had a laceration to the right forehead. The record stated, "Deep structures not involved, no bony deformity, no edema, no ecchymosis, no tendon involvement, no joint involvement. Wound not near neurovascular bundle...Simple repair of laceration to the face, forehead, total length 3.0 cm. Skin layer closed, using...5 sutures..."</p> <p>Resident #1 was admitted to the hospital for observation. He returned to the facility on 4/27/14 at 3:30 p.m.</p> <p>A review of Resident #2's record documented he was originally admitted to the facility on 1/7/14 with multiple diagnoses including schizophrenia undifferentiated type and other persistent mental disorders due to conditions classified elsewhere.</p> <p>Resident #2's 4/11/14 quarterly MDS coded: - Moderately impaired cognition</p>	F 323	<p>F 323 continued...</p> <p>Monitoring An audit will be conducted by the Administrator/designee weekly x4 weeks, then every other week x4 weeks, then monthly x3 months to observe appropriate de-escalation tactics with residents by staff. An audit will be conducted by the Administrator/designee weekly x4 weeks, then every other week x4 weeks, then monthly x3 months to observe proper closing and securing of the door to the basement. An audit will be conducted by the Administrator/designee weekly x 4 weeks, then every other week x 4 weeks, then monthly x 3 months to observe proper execution of 1:1 responsibilities. An audit will be conducted by the Administrator/designee weekly x4 weeks, then every other week x4 weeks, then monthly x3 months to observe appropriate implementation of Mock Code PEACE drills.</p>	

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F 323	<p>Continued From page 9</p> <ul style="list-style-type: none"> - Delusions - Physical behavioral symptoms directed towards others occurred 4-6 days - Verbal behavioral symptoms directed towards others occurred 1-3 days <p>At the time of the incident with Resident #1, Resident #2's record included information, dated 3/12/14, which stated Resident #2 had been admitted to the facility from a psychiatric hospital where he had assaulted two different staff due to auditory hallucinations and staff attempting to assist with toileting cares during the night. The document stated triggers for his maladaptive behaviors included, "When someone is looking through his stuff (for example getting his clothes for the day) & he doesn't know what they are doing."</p> <p>Another document, titled Behavior Management Guidelines and dated 1/15/14, stated "Do not get into [Resident #2's] belongings without explaining who you are & why you are in his stuff."</p> <p>Additionally, Resident #2's 1/21/14 Care Plan included a Goal, "Reduce risk of injury to resident/staff/peers." One of the four interventions was, "3. 1:1 to be within arms length at all times." A handwritten 1/22/14 intervention documented, "Ask [Resident #2] if it's OK to touch him and/or his stuff. Do not touch him or his stuff w/o [without] permission."</p> <p>Resident #2's record provided clear documentation he had engaged in physically aggressive behavior in the past, and touching his belongings (including clothing) without his permission could trigger maladaptive behaviors. The facility's 4/26/14 investigation documented</p>	F 323		

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NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201
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F 323	<p>Continued From page 10</p> <p>staff removed Resident #2's clothing without his permission or knowledge triggering a maladaptive behavior that resulted in Resident #1 being injured and requiring 5 sutures to his head.</p> <p>During an interview on 5/9/14 at 11:20 a.m., Housekeeper #3 stated, "I knew not to touch [Resident #2's] clothing because there was one time before when someone took his clothes and he became upset."</p> <p>During an interview on 5/9/14 at 8:17 a.m., the facility's Owner stated the incident should never have happened. The Owner stated the staff violated Resident #2's plans as written and should never have removed his belongings without his permission or knowledge. Staff were to stay at arms length at all times and should not have been between him and the washing machine in the basement and also stated staff did not follow their training.</p> <p>The facility failed to ensure Resident #2's care plan was sufficiently and appropriately implemented to provide a safe environment for other residents, resulting in injury sustained by Resident #1.</p>	F 323		
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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001620	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/09/2014
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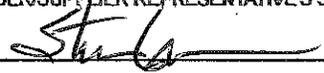
NAME OF PROVIDER OR SUPPLIER
SAFE HAVEN CARE CENTER OF POCATELLO

STREET ADDRESS, CITY, STATE, ZIP CODE
**1200 HOSPITAL WAY
POCATELLO, ID 83201**

(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
C 000	16.03.02 INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiencies were cited during the complaint investigation survey of your facility conducted 5/8/14 - 5/9/14. The facility self-reported this incident as well. The surveyors conducting the survey were: Michael Case, LSW, QIDP, Team Coordinator Karen Marshall, MS, RD, LD Trish O'Hara, RN	C 000		
C 175	02.100,12,f Immediate Investigation of Incident/Injury f. Immediate investigation of the cause of the incident or accident shall be instituted by the facility administrator and any corrective measures indicated shall be adopted. This Rule is not met as evidenced by: Refer to F225.	C 175	C 175 Please refer to response to F 225.	5/14/2014
C 893	02.203,02,g,v Incidents/Accidents v. Any incident or accident occurring while the patient/resident is in the facility. This Rule is not met as evidenced by: Refer to F323.	C 893	C 893 Please refer to response to F 323.	5/14/2014

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Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE:  TITLE: ADMINISTRATOR (X5) DATE: 5/27/14

STATE FORM 6229 ZL MY11 If continuation sheet 1 of 1



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
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May 20, 2014

Steve Gannon, Administrator
Safe Haven Care Center of Pocatello
1200 Hospital Way
Pocatello, ID 83201-2708

Provider #: 135071

Dear Mr. Gannon:

On **May 9, 2014**, a Complaint Investigation survey was conducted at Safe Haven Care Center of Pocatello. Michael Case, L.S.W., Q.M.R.P., Patricia O Hara, R.N. and Karen Marshall, R.D. conducted the complaint investigation. The complaint investigation was conducted at the facility from May 8, 2014 through May 9, 2014.

The following documentation was reviewed:

- The medical records of six residents including those of the two identified residents,
- Resident-to-Resident Investigations dated February 25, 2014 through May 7, 2014,
- Grievances dated February 25, 2014 through May 7, 2014, and
- Resident Council Meeting minutes from February 25, 2014 through May 7, 2014.

Interviews were conducted with three Certified Nurse Aides (CNAs), one Housekeeper, the Administrator, the Director of Nursing Services, the facility Owner, the Chief Operations Officer and the first identified resident.

Observations were conducted on both identified residents, as well as other residents in the facility.

The complaint allegations, findings and conclusions are as follows:

Steve Gannon, Administrator
May 20, 2014
Page 2 of 4

Complaint #ID00006474

ALLEGATION #1:

The complainant stated on April 26, 2014, at 9:30 a.m., an unidentified staff member removed an identified resident's laundry without notification of the resident, hereafter identified as Resident A. The complainant said this was a huge issue for Resident A. Resident A became enraged and threw a second identified resident, hereafter identified as Resident B, against the wall.

Resident B was transported to a local hospital, diagnosed with a subdural hematoma and spent the night in the hospital.

FINDINGS:

Resident A's care plan instructed staff to ask the resident if it was okay to touch him and/or his stuff (personal belongings). In addition, the care plan instructed staff not to touch him or his stuff without permission.

Residents A and B resided on the same hallway and their rooms were next to each other.

Review of the facility's Resident-to-Resident Investigations revealed that Resident A became agitated when a staff person removed his laundry from his room when he was out of the room. This action caused the resident to become enraged. This resulted in the Resident A grabbing Resident B's wheelchair and causing Resident B to be thrown from his wheelchair.

Resident B sustained a laceration to his forehead and had to be transported to a local hospital's emergency department, where he required five sutures for laceration repair.

The facility was cited at F323 for failure to provide a safe environment for residents, and as a result, Resident B was harmed when he sustained a laceration to his forehead that required sutures.

CONCLUSIONS:

Substantiated. Federal and State deficiencies related to the allegation are cited.

ALLEGATION #2:

The complainant stated there is a concern about Resident B's safety and the safety of other residents. The biggest concern was that staff, particularly the nurse aides are just not sufficiently trained in handling things like violence. Staff have not had any de-escalation training.

FINDINGS:

Review of the Resident Council Meeting Minutes and facility's grievances did not provide evidence of the residents, family members or any interested party being concerned about the safety of residents in the facility. There were no concerns or complaints about staff not being sufficiently trained in handling things like violence or requiring de-escalation training.

The CNA who removed the resident's clothing from his room without first asking permission was not working at the time of the complaint investigation.

The Administrator was interviewed and said nursing staff receives one-to-one training before nursing staff can be assigned as a one-to-one with a resident.

The CNA who was providing one-to-one supervision for Resident A when the surveyors entered the building was interviewed. The CNA said he received training prior to working with residents who required one-to-one supervision, including how to de-escalate a situation. The CNA said the resident's care plan that was in place at the time of the incident had specific interventions to prevent the resident from becoming angry, and staff must follow the care plan.

Two other CNAs were interviewed and asked how the facility provided training for nursing staff. Both CNAs said prior to working with any resident who resides in the facility, the facility provided training about how to handle residents with behaviors and how to intervene appropriately as to not cause a resident increased anxiety or agitation.

Both CNAs said after the initial training, CNAs receive additional resident specific training before they are assigned as a resident's one-to-one. Both CNAs said they received sufficient training and were not afraid to work on the hall where Resident A resides.

All three CNAs said each of the residents who required one-to-one supervision has resident specific individual binders and staff is required to document fifteen-minute checks in these binders. In addition, should a CNA not remember any of the specific information they received during the additional resident specific one-to-one training, there is a copy of the information in the fifteen-minute check binder for staff to review as necessary. The CNAs said the hall nurse also talks to them about providing one-to-one supervision for residents.

One of the CNAs said that all staff who works on the hallway where Resident A resides knew prior to the incident when the resident became angry and not to touch the resident's personal belongings including clothes without first asking permission from the resident.

The Housekeeper for the hallway where both of the identified residents resides was interviewed.

Steve Gannon, Administrator
May 20, 2014
Page 4 of 4

The Housekeeper said he has worked at the facility for approximately ninety days. He also said that although he did not provide any one-to-one care, he was made aware of Resident A's preference of not having anyone touch his clothing without first asking permission, as this would cause him to become upset.

It was determined the facility was in substantial compliance with Federal guidelines related to staff training.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the complaint investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this complaint's findings letter, as it will be addressed in the provider's Plan of Correction.

If you have questions, comments or concerns regarding our investigation, please contact Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

A handwritten signature in black ink that reads "David Scott, R.N.". The signature is written in a cursive style with a large initial "D" and "S".

DAVID SCOTT, R.N., Supervisor
Long Term Care

DS/dmj