



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

August 27, 2013

Kara Reese, Administrator
Safe Haven's Mount Vernon/Monticello
3620 Potomac Way
Idaho Falls, ID 83404

License #: RC-1034

Dear Ms. Reese:

On June 27, 2013, an initial licensure and complaint investigation survey was conducted at Carefix Management & Consulting dba Safe Haven's Mount Vernon/Monticello. As a result of that survey, deficient practices were found. The deficiencies were cited at the following 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 not recur.

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

Sincerely,

Maureen McCann
Maureen McCann, RN
Team Leader
Health Facility Surveyor

MM/TFP

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



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July 12, 2013

CERTIFIED MAIL #: 7012 1010 0002 0836 0140

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

Dear Ms. Reese:

Based on the complaint investigation and initial licensure survey conducted by Department staff at Carefix Management & Consulting dba Safe Haven's Mount Vernon/Monticello between June 24, 2013 and June 27, 2013, it has been determined that the facility failed to provide adequate care.

This core issue deficiency substantially limits the capacity of Carefix Management & Consulting dba Safe Haven's Mount Vernon/Monticello to furnish services of an adequate level or quality to ensure that residents' health and safety are protected. 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 **August 11, 2013**. **We urge you to begin correction immediately.**

After you have studied the enclosed Statement of Deficiencies, please write a Plan of Correction by answering **each** of the following questions for **each** deficient practice:

- ◆ What corrective action(s) will be accomplished for those specific residents/personnel/areas found to have been affected by the deficient practice?
- ◆ How will you identify other residents/personnel/areas that may be affected by the same deficient practice and what corrective action(s) will be taken?
- ◆ What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?
- ◆ How will the corrective action(s) be monitored and how often will monitoring occur to ensure that the deficient practice will not recur (i.e., what quality assurance program will be put into place)?
- ◆ By what date will the corrective action(s) be completed?

Return the **signed** and **dated** Plan of Correction to us by **July 25, 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.

Kara Reese
July 12, 2013
Page 2 of 2

In accordance with IDAPA 16.03.22.003.02, you have available the opportunity to question cited deficiencies through an informal dispute resolution process. If you disagree with the survey report findings, you may make a written request to the Supervisor of the Residential Care Program for a Level 1 IDR meeting. The request for the meeting must be made within ten (10) business days of receipt of the Statement of Deficiencies. See the IDR policy and directions on our website at www.assistedliving.dhw.idaho.gov. If your request for informal dispute resolution is not received within the appropriate time-frame, your request will not be granted.

Please bear in mind that non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference. Your evidence of resolution (e.g., receipts, pictures, policy updates, etc.) for each of the non-core issue deficiencies is to be submitted to this office by **July 27, 2013**.

If, at the follow-up survey, the core deficiency still exists or a new core deficiency is identified, the Department will have no alternative but to initiate an enforcement action against the license held by Carefix Management & Consulting dba Safe Haven's Mount Vernon/Monticello.

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.

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) 364-1962. 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

MM/tfp

Bureau of Facility Standards

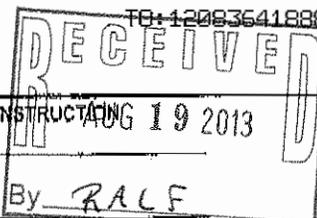
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R1034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/27/2013
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R 000	<p>Initial Comments</p> <p>The following deficiency was cited during the initial survey and complaint investigation conducted between 6/24/2013 and 6/27/2013 at your residential care/assisted living facility. The surveyors conducting the survey were:</p> <p>Maureen McCann, RN Team Leader Health Facility Surveyor</p> <p>Rachel Corey, BSN, RN Health Facility Surveyor</p> <p>Gloria Keathley, LSW Health Facility Surveyor</p> <p>Karen Anderson, RN Health Facility Surveyor</p> <p>Abbreviations used in this report: # = number % = percentage ADL = activities of daily living cm = centimeters Cont = continue d/t = due to MAR = medication assistance record mcg = milli-equivalent min = minute NSA = negotiated service agreement mg = milligram PRN = as needed R = right RES = resident RN = registered nurse UAI = universal assessment instrument</p>	R 000	<p style="text-align: center;">RECEIVED</p> <p style="text-align: center;">JUL 25 2013</p> <p style="text-align: center;">DIV OF LIC & CERT</p>	

Bureau of Facility Standards

TITLE

(X6) DATE

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



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R 008	<p>Continued From page 2</p> <p>further documented, "In the event the resident is receiving hospice services, it is not appropriate to call the hospice staff prior to calling 911...In the event that the facility's RN is on duty to assess the resident, he/she may make the determination if the emergency condition is related to the terminal illness and should be treated."</p> <p>Resident #10 was a 93 year-old female, admitted to the facility on 11/26/12, with diagnoses including diabetes, hypertension and osteoporosis. Resident #10 was receiving hospice services</p> <p>On 6/24/13 at 3:30 PM, the resident was observed in her recliner with a family member beside her. Resident #10 was observed to be unable to answer questions or express her needs.</p> <p>A hospice note, dated 5/23/13, documented Resident #10 fell and received "new" skin tears. The note further documented the resident "was very excitable during my assessment of the wounds, so I ordered her (to be given an Ativan." The note documented no further injuries were discovered.</p> <p>There was no evidence in Resident #10's record indicating the fall on 5/23/13 was investigated by the facility. There was no documentation the facility RN was notified at the time of the fall or that the facility RN had assessed the resident for injuries.</p> <p>A hospice note, dated 5/25/13, documented Resident #10's daughter called the hospice RN to report that the resident was in "severe pain." The note further documented, the hospice RN observed that Resident #10 "was in her recliner</p>	R 008	<p>a physician scheduled to do a visit/assessment on #10 on 7-24-13. Physician orders for the rib wraps & pain meds were obtained on 7-23-13 & 5-30-13. The DC order for the rib wraps was signed by the physician & received 7-23-13. See Attachment 1.</p> <p>- I implemented an updated Emergency Policy & an Alert Charting Policy. I educated by staff on both policies on 6-28-13 & 7-12-13. See Attachment 2. I also created a RN contract with my facility RN specifying that all residents will be assessed within 24 hrs of a fall or Change of Condition. If she is unavailable within that 24 hours, HH Oversight will send in their</p>

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R 008	<p>Continued From page 3</p> <p>with her brows furrowed and grimacing, calling out with movement." The note documented, the nurse wrapped the resident's ribs, increased the resident's pain medication and talked with aides about transferring the resident with gait belt and minimizing movement.</p> <p>An "Outside Services Visit Report Form," dated 5/25/13, documented "Received call that [Resident #10's name] was in severe pain by daughter...when I arrived [Resident #10's name] was wincing and guarding with any movement and breathing. Facility reports fall on Thursday night." The note further documented staff were instructed to increase her pain medication and "wrap ribs in am, remove in pm. Use gait belt at level of hips during transfer." The facility RN signed the report on 5/31/13 (6 days later). The facility nurse did not document an assessment of the resident or make recommendations regarding her care.</p> <p>A hospice "Physician Telephone" order sheet, dated 5/25/13, documented the facility was to increase the resident's hydrocodone to 2 tablets, three times daily and the facility was to wrap the resident's ribs with an ace bandage in the morning and remove in the evening. The order was written by the hospice nurse, but not signed by the physician.</p> <p>A hospice note, dated 5/31/13, documented Resident #10 "visibly shows pain on that R side while dressing her."</p> <p>*According to mayoclinic.org (2012), "While there's no direct treatment for fractured ribs that remain in alignment, medical care is still important to avoid serious complications...Rib bones moved out of alignment can cause</p>	R 008	<p>on call RN to do the assessment & I will report the assessment to the facility RN. See Attached RN contract.</p> <p>- Along with implementing the Emergency Policy & Alert Charting, I have created a Change of Condition document that is for use by my Facility RN. The Facility RN would, in this situation, have assessed the resident & considered her rib pain a change of condition. She would then give her recommendations to me & my staff. Again, in this case, the recommendation would have been to seek medical treatment immediately to be evaluated by a physician. See Attachment 2.</p>	

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R 008	Continued From page 4 life-threatening complications including punctures and damage to the lungs and other critical blood vessels or organs." According to mayoclinic.com (2011) "In the past, doctors would use compression wraps - elastic bandages that you can wrap around your chest - to help splint and immobilize the area. Compression wraps aren't recommended for broken ribs anymore because they can keep you from taking deep breaths, which can increase the risk of pneumonia." On 6/26/13 at 9:20 AM, the administrator confirmed there was no investigation into Resident #10's fall. She stated she remembered getting a call regarding the fall, then two days later the resident was in "severe pain" and the resident had "possible cracked ribs." The administrator stated the resident was not evaluated by a physician, but the hospice nurse instructed staff on what measures to take. On 6/26/13 at 9:45 AM, the facility nurse stated she had not assessed the resident at the time of the fall. She further stated, "I only come in on Thursdays, so if it didn't happen on a Thursday I wouldn't have been called in." She further stated, she remembered reading a note about the resident being in severe pain, but by the time she observed the resident, on 5/30/13, "she was fine." On 6/26/13 at 9:55 AM, a hospice RN stated Resident #10 had "fallen a lot and we are not sure what fall caused the rib pain." She confirmed the resident was not further medically evaluated, because she was on hospice. On 6/26/13 at 10:20 AM, a caregiver stated after Resident #10 fell, "anytime we moved her, she was crying in pain." She stated the pain lasted about a week. She further stated, the daughter	R 008	- In many cases such as this, a resident does not always show signs/symptoms of pain immediately after a fall. If that's the case, the Facility RN may not have recommended medical treatment in her assessment after the fall. This is where Alert Charting would come into place. Alert Charting will be done on all residents after every fall or Change of Condition. The purpose of that is to do frequent checks & document every two hours on the progress of that resident. If the Facility RN feels a Change of	

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R 008	<p>Continued From page 5</p> <p>"evaluated" the pain and thought the resident had cracked a rib.</p> <p>On 6/26/13 at 10:25 AM, a caregiver stated after Resident #10 fell, staff were instructed to wrap her ribs with an ace bandage and be "really careful when moving her." She further stated, the resident "seemed be in pain when repositioning."</p> <p>On 6/26/13 at 2:30 AM, Resident #10's daughter stated after Resident #10 fell, caregivers noticed that she was in pain and called her. "They asked me to watch her and see if I noticed a change, because she had been flinching in pain." She further stated, "We didn't take her in," because leaving the facility caused Resident #10 to be anxious. She stated, after she appeared to have rib pain, Resident #10 was fed in her room, so she would not have to be moved so much.</p> <p>Resident #10 fell and was observed by family, caregivers, and hospice staff to have severe rib pain, indicating possible rib fractures or further injuries. The fall was not related to the terminal illness, yet Resident #10 was not evaluated by a medical doctor, who could determine the extent of her injuries and the appropriate treatment and care. The hospice nurse provided instructions to staff, but there was no evidence in the record to indicate the orders were approved by a medical doctor. By not providing the appropriate medical interventions to Resident #10, the resident's health was placed in jeopardy.</p> <p>II. Assistance and Monitoring of Medications</p> <p>Resident #5 was a 60 year-old female who was admitted to the facility on 6/6/13, with a diagnosis of Stage IV metastatic liver cancer.</p>	R 008	<p>Condition is needed due to the Alert Charting findings, she can assess & the facility can seek emergency services if recommended.</p> <p>The above corrective actions will be fully in place by 8-11-13. Kantler, PCA</p> <p>- Resident #5 passed away on 7-1-13 due to the natural course of her diagnosis. From 6-25-13 to 6-26-13</p>	

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R 008	<p>Continued From page 6</p> <p>On 6/25/13 at 8:55 AM, during the facility tour, Resident #5 was observed to be very somnolent at the breakfast table. The resident appeared to struggle to open her eyes. Her head was bobbing as she attempted to hold it up while a caregiver offered her a sip of fluid.</p> <p>The night shift documented in a "Daily Note", dated 6/25/13, "Res okay, very lethargic, slept all night."</p> <p>A June 2013 MAR, documented the resident had received the following routine medications, which could have sedating effects, that morning on 6/25/13, at 8:00 AM:</p> <p>*Fental 125 mcg patch *Lorazepam 0.75 mg</p> <p>The MAR further documented the following medications were to be given PRN:</p> <p>*Benedryl 25 mg for itching</p> <p>The MAR also documented the following medications were to be given PRN, but a hospice nurse changed the MAR so that the medications were given on a routine schedule:</p> <p>*Haldol 2 mg for agitation/nausea, 4 times daily *morphine 20 mg for pain, 4 times daily *promethazine 12.5 mg for nausea, twice daily</p> <p>The resident's record did not contain a copy of signed physician's orders.</p> <p>At a surveyor's request, signed physician's orders, dated 5/28/13, were received by the</p>	R 008	<p>My staff called a RN before administering/holding each dose of scheduled medication. From 6-27-13 to the time of her passing, her Benedryl, promethazine, haldol & Morphine were used as PRN medications & my medication aids called a RN before administering. See Attachment 3.</p> <p>- The Change of Condition document that I have implemented will be used by the Facility RN to assess & make recommendations on situations such as over-sedation. It is stated in my RN contract that it is her responsibility to educate staff about possible side effects of certain medications. See</p>	

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R 008	<p>Continued From page 7</p> <p>facility in the evening of 6/26/13. Haldol, morphine, promethazine and Benedryl were all ordered as PRN medications. However, on 6/6/13, the hospice nurse had changed the Haldol, morphine and promethazine orders to scheduled medications. For 20 days the resident received these sedating PRN medications routinely.</p> <p>The Benedryl PRN was signed off on the MAR as given 46 times out of a possible 87 times, with no documentation why the PRN was needed.</p> <p>On 6/25/13 at 9:00 AM, a caregiver stated, she had assisted the resident with the above medications at 7:00 AM. When asked if the resident had complained of itching or nausea, the caregiver stated the resident had not. When asked if the resident was agitated or in pain, the caregiver stated, "yes, she was moving around, holding her stomach." She confirmed she felt these were signs that the resident was agitated and in pain. When asked if the resident appeared sedated, she stated, "yes." When asked what the medication protocol was when a resident appeared sedated, she stated, "I give the medications that are here (she pointed to the MAR). I don't know, you'll have to ask the nurse."</p> <p>On 6/25/13 at 10:30 AM, the facility nurse stated, she had not given instructions to caregivers during delegation of assistance with medications regarding what to do if a resident appeared to be overly sedated. She further stated, "I haven't been concerned about that."</p> <p>On 6/26/13 at 9:05 AM, the administrator stated, she did not have signed orders from the physician. When asked why the PRN medications were being given routinely, she stated, the</p>	R 008	<p>RN Contract.</p> <p>- Training will be held on 8-8-13 to educate staff on side effects & interactions of medications. I also had training on our Facility Medication Policy on 7-12-13. See Attachment 4.</p> <p>- In addition to the RN Contract, I have been verbally educating my Facility RN about the expectations & importance of her delegations to my unlicensed staff. The Change of Condition form will be used to ensure that no such incident goes unaddressed in the future.</p> <p>- The facility RN will do weekly monitoring for any changes of condition that</p>	

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R 008	<p>Continued From page 8</p> <p>hospice nurse wrote the orders in the MAR and crossed through the "PRN". "I think they were never supposed to be PRN, so she changed them."</p> <p>On 6/26/13 at 3:45 PM, the resident's hospice nurse stated, the resident had been somnolent which was due to her disease process. She confirmed she had changed the PRN medications to routine and acknowledged the facility needed a copy of signed physician's orders. However, when the physician's orders were received that evening, they indicated the Haldol, morphine and promethazine, should have been given PRN, not routinely.</p> <p>On 6/27/13 at 11:00 AM, the MAR had not yet been corrected to reflect the correct physician's orders which arrived the evening before. The resident received Haldol, morphine and promethazine at 8:00 AM. There was no documentation that the resident had requested those medications or was observed to have any symptoms requiring them.</p> <p>The facility did not have current physician's orders for Resident #5. The resident received PRN medications routinely for 21 days. There was no documentation that the resident showed signs or symptoms which required the PRN medications. The resident was observed to be very somnolent/lethargic, and yet sedating, PRN medications were still given by unlicensed staff, without a licensed nurse's assessment. The facility failed to appropriately assist and monitor Resident #5 with her medications.</p> <p>III. Assistance with Eating</p> <p>Resident #1 was a 75 year-old man, admitted to</p>	R 008	<p>She observes that weren't already reported to her by me or my staff. Any change of conditions she does will be completed within 24 hours of the change.</p> <p>The RN will complete Nurse Delegations to my Medication certified aids at an increased frequency of every 3 months. She will do continuing education during this time to ensure that each staff is aware of proper protocol for administering of all medications, including PRN's & to always monitor for side effects or over sedation.</p> <p>- The above will be completed no later than 8-11-13. Karrh, RCH</p> <p>on 7-3-13, I implemented a snack log w/verbal</p>	

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R 008	<p>Continued From page 9</p> <p>the facility on 6/11/13, with a diagnosis of severe dementia with behavioral disturbances.</p> <p>An interim plan of care, not dated, documented the resident needed minimal assistance with eating. "Can feed self, chew and swallow food; May need some cueing to maintain adequate intake..." The plan further documented, "Always disoriented and requires constant supervision and oversight for safety; Extensive intervention needed to manage behavior." However, the plan did not describe what behavior the resident required help managing. The plan further documented, "Poor judgement needs protection and supervision because client makes unsafe or inappropriate decisions."</p> <p>An admission agreement, dated 6/11/13, documented, "A resident will be admitted or retained only when the facility has the capability, capacity, and services to provide appropriate care...(and) the personnel, appropriate in numbers and with the appropriate knowledge and skills to provide such services..." The agreement also documented, "Staff will assist residents in eating as circumstances require."</p> <p>An ADL's flow chart documented the resident's following intake at meals between 6/11/13 and 6/24/13:</p> <ul style="list-style-type: none"> *6/11/13, nothing documented at dinner *6/12/13, refused all meals *6/13/13, refused all meals *6/14/13, ate 5% at breakfast, refused lunch and dinner *6/15/13, ate 10% at breakfast, refused lunch. The dinner block was blank *6/16/13, refused all meals *6/17/13, ate 5% at breakfast, 10% at lunch and 	R 008	<p>direction to staff to record all snacks & fluids given to Resident #1. I obtained a physician order to give Ensure twice daily as a meal substitute. Resident #1 has done well thus far with the ensure & offered snacks. See Attachment 5.</p> <p>- Education was given to staff on 7-19-13 regarding Negotiated Service Agreements. My assessment & the Facility RN's assessment will determine if the NSR will state that assistance is required with eating. The staff are now required to sign each resident's NSR acknowledging the required assistance. See Attachment 6</p> <p>- I implemented a</p>	

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R 008	<p>Continued From page 10</p> <p>refused dinner *6/18/13, refused all meals *6/19/13, refused breakfast, refused lunch and ate 100% at dinner *6/20/13, refused breakfast, refused lunch and ate 100% at dinner *6/21/13, refused all meals *6/22/13, refused all meals *6/23/13, refused all meals *6/24/13, refused breakfast, refused lunch and ate 20% at dinner</p> <p>Over 14 days and 40 potential meals, Resident #1 only ate 7 times; 5 times at less than 20%.</p> <p>There was no other documentation from the administrator or the facility nurse regarding the resident's refusal to eat or instructions to caregivers on what to do when the resident refused meals. Further, there was no documentation that the resident's physician had been notified of the resident's refusal to eat.</p> <p>A "90 DAY RN ASSESSMENT", marked "Initial" assessment and dated 6/13/13, contained no documentation regarding the resident's refusal to eat or that the resident became combative when eating. There was no other nursing assessment in the resident's record.</p> <p>There was no behavior or care plan found in the resident's record to instruct caregivers how assist him with eating.</p> <p>There was no documentation in the resident's record the resident had been aggressive or combative when assisted with meals.</p> <p>Between 6/24/13 and 6/27/13, the resident was observed at various times either in his room lying</p>	R 008	<p>Snack Policy on 7-12-13 & held training for the staff. Any residents who are unable to access or ask for a snack will have a snack log implemented. In addition, we will take the Facility RN's recommendations on Change of Conditions in a situation such as this where a resident is refusing meals. See Attachment 7 - Weekly checks will be done on residents ADL Charting to ensure snacks are being offered & documented properly. Change of Conditions will be done on all residents who start refusing meals.</p> <p>- The above corrections will be completed by 8-11-13. L.M., RCA</p>	

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R 008	<p>Continued From page 11</p> <p>in bed, lying on the floor in his room or on the floor in the common area, wandering around the facility or asleep on the couch in the common area. When approached and asked a question, the resident appeared startled, did not look up and stared at the ground whether sitting or standing. The resident appeared to be very confused and not able to make his needs known. When the resident was observed ambulating, he had an unsteady gait and did not appear to know where he was going. He often did not respond to his name.</p> <p>On 6/24/13 at 4:30 PM, the resident was observed lying on his bed. He did not respond to his name or several simple questions, although he was awake. There was no food or fluid observed in his room.</p> <p>On 6/25/13 at 8:00 AM, two caregivers stated, Resident #1's wife comes in to visit daily and "gets him to eat." They further stated the staff were afraid of him because he would become combative when staff tried to assist him with meals. The caregivers stated, the resident's wife told them, "Don't force him to eat."</p> <p>On 6/26/13 at 8:34 AM, the administrator stated, Resident #1's wife lived in northern Idaho and had not been to the facility. She further stated the resident received hospice care who sometimes fed him snacks.</p> <p>On 6/25/13 between 8:00 AM and 9:25 AM, Resident #1 was observed lying in his bed awake. He appeared very confused and unable to carry on a conversation or even answer simple questions. No food or fluid was observed in Resident #1's room. Further, caregivers had not been observed to offer Resident #1 food or fluid,</p>	R 008			

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R 008	<p>Continued From page 12</p> <p>or assist the resident to come out of his room for breakfast.</p> <p>At 9:25 AM, after the other residents' breakfast was over and the caregivers were cleaning up the kitchen, a surveyor requested the caregivers offer Resident #1 something to eat. The resident had ambulated out to the living room, was standing in the middle of the room and appeared to be lost. A caregiver offered the resident a dry muffin. The resident was clearly confused and did not know what to do with it as he waved it around in his hand a few times before the caregiver helped him bring it to his mouth. The caregiver then left the area and was not observed to "cue" the resident to eat the muffin, nor was the resident observed to be offered fluid to go with the dry muffin. The resident took a few bites of the muffin and spit some of it out onto the floor. There were no caregivers in view of the resident.</p> <p>At 10:05 AM, a caregiver asked Resident #1 if he wanted a drink and he said "no." At 10:10 AM, the caregiver stated, "I'll get you a drink, OK?" but the resident did not respond. At 10:15 AM, the caregiver approached the resident again. The resident was kneeling on the floor with his head on a couch cushion. She assisted him to sit on the couch and stated, "I need to get you a drink." At 10:30 AM, the resident still had not been brought something to drink.</p> <p>Except at 9:25 AM, when a surveyor requested the resident be given something for breakfast, the resident had not been offered food or fluids between 8:00 AM and 10:30 AM.</p> <p>On 6/25/13 between 11:00 AM and 12:50 PM, residents received their lunch meal. Resident #1 had been in his room in bed during this time and</p>	R 008		

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R 008	<p>Continued From page 13</p> <p>had not eaten. Caregivers were not observed to wake the resident for lunch or bring any food to the resident room.</p> <p>On 6/25/13 at 11:25 AM, the administrator stated, the staff did not feed Resident #1 at meal times, because he become combative. She also stated, the resident refused meals and mostly ate snacks.</p> <p>On 6/26/13, between 8:30 AM and 12:20 PM, no snacks or fluids were observed in the resident's room. A caregiver asked the resident if he wanted lunch at 12:20 PM and without making eye contact, he said "no". The caregiver did not offer food or fluids to the resident.</p> <p>On 6/26/13 at 3:10 PM, a staff member stated, he was able to get Resident #1 to eat. "I think it's all in the approach. I got down to his level (staff knelt down) and he ate half of a donut and drank 4 cups of water...He had refused it when I just handed it to him."</p> <p>Caregivers stated they did not assist Resident #1 with meals because they were frightened of his aggressive behaviors. However, there was no documentation to support that the resident was combative with staff during eating. The facility did not provide Resident #1 adequate assistance with eating.</p> <p>IV. Retention of a Resident with a Stage III Pressure Ulcer</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>	R 008			
			- An eviction notices was issued on 6-28-13 to the responsible party for Resident # 2. I began working with her POA		

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R 008	<p>Continued From page 14</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. *Stage III pressure ulcer - may include tunneling and slough. *Unstageable - Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed.</p> <p>Resident #2 was an 88 year-old female, admitted to the facility on 11/1/12 with a diagnosis of dementia and a history of pressure ulcers on the right heel.</p> <p>Resident #2's NSA, dated 11/1/12, documented the resident needed to wear a protective foam boot on her "R foot at all times due to wound on heel."</p> <p>On 1/22/13, the facility RN's assessment, documented Resident #2 had a pressure ulcer that measured 1.5 cm x 1.2 cm. There was no documentation where the ulcer was located on the resident's body or what stage it was.</p> <p>On 2/27/13, the facility RN's assessment, documented Resident #2's skin was "pink, warm, dry, intact." The nurse's recommendations were to "Cont to wrap feet daily, examine feet for sores."</p> <p>A clinical note, from Resident #2's physical therapist dated 3/1/13, documented the resident had a Stage III pressure ulcer on her right heel</p>	R 008	<p>to find an appropriate & safe place for Resident #2 to discharge to. During discharge planning Resident #2 passed away due to the natural progression of her disease. Date of passing was 7-10-13. See Attachment 8.</p> <p>- my facility RN will follow her contract & monitor notes from outside service agencies on a weekly basis. A change of condition will be implemented for any resident that develops a wound. Staff education will be given on 8-8-13 to discuss skin checks & reporting any issues or concerns to the facility</p>	

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R 008	<p>Continued From page 15</p> <p>that measured "2.0 cm x 2.0 cm." The physical therapist documented the wound bed was "Red/white mixture of granulation and granulating fatty tissue." He further documented, the resident needed a pressure redistribution boot for the pressure ulcer to help with healing and to "coordinate" with a hospice nurse to ensure the dressing on the wound was changed two times per week or more often if needed.</p> <p>A hospice RN's assessment, dated 4/18/13, documented the resident's right heel pressure ulcer had necrotic tissue and was unstageable.</p> <p>The facility RN documented on the hospice RN assessment, dated 4/18/13, that the pressure ulcer on the resident's right heel needed to be staged, because if it was unstageable, the facility would need to give Resident #2, a thirty day discharge notice. However, there was no further documentation the hospice RN staged the pressure ulcer.</p> <p>A hospice RN's assessment, dated 4/22/13, documented the resident's pressure ulcer was a "deep pressure wound."</p> <p>On 5/15/13, the facility RN's assessment, documented Resident #2 had a pressure sore on her right heel. The RN made recommendations for staff to ensure the resident wore a "Podus" boot on her right foot to help protect and prevent the pressure ulcer from further breakdown. The assessment did not include a description of the pressure ulcer on her right heel, a measurement or the stage of the pressure ulcer.</p> <p>A hospice RN's assessment, dated 5/21/13, documented "Wound measurements 6 cm x 6 cm minimal drainage - odor decreased significantly."</p>	R 008	<p>RN. I also developed a Nurse Notification Sheet for the staff to use as an easy way to communicate with the Facility RN when she isn't at the facility. The staff will leave the notification in the Nurse's Box for review. See Attachment 9</p> <p>- The facility RN will be required to follow up on any wound & document bi-weekly improvement. If the wound does not improve, the Facility RN is responsible for informing the Admin. If a resident's wound is beyond RALF level of care.</p> <p>- Any wound requiring wound care will have an outside agency brought in to care for that resident.</p>	

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R 008	<p>Continued From page 16</p> <p>The facility RN documented on the hospice assessment form, "Will continue to monitor."</p> <p>From 1/22/13 through 5/21/13, (4 months) Resident #2's pressure ulcer increased in size from a measurement of 1.5 cm x 1.2 cm to a measurement of 6 cm x 6 cm.</p> <p>On 6/11/13, the facility RN's assessment documented Resident #2 had a Stage II pressure ulcer on her right heel that was covered with eschar.</p> <p>According to the "National Pressure Ulcer Advisory Panel" pressure ulcer staging criteria, an ulcer covered with eschar is considered unstageable and therefore is greater than a Stage II.</p> <p>On 6/24/13, a hospice RN's assessment documented, "Wound unstageable d/t eschar."</p> <p>On 6/25/13 at 9:45 AM, a hospice RN stated the wound had been unstageable for a few months due to eschar covering the wound.</p> <p>On 6/25/13 at 10:00 AM, a previous facility RN stated she had observed the wound one time in either April or May. She stated at that time, the pressure ulcer had black edges and the wound did not feel "boggy" (soft).</p> <p>The facility retained a resident whose pressure ulcer was increasing in size and severity and was greater than a Stage II for at least 3 months. There was no documentation the facility had given Resident #2 a thirty day discharge notice.</p> <p>V. Safe and Secure Environment</p>	R 008	<p>My facility RN will be required to monitor all wounds every other week & make her recommendations on said wounds. Change of conditions will be completed by the RN as less necessary & any wound that is unstageable or greater than a stage II, will have a 30 day eviction notice issued!</p> <p>- Corrective actions will be completed by 8-11-13. Karl, RCB</p> <p>- I completed an investigation on Resident #6's elements</p>	

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R 008	<p>Continued From page 17</p> <p>IDAPA rule 16.03.22.011.08 defines inadequate care as: "When a facility fails to provide...supervision...a safe living environment..."</p> <p>IDAPA rule 16.03.22.011.010 defines elopement as: When "a resident who is unable to make sound decisions physically leaves the facility premises without facility's knowledge."</p> <p>On 6/24/13, the facility property was observed. The facility consisted of two buildings, with a fenced yard between the two buildings. Each building, also had a front door, which required a keypad code to exit. Each building had an unlocked side door, which opened into the fenced yard. Within the fenced yard, a sidewalk joined the two buildings together. At this time, there were 14 residents in one building and 15 residents in another.</p> <p>The June 2013 employee schedule, documented the general staffing patterns were two caregivers in each building, except for 10:00 PM to 6:00 AM, when one caregiver was scheduled in each building.</p> <p>Resident #6 was a 75 year-old male, admitted to the facility on 11/1/12, with a diagnosis of dementia.</p> <p>Resident #6's UAI, dated 2/27/13, documented, "Wanders within the residence or facility. May wander outside; health or safety may be jeopardized...Frequently disoriented to person, place, time or situation, even if in familiar surroundings, and requires supervision and oversight for safety."</p> <p>On 6/19/13, it was reported to Licensing and</p>	R 008	<p>and discovered a broken gate in our back courtyard that was opening freely & would have given Resident #6 access to the front/road. I called Maintenance & the gate was fixed prior to Resident's #6 return to the facility on 7-1-13. His medications were also adjusted during his stay at the behavioral hospital & since his return, his behaviors have minimized. See Attachment 10.</p> <p>-I created a Behavior Observations log, a RN Behavior Observations document with a spot for recommendations,</p>	

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R 008	<p>Continued From page 18</p> <p>Certification that on 6/15/13 at 3:30 PM, Resident #6 "got out the front door and made it about two blocks down the street." It was also reported, the resident "wanders in the facility most of the time...will need to monitor his anxiety levels and try distractions so he does not need to feel the need to leave on his own."</p> <p>An un-timed incident report of the 6/15/13 elopement, documented "staff was doing rounds after giving a shower and noticed that said resident was no where in sight. I called [the other building] to see if [Resident #6's name] had gone there. I called my administrator to let her know. I got off the phone and 5 min later police showed up with [Resident #6's name]. Staff brought him in and got him on oxygen and gave fluids." The incident report did not document an investigation into how the resident got out or what interventions staff were to implement to keep the resident safe.</p> <p>A second incident report, dated 6/20/13 at 9:00 PM, documented Resident #6 had eloped the facility a second time. The report documented, a caregiver noticed the resident was missing and "searched everywhere for him." When the caregiver could not find him, she called the administrator who instructed her to call 911. After calling 911, the caregiver was informed the police had already located the resident, as he was found by "a lady driving by" who called 911. The incident report did not document an investigation or interventions that staff were to implement to keep the resident safe. The report documented the administrator instructed staff that once the resident returned "she wanted his oxygen put on him."</p> <p>On 6/21/13, the administrator documented the following in a letter to a behavioral hospital,</p>	R 008	<p>and held staff training on Behavior Observations & Documentation on 6-28-13. Between the staff observations/documentation & following RN recommendations, we should be able to recognize & prevent the risk of elopements in the future. See Attachment 11.</p> <p>- In addition to the above, we will utilize the implemented Alert Charting if a resident is at risk of Elopement. We will also do one on one supervision for elopement risks during the 72 hour Alert period. See Attachment 2, Alert</p>	

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R 008	<p>Continued From page 19 requesting the resident be admitted:</p> <p>*6/15/13 at 3:30 PM: Resident #6 eloped and was found by a passing officer two blocks away and was crawling on the sidewalk. "He was without his oxygen and exhausted. The officer figured he belonged to our facility, due to the fact that he was so close, and brought him back to us, no injury."</p> <p>*6/18/13 at 6:00 PM: Resident #6 "got out of the facility but only got to the end of the parking lot before my staff caught him. He was agitated about coming back inside, but eventually did because he did not have his oxygen on and knew he was running out of air."</p> <p>*6/20/13 at 8:30 PM: Resident #6 eloped and was found on the side of a street "out of air, again without his oxygen."</p> <p>**"This behavior has been going on for the last few weeks and just seems to be getting continually worse... Two days ago, he came into my office very agitated... He then proceeded to the front door and tried repeatedly to push it open... [Resident #6's name] constantly gets out our back doors, which are unlocked to our gated backyard, but more often, he stands at the front door waiting for visitors to come and go, and he tries to sneak out with them. He poses a great danger to himself as he wouldn't make it long without his oxygen and does not pay attention when crossing the street. He could easily be hit by a car or pass out from lack of oxygen when he escapes..."</p> <p>On 6/25/13 at 2:45 PM, the administrator stated she had not completed an investigation into Resident #6's elopements.</p>	R 008	<p>Charting Policy.</p> <p>- At the conclusion of the Alert Charting I will conduct an investigation, along with the Facility RN completing an assessment & together we will determine if the risk has subsided, or if the resident needs further evaluation & may need to find a more secure environment. We will consult the Resident physician as needed.</p> <p>- The above will be completed by 8-11-13. Kuh, RCA</p>	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R1034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/27/2013
NAME OF PROVIDER OR SUPPLIER CAREFIX-SAFE HAVEN'S MOUNT VERNON/MC		STREET ADDRESS, CITY, STATE, ZIP CODE 3620 POTOMAC WAY IDAHO FALLS, ID 83404		
(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 20</p> <p>On 6/25/13 at 3:25 PM, the administrator stated after Resident #6 eloped the first time, she instructed staff to do frequent checks on him and try more distractions. She stated, Resident #6 was in the mindset that he wanted to work, so chores were offered to him, but "nothing was helping and he continued to want to leave." The administrator stated, she had provided verbal training to staff on providing frequent checks, but had not developed a written plan to keep him safe.</p> <p>On 6/26/13 at 8:20 AM, a caregiver stated Resident #6 "was always trying to leave." She further stated, after his elopement, staff were instructed to "watch him more closely."</p> <p>On 6/26/13 at 8:30 AM, a caregiver stated after Resident #6's elopement, she was instructed "to keep an extra close eye on him and keep him occupied." She further stated, as soon as she was done with providing personal cares with a resident, she would "try to make it to his room to check on him and make sure he was still there."</p> <p>On 6/26/13 at 3:15 PM, a caregiver stated after resident #6 eloped, she was instructed to "keep an eye on him." She further stated, "The hardest part with [Resident #6's name] is that when you are passing medications and trying to watch [Resident #6's name]. He is fast. He will be in a chair and when you come back he will be gone."</p> <p>After Resident #6 eloped on 6/15/13, the facility administrator did not conduct an investigation into the elopement and evaluate if the facility could provide a safe and secure environment for him. Additionally, the facility administrator did not develop a plan to keep the resident safe. Staff</p>	R 008		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R1034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/27/2013
NAME OF PROVIDER OR SUPPLIER CAREFIX-SAFE HAVEN'S MOUNT VERNON/MC		STREET ADDRESS, CITY, STATE, ZIP CODE 3620 POTOMAC WAY IDAHO FALLS, ID 83404		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 008	Continued From page 21 were instructed to implement frequent checks, but staff were still unable to meet the resident's supervision needs. As as result, the resident left the building again, but not the facility premises, on 6/18/13. Then, on 6/20/12, Resident #6 eloped a second time. The facility did not provide a safe and secure environment for Resident #6. The facility failed to provide emergency medical care for Resident #10 after a fall. Additionally, the facility failed to appropriately assist Resident #5 with her medications and Resident #1 with eating. The facility also retained Resident #2, who had a Stage III pressure ulcer. The facility further failed to provide a safe and secure environment for Resident #6 when he left the building unsupervised three times and the facility premises unsupervised twice. These findings resulted in inadequate care.	R 008		



Facility Name Carefix – Safe Haven’s Mount Vernon/Monticello	Physical Address 3620 Potomac Way	Phone Number 208-528-0467
Administrator Kara Reese	City Meridian IDAHO FALLS	ZIP Code 83404
Survey Team Leader Maureen McCann, RN	Survey Type Initial Survey and Complaint investigation	Survey Date June 27, 2013

NON-CORE ISSUES PAGE 1 OF 3

ITEM #	RULE #	DESCRIPTION	DATE RESOLVED	L&C USE
1	009.03	1 of 8 staff worked alone without completing a criminal history background check.		
2	152.05.iii	Resident #1, #5, and #9's, beds had side rails attached.		
3	210	The facility did not provide an on-going activity program that encouraged and promoted Residents to maintain and develop their highest potential.		
4	215.01	The facility administrator did not ensure the facility's emergency policy was followed, when caregivers notified the administrator prior to emergency services.		
5	225.01	Resident #2 and #10's behaviors were not evaluated.		
6	225.02	Interventions were not developed for Resident #2 and #10's behaviors.		
7	250.10	Water temperatures were not maintained between 105 and 120 degrees.		
8	300.01	The facility RN did not conduct an initial assessment for Resident #2 and #8.		
9	300.02	Resident #3's low carb diet was not implemented and Resident #8's new insulin orders were not reviewed by the RN before being implementation.		
10	305.02	Not all PRN medications were not available for Resident #8 and #9. Resident #5 did not have signed physician orders.		
11	305.03	The RN did not assess changes of conditions such as: Resident #2, #4 and #10's pressure ulcer, Resident #2's UTI, Resident #5's increased lethargy and Resident #7's seizure.		
12	305.04	The facility RN did not make recommendations such as: Skin breakdown interventions for Residents #'s 2, 4, 8, 10 & 11 or Resident #5's increased sedation or Resident #1's decreased food intake.		

Response Required Date
July 27, 2013

Signature of Facility Representative

Date Signed
6-27-13



Facility Name Carefix – Safe Haven’s Mount Vernon/Monticello	Physical Address 3620 Potomac Way	Phone Number 208-528-0467
Administrator Kara Reese	City Meridian IDAHO FALLS	ZIP Code 83404
Survey Team Leader Maureen McCann, RN	Survey Type Initial Survey and Complaint investigation	Survey Date June 27, 2013

NON-CORE ISSUES PAGE 2 OF 3

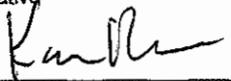
ITEM #	RULE #	DESCRIPTION	DATE RESOLVED	L&C USE
	16.03.22			
13	305.06	Resident #3 was not assessed by the RN to safely self-administer his own insulin.		
14	305.07	The RN did not review Resident #5’s medications for side effects or interactions ^{interactions} interventions ^{interventions} .		
15	310.01.c	There wasn’t a temperature log kept for 2 refrigerators that stored medications.	COS	
16	310.01.a	Medications were not kept secured in 2 refrigerators.	COS	
17	310.01.d	Assistance with medications did not comply with the board of nursing rules such as: Staff were interpreting Resident #3’s sliding scale insulin. Unlicensed staff were assisting with PRN medications which required a nursing assessment. A family member injected Resident #8’s insulin.		
18	310.03	Controlled substance tracking sheets were not accurate.		
19	310.04.e	Psychotropic medication reviews were not conducted every 6 months for Resident #9 & #10.		
20	320.01	Resident #2’s NSA was not implemented regarding assistance with eating.		
21	335.03	Staff were not observed to change gloves and wash hands between tasks.		
22	350.02	The administrator did not investigate all incidents and accidents such as: Resident #11’s unknown bruising, Resident #10’s falls and when Resident #9 left the facility unsupervised.		

Response Required Date July 27, 2013	Signature of Facility Representative 	Date Signed 6-27-13
---	--	------------------------



Facility Name Carefix -- Safe Haven's Mount Vernon/Monticello	Physical Address 3620 Potomac Way	Phone Number 208-528-0467
Administrator Kara Reese	City Meridian IDAHO FALLS	ZIP Code 83404
Survey Team Leader Maureen McCann, RN	Survey Type Initial Survey and Complaint investigation	Survey Date June 27, 2013

NON-CORE ISSUES PAGE 3 OF 3

ITEM #	RULE #	DESCRIPTION	DATE RESOLVED	L&C USE
23	430.03	A random resident did not have a bed in her room.		
24	451.02	The facility did not offer snacks between meals and at bedtimes.		
25	600.05	The administrator did not ensure 1 of 8 employees had documented evidence of orientation training prior to working alone.		
26	600.06.b	One of 8 staff worked alone without CPR and First Aid training.		
27	625.03.k	Staff were not aware of the purpose of the NSA.		
28	711.04	Resident #1's physician was not informed of his refusals of cares.		
29	711.08.c	The facility did not document all unusual events such as, incidents and accidents.		
30	711.08.d	The facility did not document when the physician was called.		
31	711.08.e	Facility staff did not document when they notified the facility RN for residents who had a change of condition.		
32	711.08.f	Care notes from outside services were not available in the record for all residents.		
Response Required Date July 27, 2013	Signature of Facility Representative 		Date Signed 6-27-13	



IDAHO DEPARTMENT OF

HEALTH & WELFARE Food Establishment Inspection Report

Residential Assisted Living Facility Program, Medicaid L & C
3232 W. Elder Street, Boise, Idaho 83705
208-334-6626

Critical Violations

Noncritical Violations

Care Lin Mt Vernon & Montice

Establishment Name <i>Safe Haven's</i>		Operator <i>Karen Reese</i>	
Address <i>3220 Potomac Way Idaho Falls 83401</i>			
County <i>Bonneville</i>	Estab # <i>20828</i>	EHS/SUR #	Inspection time: _____ Travel time: _____
Inspection Type:	Risk Category: <i>High</i>	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 <i>2</i>	# of Retail Practice Violations <i>1</i>
# of Repeat Violations <i>2</i>	# of Repeat Violations <i>2</i>
Score <i>2</i>	Score <i>1</i>
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
<i>(Y)</i> 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)			
<i>(Y)</i> N	2. Exclusion, restriction and reporting	<input type="checkbox"/>	<input type="checkbox"/>
Good Hygienic Practices			
<i>(Y)</i> N	3. Eating, tasting, drinking, or tobacco use (2-401)	<input type="checkbox"/>	<input type="checkbox"/>
<i>(Y)</i> N	4. Discharge from eyes, nose and mouth (2-401)	<input type="checkbox"/>	<input type="checkbox"/>
Control of Hands as a Vehicle of Contamination			
<i>(Y)</i> N	5. Clean hands, properly washed (2-301)	<input type="checkbox"/>	<input type="checkbox"/>
<i>(Y)</i> N	6. Bare hand contact with ready-to-eat foods/exemption (3-301)	<input type="checkbox"/>	<input type="checkbox"/>
<i>(Y)</i> N	7. Handwashing facilities (5-203 & 6-301)	<input type="checkbox"/>	<input type="checkbox"/>
Approved Source			
<i>(Y)</i> N	8. Food obtained from approved source (3-101 & 3-201)	<input type="checkbox"/>	<input type="checkbox"/>
<i>(Y)</i> N	9. Receiving temperature / condition (3-202)	<input type="checkbox"/>	<input type="checkbox"/>
<i>(Y)</i> N <i>(N/A)</i>	10. Records: shellstock tags, parasite destruction, required HACCP plan (3-202 & 3-203)	<input type="checkbox"/>	<input type="checkbox"/>
Protection from Contamination			
<i>(Y)</i> N <i>(N/A)</i>	11. Food segregated, separated and protected (3-302)	<input type="checkbox"/>	<input type="checkbox"/>
<i>(Y)</i> N <i>(N/A)</i>	12. Food contact surfaces clean and sanitized (4-5, 4-6, 4-7)	<input type="checkbox"/>	<input type="checkbox"/>
<i>(Y)</i> N	13. Returned / reserve of food (3-306 & 3-801)	<input type="checkbox"/>	<input type="checkbox"/>
<i>(Y)</i> N	14. Discarding / reconditioning unsafe food (3-701)	<input type="checkbox"/>	<input type="checkbox"/>

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

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

Fridge Cold holding

Item/Location	Temp	Item/Location	Temp	Item/Location	Temp	Item/Location	Temp
<i>Hot</i>	<i>34°</i>	<i>Chicken</i>	<i>38°</i>	<i>Fish</i>	<i>177°</i>	<i>Chicken - Fridge</i>	<i>42</i>
<i>Hot</i>	<i>35.4°</i>	<i>Mashed potatoes</i>	<i>141</i>	<i>Beef</i>	<i>145</i>	<i>Asparagus - Hot</i>	<i>176</i>

GOOD RETAIL PRACTICES (X = not in compliance)

	COS	R		COS	R		COS	R	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	27. Use of ice and pasteurized eggs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	42. Food utensils/in-use	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	28. Water source and quantity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	43. Thermometers/Test strips	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	29. Insects/rodents/animals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	44. Warewashing facility	<input type="checkbox"/>	<input type="checkbox"/>
<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"/>	45. Wiping cloths	<input type="checkbox"/>	<input type="checkbox"/>
<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"/>	46. Utensil & single-service storage	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	32. Sewage and waste water disposal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	47. Physical facilities	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	33. Surks contaminated from clearing maintenance tools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	48. Specialized processing methods	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	49. Other: <i>Sanitizing Rinse</i>	<input type="checkbox"/>	<input type="checkbox"/>

OBSERVATIONS AND CORRECTIVE ACTIONS (CONTINUED ON NEXT PAGE)

Person in Charge (Signature) <i>Karen Anderson</i> (Print)	Title	Date <i>6-27-13</i>	Follow-up: (Circle One) Yes No
Inspector (Signature) <i>Karen Anderson</i> (Print)	Date <i>6/27/13</i>		



Food Protection Program, Office of Epidemiology
450 West State Street, Boise, Idaho 83702
208-334-5938

Page 2 of 2
Date 6/27/13

Caregiver: Sade Hansen

Establishment Name Hot Vernon/Monterey		Operator KARA Reese	
Address 3620 Potomac Way		Idaho Falls, ID 83404	
County Bonanza	Estab # 20828	EHS/SUR #	License Permit #

OBSERVATIONS AND CORRECTIVE ACTIONS (Continuation Sheet)

#5: Kitchen staff/caregivers were not observed to wash their hands between caregiving tasks & food prep & food service.

COS: Informed staff of cross contamination & hand washing to prevent/reduce food borne illness.

#6: Kitchen staff/caregivers wore the same pair of gloves to perform tasks & prep area & served food.

COS: Instructed staff of proper glove use.

#49: A sanitizing rinse was not used in the hot Vernon house when staff washed dishes by hand.

COS: Instructed staff on proper washing, rinsing & use of a sanitizing rinse for all hand washed dishes, utensils, pots & pans.



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 83720-0099
PHONE: 208-334-6626
FAX: 208-364-1888

July 12, 2013

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

Dear Ms. Reese:

An unannounced, on-site complaint investigation survey was conducted at Carefix Management & Consulting dba Safe Haven's Mount Vernon/Monticello between June 24, 2013 and June 27, 2013. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00005990

Allegation #1: The facility did not investigate bruises of unknown origin for an identified resident.

Findings #1: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.350.02 for the administrator not investigating all bruises of unknown origin. The facility was required to submit evidence of resolution within 30 days.

Allegation #2: An identified resident was neglected when the facility failed to provide medical treatment in a timely manner.

Findings #2: Insufficient evidence was available at the time of the investigation to substantiate this allegation.

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

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 **June 27, 2013**. The completed punch list

Kara Reese, Administrator

July 12, 2013

Page 2 of 2

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,

A handwritten signature in cursive script that reads "Maureen McCann, RN". The signature is written in black ink and is positioned above the printed name.

Maureen McCann, RN

Health Facility Surveyor

Residential Assisted Living Facility Program

MM/TFP

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



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – GOVERNOR
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P.O. Box 83720
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FAX: 208-364-1888

July 12, 2013

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

Dear Ms. Reese:

An unannounced, on-site complaint investigation survey was conducted at Carefix Management & Consulting dba Safe Haven's Mount Vernon/Monticello between June 24, 2013 and June 27, 2013. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00005845

Allegation #1: A newly hired employee did not receive 16 hours of orientation prior to providing unsupervised care.

Findings #1: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.600.05 for not ensuring an employee had orientation training prior to working alone. The facility was required to submit evidence of resolution within 30 days.

Allegation #2: A newly-hired caregiver worked unsupervised prior to the completion of a criminal history and background check.

Findings #2: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.009.03 for not ensuring a caregiver had a criminal history background check completed prior to working alone. The facility was required to submit evidence of resolution within 30 days.

Allegation #3: The facility did not schedule CPR and first aid certified staff on all shifts.

Findings #3: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.600.06.b for not ensuring a caregiver who worked alone had CPR and first aid training. The facility was required to submit evidence of resolution within 30 days.

Allegation #4: The call system did not work properly.

Findings #4: An unannounced Licensing and Certification survey was conducted between 6/24/13 and 6/27/13. During this time, the facility call system was observed functioning appropriately. During the survey, the administrator and nine staff were interviewed. They all stated they were unaware of a time when the call system was not functional. They further stated, each resident had a pendant, which was assigned a number. They stated, a chart was posted in each kitchen, documenting what number was associated with each resident. During the survey, the chart was observed posted and found to be accurate.

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

Allegation #5: Staff were instructed to call the house manager or administrator prior to calling 911 in an emergency.

Findings #5: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.215.01 for not ensuring the facility's emergency policy was implemented. The facility was required to submit evidence of resolution within 30 days.

Allegation #6: Caregivers were unaware of the purpose of the Negotiated Service Agreement.

Findings #6: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.625.03.k for not ensuring staff were trained on the purpose of the Negotiated Service Agreement. The facility was required to submit evidence of resolution within 30 days.

Allegation #7: The administrator was not at the facility enough to supervise staff.

Findings #7: An unannounced Licensing and Certification survey was conducted between 6/24/13 and 6/27/13. Upon entering the facility on 6/24/13 at 2:40 PM, the administrator was observed to be present at the facility. At this time, she stated she had been the administrator since 2/21/13. She stated, prior to her becoming the administrator, she was a caregiver and the former administrator had been at the facility almost daily, training her to become the administrator.

During the survey, nine staff were interviewed. All stated they were unaware of a time when the facility administrator was not available to staff.

Unsubstantiated; however, the facility received 32 non-core deficiencies, some of which were related to oversight of the administrator.

Allegation #8: Caregivers did not have access to master keys.

Kara Reese, Administrator

July 12, 2013

Page 3 of 3

Findings #8: An unannounced Licensing and Certification, survey was conducted between 6/24/13 and 6/27/13. During this time, all caregivers were observed to carry a set of master keys with them. Nine staff and the administrator were interviewed. Each stated master keys were available to all caregivers, and they were unaware of a time when they were not.

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

Allegation #9: The administrator did not schedule sufficient staff to meet the residents' needs.

Findings #9: Substantiated. It was determined the facility had insufficient staffing at one time, but additional staff were hired to correct the issue. During the time of the survey, it could not be determined that staffing was insufficient. However, the facility did receive a core issue deficiency at 16.03.22.520 for inadequate care.

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 **June 27, 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) 364-1962. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,



Maureen McCann, RN

Health Facility Surveyor

Residential Assisted Living Facility Program

MM/TFP

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