



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

C.L. "BUTCH" OTTER – GOVERNOR  
RICHARD M. ARMSTRONG – DIRECTOR

TAMARA PRISOCK – ADMINISTRATOR  
DIVISION OF LICENSING & CERTIFICATION  
JAMIE SIMPSON – PROGRAM SUPERVISOR  
RESIDENTIAL ASSISTED LIVING FACILITY PROGRAM  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: 208-364-1962  
FAX: 208-364-1888

August 22, 2014

Charlene Humpherys, Administrator  
Cedar Crest Residential Care  
1200 East 6th South  
Mountain Home, Idaho 83647

Provider ID: RC-428

Ms. Humpherys:

On July 14, 2014, a complaint investigation was conducted at Cedar Crest Residential Care. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level(s):

- Core issues, which are described on the Statement of Deficiencies, and for which you have submitted a Plan of Correction.
- Non-core issues, which are described on the Punch List, and for which you have submitted evidence of resolution.

Your submitted plan of correction and evidence of resolution are being accepted by this office. Please ensure the corrections you identified are implemented for all residents and situations, and implement a monitoring system to make certain the deficient practices do not recur.

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

Sincerely,

  
POLLY WATT-GEIER, MSW  
Team Leader  
Health Facility Surveyor

PWG/sc

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



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July 25, 2014

**CERTIFIED MAIL #: 7007 3020 0001 4050 8487**

Charlene Humpherys  
Cedar Crest Residential Care  
1200 East 6th South  
Mountain Home, Idaho 83647

Provider ID: RC-428

Ms. Humpherys:

Based on the complaint investigation survey conducted by Department staff at Cedar Crest Residential Care between July 8, 2014 and July 14, 2014, it has been determined that the facility failed to protect residents from inadequate care and neglect.

These core issue deficiencies substantially limit the capacity of Cedar Crest Residential Care 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 28, 2014**. **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 **August 7, 2014**, and keep a copy for your records. Your license depends upon the corrections made and the evaluation of the Plan of Correction you develop.

Charlene Humpherys

July 25, 2014

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](http://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 **August 13, 2014**.

Two (2) of the nineteen (19) non-core deficiencies cited were identified as repeat punches. Please be aware, any non-core deficiency which is identified on three consecutive surveys will result in a civil monetary penalty.

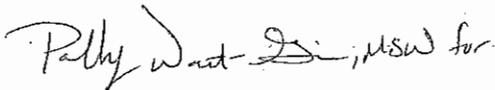
If, at the follow-up survey, the core deficiencies still exists or a new core deficiency is identified, or if any of the repeat non-core punches are identified as still out of compliance, the Department will have no alternative but to initiate an enforcement action against the license held by Cedar Crest Residential Care.

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 enforcement actions. Should you have any questions, or if we may be of assistance, please contact us at (208) 364-1962 and ask for the Residential Assisted Living Facility program. Thank you for your continued participation in the Idaho Residential Care Assisted Living Facility program.

Sincerely,



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

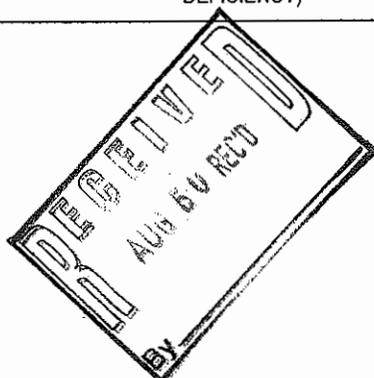
JS/sc

Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13R428</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/14/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CEDAR CREST RESIDENTIAL CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1200 EAST 6TH SOUTH MOUNTAIN HOME, ID 83647</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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R 000	<p>Initial Comments</p> <p>The following deficiencies were cited during the complaint investigation survey conducted between July 8, 2014 and July 14, 2014 at your residential care/assisted living facility. The surveyors conducting the survey were:</p> <p>Polly Watt-Geier, MSW Team Coordinator Health Facility Surveyor</p> <p>Matt Hauser, QMRP Health Facility Surveyor</p> <p>Survey Definitions:</p> <p>&amp; = and ADLs = Activities of Daily Living Apr = April Avail = Available cm = centimeters CT = Computerized Tomography MAR = Medication Assistance Record mg = milligram NSA = Negotiated Service Agreement PRN = as directed by the RN Pt = Patient RN = Registered Nurse UAI = Uniform Assessment Instrument</p>	R 000		
R 008	<p>16.03.22.520 Protect Residents from Inadequate Care.</p> <p>The administrator must assure that policies and procedures are implemented to assure that all residents are free from inadequate care.</p>	R 008	<p>R008 Please refer to attached POC. Complete date for all R008's 8/28/14</p>	

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

TITLE

(X6) DATE

*Charlene Lumpkin*

*Adm.*

*Aug. 2, 2014*

Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13R428</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/14/2014</b>
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R 008	<p>Continued From page 1</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide appropriate supervision for 1 of 8 sampled residents (Resident #5). Additionally, the facility failed to provide emergency interventions in a timely manner for 1 of 4 sampled residents (Resident #3), when an injury was sustained. The findings include:</p> <p>On 7/9/14 at 12:08 PM, the facility roster documented there were currently 39 residents residing in the facility.</p> <p>On 7/11/14 at 10:30 AM, the administrator, who was not a licensed nurse or licensed medical professional, stated the former facility RN quit in August 2013 and they were without a nurse for approximately 7 months. She confirmed there was not an RN available to provide oversight or complete nursing assessments during that time frame.</p> <p>On 7/11/14 at 11:04 AM, the current facility nurse stated, she believed she started in April 2014 and currently worked at the facility approximately 3 to 6 hours a week.</p> <p>Eight resident records were sampled. Seven of the 8 residents' records, documented the former nurse completed a quarterly nursing assessment at the end of August 2013. There were no other nursing assessments, nursing notes, or nursing documentation in the records until April 2014. One resident's record did not contain a quarterly nursing assessment.</p> <p>From September 2013 to April 2014, for approximately 7 months, the facility did not have a nurse available to meet the needs of the</p>	R 008		
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Residential Care/Assisted Living

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R 008	<p>Continued From page 2</p> <p>residents. In April, the facility hired a facility RN; however, she only worked between 3 to 6 hours a week.</p> <p>I. Supervision</p> <p>IDAPA 16.03.22.012.25, defines supervision as "A critical watching and directing activity which provides protection...and assistance with activities of daily living...."</p> <p>1. Resident #5's record documented he was a 73 year-old male, who was admitted to the facility on 7/26/13, with diagnoses of a cardiovascular accident (stroke), right-sided hemiparesis (weakness) and diabetes.</p> <p>A "Department of Health &amp; Welfare UAI," dated 8/21/13, documented the resident required staff to provide assistance with washing Resident #5's feet.</p> <p>A nursing assessment, dated 8/30/13, completed by the former facility nurse, documented Resident #5 had no skin issues.</p> <p>The back of a facility incident report, dated 3/12/14 at 11:30 AM, documented the caregivers went to change the resident's bed and found "blood at the bottom." The note documented the caregivers saw a "a bad sore" on the resident's "left heel" and he was taken to the hospital. Attached to the incident report was a form titled, "Weekly Skin Integrity Review." The form had a handwritten note by the administrator, which documented, "[Physician's name] gave me this to talk with staff on accessing [sic] the body for possible sores."</p> <p>A "Change in Condition" note, written by the</p>	R 008		

Residential Care/Assisted Living

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R 008	<p>Continued From page 3</p> <p>administrator on 3/12/14, documented the administrator took off the resident's sock and saw a sore on his heel, which was "the size of a half dollar." The note documented she immediately took him to the emergency room. The note also documented, the resident's family member was contacted and reported "...that is how he lost the half of his foot due to sores he would not report or care for in his home."</p> <p>A hospital history &amp; physical, dated 3/12/14, documented the resident had a "very bad decubitus on his heel" with "2 x 3 eschar [dead skin] on his posterior heel." The history and physical also documented the pressure ulcer looked like it was "starting to get infected."</p> <p>Hospital progress notes and skin impairment records, dated between 3/14 and 3/16/14, documented the resident's pressure ulcer on his heel was debrided and the pressure ulcer went down to the resident's periosteum [A fibrous sheath that covers bones]." The hospital skin impairment record, dated 3/16/14, documented the pressure ulcer measured 3.5 cm with a middle eschar area measuring 2.5 cm.</p> <p>On 7/11/14 between 1:40 PM and 1:44 PM, three caregivers were interviewed. Two denied remembering the resident. One caregiver stated the resident was assisted with showers, but she had not seen the wound on his heel.</p> <p>On 7/11/14 at 2:03 PM, the current facility nurse stated she had not worked at the facility during that time, so she had not seen the pressure ulcer.</p> <p>On 7/11/14 at 2:11 PM, the administrator stated the resident "was kind of a piggywig at home." She stated when he moved into the facility he</p>	R 008		
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R 008	<p>Continued From page 4</p> <p>cooperated with staff in allowing assistance with his grooming and showering. She stated he would refuse some showers, but would at least receive one shower every Saturday. She stated she was not sure when the wound developed, as no one reported they saw it. Additionally, she stated the wound was "awful" and it was "very traumatic to see it."</p> <p>The facility did not provide supervision to ensure Resident #5's skin integrity was monitored when staff assisted him with his showers. This failure resulted in Resident #5 developing a pressure ulcer, that extended down to his heel bone.</p> <p>II. Emergency Intervention</p> <p>An undated, handwritten note was found in the facility's policy book on 7/11/14. The note was entitled, "What to do if there is problems...Residents...falls - call ambulance to assess [sic]."</p> <p>1. Resident #3's record documented he was a 68 year-old male, who was initially admitted to the facility on 7/17/13, with a diagnoses of Type II diabetes and below the right knee amputation. The resident was discharged from the facility on 2/10/14 and readmitted to the facility on 6/21/14, with a diagnosis of left subdural hematoma.</p> <p>An incident report, dated 2/7/14 at 11:00 PM, documented another resident rang his call bell and a caregiver found Resident #3 on the floor inside of the door. The caregiver ran and got another caregiver to assist in picking up the resident. The resident "got a nasty additude [sic] and was hitting." The report documented the caregivers notified the administrator, who was not a licensed nurse or licensed medical</p>	R 008		
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Residential Care/Assisted Living

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R 008	<p>Continued From page 5</p> <p>professional, "to help him up." The report further documented, "We put him in the lobby as the [Administrator's name] requested."</p> <p>A daily log, dated 2/8/14, documented Resident #3 fell in another resident's room and the administrator helped pick him up and brought him into the lobby.</p> <p>Notes written by the administrator over a 3 day period, documented the resident was "a bit different," became "a little passive," was not eating and became "heavy to change - 4 assist." The note documented, on the third day of experiencing changes, the resident was taken to the emergency room, as he was confused, incontinent and could not stand.</p> <p>A daily log, dated 2/9/14, documented Resident #3 needed assistance in the "bathroom, dressing, and maybe feeding meals? He seems confused. He says he can't stand - his legs feel weak."</p> <p>Resident #3's NSA, dated 7/24/13, documented the resident was independent with his Activities of daily living, such as: dressing, toileting and feeding himself.</p> <p>Resident #3 had a change in condition with his ability to complete activities of daily living tasks, after falling on 2/7/14.</p> <p>A daily log, dated 2/10/14, documented Resident #3 was in the hospital.</p> <p>A handwritten note by the administrator, dated 2/15/14, documented the resident was taken to the hospital as "he was not himself." The note documented the resident was then transported to a hospital in Boise. The note further documented</p>	R 008		
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R 008	<p>Continued From page 6</p> <p>"at sometime he fell hit his head - causing a brain bleed - surgery was performed...." Additionally, the note documented, "...I don't know when this fall happened - there was no signs of injuries."</p> <p>Hospital "Physician Documentation" notes, dated 2/10/14, documented the "presenting complaint: Assisted living states patient has been becoming more weak over past few weeks and incontinent of urine. Pt is awake at this time, not oriented to place or date, oriented to person at this time. Pt unable to transfer or assist in own transfer due to weakness...." The notes further documented the resident was transferred to a hospital in Boise.</p> <p>A hospital history &amp; physical, dated 2/10/14, documented the "CT scan demonstrated left subdural hematoma." The history &amp; physical documented, the physician "recommended urgent surgical intervention...."</p> <p>On 7/10/14 at 10:38 AM, the administrator stated Resident #3 "was not himself," so she took him to the hospital. She stated the resident must of fallen at some unknown time and required surgery. She stated after his surgery he went to a long-term care facility and he had just recently returned to the facility.</p> <p>On 7/11/04 at 11:04 AM, the facility nurse stated she had not worked at the facility when Resident #3 had fallen. However, she stated she had not given direction to caregivers on what signs and symptoms to observe for or how often to observe the residents after falls. She stated that the administrator may have provided the instructions.</p> <p>On 7/11/14 at 11:26 AM, the administrator stated she had not provided specific instructions on how staff should monitor residents after they hit their</p>	R 008		

Residential Care/Assisted Living

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R 008	<p>Continued From page 7</p> <p>heads. She stated they would do "what they always do."</p> <p>On 7/14/14 at 2:45 PM, Resident #3 stated he did not recall the incident when he was injured, but was happy to be alive and was doing well.</p> <p>Resident #3 fell on 2/7/14 and began to exhibit changes of condition, such as: being unable to perform ADLs, becoming incontinent and experiencing weakness. The resident was not medically evaluated until 3 days after exhibiting these changes. When he was medically evaluated, he was found to have a subdural hematoma.</p> <p>The facility failed to provide appropriate supervision for Resident #5, when the staff did not report the development of a pressure ulcer, that went down to his heel bone. Additionally, the facility failed to provide emergency intervention in a timely manner for Resident #3, when he sustained a subdural hematoma. These findings resulted in inadequate care.</p>	R 008		
R 009	<p>16.03.22.525 Protect Residents from Neglect.</p> <p>The administrator must assure that policies and procedures are implemented to assure that all residents are free from neglect.</p> <p>This Rule is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure 1 of 8 sampled residents (Resident #2) was free from neglect. The findings include:</p> <p>IDAPA 16.03.22.011.24 defines neglect as</p>	R 009	<p><i>R009 - Please refer to attached POC. Complete date for all R009 is 8/28/14</i></p>	

Residential Care/Assisted Living

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R 009	<p>Continued From page 8</p> <p>"Failure to provide...medical care necessary to sustain the life and health of a resident."</p> <p>A. Wound Care and/or skin conditions:</p> <p>1. Resident #2's record documented he was a 95 year-old male, who was initially admitted to the facility on 3/1/09, with a diagnosis of dementia. A hospital discharge summary, dated 4/23/14, documented Resident #2 had "severe dementia" and was "nonverbal and noncommunitive."</p> <p>The facility's daily log notes, administrator notes, facility nurse's notes and physician's orders, dated between 3/25/14 and 4/14/14, documented Resident #2 was prescribed an antibiotic on 4/8/14. On 4/10/14, the resident's hands and arms became swollen. The notes documented, the antibiotic was discontinued, but "by Apr 20" a rash had spread "down on his body" and the resident was taken to the hospital.</p> <p>A hospital history &amp; physical, dated 4/20/14, documented on 4/8/14, the resident was started on an antibiotic for a "bedsore" on his right calf and approximately 3 days ago, he began having a "truncal rash." The history &amp; physical documented the assisted living staff noticed "today" the resident's "rash was spreading and becoming more widespread on his body. Additionally, the history &amp; physical documented the resident skin from his head to his toes was covered with intact blisters, open sores from ruptured blisters and the top layer of skin was shedding.</p> <p>Copies of the physician's notes, nurses notes, clinic notes and discharge summary for Resident #2's, hospitalization 4/20 through 4/23/14, were obtained by the survey team on 7/14/14, as they were not available at the facility. The physician's</p>	R 009		

Residential Care/Assisted Living

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NAME OF PROVIDER OR SUPPLIER  <b>CEDAR CREST RESIDENTIAL CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1200 EAST 6TH SOUTH MOUNTAIN HOME, ID 83647</b>
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R 009	<p>Continued From page 9</p> <p>note documented the resident had an allergic reaction to an antibiotic and developed Steven-Johnson's Syndrome.</p> <p>* According to the Mayo Clinic website, "Steven-Johnson syndrome is a rare, serious disorder of your skin and mucous membranes. It's usually a reaction to medication or an infection. Often, Stevens-Johnson syndrome begins with flu-like symptoms, followed by a painful red or purplish rash that spreads and blisters. Then the top layer of the affected skin dies and sheds."</p> <p>A hospital discharge summary, dated 4/23/14, documented the resident's skin was improving and "healing quite well." The discharge summary documented the primary physician would visit the resident at the assisted living facility on 5/6/14 to follow-up on the resident's condition.</p> <p>Resident #2's record contained a physician's order, dated 4/23/14, which documented the resident was to receive Nystatin powder, three times a day, for 1 week, to the penis and groin area.</p> <p>The facility's April 2014 MAR, documented the Nystatin topical powder was "Not Avail." The MAR did not document what if any wound care was provided to Resident #2.</p> <p>An untitled, handwritten note by the administrator, dated 4/23/14, documented the resident returned to the facility without physician's orders to treat the resident's skin condition. The note further documented, the administrator decided to apply cornstarch to the affected areas.</p> <p>An untitled, handwritten note by the administrator,</p>	R 009		

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R 009	<p>Continued From page 10</p> <p>dated 4/25/14, documented, "still using the cornstarch."</p> <p>There was no documentation the facility administrator, who was not a licensed nurse or licensed medical professional, obtained or clarified what medications should be applied to Resident #2's skin, prior to using cornstarch to treat his wounds.</p> <p>An untitled, handwritten note by the facility nurse, dated 4/26/14, documented that staff "reported" the resident's skin areas were "dry" and had decreased "reddness [sic]." The RN documented, she spoke to the administrator and advised her to have the physician visit "if skin flares again." There was no documentation indicating the facility nurse visualized the current condition of Resident #2's skin.</p> <p>A daily log note, dated 5/2/14, documented Resident #2's "body ist [sic] not good."</p> <p>A "Nurse Notification Form," dated 5/6/14, documented Resident #2 continued to have "a lot of raw spots." Additionally, the administrator documented she was applying an "ointment &amp; Bandages."</p> <p>There was no documentation in Resident #2's record as to what "ointment" or "bandages" were being used nor was there documentation the ointment or bandages had been ordered by a physician.</p> <p>A daily log note, dated 5/7/14, documented Resident #2 was sent to the hospital. The note further documented, the ambulance took him "because him not feeling good the skin condition is not good."</p>	R 009		

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R 009	<p>Continued From page 11</p> <p>Resident #2's skin condition had improved prior to his readmission to the facility on 4/23/14. The facility failed to obtain wound care instructions; instead, they applied cornstarch, ointment and bandages that had not been ordered. From 4/23 to 5/7/14 (14 days), the facility documented the resident's skin condition worsened before he was transported out of the facility.</p> <p>Copies of the history &amp; physical and discharge summary, for Resident #2's, hospitalization from 5/7/14 through 6/13/14, were obtained by the survey team on 7/14/14, as they were not available at the facility.</p> <p>A hospital history &amp; physical, dated 5/7/14, documented after the resident returned to the assisted living facility in April, he developed large blisters that had ruptured and the skin had "peeled off," leaving large "open sores." The history &amp; physical documented the physician had visited the resident on 5/6/14 and he did not feel the assisted living staff were "...equipped to adequately take care of the patient's wounds and needs." The history &amp; physical also documented, "the assisted living staff" were attempting to get the resident up "by pulling on the arms" and they had "disrupted a lot of the skin off of the arms." The history &amp; physical documented the resident "also has a lot of skin off the peri area [sic] especially in the crural folds and on the penis." Additionally, the history &amp; physical documented the assisted living staff were "not sure what to do and do not have the staff or the training to really take care of him so I am transferring him...for further evaluation and treatment."</p> <p>A hospital discharge summary, dated 6/13/14, documented when the resident was admitted to</p>	R 009		
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R 009	<p>Continued From page 12</p> <p>the hospital Bacitracin ointment was used, but it made the wounds "worse rather than better." The summary documented medication was changed to Temovate cream, which "dramatically improved the blisters and sores." The summary documented the resident "only had a few" sores "left on his upper extremities."</p> <p>Resident #2's record contained a June 2014 MAR, from the hospital, documenting the resident was supposed to have Temovate Cream applied to his blisters twice a day. Additionally, the MAR documented "Do Not Use Bacitracin."</p> <p>A daily log note, dated 6/13/14, documented Resident #2 returned to the facility at 10:30 AM, and was "doing good."</p> <p>Resident #2's record contained a physician's order, dated 6/10/14, which documented the resident was supposed to have Temovate Cream applied to blisters and blistered areas. The order further documented, it had been faxed to the pharmacy on 6/12/14.</p> <p>The facility's June 2014 MAR, did not document Temovate Cream was applied to Resident #2's blisters or blistered areas, as ordered by the physician. Additionally, no wound care was documented on the MAR.</p> <p>From 6/13 to 7/8/14, there were no daily log notes regarding the condition of Resident #2's skin condition.</p> <p>On 7/8/14 at 12:49 PM, Resident #2 was observed lying in a hospital bed. The resident was lying on his back with a white sheet draped over him. The resident's feet were observed poking out of the sheet, encased in blue foam</p>	R 009		
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R 009	<p>Continued From page 13</p> <p>boots and he had gauze wrappings over his legs. The resident also had gauze wrappings around both of his upper arms, which appeared damp and pink in color. The resident did not respond verbally, or non-verbally when spoken to.</p> <p>On 7/8/14 at 12:49 PM, a caregiver stated the resident had blisters all over his body, including his penis and genitals, that would "pop open" and bleed. She stated the administrator was the only one cleaning and bandaging the wounds and the facility nurse had not been involved. She further stated, the blisters had been on the resident for months and he had not been seen by a physician.</p> <p>On 7/8/14 at 1:27 PM, Resident #2's wounds were observed after the gauze wrappings were removed by staff. The following skin conditions were observed:</p> <ul style="list-style-type: none"> <li>* His upper left arm above the elbow had a large beefy, red area and the top layer of skin was missing. The left elbow was observed to have several open red areas. The remaining top layer of skin had white, mottled areas that appeared ready to peel away from the resident's arm.</li> <li>* Between his fingers on his right hand, he had numerous red open areas. When his hand touched the white sheet, a trace of red blood was deposited.</li> <li>* The left forearm was observed to have a dried and cracked skin tear, approximately 2 inches long that had four steri-strips on top of the skin tear. The underside of his left arm was observed to have numerous red open wounds and the top layer of skin was missing from these wounds.</li> <li>* His right ankle to mid-calf was was observed to</li> </ul>	R 009		
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R 009	<p>Continued From page 14</p> <p>be red and the top layer of skin appeared to have peeled off.</p> <p>* His right groin area was observed to be red and the top layer of skin was missing.</p> <p>* His left lower leg and upper right and left legs had numerous red open wounds and seven or more intact blisters.</p> <p>* The resident's stomach was observed to have a large open red area above his umbilicus (belly button) that appeared to be approximately 3 inches wide by 2 inches in length.</p> <p>* His left outer ankle had two open red areas, where the top layer of skin was missing and 1 intact blister.</p> <p>* His toes and feet had several intact blisters.</p> <p>On 7/8/14 at 1:38 PM, the current facility nurse stated she had not assessed Resident #2 or his skin condition. She stated, the administrator had called her on 7/5/14 (3 weeks after readmission), and told her he had come back to the facility. The nurse stated, "I was not expecting him to return." She stated, she was not sure what was "going on with him," but she was planning to look at him today. She stated, the administrator had reported to her, that the wrong cream, Bacitracin had been applied to Resident #2's wounds. She stated, "if I had looked at [Resident's name] legs, I would have got him on home health or into another facility."</p> <p>On 7/8/14 at 3:27 PM, the administrator stated Resident #2 had a "reaction to an antibiotic" in April and was sent to the hospital, then was sent to the long-term care unit attached to the hospital.</p>	R 009		
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R 009	<p>Continued From page 15</p> <p>He came back to the facility in the middle of June. She stated the resident came back to the facility with blisters, but she did not receive orders on how to provide wound care. Instead, the unit sent cream and wraps, which she applied. She further stated, the physician had visited the facility, about 5 days prior and informed her she was using the wrong "salve." She stated the "salve" was replaced and it was "making a difference." She stated she had asked the facility nurse to look at the wounds when she came into visit today. She confirmed the facility RN had not delegated wound care to her; however, she had received instructions from the physician when he visited 5 days prior. When asked, where she had received previous wound care instructions, she stated by a nurse at the hospital. She further stated she had been considering sending the resident back to the nursing facility.</p> <p>On 7/10/14 at 8:11 AM, the resident's family member stated Resident #2's skin issues started in April and it was thought he was reacting to antibiotics. She stated he was taken to the hospital and "let go after a couple nights there." She stated after he returned to the facility, the administrator called because "it got really bad." She stated at that time, the resident was taken to the hospital. The family member stated she wanted to have the resident back at facility, so he was transferred back. She stated the hospital sent the wrong medication back to the facility. As a result, his feet became swollen, he developed a huge sore on his right foot that went up to his ankle, his arms looked "horrible" and he had another "lesion" behind his right ear.</p> <p>On 7/10/14 at 10:38 AM, the administrator confirmed that when the resident returned in June, she had applied Bacitrim cream. Although,</p>	R 009		
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R 009	<p>Continued From page 16</p> <p>5 days ago, the physician came into the facility and instructed her to use a different cream.</p> <p>Prior to Resident #2's readmission to the facility on 6/13/14, the hospital documented the resident had a few blisters and sores on his upper arms. Additionally, they noted Bacitracin cream worsened the sores and Temovate cream should be applied to Resident #2's skin, until the skin was healed. After Resident #2 was readmitted to the facility on 6/13/14, the facility did not follow physician's orders to apply Temovate cream; instead the administrator applied Bacitracin cream, which the facility was advised made the resident's skin conditions worse. The resident's extremities and stomach were observed on 7/8/14, to be covered with open red sores and numerous intact blisters.</p> <p>The facility did not ensure appropriate wound care was provided to Resident #2's wounds, resulting in neglect.</p> <p>B. Management of pain</p> <p>On 7/8/14 at 12:49 PM, Resident #2 was observed lying in a hospital bed. The resident did not respond verbally or non-verbally when spoken to; however, when touched or moved he grimaced and appeared to be in pain.</p> <p>On 7/8/14 at 12:49 PM, a caregiver stated the resident had blisters all over his body for months and was not on any pain medications.</p> <p>Resident #2's record contained a physician's order, dated 6/10/14, which documented the resident was supposed to have Tylenol 325 mg two tablets every 6 hours, as needed for pain. The order further documented, it had been faxed</p>	R 009		
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R 009	<p>Continued From page 17 to the pharmacy on 6/12/14.</p> <p>The facility's June 2014 MAR, documented the resident should receive Tylenol 325 mg, every 6 hours, as needed for pain.</p> <p>A PRN Medication sheet, documented Resident #2 received 10 doses of Tylenol from 6/13 to 6/30/14, for "body pain."</p> <p>A PRN Medication sheet, documented Resident #2 received PRN Tylenol on the following days and times in July 2014:</p> <ul style="list-style-type: none"> <li>* 7/6/14 at 8:00 AM due to "body pain."</li> <li>* 7/7/14 at 8:00 AM due to "body pain."</li> <li>* 7/8/14 at 2:20 PM due to "generalized discomfort."</li> <li>* 7/8/14 at 5:00 PM due to "body pain."</li> <li>* 7/9/14 at 5:00 AM due to "body pain."</li> <li>* 7/9/14 at 8:00 AM due to "body pain."</li> <li>* 7/9/14 at 5:00 PM due to "body pain."</li> </ul> <p>There was no documentation the facility RN or other medical professionals were contacted to assess and evaluate Resident #2's pain. Instructions to facility staff on how to manage the resident's pain, prior to providing cares to the resident, such as: bathing or toileting, were not evident.</p> <p>When Resident #2 developed a skin condition, which consisted of peeling skin, intact and ruptured blisters, the facility did not ensure his level of discomfort was assessed or addressed. Additionally, the facility did not ensure the resident received adequate medication to reduce his level of pain.</p> <p>Resident #2's skin condition had improved prior to his readmission to the facility on both 4/23/14</p>	R 009		

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R 009	Continued From page 18  and 6/13/14. However, after each admission, the resident's skin worsened as the facility failed to provide the appropriate wound care that was ordered by the physician. Additionally, after the resident's skin worsened in June/July 2014, the facility did not assess his discomfort and ensure that he received appropriate treatment to reduce his pain. This resulted in Neglect.	R 009		
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Facility CEDAR CREST RESIDENTIAL CARE	License # RC-428	Physical Address 1200 EAST 6TH SOUTH	Phone Number (208) 587-9073
Administrator Charlene Humphreys	City MOUNTAIN HOME	ZIP Code 83647	Survey Date July 14, 2014
Survey Team Leader Polly Watt-Geier	Survey Type Complaint Investigation and Follow-up	RESPONSE DUE: August 13, 2014	
Administrator Signature <i>Charlene Humphreys</i>	Date Signed 7-14-14		

**NON-CORE ISSUES**

Item #	IDAPA Rule #	Description	Department Use Only	
			EOR Accepted	Initials
1	009.01	Criminal history background checks were not conducted for contracted workers, who also resided in the facility for over a month.	8/21/14	Pwh
2	152.05.b.iii	Resident #2 was observed with bed rails in the up position on the bed.	8/21/14	Pwh
3	215.06	The administrator did not ensure that non-residents, who lived and worked in the facility, were not on the sex offender registry.	8/21/14	Pwh
4	260.04.a	The facility did not ensure all toxic chemicals were secured or locked.	8/21/14	Pwh
5	260.06	Interior: Room 39's bathroom was observed to have a toilet without a toilet seat or lid, the vanity had broken drawers, <del>no shower curtain was available</del> <sup>error Pwh</sup> . Room 39's living/bedroom was observed to have a torn and stained couch, the counter was observed with used gloves sitting on the counter top. A common use shower room had one shower where the cement had cracked on the floor. Several residents' rooms had broken or missing sections of blinds. A heating unit, by the conference room was noted to be partially disassembled and covered with dead insects. Exterior: By the shed in the parking lot: broken benches were observed sitting on the sidewalk; debris was observed on the ground outside an exit door; A toilet, satellite dishes, an old walker and boxes were stacked next to the shed.	8/21/14	Pwh
6	300	The facility administrator performed acts requiring a nursing license, i.e., performed quarterly nursing assessments and provided wound care without obtaining physician's orders or being delegated to provide wound dressings. Additionally, the facility did not have facility RN on staff or under contract to perform nursing tasks for approximately 8 months.	8/21/14	Pwh
7	300.01	The facility did not have a nurse available to complete quarterly nursing and change of condition assessments after August 2013 until April 2014.	8/21/14	Pwh
8	305.03	The current facility nurse did not complete nursing assessments for residents' health status. For example: Resident #1's wound condition and hospitalizations, Resident #2's wound conditions and Resident #6's hospitalizations	8/21/14	Pwh
9	305.04	The current facility nurse did not make recommendations about care changes. For example: Resident #2's wound care, Resident #7's signs/symptoms to monitor after hitting his head.	8/21/14	Pwh
10	305.06	The current facility nurse did not assess Resident #4's ability to adjust his oxygen and Resident #8's ability to self-inject his insulin. ***Previously Cited 3/13/13***	8/21/14	Pwh
11	310.01.a	Medications were observed to be unlocked in the medication cart and residents' rooms.	8/21/14	Pwh
12	310.01.d	Assistance with medications did not comply with Board of Nursing requirements, when medications were shared between residents. ***Previously cited <del>2/24/14</del> <sup>error Pwh</sup> and 3/13/13***	8/21/14	Pwh
13	320.08	The facility did not update residents' NSAs annually or with changes of conditions.		





IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

C.L. "BUTCH" OTTER – GOVERNOR  
RICHARD M. ARMSTRONG – DIRECTOR

TAMARA PRISOCK – ADMINISTRATOR  
DIVISION OF LICENSING & CERTIFICATION  
JAMIE SIMPSON – PROGRAM SUPERVISOR  
RESIDENTIAL ASSISTED LIVING FACILITY PROGRAM  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: 208-364-1962  
FAX: 208-364-1888

July 25, 2014

Charlene Humpherys, Administrator  
Cedar Crest Residential Care  
1200 East 6th South  
Mountain Home, Idaho 83647

Provider ID: RC-428

Ms. Humpherys:

An unannounced, on-site complaint investigation was conducted at Cedar Crest Residential Care between July 8, 2014 and July 14, 2014. During that time, observations, interviews, and record reviews were conducted with the following results:

**Complaint # ID00006398**

**Allegation #1:** The facility did not have a facility nurse available to provide nursing oversight.

**Findings:** Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.300.01 for not having a facility nurse available from August 2013 until April 2014. The facility was required to submit evidence of resolution within 30 days.

**Allegation #2:** The facility did not ensure residents were immediately evaluated after they fell and exhibited changes of conditions.

**Findings:** Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.520 for not providing immediate emergency interventions for an identified resident who fell and had a significant change of condition. The facility was required to submit a plan of correction.

**Allegation #3:** The facility did not notify Licensing and Certification of all reportable incidents.

**Findings:** Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.350.07 for the facility not notifying Licensing & Certification of all reportable incidents. The facility was required to submit evidence of resolution within 30 days.

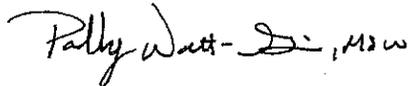
Charlene Humpherys, Administrator

July 25, 2014

Page 2 of 2

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,

A handwritten signature in cursive script that reads "Polly Watt-Geier, MSW".

POLLY WATT-GEIER, MSW  
Health Facility Surveyor  
Residential Assisted Living Facility Program

PWG/sc

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



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July 25, 2014

Charlene Humpherys, Administrator  
Cedar Crest Residential Care  
1200 East 6th South  
Mountain Home, Idaho 83647

Provider ID: RC-428

Ms. Humpherys:

An unannounced, on-site complaint investigation was conducted at Cedar Crest Residential Care between July 8, 2014 and July 14, 2014. During that time, observations, interviews or record reviews were conducted with the following results:

**Complaint # ID00006405**

Allegation #1: The facility did not appropriately monitor residents' skin condition.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.520 for not monitoring an identified resident's skin, resulting in the development of an extensive pressure ulcer. The facility was required to submit a plan of correction.

Allegation #2: The facility did not provide adequate assistance to meet residents' hygiene and bathing needs.

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

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,

POLLY WATT-GEIER, MSW  
Health Facility Surveyor  
Residential Assisted Living Facility Program

PWG/sc



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July 25, 2014

Charlene Humpherys, Administrator  
Cedar Crest Residential Care  
1200 East 6th South  
Mountain Home, Idaho 83647

Provider ID: RC-428

Ms. Humpherys:

An unannounced, on-site complaint investigation survey was conducted at Cedar Crest Residential Care between July 8, 2014 and July 14, 2014. During that time, observations, interviews, and record reviews were conducted with the following results:

**Complaint # ID00006427**

Allegation #1: A facility employee worked at the facility, without a criminal history background check.

Findings #1: Three employee records were reviewed on 7/11/14. All three employees, including the identified employee, had completed criminal history checks in their files.

Unsubstantiated.

As no deficiencies were cited as a result of our investigation, no response is necessary to this report. Thank you to you and your staff for the courtesies extended to us on our visit.

Sincerely,

POLLY WATT-GEIER, MSW  
Health Facility Surveyor  
Residential Assisted Living Facility Program

PWG/sc