



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

September 20, 2013

Duke Rogers, Administrator
Discovery Care Center
600 Shanafelt Street
Salmon, ID 83467

License #: RC-1029

Dear Mr. Rogers:

On August 9, 2013, an initial licensure survey was conducted at Sawtooth Healthcare, Inc., dba Discovery Care Center. 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 Maureen McCann, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 364-1962.

Sincerely,

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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August 16, 2013

CERTIFIED MAIL #: 7012 1010 0002 0836 0157

Steve Lish, Administrator
Discovery Care Center
600 Shanafelt Street
Salmon, ID 83467

Dear Mr. Lish:

Based on the Initial Licensure survey conducted by Department staff at the Sawtooth Healthcare, Inc., dba Discovery Care Center between August 7 and August 9, 2013, it has been determined that the Residential Care Assisted Living facility failed to protect residents from inadequate care by retaining a resident who required skilled nursing care

This core issue deficiency substantially limits the capacity of Sawtooth Healthcare, Inc., dba Discovery Care Center 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 **September 23, 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 **August 29, 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.

Steve Lish
August 16, 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 **September 8, 2013**.

Also, be aware that the variance allowing the administrator to serve over both the residential care and the skilled nursing facilities is revoked as of the date of the exit conference. The facility must now employ a single, licensed administrator who is not serving as administrator over any other facilities. Failure to do so within thirty (30) days of the date of the exit conference will result in a core issue deficiency.

If, at the follow-up survey, the core deficiency 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 Sawtooth Healthcare, Inc., dba Discovery Care Center.

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 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

MAM/TFP

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R1029	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/09/2013
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NAME OF PROVIDER OR SUPPLIER DISCOVERY CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 600 SHANAFELT STREET SALMON, ID 83467
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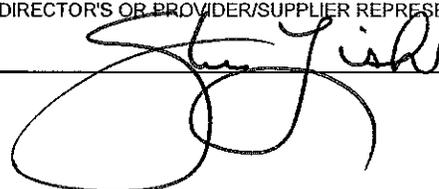
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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R 000	Initial Comments The following deficiency was cited during the initial survey conducted between 8/7/2013 and 8/9/2013 at your residential care/assisted living facility. The surveyors conducting the survey were: Maureen McCann, RN Team Leader Health Facility Surveyor Donna Henscheid, LSW Health Facility Surveyor Survey Definitions: @ = at d/t = due to h202 = hydrogen peroxide LPN = Licensed Practical Nurse NSA = Negotiated Service Agreement PRN = As Needed Q = every Res = Resident trach = tracheotomy tx = treatment UAI = Uniform Assessment Instrument W/ = with	R 000	<p>RECEIVED</p> <p>AUG 29 2013</p> <p>DIV OF LIC & CERT</p>	
R 008	16.03.22.520 Protect Residents from Inadequate Care. The administrator must assure that policies and procedures are implemented to assure that all residents are free from inadequate care. This Rule is not met as evidenced by: Based on observation, record review and	R 008		

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

TITLE

(X6) DATE



Administrator

8/28/2013

Bureau of Facility Standards

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R 008	<p>Continued From page 1</p> <p>interview, it was determined the facility retained 1 of 1 sampled Residents (#4) who had a tracheotomy the resident was not able to care for independently. The findings include:</p> <p>IDAPA 16.03.22.152.05.b states that "No resident will be admitted or retained who requires ongoing skilled nursing care not within the legally licensed authority of the facility. Such residents include:</p> <p>vi. A resident who has a tracheotomy who is unable to care for the tracheotomy independently."</p> <p>Resident #4, a 60 year old female, was admitted to the facility on 9/14/12 with diagnoses of hemiplegia and a tracheotomy due to history of cancer.</p> <p>On 8/8/13 at 1:55 PM, Resident #4 was observed at the business office window. The resident coughed and cleared her throat several times during the conversation with a staff member. When not speaking, moist, gurgling sounds were heard from the resident when she breathed in and out.</p> <p>An NSA, dated 5/4/13, documented Resident #4 required extensive night needs and required staff to check the tracheotomy for placement.</p> <p>A UAI, dated 9/12/12, documented the resident required "hands on assist with trach."</p> <p>A physician's order, dated 7/30/13, documented the staff were to "assist" everyday and as needed to "cleanse w/h202 & trach brush...." It further documented, "If trach is out: Place small amount of lidocaine jelly on trach. Hold in ostomy w/gentle pressure for few minutes, then slowly increase</p>	R 008		

Bureau of Facility Standards

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R 008	<p>Continued From page 2</p> <p>pressure."</p> <p>Resident Care Notes documented the following:</p> <p>*3/27/13 at 8:30 PM - It was reported during shift change the resident had not changed her trach in the morning. At 3:00 PM, the resident was asked to clean her trach after dinner. At 5:15 PM, the resident "still had dirty trach with pudding all over. The resident refused to change it before dinner." The resident cleaned the trach at 7:30 PM.</p> <p>*5/4/13 at 10:00 AM - The caregiver found an "unused trach kit next to sink from yesterday." The caregiver asked the resident why she had not cleaned it, and the resident replied, "I did not feel like it." The caregiver "could not see into res trach at all d/t tons of pudding stuck in it." The resident "finnaly" [sic] cleaned the trach around 1:00 PM because she "could not breath anymore."</p> <p>*6/17/13 (no time) - The caregiver assisted the resident with "pants and trach. I assisted with trach cleaning/tying before activities today."</p> <p>*6/18/13 at 2:00 PM - "Res coughing @ meals this aide offered to assist with trach tx this am and res refused."</p> <p>*6/23/13 at 2:00 PM -The housekeeper informed the caregiver that Resident #4 was "choking." The caregiver called the attached skilled nursing facility and someone from there came and "helped" with the resident. The resident stated she had not cleaned the trach because she went to church. The caregiver asked the resident, "Why didn't you clean it after or before you left the building?" The resident responded, "I didn't want to." The caregiver told the resident "This would</p>	R 008		

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R 008	<p>Continued From page 3</p> <p>not happen if you would clean it before meals."</p> <p>*6/29/13 at 12:00 PM - The caregiver "heard/witnessed" Resident #4 have three "coughing fits." The caregiver asked the resident if she had cleaned the trach "yet" and the resident responded "No, I have not." The caregiver asked the resident to clean the trach before lunch. "So I don't have to worry...possibly choking, d/t that's what happened on 6/23/12...."</p> <p>*7/16/13 at 1:00 PM - After returning from a therapy appointment, the resident complained of shortness of breath and had a "coughing episode." The resident was "unable to sit up without coughing and turning colors." The caregiver requested the resident "please remove trach and I assisted cleaning. Trach was so plugged, it took a while to push brush through. I reminded res of importance of clean trach and breathing."</p> <p>From 8/7/13 through 8/9/13, staff members were interviewed and stated the following regarding Resident #4's tracheotomy care:</p> <p>*If the resident required help, "we help with it, we physically clean it" because the resident "has a hard time pushing the brush through. The girls are making sure it gets done once a day." She further stated, the facility had to send her to the emergency room once, but the facility got an order to assist her with putting it back in, so they did not have to send her out again.</p> <p>**I bring her the kit (cleaning) and other caregivers have cleaned it for her...I don't believe it's a memory problem, she's just not wanting to comply. From what I understand, we're not suppose to (clean it). It's gotten so clogged,</p>	R 008		
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R 008	<p>Continued From page 4</p> <p>plugged up we had to do it. Not me, but others."</p> <p>*The resident was "not very good at taking care of her trach." The caregiver stated it was due to an "attitude" issue and not because the resident was not capable.</p> <p>On 8/8/13 at 10:50 AM, when shown the notes regarding staff cleaning the trach, the administrator stated, "They (staff) were suppose to inform me when she was unable to care for it herself."</p> <p>On 8/8/13 at 1:25 PM, the LPN stated the resident was checked each shift for trach placement and had to be verbally reminded to clean it. She further stated, she was not aware the staff were cleaning the trach.</p> <p>The facility retained Resident #4 who did not independently care for her tracheotomy. This led to inadequate care.</p>	R 008	<ol style="list-style-type: none"> 1. The resident in question was already in the process of being discharged to a local certified group home. In fact, resident was discharged on August 12, 2013. 2. All other residents have been reviewed for care needs. The facility has reviewed the rules related to retention of residents. All residents currently residing in the Assisted Living Unit meet the criteria for retention within the AL facility. 3. Staff have been educated about Assisted Living Rules for retaining residents as well as the need to communicate noncompliance, refusals of care and changes in condition. Communication process has been reviewed with staff to ensure the Nurse Supervisor and Administrator are made aware of changes in resident condition. 4. Upon completion of a Change of Condition or Quarterly Assessment of residents, RN will review changes with the Administrator to ensure that resident continues to be eligible for retention. 5. Completion Date: September 8 	
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Facility Discovery Care Center	License # RC-1029	Physical Address 600 Shanafelt Street	Phone Number (208) 756-8391
Administrator Steve Lish	City Salmon	ZIP Code 83467	Survey Date August 9, 2013
Survey Team Leader Maureen McCann	Survey Type Initial Licensure	RESPONSE DUE: September 8, 2013	

NON-CORE ISSUES

Item #	IDAPA Rule #	Description	Department Use Only	
			EOR Accepted	Initials
1	220.02	The admission agreement did not provide a clear reflection of the facility's charges.		
2	220.04	The admission agreement did not identify staffing patterns and the qualifications of the staff on duty.	9/17/13	me
3	220.05	The admission agreement did not disclose whether the facility carried liability insurance.	9/17/13	me
4	220.06	The admission agreement did not document the facility's and residents' roles and responsibilities related to assistance with medications.	9/17/13	me
5	220.09	The admission agreement did not identify under which emergency transfers would be made as provided in section 152 of the rules.	9/17/13	me
6	220.10	The admission agreement did not provide a description of the facility's billing practices, procedures for payments and refunds.		
7	220.16	The admission agreement did not provide the methods by which a resident may contest charges that include contacting the Ombudsman.	9/18/13	me
8	220.17	The admission agreement did not document what happens when a resident converts to a publicly funded program.	9/17/13	me
9	221.01.a	The admission agreement did not reflect a 30 day discharge notice.	9/17/13	me
10	225.01	Residents #1, #3 and #4's behaviors were not evaluated to determine if they required behavior management plans.	9/17/13	me
11	225.02	The facility did not develop interventions for each behavioral symptom for Residents #1, #3 and #4.	9/17/13	me
12	320.01	Residents #1, #3 and #4's NSAs were not updated to reflect the residents' current needs. For example: Resident #1's behaviors (pinching residents, wandering in rooms, etc.), laundry, incontinence and supervision. Resident #3's showers. Resident #4's behaviors (stealing, refusing cares), laundry and incontinence.	9/17/13	me
13	430.05.e	The facility did not assess Resident #1, 2 and 4 to determine if the residents were safe to leave the facility unsupervised.	9/17/13	me
14	625	The facility did not have a method of documenting that new employees had received 16 hours of orientation.	9/17/13	me

Administrator's
Signature:

Date:

08/09/2013

Page 1 of 1



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Administrator Steve Lish	City Salmon	ZIP Code 83467	Survey Date August 9, 2013
Survey Team Leader Maureen McCann	Survey Type Initial Licensure	RESPONSE DUE: September 8, 2013	

NON-CORE ISSUES

Item #	IDAPA Rule #	Description	Department Use Only	
			EOR Accepted	Initials
17	625.03.1	Four of five staff did not have infection control training.	9/17/13 <i>me</i>	
18	630.02	Five of five staff did not have mental illness training.	9/17/13 <i>me</i>	

Administrator's
Signature: _____

Steve Lish

Date: 08/09/2013