



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

October 1, 2014

Glenda Stoddard, Administrator
Morningstar of Idaho Falls
4000 South 25th East
Idaho Falls, Idaho 83404

Provider ID: RC-1068

Ms. Stoddard:

On August 27, 2014, a complaint investigation was conducted at Morningstar of Idaho Falls. 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 Donna Henscheid, LSW, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 364-1962.

Sincerely,

DONNA HENSCHIED, LSW
Team Leader
Health Facility Surveyor

DH/sc

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



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September 9, 2014

CERTIFIED MAIL #: 7007 3020 0001 4050 8555

Glenda Stoddard
Morningstar of Idaho Falls
4000 South 25th East
Idaho Falls, ID 83404

Provider ID: RC-1068

Ms. Stoddard:

Based on the complaint investigation conducted by Department staff at Morningstar of Idaho Falls between August 7, 2014 and August 27, 2014, it has been determined that the facility failed to protect residents from inadequate care.

This core issue deficiency substantially limits the capacity of Morningstar of Idaho Falls 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 **October 11, 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 **September 22, 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.

Pursuant to IDAPA 16.03.22.003.02, you have available the opportunity to question the core issue deficiency 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 Assisted Living Facility Program for an IDR meeting. The request for the meeting must be in writing and must be made within ten (10) business days of receipt of the Statement of Deficiencies. The facility's request must include sufficient information for Licensing and Certification to determine the basis for the provider's appeal, including reference to the specific deficiency to be reconsidered and the basis for the reconsideration request. If your request for informal dispute resolution is received more than ten (10) days after you receive the Statement of Deficiencies, your request will not be granted. Your IDR request must be made in accordance with the Informal Dispute Resolution Process. The IDR request form and the process for submitting a complete request can be found at www.assistedliving.dhw.idaho.gov under the heading of Forms and Information.

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 26, 2014**.

PROVISIONAL LICENSE

935. Enforcement remedy of provisional license.

A provisional license may be issued when a facility is cited with one (1) or more core issue deficiencies, or when noncore issues have not been corrected or become repeat deficiencies. The provisional license will state the conditions the facility must follow to continue to operate. See subsections 900.04, 900.05 and 910.02 of these rules.

A provisional license is being issued for a period of 6 months from the date of this letter. Return the license currently held by Morningstar of Idaho Falls.

ADMINISTRATIVE REVIEW

You may contest the issuing of the the provisional license by filing a written request for administrative review pursuant to IDAPA 16.05.03.300, which states: **the request must be signed by the licensed administrator of the facility, identify the challenged decision, and state specifically the grounds for your contention that this desicion is erroneous.** The request must be recieved **no later than twenty-eight (28) days after this notice was mailed.** Any such request should be addressed to:

**Tamara Prisock, Administrator
Division of Licensing and Certification - DHW
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036**

Glenda Stoddard
September 9, 2014
Page 3 of 3

Upon receipt of a written request that meets the requirements specified in IDAPA 16.05.03.300, an administrative review conference will be scheduled and conducted. The purpose of the conference is to clarify and attempt to resolve the issues. A written review decision will be sent to you within thirty (30) days of the date of the conclusion of the administrative review conference.

If the facility fails to file a request for administrative review within the time period, this decision shall become final.

If, at the follow-up survey, the core deficiency still exists or a new core deficiency is identified, or if any of the 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 Morningstar of Idaho Falls.

Enforcement actions may include:

- imposition of civil monetary penalties;
- summary suspension or revocation of the facility license
- limitation or ban 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

JS/sc

PRINTED: 09/08/2014
FORM APPROVED

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R1068	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/27/2014
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NAME OF PROVIDER OR SUPPLIER MORNINGSTAR OF IDAHO FALLS	STREET ADDRESS, CITY, STATE, ZIP CODE 4000 SOUTH 25TH EAST IDAHO FALLS, ID 83404
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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
R 000	<p>Initial Comments</p> <p>The following deficiency was cited during the complaint survey conducted between 8/7/14 and 8/27/14 at your residential care/assisted living facility. The surveyors conducting the survey were:</p> <p>Donna Henscheid, LSW Team Coordinator Health Facility Surveyor</p> <p>Karen Anderson, RN Health Facility Surveyor</p> <p>Gloria Keathley, LSW Health Facility Surveyor</p> <p>Rae Jean McPhillips, RN, BSN Health Facility Surveyor</p> <p>Survey Definitions: ED = Executive Director Min = Minute Random Resident = A resident whose full record was not reviewed, but was identified during the complaint investigation when reviewing accident and incident reports RCC = Resident Care Coordinator RN = Registered Nurse Sampled Resident = A resident whose full record was reviewed during the complaint investigation</p>	R 000	<p>"This Plan of Correction is prepared and submitted as required by law.</p> <p>16.03.22.520 R 008 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> <p>The following corrective actions will be accomplished for all MC residents who have the potential to be affected by the deficient practice;</p> <ul style="list-style-type: none"> A Licensed Nurse will perform an elopement risk assessment on existing MC residents to establish a baseline. The Licensed Nurse will perform an elopement assessment on potential MC residents prior to admission; a reevaluation assessment will occur at six months and or with any new behavior (change of condition) related to exit seeking activity. 	10/3/14
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		

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

TITLE

(X6) DATE

STATE FORM

6899

8SG011

If continuation sheet 1 of 14

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R1068	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/27/2014
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NAME OF PROVIDER OR SUPPLIER **MORNINGSTAR OF IDAHO FALLS** STREET ADDRESS, CITY, STATE, ZIP CODE **4000 SOUTH 25TH EAST (IDAHO FALLS, ID 83404)**

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R 008	<p>Continued From page 1</p> <p>This Rule is not met as evidenced by: Based on observation, record review and interview, it was determined the facility failed to provide supervision when 1 of 1 sampled residents (Resident #1) and a Random Resident eloped from the facility's secured memory unit. Further, the facility failed to provide supervision when they did not implement facility policies or educate staff on new policies. The findings include:</p> <p>I. Elopement</p> <p>IDAPA 16.03.22.012.25 - Supervision is "a critical watching and directing activity which provides protection, guidance, knowledge of the resident's general whereabouts..."</p> <p>1. According to her record, Resident #1 was a 90 year old female admitted to the facility's secured memory care unit, on 5/5/14, with a diagnosis of dementia.</p> <p>A behavior management assessment, dated 4/30/14, documented, "She wanders about 3 times a week. Wandering to reflections and to independent living."</p> <p>A resident progress note, dated 5/1/14, documented Resident #1 was found "wandering in" the independent living side of the facility. She was redirected back to the assisted living. The daughter was called and came to the facility.</p> <p>An incident report, dated 5/3/14, documented Resident #1 was found sitting in an employee's car in the parking lot in front of the facility. The plan to keep her safe was to move Resident #1 to the facility's secured memory care unit.</p>	R 008	<p>The elopement assessment tool will assist the licensed Nurse in identifying the resident's risk factors. If the resident is determined to be at elopement risk, interventions will be put in place, staff, family, physician will be notified and the resident's plan of care will be revised.</p> <ul style="list-style-type: none"> All MC exit doors and exterior windows are alarmed. All exterior windows, if breached will alarm to pagers with location; if MC exit doors are breached an audible alarm and pager notification with location will occur. Staff will respond immediately to the identified area, and perform a resident count. If after a resident count it is determined that a resident is unaccounted for the staff will enact the Missing Resident Policy. Immediately the Executive Director/designee will be notified. The Executive Director/designee will notify members of the Search 	<p>10/3/14</p> <p>9/26/14</p> <p>9/26/14</p> <p>9/26/14</p>

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NAME OF PROVIDER OR SUPPLIER MORNINGSTAR OF IDAHO FALLS	STREET ADDRESS, CITY, STATE, ZIP CODE 4000 SOUTH 25TH EAST IDAHO FALLS, ID 83404
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R 008	<p>Continued From page 2</p> <p>On 8/7/14, four surveyors completed a tour of the memory unit, including the location of Resident #1's room. The following observations were made:</p> <p>"The facility's memory unit was a J-shaped building with a courtyard in between which connected at the ends of the building by a fence. The unit consisted of twenty resident rooms. There was a total of 8 exits. Four exits led to the courtyard, three to the parking lot and one to the main assisted living facility. The memory unit had two dining room areas which were located on opposite sides of the building. Not all hallways or residents' rooms could be observed from all areas of the building.</p> <p>An accident/incident report, dated Friday 5/23/14, documented Resident #1 was missing from the memory care unit. It documented the resident was "escorted to her room at 1:10 PM" and when the caregiver went back to invite her to activities, she was not in her room.</p> <p>An "Incident Report" follow-up, dated 5/25/14, documented once being told Resident #1 was missing, the RN/Administrator's Designee had a staff member call family and "staff were alerted and directed to check surrounding grounds and to get in their cars and check up and down the road." The RN/Designee documented the police were notified around 2:00 PM. The RN/Designee further documented, "On Friday all windows and doors in reflections were tested to make sure that alarms were working and they were."</p> <p>Between 8/7/14 and 8/26/14, interviews regarding the incident on 5/23/14 were conducted with several current and former staff members and</p>	R 008	<p>Committee and all other team members in the Community. An immediate search of the Community and grounds will be conducted.</p> <ul style="list-style-type: none"> • If after 10 minutes the resident is not found the Executive Director/designee will immediately contact family or responsible party to see if the resident may be with family. • After notification of the family, local law enforcement will be notified. • If the resident is not found, the Search Committee will use their own vehicles to continue the search per area defined in the Missing Resident Policy. • If the resident is found The Search Committee notifies the MSIF Team Member stationed at the Community who in turn will notify all Team Members. The Executive Director will notify family and law enforcement. • IF the resident is not found in one hour, the Search 	<p>9/26/14</p> <p>9/26/14</p> <p>9/26/14</p> <p>9/26/14</p> <p>9/26/14</p>

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R1088	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/27/2014
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NAME OF PROVIDER OR SUPPLIER
MORNINGSTAR OF IDAHO FALLS

STREET ADDRESS, CITY, STATE, ZIP CODE
**4008 SOUTH 25TH EAST
IDAHO FALLS, ID 83404**

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R 008	<p>Continued From page 3</p> <p>family members. The following information was consistent with all people interviewed:</p> <ul style="list-style-type: none"> *Prior to lunch, Resident #1 had attempted to go out the doors to the courtyard several times and attempted to go out of the main entrance at least once. *The activity coordinator took Resident #1 for a walk outside in the courtyard prior to lunch. *An activity started at 1:00 PM and was being conducted in dining room #2 by the activity coordinator. *Previously, all alarmed exit doors had key pads where a specific code had to be entered to release the magnetic lock. *The doors in the memory unit would release after 15 seconds when the door opener bar was pushed. *There was a sign near the exit doors that said to push the bar for 15 seconds and the door would release. *An alarm sounded when the bars on the doors were pushed, but after a few seconds the alarms would stop. *Several family members, outside agency staff, other residents and staff had the entry code and had unrestricted access to the facility. *Residents from other areas of the facility were allowed to use the memory unit as a shortcut. *At 1:00 PM, one caregiver's shift was over and she left the facility. (This left two caregivers on 	R 008	<p>Committee will return to the Community and await instructions from local authorities.</p> <ul style="list-style-type: none"> • At this time the Executive Director/Designee will notify the State agency and local Ombudsman. • An Incident Report should be completed by the team member who initially discovered the resident was missing. • Elopement drills will be conducted twice a month. The Missing Resident Policy will be followed. • The Maintenance Director or designee will be responsible for proper function of all alarmed windows and doors in memory unit. • The Maintenance Director/Designee will physically check all MC windows and doors on monthly basis. Each window and door will be opened and closed to confirm proper functioning and ensure 	<p>9/26/14</p> <p>9/26/14</p> <p>10/11/14</p> <p>10/11/14</p> <p>10/11/14</p>

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R 008	<p>Continued From page 4</p> <p>duty in the memory unit for 13 residents.)</p> <p>*One caregiver was assisting residents with cares and the other caregiver was in the kitchen cleaning up after the meal. At one point, one of the caregivers assisted another resident outside and into a car.</p> <p>*Family members did not consistently sign residents out when they took them out of the memory unit.</p> <p>*Several family members of another resident were going in and out of the memory unit by the main entrance door.</p> <p>*It was unclear if any doors had been propped opened or deactivated.</p> <p>*None of the staff in the memory unit stated they heard alarms going off after Resident #1 attempted to leave prior to lunch.</p> <p>*At approximately 1:30 PM, a caregiver from the unit contacted the facility RN, who was in charge during the administrator's absence, and told her Resident #1 was missing.</p> <p>*A caregiver called Resident #1's family at 1:45 PM to see if the family had taken her out of the unit.</p> <p>*All staff members denied seeing the courtyard unsecured.</p> <p>*Cameras in the courtyard had not been activated.</p> <p>*At approximately 2:00 PM, the all-staff meeting was canceled and staff waiting for the meeting</p>	R 008	<p>alarms are alarming audibly and ringing to pagers.</p> <ul style="list-style-type: none"> ▪ The Executive Director/designee will be notified immediately of any non-functioning door or window. Until the door or window is repaired, team members will be assigned to monitor window or door until repaired. ▪ Monthly audit sheets will be completed and reviewed with Executive Director/designee for her signature. ▪ Staff will be in-serviced the week of September 26, 2014. In-service conducted regarding <ol style="list-style-type: none"> 1. Audits being performed 2. Missing Resident Policy 3. Elopement drills 4. Risk assessment: elopement 5. Securing doors. ▪ The Executive Director will forward a letter to MC resident family member or responsible party to outline the sign-in and sign-out policy, and to inform them of the procedure 	<p>10/1/14</p> <p>10/1/14</p> <p>9/26/14</p> <p>10/1/14</p>

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NAME OF PROVIDER OR SUPPLIER MORNINGSTAR OF IDAHO FALLS	STREET ADDRESS, CITY, STATE, ZIP CODE 4000 SOUTH 25TH EAST IDAHO FALLS, ID 83404
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R 008	<p>Continued From page 5</p> <p>were asked to assist in the search.</p> <p>*At approximately 2:43 PM, a family member found Resident #1 lying in a field with her walker and 911 was called.</p> <p>*Resident #1 was transported to the hospital where she passed away on 5/27/14.</p> <p>*The coronor's report documented Resident #1's cause of death was listed as "Anoxic Encophalopathy due to Airway Occlusion due to fall" (lack of oxygen to her head due to airway blockage) and her manner of death was "Accidental."</p> <p>Between 8/7/14 and 8/26/14 interviews were conducted with several current and former employees and family members. The following information was not consistent with all interviews:</p> <p>*One caregiver stated Resident #1 was "always" trying to escape. She would try "any door possible" and would push on the bar until the door opened.</p> <p>*Three caregivers stated at times, the door by the RCC office malfunctioned. One employee stated the door by the RCC office "didn't always click." Further, another employee stated the "front door" would not latch and the "door near the med room malfunctions."</p> <p>*A caregiver stated that at approximately 1:00 PM, she was told by another caregiver Resident #1 was missing.</p> <p>*A kitchen aide stated that between 1:00 PM and 1:10 PM, a caregiver brought dirty dishes to the kitchen and told him Resident #1 was missing.</p>	R 008	<p>pertaining to the opening and closing of MC doors.</p> <ul style="list-style-type: none"> On a weekly basis, the Reflections Care Coordinator or designee will review 10 minutes of random camera footage from the MC courtyard. This review will confirm proper functioning of the camera. If the camera is not functioning properly the Executive Director/Designee will be notified and the camera will be repaired or replaced as necessary. The Reflections Coordinator or designee will report audit findings to the Executive Director weekly. Staff will perform walking rounds with resident count at each change of shift. The oncoming and off going caregivers will walk each wing and resident rooms to complete resident count. If a resident is found missing, the Executive Director will be notified and the Missing Resident Policy will be executed. <p>Plan of care corrections will be completed by 10/11/14.</p>	<p>8/1/14</p> <p>8/1/14</p> <p>8/1/14</p>

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

MORNINGSTAR OF IDAHO FALLS **4000 SOUTH 25TH EAST**
IDAHO FALLS, ID 83404

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R 008	<p>Continued From page 6</p> <p>*The activity coordinator stated "five minutes" after starting the activity, she was told the identified resident was missing. She further stated, she was unsure if any doors were propped open in the unit when family members were moving belongings out.</p> <p>*A family member stated she arrived at the facility at approximately 2:00 PM. She stated a male employee said he had seen a woman fitting Resident #1's description when looking out a window from the third floor of the facility. The family member stated, she got into her car and followed a woman in another car and they went towards the area where the "woman" was seen by the male employee. The family member stated she returned to the memory unit, searched around Resident #1's room and left through a door leading to the parking lot. She stated she did not hear any alarms sound as she left the facility.</p> <p>On 8/7/14 at 1:10 PM, the administrator stated she had conducted an investigation and it was inconclusive how Resident #1 got out of the unit. She stated the cameras in the courtyard were not activated when Resident #1 eloped, but she believed the courtyard was locked. She stated after that incident, the alarms were changed to a new key fob system and tighter controls were placed on who had the fobs. She stated other residents were no longer allowed to use the unit for a shortcut. She stated the 15 second egress doors continued to alarm until they were manually reset.</p> <p>2: Random Resident</p> <p>An incident report, dated 6/22/14 at 8:50 AM, documented a resident from the assisted living</p>	R 008		
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R 008	<p>Continued From page 7</p> <p>side of the facility called staff for assistance. When the caregiver arrived in the resident's room, the resident was "very shaken up" and asked what "that man" was doing outside her window. The caregiver looked out the window and saw the Random Resident with a fork, trying to pry open the window. The caregiver called the memory unit manager by walkie-talkie to ask for assistance.</p> <p>The RN documented "a small amount of blood was found on the window sill and the plastic stops to keep the window from opening more than 6 inches were pried off. The window was found halfway open and then closed by staff." There was no further documentation to determine where the memory unit staff were when the Random Resident pried open a window and got out of a secured unit without being seen.</p> <p>Interviews conducted with the facility RN and staff members between 8/7/14 and 8/15/14, identified the following events occurred:</p> <p>*A window was found open by a caregiver and the caregiver closed the window without checking to see why it was opened or who opened it.</p> <p>*The Random Resident eloped through a window in a common area by removing the plastic window stoppers on the sides of the window.</p> <p>*No one working at the time knew the Random Resident was missing.</p> <p>*It was uncertain how long the resident was outside.</p> <p>On 8/7/14 at 4:40 PM, the administrator stated all the windows in the memory unit were adjusted to</p>	R 008		
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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R1068	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/27/2014
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NAME OF PROVIDER OR SUPPLIER MORNINGSTAR OF IDAHO FALLS	STREET ADDRESS, CITY, STATE, ZIP CODE 4000 SOUTH 25TH EAST IDAHO FALLS, ID 83404
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R 008	<p>Continued From page 8</p> <p>open to only 6 inches. She stated after the incident on 6/22/14, the facility installed window alarms.</p> <p>On 8/14/14, at 2:30 PM, the facility RN stated the window the Random Resident eloped from was located in a common area. She stated she was uncertain how the Random Resident had pried open and climbed out a window in a common area, without anyone seeing or hearing him.</p> <p>Resident #1 and a Random Resident eloped from the facility's secured memory unit without anyone's knowledge or "critical watching."</p> <p>II. Implementing Policy</p> <p>IDAPA 16.03.22.215.10 - Administrator's Designee. A person authorized in writing to act in the absence of the administrator and who is knowledgeable of facility operations, the residents and their needs, emergency procedures...</p> <p>A letter from the administrator, dated 5/22/14, documented the Director of Wellness (RN) was responsible for all administrative duties in the event the administrator was not available. The dates of the delegation were from 5/23/14 through 5/26/14.</p> <p>The facility's "Missing Resident Policy" documented the following:</p> <p>*"When staff is unable to locate a resident, notify the Executive Director.</p> <p>*All team members present in the community will search their immediate work areas for the resident. Check every floor, room, bathroom, closet, bed storage area, office, common areas</p>	R 008		
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R 008	<p>Continued From page 9</p> <p>and check the sign in/out log.</p> <p>*If the resident it [sic] is not found in the internal building search, the Executive Director then calls the family and/or responsible party. Ask if he/she will call others in the family to see if the resident may be with another family member.</p> <p>*...One team member (or more if the area is large) will search the grounds.</p> <p>*Engage the 'Search Committee.' The search committee is the Executive Director, Wellness Director, Assisted Living Coordinator, and Reflections Coordinator and/or Resident Care Coordinator to conduct a search in his/her vehicle. If after hours, these managers are expected to come in to aid in the search.</p> <p>*Prior to starting search in their vehicle, the [sic] each person on the Search Committee will be given:</p> <p>a. A copy of the department managers cell phone list (or ensure that all numbers on in [sic] his/her cell phone)</p> <p>b. A map of 3 square miles around the community divided into 4 quadrants. This should be kept/found in the Emergency Operations Manual. The Executive Director will assign a quadrant for each person.</p> <p>c. A picture of the resident.</p> <p>*The Search Committee will conduct a thorough search of every retail establishment, restaurant, etc. within this quadrant and show the resident's picture to help in the search.</p>	R 008		

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R 008	<p>Continued From page 10</p> <p>*If the resident is not found in 30 minutes, the ED will call the police..."</p> <p>Between 8/7/14 and 8/26/14 interviews were conducted with several current and former employees, family members and the ombudsman. The following information was provided:</p> <p>*Two employees stated they knew the resident was missing between 1:05 PM and 1:10 PM. However, the RN/Designee was not notified until 1:30 PM.</p> <p>*A family member stated she asked the RN/Designee, during a phone conversation at 1:50 PM, if the facility had started a search outside or if the police had been called. The family member stated the RN/Designee asked her if she felt an outside search was necessary. Further, the family member stated the RN told her the police had not yet been contacted.</p> <p>Forty-five minutes after Resident #1 was reported missing, a search of the grounds had not been started.</p> <p>*A kitchen aide stated he had seen a woman walking towards the field with a walker from a third story window, but thought she was from a neighboring facility.</p> <p>This employee did not report this immediately to the RN/Designee who could have initiated and coordinated a search in the area the "woman" was seen.</p> <p>*A family member of Resident #1 stated she arrived at the memory unit at approximately 2:00 PM. She stated two employees were standing</p>	R 008		

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R 008	<p>Continued From page 11</p> <p>outside and said to her, "No big deal. The resident's family took her and forgot to sign her out." She said the employees seemed to have "no sense of urgency" and were not aware Resident #1 was not with family.</p> <p>The search efforts were not clearly coordinated between the RN/Designee and staff conducting the search. Staff nor family had clear directions of where to look or who to communicate with.</p> <p>A police report, dated 5/23/14, documented at 2:41 PM, a missing person report was called into the police department by the business office manager. This was not within the 30 minutes as outlined in the facility's missing person's policy.</p> <p>On 8/7/14 at 1:10 PM, the administrator stated she felt Resident #1 left the unit when another resident's family was going in and out. She stated the facility had not changed their missing person's policy, but had put new procedures into place. The administrator stated, the facility now assigned each department a search area and two elopement drills were being conducted each month.</p> <p>After Resident #1 eloped from the secured memory unit on 5/23/14, the facility developed new policies and procedures such as "elopement drills" to ensure a coordinated and thorough search would be conducted when a resident was missing.</p> <p>During the course of the investigation/interviews, no staff could confirm they had ever participated in an "elopement drill."</p> <p>On 8/7/14 at 1:20 PM, a caregiver stated the facility had implemented new locks and "head</p>	R 008		
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R 008	<p>Continued From page 12</p> <p>counts" every hour in the memory unit. The caregiver stated the unit currently had 16 residents.</p> <p>On 8/7/14 at 2:10 PM, the administrator stated the facility had implemented a "head count" of all the residents in the memory unit every "two hours." She stated the unit currently had 18 residents. After being told the caregiver just told surveyors there was only 16 residents, the administrator stated she needed to do some additional training.</p> <p>On 8/7/14 at 4:50 PM, the administrator stated the facility had not developed any procedures for when families were moving residents' belongings in and out. She stated staff are more aware, but there should be someone there to monitor the doors to ensure residents do not elope.</p> <p>On 8/14/14 at 11:11 AM, the kitchen manager stated he was not familiar with the "search committe" or that departments had been assigned areas to search when residents were missing.</p> <p>On 8/14/14 at 2:20 PM, the RN/Designee was interviewed. She stated the Administrator had provided "general training" regarding designee duties. She stated she had not completely read the missing person's policy prior to this incident. The RN/Designee stated, she had not formed a search committee, but had "used common sense."</p> <p>The facility's RN/Designee was not properly trained on the facility's policy regarding missing persons. No "search committee" was initiated. No map of the area, phone list of committee members, or a picture of the resident was</p>	R 008		
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R 008	<p>Continued From page 13</p> <p>provided to those searching. Further, staff were not told who to report, were not given direction as to what to do, and were not kept informed of what had already been done. Additionally, the facility developed new policies that had either not been fully implemented or had not been communicated to all staff.</p> <p>The facility failed to provide supervision or a "critical watching" of Resident #1 and a Random Resident who eloped from the facility's secured memory unit. Further, the facility failed to provide supervision when policies were not fully implemented and staff were not appropriately trained. These failures resulted in inadequate care.</p>	R 008		



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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September 9, 2014

Glenda Stoddard, Administrator
Morningstar of Idaho Falls
4000 South 25th East
Idaho Falls, Idaho 83404

Provider ID: RC-1068

Ms. Stoddard:

An unannounced, on-site complaint investigation survey was conducted at Morningstar of Idaho Falls between August 7, 2014 and August 27, 2014. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00006501

Allegation #1: The facility did not have a system in place to prevent residents from eloping from a secured memory unit.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 15.03.22.520 for not putting a system in place to provide supervision to prevent residents from eloping from a secured memory unit. The facility was required to submit a plan of correction within 10 days.

Allegation #2: The facility did not follow their emergency policy when residents were missing from the memory unit.

Findings: Substantiated. The facility was issued a core deficiency at IDAPA 16.03.22.520 for not providing adequate supervision to ensure a designee and staff were fully trained on facility policies regarding missing persons. The facility was required to submit a plan of correction within 10 days.

Allegation #3: The facility did not document a thorough investigation was conducted when residents were missing from the facility.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.350.02 for not documenting they had conducted a thorough investigation. The facility was required to submit evidence

Glenda Stoddard, Administrator
September 9, 2014
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of resolution within 30 days.

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 black ink, appearing to read "Donna Henscheid". The signature is fluid and cursive, with a long horizontal stroke at the end.

DONNA HENSCHIED, LSW
Health Facility Surveyor
Residential Assisted Living Facility Program

DH/sc

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