



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 13, 2013

**CERTIFIED MAIL #: 7012 1010 0002 0836 0195**

Kathy Adams, Administrator  
Safe Haven Homes of Wendell  
PO Box 306  
Wendell, ID 83355

Dear Ms. Adams:

Based on the complaint investigation survey conducted by our staff at Carefix Management & Consulting Inc, dba Safe Haven Homes of Wendell-Magic Valley Manor on **August 28, 2013**, we have determined that the facility failed to protect residents from neglect.

This core issue deficiency substantially limits the capacity of Carefix Management & Consulting Inc, dba Safe Haven Homes of Wendell-Magic Valley Manor to provide for residents' basic health and safety needs. The deficiency is described on the enclosed Statement of Deficiencies.

**BACKGROUND:**

This is the second time in a twelve month period that this particular core-level deficiency has been cited at this facility. The first time was during the survey of November 9, 2012.

**PROVISIONAL LICENSE:**

As a result of the survey findings, the Department is issuing the facility a provisional license, effective September 12, 2013, through March 12, 2014. The following administrative rule for Residential Care or Assisted Living Facilities in Idaho (IDAPA 16.03.22) gives the Department the authority to issue a 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.*

The conditions of the provisional license are as follows:

1. **Compliance.** The facility will achieve substantial compliance with the rules for Residential Care or Assisted Living Facilities in Idaho (IDAPA 16.03.22) as demonstrated by having no core issue deficiencies identified during the follow-up survey, and will ensure correction of all non-core deficiencies as demonstrated by no deficiencies repeated from either the November 9, 2012 or the August 28, 2013 Non-Core Issues Punch Lists.
2. A provisional license is issued which is to be prominently displayed in the facility. Upon receipt of this provisional license return the full license, currently held by the facility.
3. When the administrator determines the facility is in full compliance, she will notify the Department and a follow-up survey will be conducted.

Please be advised that you may contest this decision by filing a written request for administrative review pursuant to IDAPA 16.05.03.300. 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**  
**Department of Health and Welfare**  
**3232 Elder Street**  
**P.O. Box 83720**  
**Boise, ID 83720-0009**

If you fail to file a request for administrative review within the time allowed, this decision shall become final.

You have an opportunity to make corrections and thus avoid further enforcement action. Correction of this deficiency must be achieved by . 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 25, 2013**, and keep a copy for your records. Your license depends upon the corrections made and the evaluation of the Plan of Correction you develop.

Kathy Adams  
September 13, 2013  
Page 3 of 3

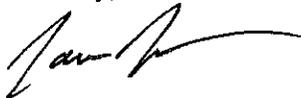
You have available the opportunity to question cited deficiencies through an informal dispute resolution process. If you disagree with the survey report findings, you may make a written request to the Supervisor of the Residential Care Program for a Level 1 IDR meeting. The request for the meeting must be made within ten (10) business days of receipt of the Statement of Deficiencies (**September 25, 2013**). The specific deficiencies for which the facility asks reconsideration must be included in the written request, as well as the reason for the request for reconsideration. The facility's request must include sufficient information for Licensing and Certification to determine the basis for the provider's appeal. If your request for informal dispute resolution is received after **September 25, 2013**, 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](http://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. The completed punch list form and accompanying proof of resolution (e.g., receipts, pictures, policy updates, etc.) are to be submitted to this office by **September 27, 2013**.

If, at the follow-up survey, it is found that the facility is not in compliance with the rules and standards for residential care or assisted living facilities, the Department will have no alternative but to initiate an enforcement action against the license held by Carefix Management & Consulting Inc, dba Safe Haven Homes of Wendell-Magic Valley Manor.

Should you have any questions, or if we may be of assistance, please call our office at (208) 364-1962.

Sincerely,



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

DH/TFP

cc: Medicaid Notification Group  
Steve Millward, Licensing & Certification

55 pages.

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13R032	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  C 08/28/2013
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NAME OF PROVIDER OR SUPPLIER  CAREFIX-SAFE HAVEN HOMES OF WENDELL	STREET ADDRESS, CITY, STATE, ZIP CODE 210 NORTH IDAHO WENDELL, ID 83355
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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 deficiency was cited during a complaint investigation conducted between 8/27/2013 and 8/28/2013 at your residential care/assisted living facility. The surveyors conducting the survey were:</p> <p>Donna Henscheld, LSW Team Leader Health Facility Surveyor</p> <p>Gloria Keathley, LSW Health Facility Surveyor</p> <p>Karen Anderson, RN Health Facility Surveyor</p> <p>Survey Definitions: A1C = A blood test that measures your average blood sugar level for the past two to three months. BG = Blood Glucose BG parameters for diabetics = Normal range is 70 to 130 mg/dL before meals, and less than 180 mg/dL after meals CM = Centimeter EMS = Emergency medical services ER = Emergency Room MAR = Medication Assistance Record Mg/dL = Is Milligrams per deciliter, a unit of measure that shows the concentration of a substance in a specific amount of fluid. NSA = Negotiated Service Agreement O2 = Oxygen Pt. = Patient Q = Every RN = Registered Nurse Sx = Symptoms</p>	R 000	<p>Please accept the following documents are corrections to the following core cited on 8/28/2013.</p> <ul style="list-style-type: none"> <li>#1 Abuse/Neglect Policy</li> <li>#2-2c Incident/Event Policy</li> <li>#3 Emergency preparedness</li> <li>#4 In service date 9-4-2013</li> <li>#5-5b Documentation training</li> <li>#6-6b Fly notifying RN</li> <li>#7-7b Monitoring/Observation by staff change in condition</li> <li>#8 Documentation, RN, social worker, HH hospice parameters w/ prn</li> <li>#9-9a change in w/resident All RN asst all documentation.</li> <li>#10 In service Recs</li> <li>#11-11j Diabetes training</li> </ul>	
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Bureau of Facility Standards  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Patricia Adams* Administrator

TITLE *Compliance* DATE

*10/12/13*

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13R932</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/28/2013</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CAREFIX-SAFE HAVEN HOMES OF WENDELL</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>210 NORTH IDAHO WENDELL, ID 83355</b>
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R 000	Continued From page 1	R 000		
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 did not seek timely medical treatment for 2 of 7 sampled Residents (#2 and #5). This failure constituted neglect.</p> <p>IDAPA 16.03.22.001.03 documents, "The facility must have an administrator and staff who have the knowledge and experience required to provide safe and appropriate services to all residents of the facility."</p> <p>IDAPA 16.03.22.011.24 defines neglect as "Failure to provide...medical care necessary to sustain the life and health of a resident."</p> <p>1. Resident #2, an 83 year old female, was admitted to the facility on 2/1/08, with diagnoses including Alzheimer's dementia and diabetes mellitus type II.</p> <p>An NSA, dated 2/5/13, documented Resident #2 required finger foods to eat independently and "some verbal cueing." It further documented, Resident #2 required stand-by assistance with walking and required minimal assistance with transfers.</p> <p>A fax sent to Resident's physician, on 12/14/12,</p>	R 009	<p>New policy &amp; procedures regarding Abuse &amp; Neglect Incident - Event policy Emergency Preparedness have been put in place. A staff meeting held on 9-4-13 was provided to Administrator, House Manager &amp; All staff. The following policies when reviewed Abuse &amp; Neglect, Incident / Event policy Emergency Preparedness also appropriate documentation, when &amp; why to notify the RN, what is a change in condition monitoring &amp; Observing changes appropriate way to do a Incident / Accident who to notify.</p>	

Bureau of Facility Standards

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R 009	<p>Continued From page 2</p> <p>requested Resident #2 have a lab test for "A1C" every 6 months. The facility RN documented the resident was no longer able to do her own blood glucose checks. The physician signed the order for "A1C labs Q 6 months" and the facility RN, noted the new order on 12/23/12.</p> <p>A nursing assessment, dated 6/17/13, documented the resident's weight had remained stable. The facility RN did not document the resident's blood glucose level checks or lab results of her A1C.</p> <p>There was no documentation from the facility RN regarding the lab results from the A1C blood test. According to the physician's orders, an A1C, to check the stability the resident's blood glucose, should have been done in June 2013.</p> <p>A "Resident Events - Change of Shift Report," dated 8/26/13, documented Resident #2 was not eating and was drinking less liquids."</p> <p>On 8/27/13 at 9:15 AM, the administrator stated the resident had a dental appointment in the afternoon because she had stopped eating and had not been drinking since 8/26/13. The administrator stated, "This is very unusual for her, she is such a good eater." The administrator further stated, the resident walked the day before. She stated, as of today, the resident required a two-person assist to transfer and a wheelchair.</p> <p>On 8/27/13, from 8:00 AM until 2:00 PM, the following observations and interviews were made:</p> <p>*8:00 to 8:55 AM, Resident #2 sat in a wheelchair at the dining room table. The resident was hunched over, leaning to the right. Her breakfast consisted of a fried egg, sausage and toast. The</p>	R 009	<p>New policies &amp; monitoring for changes have been posted. Also a FYI regarding who to call with falls / incident / Passing of Resident, Reportable Incidents has been posted for all staff.</p> <p>In addition House Manager, &amp; Administrator have been trained &amp; implemented progress charting, appropriate use of RN to provide Recommendation &amp; education. Alert charting has been implemented &amp; trained on for staff. House manager, Admin. Also Administrator &amp; House Manager are doing documentation on a weekly basis bare minimal.</p>	

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R 009	<p>Continued From page 3</p> <p>food was untouched. Another resident sitting at the table, was observed to take the toast off Resident #2's plate and eat it. No staff assisted the resident with eating during this time or intervened when the other resident took food from her plate.</p> <p>*9:05 AM to 9:10 AM, the housekeeper took Resident #2 away from the breakfast table and pushed the resident back to her room. The housekeeper tried to transfer the resident from her wheelchair to her rocking chair, but was unable to perform the transfer alone. Another caregiver arrived and the two of them took a hold of the resident from both sides. The resident's legs would not support her. The caregivers grabbed the back of the resident's pants to transfer her from the wheelchair to the rocking chair. The housekeeper and the caregiver both stated this was a significant change for the resident as she was able to ambulate the day before.</p> <p>*9:10 AM to 9:30 AM, Caregiver A came into the resident's room. The resident had drool coming out of her mouth. The caregiver took a rough dry paper towel and wiped the drool from her face. The resident was not alert, but grimaced and flinched when having her face rubbed with the paper towel.</p> <p>*9:30 AM to 10:00 AM, Caregiver A offered the resident a drink of Ensure. The resident was not alert or responsive and was not be able to drink the Ensure the caregiver was holding to her lips. The Ensure ran down the side of the resident's face. The caregiver wiped her face off with another dry rough paper towel. The resident grimaced and flinched again when the paper towel was rubbed over her face.</p>	R 009	<p>On 9-18-13 a change in condition occurred &amp; staff, house manager &amp; Administrator were able to use their training to put the new policies &amp; training in place. RN provided education, new asst was completed &amp; staff did alert charting. Administrator provided documentation to reflect changes &amp; concerns.</p> <p>On 9-25-13 a staff meeting was held for all staff house manager, &amp; Administrator regarding Diabetes, hypo/hyper s/s of. Appropriate Adv's and how to asst Resident with hand, face washing. All caregivers &amp; medication Asst staff were provided a hand out &amp; completed a test regarding Diabetes</p>	
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NAME OF PROVIDER OR SUPPLIER: **CAREFIX-SAFE HAVEN HOMES OF WENDELL**  
STREET ADDRESS, CITY, STATE, ZIP CODE: **210 NORTH IDAHO WENDELL, ID 83355**

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R 009	<p>Continued From page 4</p> <p>*10:00 AM to 10:30 AM, Resident #2 was sitting in her chair. She was rocking side to side while grabbing at the air and moaning. She had not opened her eyes since being placed in the chair at 9:05 AM.</p> <p>*10:30 AM, Caregiver A checked Resident #2's blood glucose. The reading from the glucometer was 590 mg/dL. The caregiver stated she would report this to the administrator, she then stated she would call the facility RN.</p> <p>*10:40 AM, Caregiver A stated, she had called the facility RN and he had instructed her to keep a close eye on the resident and re-check her BG before lunch.</p> <p>*10:55 AM, Caregiver A and the administrator transferred Resident #2 from the rocking chair into her bed. The resident was flaccid and her legs were unable to hold her weight during the transfer.</p> <p>*10:55 AM to 11:42 AM, Caregiver A and B stated they were not allowed to check BG levels, because the facility RN said it required a physician's order. Both stated they were trained to call the physician when blood glucose levels were over 400 mg/dl. Both caregivers stated the resident had been a "two-person transfer for a couple of days," but the facility RN had not been called until today. Caregiver B stated, "I told the administrator about her change of condition."</p> <p>*11:42 AM, Caregiver A and B, lifted Resident #2 out of bed and into her wheelchair to assist her to use the toilet. The resident's body was flaccid and her legs were not able to support her weight. The resident did not open her eyes and was observed</p>	R 009	<p>Blood Glucose monitoring signs and symptoms of hypo/hyper. Who to notify with BG concerns not in normal limits.</p> <p>Administrator, House Manager &amp; Staff have all been instructed to review careplans to make sure all needs of residents are being met. To report change in conditions with normal ADH's to RN &amp; to obtain a assessment/education &amp; training.</p> <p>Administrator, House Manager &amp; facility RN are to monitor for change in condition complete RN asst within 24 of change. RN also to complete RN asst every 90 days with no changes.</p>	

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R 009	<p>Continued From page 5</p> <p>hunched over the top of her legs while sitting on the toilet. After toileting the resident, the caregivers assisted her back into her wheelchair and to the dining room. The wheelchair did not have footrests and the resident's feet were observed dragging on the floor on the way to the dining room. Both caregivers stated, the wheelchair did not belong to the resident and they thought the footrests may be in the storage.</p> <p>*11:42 AM to 12:25 PM, Resident #2 arrived at the dining room for lunch. Caregiver A rechecked the resident's BG. The glucometer only read "High" and was not able to register her BG level. Caregiver A performed another finger stick and tested her blood. The glucometer read, "High" again. The caregiver stated the administrator was on the phone with a physician's assistant (PA) and he would come examine the resident at the facility.</p> <p>*12:25 PM, the administrator stated, "I called the facility RN today because [Resident #2's name] was not eating well yesterday." The administrator stated, "I was off all weekend and I was not aware of any change of condition until today." She said, "I worked yesterday (Monday) and I saw her walking down the hallway. I did notice she was in a wheelchair later that day."</p> <p>*12:45 PM, Resident #2 remained at the dining room table and was not eating or drinking, her eyes remained closed. From 11:42 AM until 12:50 PM, the resident fell forward with her face on the table. Caregiver C noticed and pulled the resident's wheelchair away from the table so the resident would not hit her head.</p> <p>*At 12:50 PM, the administrator requested help to take the resident back to bed as she was not</p>	R 009		

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R 009	<p>Continued From page 6</p> <p>responsive or able to eat. The Administrator and the house manager assisted the resident out of her wheelchair and into her bed. Again the administrator stated, "I saw the resident walking yesterday afternoon, I was not aware she was no longer able to walk and needed a two-person assist to transfer." She stated, "Staff did not inform me."</p> <p>*1:10 PM to 1:20 PM, a PA arrived and observed the resident laying on the bed. He asked Caregiver A and B, how long the resident had been unresponsive. Caregiver A and B stated she "had been like this all morning." He further questioned whether or not they had obtained vital signs. They stated they had not taken any vital signs. The administrator came into the room and stated, "I'm thinking she may have a tooth problem or infection, because the left side of her face looks swollen." The administrator said, "When I tried to offer her fluids she flinched away." The administrator additionally stated, "I have a lot of new staff that are not communicating and passing on information to me."</p> <p>On 8/27/13 at 3:46 PM, Caregiver D stated she had been off work for four days and when she returned she was "not impressed" with Resident #2's condition. She said when she returned to work on Saturday, two other caregivers told her the resident had to be in a wheelchair now. Further, she stated when changing the resident's brief, she found a 2 inch long by 1 inch wide sore on the resident's buttocks. She stated, it looked like the resident had "skidded across the floor." The caregiver stated, "I was shocked," because she was not walking and not eating. The caregiver stated she told the assistant administrator about the area on the resident's</p>	R 009		
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R 009	<p>Continued From page 7</p> <p>buttocks. She stated, she was never instructed to take residents' blood sugars.</p> <p>From 8/24/13 to 8/27/13, the resident had a change of condition and the facility RN had not been notified until 10:40 AM when surveyors began asking questions about the resident's condition.</p> <p>On 8/28/13 at 8:35 AM, the facility RN stated, he was not called about Resident #2's change of condition until this morning, when a caregiver called to tell me that her BG was 590 mg/dL. The RN stated, the administrator told him the resident had a dentist appointment today, because she had a tooth problem and had not been eating well. Further, he stated he had not been informed of the wound on her buttocks. He stated, "I wish I would have been told, because I was in the facility on Saturday and I could have assessed her then."</p> <p>Resident #2 went from being ambulatory and a "good eater," to being unable to bear weight and non-responsive within two to three days. Further, the resident had a diagnosis of diabetes and the facility did not have an A1C done every 6 months as ordered. When the resident's blood glucose level was tested, it was so high it would not register on the glucometer. For approximately three days, the resident had a significant change of condition and was not assessed by a medical professional and did not receive medical treatment.</p> <p>2. Resident #5, a 63 year old female, was admitted to the facility on 2/15/12 with diagnoses including schizophrenia and dementia.</p>	R 009	

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STREET ADDRESS, CITY, STATE, ZIP CODE  
**210 NORTH IDAHO WENDELL, ID 83355**

(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 009	<p>Continued From page 8</p> <p>An NSA, dated 3/29/13, documented the resident was independent with toileting, transferring, and mobility within the facility.</p> <p>A nursing assessment, dated 5/20/13, documented the resident remained "stable" and weighed 131.2 pounds. This was the last nursing assessment found in the resident's record.</p> <p>Staff communication notes documented the following:</p> <p>*6/7 - Resident "not feeling well, keep eye on her."</p> <p>*6/8 - "walk her to toilet per [Administrator's name]."</p> <p>On 6/13/13, a psychiatric evaluation, documented the resident was "unable to provide much information at today's appointment. She will start to answer a question and then stop mid sentence as if she lost her train of thought. She is also taking an excessive amount of time processing information...She showed me her legs which were quite swollen and reported 'my pain starts here and moves up to my head.' [Resident #5's name] was noted to be quite disorganized today. Staff reports indicate she is talking less than she was a month ago."</p> <p>There was no documentation from the staff or facility RN regarding the resident's swollen legs or cognitive changes.</p> <p>Staff communication notes documented the following:</p> <p>*7/7 - "[Administrator's name] is very upset shifts are not communicating change of shifts on 24 hr</p>	R 009		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13R932	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  C 08/28/2013
NAME OF PROVIDER OR SUPPLIER  CAREFIX-SAFE HAVEN HOMES OF WENDELL		STREET ADDRESS, CITY, STATE, ZIP CODE 210 NORTH IDAHO WENDELL, ID 83355		
(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 009	<p>Continued From page 9</p> <p>report!!! How is on coming shift to no [sic] what going on."</p> <p>*7/8 - Resident #5 fell and 2 hour checks were implemented. It further documented the resident was to be "watched and assisted" because she was "having a hard time walking and keeps falling." There was no documentation the facility nurse assessed the resident after the fall.</p> <p>An incident report, dated 7/15/13, documented the resident was found on the floor with a skin abrasion on her left cheek bone. There was no documentation the resident had been assessed by the facility RN after the fall.</p> <p>A physician's visit progress note, dated 7/16/13, documented the resident "fell yesterday. Normally she is more stable and sits straight. She leans forward. She has had similar sx with previous UTI." The resident was assessed to have a UTI and an antibiotic was ordered. The note further documented, the resident weighed 115.2 pounds. This was 16 pounds less than she weighed in May.</p> <p>Staff communication notes "Change of Shift Report", documented the following:</p> <p>*7/16 - Resident #5 was found on the floor at 10:35 PM and had a bruise on her chin.</p> <p>*7/17 - The resident "fell again, do head checks on her."</p> <p>*7/21 - The resident refused to eat or "take pills."</p> <p>*7/24 - The resident "needs a boot on her heel foot whenever laying down."</p>	R 009		

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER  CAREFIX-SAFE HAVEN HOMES OF WENDELL		STREET ADDRESS, CITY, STATE, ZIP CODE 210 NORTH IDAHO WENDELL, ID 83355		
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R 009	<p>Continued From page 10</p> <p>There was no documentation the facility nurse was notified of the observed changes of condition.</p> <p>A "Safe Haven Comprehensive Nursing Assessment," dated 7/24/13, documented the resident had a "2.5 cm x 2.5 cm fluid filled blister to (R) heel. Area is pale, tender and intact." It further documented that staff were to monitor her footwear and contact nursing with any changes.</p> <p>There was no further documentation from the facility nurse regarding the resident's falls, bruising, abrasions, swollen legs, cognitive changes, UTI or weight loss.</p> <p>A local hospital provider note, dated 7/31/13, documented the resident was "apparently found less responsive than normal by staff this morning, they called EMS who found the patient had O2 saturation of 82%, was slightly tachycardic and febrile. Pt. normally is ambulatory and talks, but today is not responding and not giving any history."</p> <p>A local hospital progress note, dated 8/1/13, documented the "family notes that over the last few months she has lost a significant amount of weight...and her current mental status is a big change."</p> <p>Another hospital nursing note, dated 8/2/13, documented the resident weighed 119.4 pounds upon admission.</p> <p>Another hospital "Discharge Summary," dated 8/7/13, documented the resident was admitted from another hospital for "bilateral pneumonia, presumed aspiration...protein calorie malnutrition with progression of patient's neurological and</p>	R 009		

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER  <b>CAREFIX-SAFE HAVEN HOMES OF WENDELL</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>210 NORTH IDAHO WENDELL, ID 83355</b>
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R 009	<p>Continued From page 11</p> <p>cognitive decline." It further documented the resident had been "less ambulatory, losing weight...and had sustained falls and may have been aspirating"...There was "Initially an attempt at some NG tube for nutritional support although this was unsuccessful with tube unable to be placed due to patient's lethargy and somnolence." The resident was discharged on hospice and her "life expectancy was probably 1 week or less."</p> <p>Between 8/27/13 and 8/28/13, staff interviews were conducted and the following information was collected regarding Resident #5's change of condition:</p> <p>*A caregiver stated, "I didn't notice any weight loss," but it was a "hit and miss" with her eating." The caregiver also stated "falling was the change."</p> <p>*The resident fell on 7/15 and "I panicked. I called [Administrator's name] and was told to put ice on it." The caregiver stated she "tried calling" the facility nurse, but had to leave a message. She further stated, the resident was not drinking as much and was not walking as often. She stated after 7/17, the resident started "going downhill again." She stated she tried to feed the resident in her room, but the resident "refused a lot of it." The caregiver said she spoke to the administrator and the administrator said she was going to check weights.</p> <p>*The resident would "come hang around me at the med cart," but for a few days she did not come down.</p> <p>**It's been progressive, she quit talking, not verbalizing what she wanted." She had falls and "two UTI's back to back." She further stated, after</p>	R 009		

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER: CAREFIX-SAFE HAVEN HOMES OF WENDELL  
STREET ADDRESS, CITY, STATE, ZIP CODE: 210 NORTH IDAHO WENDELL, ID 83355

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R 009	<p>Continued From page 12</p> <p>the falls the resident never "came back" to where she was physically and mentally. The caregiver stated, when the resident stopped talking, she thought it was because the resident was "mad." "I thought it was more of a behavior instead of being sick." She further stated, the resident did not want to get up for meals.</p> <p>*The resident "would stay in her room a lot. I wasn't here when she went to the hospital." The caregiver further stated, she "heard" the resident was down in weight and would not eat.</p> <p>On 8/27/13 at 11:37 AM, a family member stated she saw the resident on 7/23/13 (Eight days prior to being sent to the hospital) and the resident had a "black eye, left side bruising, and bed sores." She stated the resident had "stopped eating" and was "hunched over." She stated there was a "huge change of condition" since last seeing her in May 2013. The family member stated, "We couldn't wake her" and she was in a "really bad state the next Sunday" (7/28). She stated on "Wednesday, (7/31) we got a call from the ER that she was there."</p> <p>On 8/27/13 at 1:00 PM, the administrator stated the resident was seen by the physician at the facility, on 7/16/13. When informed, there was no nursing assessments since 5/20/13 and no documentation other than the wound assessment, on 7/24/13, the administrator stated the facility "sometimes, doesn't get their notes back."</p> <p>On 8/28/13 at 9:03 AM, a family member stated, "The only call I've received in one in a half years was when they called to say she was going to the ER." The family member stated, he saw the resident on 7/28 (three days prior to being sent to</p>	R 009		





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

October 8, 2013

Kathy Adams, Administrator  
Safe Haven Homes of Wendell  
Magic Valley Manor  
PO Box 306  
Wendell, ID 83355

License #: RC-932

Dear Ms. Adams:

On August 28, 2013, a complaint investigation survey was conducted at Carefix Management & Consulting Inc, dba Safe Haven Homes of Wendell-Magic Valley Manor. 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 Henscheid, LSW  
Team Leader  
Health Facility Surveyor

DH/tfp

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



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HEALTH & WELFARE

DIVISION OF LICENSING & CERTIFICATION  
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Boise, ID 83720-0036  
(208) 364-1862 Fax: (208) 364-1888

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ASSISTED LIVING  
Non-Core Issues Punch List  
Page 1 of

No. 0281  
P. 2

Facility Safe Haven Homes of Wendell - Magic Valley Manor	License # RC-932	Physical Address 210 NORTH IDAHO	Phone Number (208) 536-6623
Administrator Kathy Adams	City WENDELL	ZIP Code 83355	Survey Date August 28, 2013
Survey Team Leader Donna Henschel	Survey Type Complaint Investigation	RESPONSE DUE September 27, 2013	
Administrator Signature <i>Kathy Adams</i>	Date Signed Sept 4, 2013		

**NON-CORE ISSUES**

Item #	IDAPA Rule #	Description	Department Use Only	
			EOB Accepted	Initials
1	153.03	The facility's emergency policy directs staff to call the administrator in a medical emergency instead of the facility nurse or 911. Further, the facility did not follow their policy to contact families when residents had a change of condition.	10/1/13	DH
2	305.03	The facility nurse did not assess residents when they had changes of condition. For example: Resident #3's fever, Resident #6's wounds and Resident #7 not getting pain patch as ordered or wounds assessed when resident first complained of problems.	10/1/13	DH
3	305.05	The facility nurse did not follow-up on recommendations made to the administrator. For example: A random resident had a catheter that was pulled out and another random resident had a leaking catheter.	10/1/13	DH
4	305.06	The facility nurse did not conduct an assessment to determine if residents were capable to self-administer their own insulin (dial insulin pens).	10/1/13	DH
5	310.01.d	Unlicensed Assistive Personnel were dialing insulin pens for Residents.	10/1/13	DH
6	711.08.b	The facility nurse did not provide delegation to all staff to include written and oral instructions for providing assistance to residents.	10/1/13	DH
7	711.08.d	The facility did not document calls to the physicians, the reason for the call and the outcome.	10/1/13	DH
8	711.08.e	Facility staff did not document calls to the facility nurse when residents had changes in physical or mental status.	10/1/13	DH

Sep. 4. 2013 11:38AM



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September 12, 2013

Kathy Adams, Administrator  
Safe Haven Homes of Wendell  
PO Box 306  
Wendell, ID 83355

Dear Ms. Adams:

An unannounced, on-site complaint investigation survey was conducted at Carefix Management & Consulting Inc., dba Safe Haven Homes of Wendell-Magic Valley Manor between August 27 and August 28, 2013. During that time, observations, interviews, and record reviews were conducted with the following results:

**Complaint # ID00006019**

**Allegation #1:** Residents' Rights were violated when residents were not given the choice to keep their current psychosocial rehab providers (PSR).

**Findings #1:** On 8/27/13, seven residents, who had PSR workers, stated they were satisfied with their current PSR providers. One resident stated he had the same agency for years.

On 8/27/13 at 9:25 AM, the administrator stated that some of the residents were receiving services from an agency in Twin Falls. She said because of the facility's location, transportation would only be paid to the closer location which happened to be in Gooding. She stated the facility was transporting the residents to their PSR agencies, but it was not a part of the residents' NSA and was not cost effective for the facility to continue those services. Therefore, some residents changed PSR agencies, because they could no longer get to the agencies in Twin Falls. The administrator further stated, some of the residents did not have to change because their PSR workers continued to pick them up at the facility.

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,

Donna Menscheid, LSW  
Health Facility Surveyor  
Residential Assisted Living Facility Program

DH/TFP



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**HEALTH & WELFARE**

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September 12, 2013

Kathy Adams, Administrator  
Safe Haven Homes of Wendell  
PO Box 306  
Wendell, ID 83355

Dear Ms. Adams:

An unannounced, on-site complaint investigation survey was conducted at Carefix Management & Consulting Inc., dba Safe Haven Homes of Wendell-Magic Valley Manor, between August 27 and August 28, 2013. During that time, observations, interviews or record reviews were conducted with the following results:

**Complaint # ID00006141**

- Allegation #1:** The facility did not follow their policy and notify families of a residents' changes of condition.
- Findings #1:** Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.153.03 for not contacting residents' families when residents had a change of condition. The facility was required to submit evidence of resolution within 30 days.
- Allegation #2:** The facility did not have residents medically evaluated after changes of condition.
- Findings #2:** Substantiated. The facility was issued a core deficiency at IDAPA 16.03.22.525 for neglecting to have residents medically evaluated after changes of condition. The facility was required submit a plan of correction within 10 days.

A core issue deficiency was identified during the complaint investigation. Please review the cover letter, which outlines how to develop a Plan of Correction. The Plan of Correction must be submitted to our office within 10 (ten) calendar days of receiving the Statement of Deficiencies.

Please bear in mind that non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference, on **August 28, 2013**. The completed punch

Kathy Adams  
September 12, 2013  
Page 2 of 2

list form and accompanying evidence of resolution (e.g., receipts, pictures, policy updates, etc) are to be submitted to this office within thirty (30) days from the exit date.

If you have questions or concerns regarding our visit, please call us at (208) 364-1962. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,



Donna Henscheid, LSW  
Health Facility Surveyor  
Residential Assisted Living Facility Program

DH/TFP

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