



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

November 12, 2014

Tara Stills, Administrator
Carefix-Safe Haven Homes of Lava Hot Springs
580 West Elm
Lava Hot Springs, Idaho 83246

Provider ID: RC-929

Ms. Stills:

On September 10, 2014, a state licensure/follow-up survey and complaint investigation were conducted at Carefix Management & Consulting Inc, dba Safe Haven Homes of Lava Hot Springs. 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



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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RESIDENTIAL ASSISTED LIVING FACILITY PROGRAM
P.O. Box 83720
Boise, Idaho 83720-0009
EMAIL: ralf@dhw.idaho.gov
PHONE: 208-364-1962
FAX: 208-364-1888

September 25, 2014

CERTIFIED MAIL #: 7007 3020 0001 4050 8579

Tara Stills, Administrator
Safe Haven Homes of Lava Hot Springs
PO Box 719
Lava Hot Springs, Idaho 83246

Ms. Stills:

On September 10, 2014, a state licensure/follow-up survey and complaint investigation were conducted by Department staff at Carefix Management & Consulting Inc, dba Safe Haven Homes of Lava Hot Springs. The facility was cited with core issue deficiencies for failing to protect residents from abuse and neglect.

The core issue deficiencies substantially limit the capacity of Carefix Management & Consulting Inc, dba Safe Haven Homes of Lava Hot Springs to provide for residents' basic health and safety needs. The deficiencies are described on the enclosed Statement of Deficiencies.

PROVISIONAL LICENSE:

As a result of the survey findings, a provisional license is being issued effective September 25, 2014 and will remain in effect until March 24, 2015. 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 non-core 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 1- 3 of the provisional license are as follows:

1. 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.

PLAN OF CORRECTION:

2. 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?

An acceptable, **signed** and **dated** Plan of Correction must be submitted to the Division of Licensing and Certification within **ten (10) calendar days of your receipt of the Statement of Deficiencies**. You are encouraged to immediately develop and submit this plan so any adjustments or corrections to the plan can be completed prior to the deadline.

EVIDENCE OF RESOLUTION:

3. 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 following administrative rule for Residential Care or Assisted Living Facilities in Idaho (IDAPA 16.03.22) describes the requirements for submitting evidence that the non-core issue deficiencies have been resolved:

910. Non-core Issues Deficiency.

01. Evidence of Resolution. *Acceptable evidence of resolution as described in Subsection 130.09 of these rules, must be submitted by the facility to the Licensing and Survey Agency. If acceptable evidence of resolution is not submitted within sixty (60) days from when the facility was found to be out of compliance, the Department may impose enforcement actions as described in Subsection 910.02.a through 910.02.c of these rules.*

The five (5) non-core issue deficiencies must be corrected and evidence (including but not limited to receipts, pictures, completed forms, records of training) must be submitted to this office by October 10, 2014.

ADMINISTRATIVE REVIEW

You may contest 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 decision is erroneous.** The request must be received **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

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.

INFORMAL DISPUTE RESOLUTION

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.

FOLLOW-UP SURVEY

An on-site, follow-up survey will be scheduled after the administrator and consultant submit a letter stating that all deficiencies have been corrected and systems are in place to assure the deficient practices remain corrected. If at the follow-up survey, the core issue deficiencies still exist, a new core issue deficiency is identified, non-core deficiencies have not been corrected, or the facility has failed to abide by the conditions of the provisional license, the Department will take further enforcement action against the license held by Carefix Management & Consulting Inc, dba Safe Haven Homes of Lava Hot Springs. Those enforcement actions will include one or more of the following:

- Revocation of the Facility License
- Summary Suspension of the Facility License
- Imposition of Temporary Management
- Limit or ban on new admissions
- Civil Monetary Penalties

Division of Licensing and Certification staff is available to assist you in determining appropriate corrections and avoiding further enforcement actions. Please contact our office at (208) 364-1962 if we may be of assistance, or if you have any questions.

Sincerely,



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

JS/sc

Enclosure

Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 19R925	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/10/2014
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NAME OF PROVIDER OR SUPPLIER
CAREFIX-SAFE HAVEN HOMES OF LAVA HOT

STREET ADDRESS, CITY, STATE, ZIP CODE
**580 WEST ELM
 LAVA HOT SPRINGS, ID 83246**

(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 the licensure survey and complaint investigation conducted between 9/8/14 and 9/10/14 at your residential care/assisted living facility. The surveyors conducting the survey were:</p> <p>Donna Henschold, LSW Team Coordinator Health Facility Surveyor</p> <p>Maureen McCann, RN Health Facility Surveyor</p> <p>Karen Anderson, RN Health Facility Surveyor</p> <p>Survey Definitions:</p> <p>1:1 = The close monitoring of a resident, keeping that resident within a dedicated staff members' view at all times. 2X = two times BMP = Behavior Management Plan Depo = Depo Provera MAR = medication assistance record mg = milligrams NSA = Negotiated Service Agreement private areas = crotch PRN = As Needed Pt. = Patient Res = resident RN = Registered Nurse Shot = injection SN = Skilled Nurse UAI = Uniform Assessment Instrument W/ = with Wernicke-Korsakoff syndrome - a brain disorder resulting in brain damage. Symptoms may</p>	R 000	<p>All staff, Administrator and facility RN have been trained on Abuse Prevention & Reporting guidelines per Safe Haven Policy. A pre test and post test has been created regarding our new abuse policy.</p> <p>Our abuse policy has been posted throughout the building for all outside agencies, visitors, staff and residents to observe and provide them with the knowledge of what our protocol regarding Abuse, and Reporting.</p> <p>10-20-14</p>	
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Bureau of Facility Standards
 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____

DATE _____

Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R529	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/18/2014
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NAME OF PROVIDER OR SUPPLIER
CAREFIX-SAFE HAVEN HOMES OF LAVA HOT

STREET ADDRESS, CITY, STATE, ZIP CODE
580 WEST ELM
LAVA HOT SPRINGS, ID 83246

(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	Continued From page 1 include confusion, memory loss and hallucinations. (http://www.nlm.nih.gov/medlineplus/ency/article/000771.htm)	R 000	An at-risk assessment has been created and is now a part of our initial assessment or interim plan of care. The facility RN and Administrator will develop individualized procedures based on residents history and physical regarding at-risk behaviors. The risk assessment will show what the risk is, the procedure who will be notified if the behavior occurs, determine if the resident will need to be removed or if the facility can safely meet the developing needs of the resident.	
R 000	16.03.22.510 Protect Residents from Abuse. The administrator must assure that policies and procedures are implemented to assure that all residents are free from abuse. This Rule is not met as evidenced by: Based on record review, observation and interview, it was determined the facility admitted a resident (Resident #6), with a known history of sexually abusive behaviors and did not provide sufficient supervision to protect the other residents. As a result, female residents residing in the facility were not protected from abuse. The findings include: IDAPA 16.02.33.510 documents, "The administrator must assure that policies and procedures are implemented to assure that all residents are free from abuse." The facility was a single story building consisting of 10 resident rooms. On 9/9/14, the facility staff schedule was reviewed. Typical staffing during the evening and overnight hours consisted of a single staff member in the building to supervise and assist all residents with their care needs, medications, housekeeping tasks and meals. The current facility administrator, Tara Stills, held the position of "House Manager" during the time	R 000		

10-20-14

Tara Stills
Administrator

PRINTED: 08/26/2014
FORM APPROVED

Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R020	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/10/2014
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NAME OF PROVIDER OR SUPPLIER CAREFIX-SAFE HAVEN HOMES OF LAVA HOT	STREET ADDRESS, CITY, STATE, ZIP CODE 500 WEST MLM LAVA HOT SPRINGS, ID 83246
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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 006	<p>Continued From page 2</p> <p>the incident occurred.</p> <p>According to his record, Resident #6 was a 81 year-old male, admitted to the facility on 11/5/13, with diagnoses including Wernicks-Korsakoff syndrome, related dementia and behaviors. The resident no longer resided in the facility at the time of the survey and was not available for observation or interview.</p> <p>A skilled nursing facility "Admission History and Physical" form, dated 10/3/12, documented Resident #6 "is long term resident at Safe Haven skilled nursing facility and requires being kept on the locked unit because of behaviors that include inappropriate sexual behavior. In fact this is the reason for his recent admission on 8/21/2012 to Safe Haven acute psychiatric hospital." The form also documented Resident #6 was receiving a Depo Provera 300 mg injection every 2 weeks to suppress sexually inappropriate behavior."</p> <p>A physician's order dated 11/5/13, documented, Resident #6 was to receive a Depo Provera 300 mg injection every 2 weeks" for "dis-inhibition." The order further documented, the injections were "due on 11/9 and 11/23 this month."</p> <p>An "Interim Plan of Care", dated 11/5/13, documented Resident #6 had been "sexually inappropriate with females in the past." The plan did not document how the facility would supervise Resident #6 to ensure all residents were protected from him.</p> <p>A "Resident Service" note, dated 11/9/13, documented the facility had informed Resident #6's physician that due to insurance issues, the facility was not able to obtain the resident's Depo-Provera which was due that day. The form</p>	R 006	<p>The risk assessment will be attached to the care at a glance which is located for observation by all staff, outside agencies. RN and any others involved in the care of each Resident.</p> <p>Regarding our Neglect Policy, all staff, Administrator and facility RN have been trained on the Abuse and Neglect Policy.</p> <p>A at-risk assessment has been created which includes current resident the facility RN and Administrator will develop individualized procedures based on current need as well as history of behavior.</p>	
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Bureau of Facility Standards
STATE FORM

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(Continuation sheet 5 of 13)

10-20-14

Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R929	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/10/2014
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NAME OF PROVIDER OR SUPPLIER CAREFIX-SAFE HAVEN HOMES OF LAVA HOT	STREET ADDRESS, CITY, STATE, ZIP CODE 500 WEST ELM LAVA HOT SPRINGS, ID 83246
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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 006	Continued From page 3 also documented staff were instructed to "monitor (the resident) and watch for behaviors." The form did not explain how staff were to monitor the resident such as to keep Resident #6 separated from female residents or if the resident was placed on a 1:1 with staff. An NSA/LIA, dated 11/19/13, documented the resident was "sexually inappropriate when ree goes w/out his depo shot" and staff were to monitor him. The form did not explain how staff were to monitor the resident. An undated Behavioral Plan, documented Resident #6 had, "a history of being sexually inappropriate towards others. He has in the past made sexual comments towards others and has also reached out and grabbed private areas. (Resident #6's name) is currently on the depo shot that decreases his sexual drive/inappropriate behaviors." The plan also documented the following interventions: "Staff will remind (Resident #6's name) what is expected of him and the consequences of his behaviors," and "Assure that (Resident #6's name) receives his depo shot on time." There were no directions to staff on how to protect the facility's female residents from potential sexual abuse. A Social Security Disability form, dated 11/26/13 and signed by the house manager, documented Resident #6, "can get verbally aggressive, sexually wothers sometimes" and "Does not rember (sic) things frequently." Resident #6's November 2013's MAR documented the resident received a Depo-Provera Injection on 11/13/13 and 11/26/13, not on 11/9/13 and 11/23/13 as ordered.	R 006	A new incident/accident form including injury, skin assessment, a accident interview guide has also been created. A new a/f investigation has been created, including who, what, when, where and why so that a thorough investigation can be completed in regards to all incidents/accidents. In addition this is included in the pre and post test in regards to Abuse, Preventional Reporting Guidelines Per Safe Haven updated Policy. The Staff, Administrator and Facility RNs have taken 2 trainings regarding documentation notification of RN or other Outside Agencies Protocol	
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Bureau of Facility Standards
STATE FORM

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KYLS-11

Reproduction Sheet 4 of 13

10-20-14 *Jac Admin*

Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33R020	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/10/2014
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NAME OF PROVIDER OR SUPPLIER: CAREFIX-SAFE HAVEN HOMES OF LAVA HOT
 STREET ADDRESS, CITY, STATE, ZIP CODE: 580 WEST ELM LAVA HOT SPRINGS, ID 83246

(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 006	<p>Continued From page 4</p> <p>Resident #6's December 2013 MAR indicated the resident was to receive a Depo-Provera injection on 12/10/13, but did not. Resident #6 missed two doses of Depo-Provera within five weeks.</p> <p>An email to the resident's physician, dated 12/9/13, documented that due to insurance issues, the pharmacy would not fill Resident #6's prescription for Depo Provera. It further documented, "He was late on this shot once before and he had severe sexual behaviors."</p> <p>An "Incident/Accident Report" form, dated 12/14/13, documented Resident #6 had reached over and grabbed a female resident's crotch "stating he wanted to bang her 2X."</p> <p>A note, dated 12/14/13 and signed by a female resident, documented "I was laying on the sofa and [Resident #6's name] grabbed my crotch [sic] and said he would like to bang me twice."</p> <p>On 8/8/14 at 2:50 PM, a caregiver stated, when Resident #6 did not receive his Depo Provera medication when it was due, the staff were instructed "to monitor him, to watch him." There was no explanation of "how" to monitor the resident or protect female residents from sexual abuse.</p> <p>On 8/9/14 at 3:30 PM, the administrator Tara Stills, stated "He had a history of being sexually inappropriate when he did not get his medication (Depo Provera), but I never thought he would touch a resident. Maybe verbally." She further stated, when the resident was admitted she thought his history of inappropriate behavior only included inappropriate verbal interactions with female residents, not physical inappropriate actions.</p>	R 006		

Bureau of Facility Standards
STATE FORM

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10-20-14

Jan
[Signature]

Production sheet 5 of 13

Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 12R028	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/10/2014
NAME OF PROVIDER OR SUPPLIER CAREPIX-SAFE HAVEN HOMES OF LAVA HOT		STREET ADDRESS, CITY, STATE, ZIP CODE 580 WEST ELM LAVA HOT SPRINGS, ID 83246		
(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 006	Continued From page 5 On 9/10/14 at 10:35 AM, the administrator Tara Stills, stated she was trying to get the resident his Depo Provera medication, but was unable to because of insurance issues. She also stated staff were instructed to monitor the resident for sexually inappropriate behaviors. The facility admitted Resident #6 who had a known history of sexual inappropriate behaviors. Further, the facility did not ensure Resident #6 received his medication as ordered nor did they increase staffing, supervision or provide detailed instructions to staff on how to protect female residents from sexual abuse. Within six weeks of admission to the facility, Resident #6 sexually abused a female resident. This resulted in abuse.	R 006		
R 009	16.03.22.525 Protect Residents from Neglect The administrator must assure that policies and procedures are implemented to assure that all residents are free from neglect. This Rule is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure of 1 of 1 sampled residents (Resident #5), who died from an unknown cause, was free from neglect. The findings include: IDAPA 16.03.22.011.24 defines neglect as "Failure to provide...medical care necessary to sustain the life and health of a resident." According to her record, Resident #5 was a 56 year old female, admitted to the facility on 7/11/13 with diagnoses including bipolar disorder.	R 009		

PRINTED: 09/23/2014
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Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R029	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/10/2014
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NAME OF PROVIDER OR SUPPLIER CARETEX-SAFE HAVEN HOMES OF LAVA HOT	STREET ADDRESS, CITY, STATE, ZIP CODE 880 WEST 12th LAVA HOT SPRINGS, ID 83248
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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 009	<p>Continued From page 6</p> <p>prescriptions drug abuse and opioid dependency.</p> <p>A 90 day RN Assessment, dated 7/12/13, documented the resident was new to the facility, had no behaviors and had no complaints of pain.</p> <p>An NSA/UAJ, dated 7/25/13, documented Resident #5 required assistance with all medications and would not be compliant with pain medications or narcotics due to her "history w/prescription drug abuse."</p> <p>A "Resident Service" note, written by the former house manager, dated 10/11/13, documented Resident #5 was to receive methadone, 10 mg, two tablets every 12 hours for 14 days.</p> <p>A Resident Service note written by the former house manager, dated 10/16/13, documented Resident #5's methadone was increased.</p> <p>An "Oversight Nursing Services" note, dated 10/16/13, documented Resident #5's methadone was increased to 30 mg twice a day.</p> <p>There were no written instructions to staff regarding the possible side-effects to monitor for from the increased medication.</p> <p>The October 2013 MAR documented that on 10/20/13, the resident requested acetaminophen (Tylenol) at 12:15 PM for a headache and "refused" to take medications scheduled for 4:00 PM and 8:00 PM.</p> <p>A handwritten note by the caregiver on duty, dated 10/20/13, documented when the caregiver did rounds at 2:30 PM, Resident #5 said she had a headache and was going to take a nap. The caregiver documented she had to "physically" (sic)</p>	R 009		

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Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R828	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/10/2014
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NAME OF PROVIDER OR SUPPLIER
CAREFIX-SAFE HAVEN HOMES OF LAVA HOT

STREET ADDRESS, CITY, STATE, ZIP CODE
580 WEST ELM
LAVA HOT SPRINGS, ID 83246

(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 7</p> <p>wake the resident and she refused her 4:00 PM medications. The caregiver went to Resident #5's room at 5:50 PM to give the 8:00 PM medications. It documented the caregiver "again" had to physically [sic] awaken Resident #5 who refused her medications. The caregiver further documented, she "put her head in" Resident #5's room around 7:30 PM and "she was sleeping." When the caregiver returned approximately 20 minutes later, "around" 7:50 PM to wake her for her 8:00 PM medications, Resident #5 was found without a pulse.</p> <p>*There was no documentation found in Resident #5's record showing that the facility nurse had been notified that the resident had to be "physically" awakened and had refused medications twice that day.</p> <p>An Incident/Accident Report, dated 10/20/2013, documented the caregiver went into Resident #5's room to "check and wake her" for her 8:00 PM medications. Resident #5 was found on her bed "not breathing."</p> <p>An "Investigation of Incident/Accident," dated 10/20/13, documented the caregiver reported she went in to wake Resident #5 "around" 7:30 and she was sleeping. It further documented the caregiver went back into Resident #5's room to give the 8:00 PM medications, and the resident was found without a pulse. It further documented Resident #5 had "history of liver failure."</p> <p>*There was no documentation other residents or caregivers had been interviewed about Resident #5's condition the day of the incident.</p> <p>A note written by the facility RN, documented she was notified of Resident #5's death on the</p>	R 009		

01/22/2013 08:01PM 2087653957

SAFEHAVEN BLACKFOOT

PAGE 10/14

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FORM APPROVED

Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1SR029	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/10/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER
GARDENIX-SAFE HAVEN HOMES OF LAVA HOT

STREET ADDRESS, CITY, STATE, ZIP CODE
880 WEST FLAM
LAVA HOT SPRINGS, ID 83246

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 008	<p>Continued From page 8</p> <p>morning of Monday, October 21, 2013 by the agency on-call nurse. The note further documented, "The pt. had not had any noticeable change in condition prior to the weekend. She had long term health concerns and chronic pain, but no recent noted decline."</p> <p>"There was no documentation by the facility RN regarding the recent medication increase or how the "liver failure" would impact Resident #5's ability to metabolize the medication.</p> <p>An autopsy report, dated 10/28/13, documented the "35 year-old female who most probably died as a drug overdose. On the day of her death, she refused to take medicine and was comatose with active snoring...While there is strong suspicion of overdose, this diagnosis cannot be made. She also had cardiomegaly with biventricular hypertrophy which is contributing factor in the cause of death. It is not possible to determine the direct relationship between cardiac and possible overdose. The cause and manner of death will therefore be undetermined."</p> <p>An anonymous letter, dated 3/5/2014, documented, "...My family member tried to wake the patient by speaking in her ear, tapping her, nudging her shoulder and then tapping her again. She tried for 60-90 seconds to arouse [Resident #5's name]...The same day, my family member was sent in to wake [Resident #5's name] for dinner...This time, my family member became alarmed so she went and expressed her concern again to the working staff. The staff member finally went to check on [Resident #5's name] between 7 and 7:30 pm, where she found [Resident #5's name] unresponsive with foam coming out of her mouth."</p>	R 008		

Bureau of Facility Standards
STATE FORM

WB

XYLS11

If continuation sheet 9 of 13

Residential Care/Assisted Living		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R029	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/10/2014
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NAME OF PROVIDER OR SUPPLIER CAREFIX-SAFE HAVEN HOMES OF LAVA HOT	STREET ADDRESS, CITY, STATE, ZIP CODE 580 WEST ELM LAVA HOT SPRINGS, ID 83248
--	---

(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>On 9/8/14 at 3:05 PM, a caregiver stated she worked the morning shift and was off work at 2:00 PM the day Resident #5 passed away. She stated Resident #5 was "sleepy all day." The caregiver stated Resident #5 had her methadone increased from 20 mg to 30 mg a few days before she passed away. She stated Resident #5 had a "bad liver" and was "non-compliant."</p> <p>On 9/9/14 between 9:15 AM and 10:30 AM, two former residents (A and B), who resided at the facility the day the resident passed away, were interviewed:</p> <p>Resident A stated:</p> <ul style="list-style-type: none"> *Resident #5 was not acting like herself on the day she passed away. *Resident #5 was usually the "life of the facility." *Resident #8 complained of having a bad headache and did not want to eat that day. *Resident A two other residents and the caregiver were unable to wake Resident #5 up. **We tried to wake her up between 4:00 PM and 5:00 PM. When we couldn't get her to wake up, we told the caregiver on duty that something was wrong. *The caregiver went into Resident #5's room about an hour later to wake her up and to give her medications, but the caregiver was unable to wake her up. *As far Resident A knew, nobody called emergency services or the nurse "until it was too late." 	R 009		

PRINTED: 09/23/2014
FORM APPROVED

Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/10/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER CAREFIX-SAFE HAVEN HOMES OF LAVA HOT	STREET ADDRESS, CITY, STATE, ZIP CODE 600 WEST ELM LAVA HOT SPRINGS, ID 83246
--	---

(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 10</p> <p>Resident B stated:</p> <ul style="list-style-type: none"> * She went into Resident #6's room to wake her up, "shook her, but got no response." * The caregiver on duty was told, but said to "let her rest." * "I told them several times, I think something's wrong. I can't wake her up." * Resident #6 would ask other residents for medications and Resident #3 was "cheeking them and giving the medications to Resident #5. They (staff), knew but didn't do shit about it. It was going on for a while." <p>On 9/9/14 at 2:35 PM, a caregiver stated she worked the morning Resident #5 passed away. She stated the resident came out of her room for lunch. The caregiver stated Resident #6 said she "wasn't feeling good," had a headache and was going back to her room to lay down. The caregiver stated Resident #6 ate only two to three bites of her lunch, was given a Tylenol and went back to her room. The caregiver stated the resident was "dizzy," had a headache and "just wasn't herself that day." The caregiver stated she did not remember if the nurse was called.</p> <p>On 9/9/14 at 3:28 PM, the administrator Tara Stills stated she was not the administrator at the time of Resident #5's death and had not worked that day. She stated Resident #5 was a "drug seeker." She stated the caregiver called her "around" 8:00 PM while she was doing chest compressions on Resident #5. Tara Stills stated the caregiver told her she "checked on her frequently" that day. She stated Resident #5 was</p>	R 008		

Bureau of Facility Standards
STATE FORM

5009

KYLS11

If continuation sheet 11 of 13

Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R929	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/10/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER
CAREPIX-SAFE HAVEN HOMES OF LAVA HOT

STREET ADDRESS, CITY, STATE, ZIP CODE
880 WEST ELM
LAVA HOT SPRINGS, ID 83246

(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 11</p> <p>"In either liver or kidney failure." She further stated, the resident's methadone was increased 2 to 4 days prior to her death. Further she stated, it was "normal" for the resident to have "high day and low days."</p> <p>On 8/9/14 at 6:19 PM, a caregiver stated Resident #5 was not feeling "top notch," was "feeling very tired" and wanted to rest. She stated, "sleeping is normal for her." The caregiver stated Resident #5 was "awake" every time she went into the room. She stated the resident refused medications and she told Resident #5 to let her know if "it's something serious" so she could "call somebody." Further, the caregiver said Resident #5 did not eat dinner that night. The caregiver stated, none of the residents said anything to her about Resident #5. She stated, "That was a long time ago, she was always really tired." She stated, she "can't remember" if the nurse was called.</p> <p>An undated handwritten note sent to Licensing and Certification, documented, "I checked on her many times. I shook really hard and yelled in her ear and no response. Many times I told [caregiver's name] and she didn't do anything until it was 7 PM. By that time she was gone. I feel she was neglected..."</p> <p>On 8/10/14 at 10:30 PM, Jodi Galloway, the former administrator and the person who investigated the incident, stated she "only knew what happened that evening." She stated she knew Resident #5 "complained of a headache," and was given Tylenol which was "effective." Jodi Galloway stated she was unsure if the facility nurse was called prior to Resident #5's death. She stated she knew Resident #5 had a change in her medications on the 17th of October, 2013.</p>	R 009		

01/22/2013 06:01PM 208765337

SAFEHAVEN BLACKFOOT

PAGE 14/14

PRINTED: 09/23/2014
FORM APPROVED

Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R029	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/10/2014
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NAME OF PROVIDER OR SUPPLIER CAREFIX-SAFE HAVEN HOMES OF LAVA HOT	STREET ADDRESS, CITY, STATE, ZIP CODE 580 WEST ELM LAVA HOT SPRINGS, ID 83246
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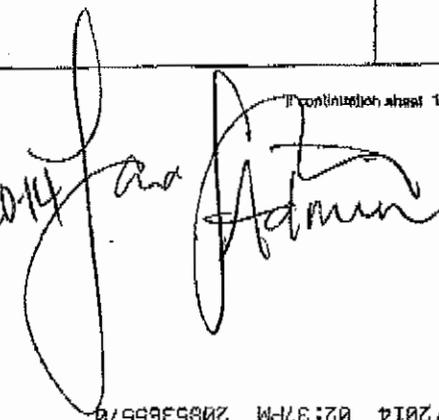
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 009	Continued From page 12 She stated Resident #6 was trying to get "more meds and more meds." Further, Jodi Galloway stated, she did not know the caregiver had to physically wake the resident up "until I read the report." The was no documentation the facility nurse had been notified of Resident #3's increased "iredness" or refusals to take medications. Although Resident #5 had pain medications increased and had to be repeatedly "physically" awakened, the resident was left alone in her room to "rest." The facility failed to ensure Resident #6, who died from unknown causes, received the appropriate medical attention. This resulted in neglect.	R 009		

Bureau of Facility Standards
STATE FORM

5537

KYL211

If continuation sheet 13 of 13

10-20-14

 Jodi Galloway



Facility CAREFIX - SAFE HAVEN HOMES OF LAVA HOT SPRINGS	License # RC-929	Physical Address 580 WEST ELM	Phone Number (208) 776-5899
Administrator Tara Stills	City LAVA HOT SPRINGS	ZIP Code 83246	Survey Date September 10, 2014
Survey Team Leader Donna Henscheid	Survey Type Licensure, Follow-up and Complaint Investigation		RESPONSE DUE: October 10, 2014
Administrator Signature 	Date Signed 9-10-14		

NON-CORE ISSUES

Item #	IDAPA Rule # 16.03.22.	Description	Department Use Only	
			EOR Accepted	Initials
1	225.01	Resident #2 & Resident #3's BMPs did not describe the specific behaviors the residents exhibited.	10/4/14	DH
2	225.02	The facility did not review Resident's #2's behavior plan after staff documented the interventions were not effective.	10/4/14	DH
3	350.04	The administrator did not provide a written response to complainants within 30 days.	10/4/14	DH
4	300.01	The facility did not delegate according to the Board of Nursing rules.	10/4/14	DH
5	630	The facility did not appropriately communicate with residents who had cognitive/mental disabilities. Such as treating adult residents like children by sending them to their room or withholding snacks.	10/4/14	DH
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				
21				



IDAHO DEPARTMENT OF HEALTH & WELFARE **Food Establishment Inspection Report**

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

Critical Violations Noncritical Violations

Amelia Dora Jaffe
 Establishment Name: Home of Love Springs Operator: Tara Stills
 Address: 380 West Elm Home of Love Springs
 County: Chambers EHS/SUR.#: _____ Inspection time: _____ Travel time: _____
 Risk Category: High Follow-Up Report: OR On-Site Follow-Up:
 Date: _____ Date: _____
 Items marked are violations of Idaho's Food Code, IDAPA 16.02.19, and require correction as noted.

# of Risk Factor Violations	<u>1</u>	# of Retail Practice Violations	<u>0</u>
# of Repeat Violations	<u>0</u>	# of Repeat Violations	<u>0</u>
Score	<u>1</u>	Score	<u>0</u>
A score greater than 3 Med or 5 High-risk = mandatory on-site reinspection		A score greater than 6 Med or 8 High-risk = mandatory on-site reinspection	

RISK FACTORS AND INTERVENTIONS (Idaho Food Code applicable sections in parentheses)
 The letter to the left of each item indicates that item's status at the inspection.

	Demonstration of Knowledge (2-102)	COS	R
<u>Y</u> N	1. Certification by Accredited Program, or Approved Course; or correct responses; or compliance with Code	<input type="checkbox"/>	<input type="checkbox"/>
	Employee Health (2-201)		
<u>Y</u> N	2. Exclusion, restriction and reporting	<input type="checkbox"/>	<input type="checkbox"/>
	Good Hygienic Practices		
<u>Y</u> N	3. Eating, tasting, drinking, or tobacco use (2-401)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N	4. Discharge from eyes, nose and mouth (2-401)	<input type="checkbox"/>	<input type="checkbox"/>
	Control of Hands as a Vehicle of Contamination		
<u>Y</u> N	5. Clean hands, properly washed (2-301)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N	6. Bare hand contact with ready-to-eat foods/exemption (3-301)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N	7. Handwashing facilities (5-203 & 6-301)	<input type="checkbox"/>	<input type="checkbox"/>
	Approved Source		
<u>Y</u> N	8. Food obtained from approved source (3-101 & 3-201)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N	9. Receiving temperature / condition (3-202)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N <u>N/A</u>	10. Records: shellstock tags, parasite destruction, required HACCP plan (3-202 & 3-203)	<input type="checkbox"/>	<input type="checkbox"/>
	Protection from Contamination		
<u>Y</u> N <u>N/A</u>	11. Food segregated, separated and protected (3-302)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N <u>N/A</u>	12. Food contact surfaces clean and sanitized (4-5, 4-6, 4-7)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N	13. Returned / reservice of food (3-306 & 3-801)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N	14. Discarding / reconditioning unsafe food (3-701)	<input type="checkbox"/>	<input type="checkbox"/>

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

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

Item/Location	Temp	Item/Location	Temp	Item/Location	Temp	Item/Location	Temp
<u>Shrimp / Meats source</u>	<u>44°</u>					<u>Chili / Sausage</u>	<u>38°</u>
<u>Wheat + rice</u>	<u>47°</u>					<u>All Grain Potatoes</u>	<u>41°</u>

GOOD RETAIL PRACTICES (input checked = not in compliance)

	COS	R		COS	R		COS	R
<input type="checkbox"/> 27. Use of ice and pasteurized eggs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 34. Food contamination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 42. Food utensils/in-use	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 28. Water source and quantity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 35. Equipment for temp. control	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 43. Thermometers/Temp strips	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 29. Insects/rodents/animals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 36. Personal cleanliness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 44. Warewashing facility	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 30. Food and non-food contact surfaces: constructed, cleanable, use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 37. Food labeled/condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 45. Wiping cloths	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 31. Plumbing installed; cross-connection; back flow prevention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 38. Plant food cooking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 46. Utensil & single-service storage	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 32. Sewage and waste water disposal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 39. Thawing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 47. Physical facilities	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 33. Sinks contaminated from cleaning maintenance tools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 40. Toilet facilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 48. Specialized processing methods	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/> 41. Garbage and refuse disposal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 49. Other	<input type="checkbox"/>	<input type="checkbox"/>

OBSERVATIONS AND CORRECTIVE ACTIONS (CONTINUED ON NEXT PAGE)

Person in Charge (Signature) [Signature] (Print) Tara Stills Title Admin Date 9/10/14
 Inspector (Signature) [Signature] (Print) Mason Allen Date 9/10/14
 Follow-up: (Circle One) Yes No



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

Page 2 of 2
Date 9/10/14

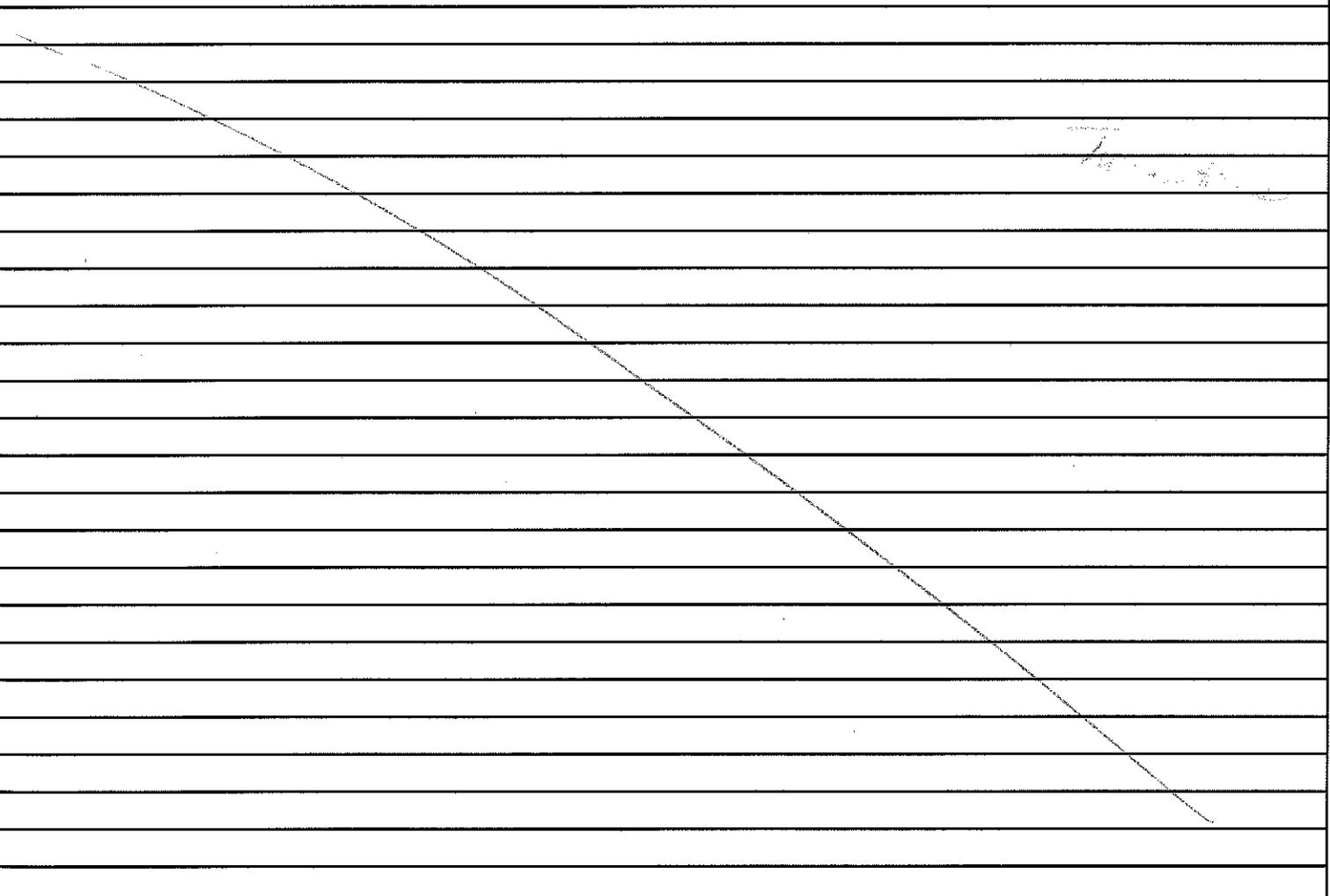
Charlie D. B. & Judy Haver

Establishment Name <i>Thomas of Two Springs</i>		Operator <i>Jane Miller</i>	
Address <i>280 West 9th</i>			
County <i>Blaine</i>	Estab #	EHS/SUR #	License Permit # <i>Tom Hot Springs</i>

OBSERVATIONS AND CORRECTIVE ACTIONS (Continuation Sheet)

19. *Wagashi with meat sauce in the refrigerator (temped @ 44°).
A chicken and sauce mix in the refrigerator (temped @ 47°)
on 9/9/14.*

POS: The administrator turned the refrigerator temperature down and discarded the wagaashi with meat sauce. Food items in the refrigerator were rechecked the next day (9/10) and all were within acceptable temperatures.



Person in Charge

Date

Inspector

Date

[Signature]

9/10/14

[Signature]

9/10/14



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

September 25, 2014

Tara Stills, Administrator
Carefix-Safe Haven Homes of Lava Hot Springs
580 West Elm
Lava Hot Springs, Idaho 83246

Provider ID: RC-929

Ms. Stills:

An unannounced, on-site state licensure/follow-up survey and complaint investigation were conducted at Carefix-Safe Haven Homes of Lava Hot Springs between September 8, 2014 and September 10, 2014. During that time, observations, interviews, and record reviews were conducted with the following results:

Complaint # ID00006423

Allegation #1: The facility did not provide medical intervention when residents had changes of condition.

Findings: Substantiated. The facility received a deficiency at IDAPA 16.03.22.525 for not seeking medical treatment in a timely manner. The facility was required to submit a plan of correction within 10 days.

Allegation #2: The facility staff were not trained to appropriately communicate with residents and intervene when residents exhibited behaviors.

Findings: Substantiated. The facility was issued deficiencies at IDAPA 16.03.22.225.01 and 225.02 for inappropriate behavioral interventions and a deficiency at IDAPA 16..03.22.630 for staff not appropriately communicating with residents who had cognitive/mental disabilities.

Allegation #3: The facility did not protect residents' rights to their belongings (cigarettes).

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

Allegation #4: The facility became residents' payees without their consent.

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

Tara Stills, Administrator
September 25, 2014
Page 2 of 2

Allegation #5: Residents did not receive assistance with cares as needed.

Findings: Unsubstantiated.

Allegation #6: The facility did not provide adequate food or snacks.

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

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 HENSCHIED, LSW
Health Facility Surveyor
Residential Assisted Living Facility Program

DH/sc

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



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

September 25, 2014

Tara Stills, Administrator
Carefix-Safe Haven Homes of Lava Hot Springs
580 West Elm
Lava Hot Springs, Idaho 83246

Provider ID: RC-929

Ms. Stills:

An unannounced, state licensure/follow-up survey and complaint investigation were conducted at Carefix Management & Consulting Inc, dba Safe Haven Homes of Lava Hot Springs between September 8, 2014 and September 10, 2014. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00006647

Allegation #1: The facility did not protect residents when they admitted a resident who had a history of being sexually inappropriate.

Findings: Substantiated. The facility was issued a core deficiency at IDAPA 16.03.22.520 for admitting a resident with a known history of sexual abuse. The facility was required to submit a plan of correction within 10 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,

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

DH/sc

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