



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

Jodie Galloway, Administrator
Safe Haven Homes Of Wendell-Magic Valley Manor
210 North Idaho
Wendell, Idaho 83355

Provider ID: RC-932

Ms. Galloway:

On September 11, 2014, a complaint investigation 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 Gloria Keathley, LSW, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 364-1962.

Sincerely,

GLORIA KEATHLEY, LSW
Team Leader
Health Facility Surveyor

GK/sc

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



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P.O. Box 83720
Boise, Idaho 83720-0009
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FAX: 208-364-1888

September 26, 2014

Jodie Galloway, administrator
Safe Haven Homes of Wendell
PO Box 306
Wendell, Idaho 83355

7007 3020 0001 4050 8609

Ms. Galloway:

On September 11, 2014, a complaint investigation was conducted by department staff at Carefix Management & Consulting Inc., dba Safe Haven Homes of Wendell-Magic Valley Manor. The facility was cited with a core issue deficiency for failing to protect residents from abuse. Additionally, the facility was cited with a core issue deficiency for admitting and retaining a resident with a documented history of physically, sexually and verbally abusing other residents.

These core issue deficiencies substantially limit 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.

Provisional license:

As a result of the survey findings, a provisional license is being issued effective September 26, 2014 and will remain in effect until March 25, 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- 6 of the provisional license are as follows:

License:

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.

Consultant:

2. A licensed residential care administrator consultant, with at least three years' experience working as an administrator for a residential care or assisted living facility in Idaho, shall be obtained and paid for by the facility, and approved by the department. This consultant must have an Idaho residential care administrator's license and may not also be employed by the facility or the company that operates the facility. The purpose of the consultant is to assist the facility in identifying and implementing appropriate corrections for the deficiencies. Please provide a copy of the enclosed consultant report content requirements to the consultant. The consultant shall be allowed unlimited access to the facility's administrative, business and resident records and to the facility staff, residents, their families and representatives. The name of the consultant with the person's qualifications shall be submitted to the department for approval no later than October 3, 2014.
3. A weekly written report must be submitted by the department-approved consultant to the department commencing on October 10, 2014. The reports will address progress on correcting the core deficiency identified on the statement of deficiencies as well as the non-core deficiencies identified on the punch list. When the consultant and the administrator agree the facility is in full compliance, they will notify the department and request a follow-up survey be scheduled.

Plan of correction:

4. 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 by October 10, 2014. 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:

5. 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 twenty-four (24) 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 11, 2014

Civil monetary penalties

- 6. Of the twenty-four (24) non-core issue deficiencies identified on the punch list, three (3) were repeat punches. One (1) of the repeat deficiencies was cited on both of the two (2) previous surveys, 8/28/2013 and 2/20/2014.

305.05 - Progress of Previous Recommendations. Conduct a review and follow-up of the progress on previous recommendations made to the administrator regarding any medication needs or other health needs that require follow up. Report to the attending physician or authorized provider and state agency if recommendations for care and services are not implemented that have affected or have the potential to affect the health and safety of residents.

The following administrative rules for residential care or assisted living facilities in Idaho give the department the authority to impose a monetary penalty for this violation:

Idapa 925. Enforcement remedy of civil monetary penalties.

01. Civil monetary penalties. Civil monetary penalties are based upon one (1) or more deficiencies of noncompliance. Nothing will prevent the department from imposing this remedy for deficiencies which existed prior to survey or complaint investigation through which they are identified. Actual harm to a resident or residents does not need to be shown. A single act, omission or incident will not give rise to imposition of multiple penalties, even though such act, omission or incident may violate more than one (1) rule.

02. Assessment amount for civil monetary penalty. When civil monetary penalties are imposed, such penalties are assessed for each day the facility is or was out of compliance. The amounts below are multiplied by the total number of occupied licensed beds according to the records of the department at the time noncompliance is established.

B. Repeat deficiency is ten dollars (\$10). (initial deficiency is eight dollars (\$8)).

For the dates of June 13, 2014 through September 11, 2014:

Penalty	Number of deficiencies	Times number of occupied beds	Times number of days of non-compliance	Amount of penalty
\$10.00	1	26	90	\$ 23,400

Maximum penalties allowed in any ninety-day period per idapa 16.03.22.925.02.c:

# of occupied beds in facility	Initial deficiency	Repeat deficiency
3-4 beds	\$1,440	\$2,880
5-50 beds	\$3,200	\$6,400
51-100 beds	\$5,400	\$10,800
101-150 beds	\$8,800	\$17,600
151 or more beds	\$14,600	\$29,200

Your facility had 26 occupied beds at the time of the survey. Therefore, your maximum penalty is: \$6400.

Send payment of \$6,400 by check or money order, made payable to:

Licensing and certification

Mail your payment to:

**Licensing and certification - RALF
Po box 83720
Boise, ID 83720-0009**

Payment must be received in full within 30 calendar days from the date this notice is received. Interest accrues on all unpaid penalties at the legal rate of interest for judgments. Failure of a facility to pay the entire penalty, together with any interest, is cause for revocation of the license.

Administrative review

You may contest the provisional license, requirement for a consultant or civil monetary penalty 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 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 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 deficiency still exists, 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 Wendell-Magic Valley Manor. 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 admissions
- Additional 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

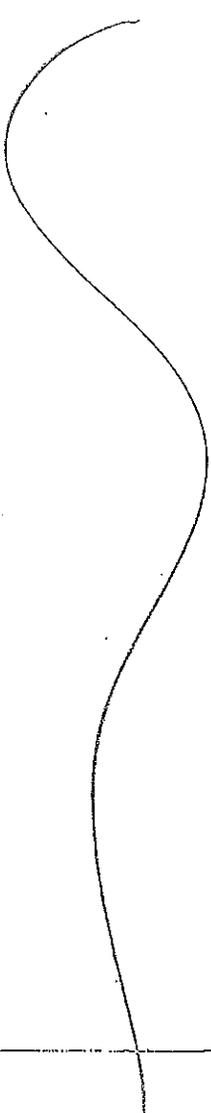
JS/sc

Enclosure

Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R932	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2014
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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

(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)	(X6) COMPLETE DATE
R 000	<p>Initial Comments</p> <p>The following deficiency was cited during the complaint investigation survey conducted between 9/8/2014 and 9/11/2014 at your residential care/assisted living facility. The surveyors conducting the survey were:</p> <p>Gloria Keathley, LSW Team Coordinator Health Facility Surveyor</p> <p>Rachel Corey, RN Health Facility Surveyor</p> <p>Rae Jean McPhillips, RN Health Facility Surveyor</p> <p>Survey Definitions:</p> <p>1:1 = One to One: When a facility has dedicated staff to keep a resident within direct eye sight at all times. & = And ALF = Assisted Living Facility ASAP = As Soon as Possible BMP = Behavior Management Plan cigs = Cigarettes ER = Emergency Room eval = Evaluation F/U = Follow-Up NSA = Negotiated Service Agreement Phys = Physical PRN = As Needed psych = psychiatric Pt = Patient Res = Resident RN = Registered Nurse SH = Safe Haven SNF = Skilled Nursing Facility s/s = Signs and Symptoms</p>	R 000		

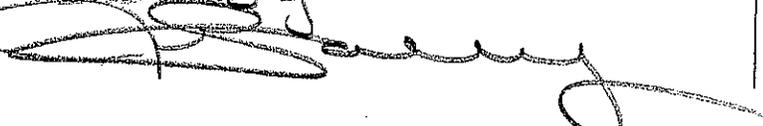
Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

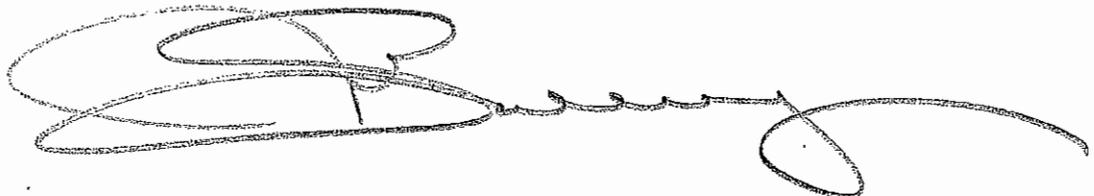
(X8) DATE

Compliance R000 & R008 will be met by November 7th 2014.



Residential Care/Assisted Living

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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		
(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 (f) = until UAI = Uniform Assessment Instrument Wernicke-Korsakoff syndrome - a brain disorder resulting in brain damage. Symptoms may include confusion, memory loss and hallucinations. (http://www.nlm.nih.gov/medlineplus/ency/article/000771.htm)	R 000	The following corrective action have been put in place. Resident #9 no longer resides in the facility. Resident #7 no longer resides in the facility. Resident #6 no longer resides in the facility. Resident #4 continues to reside in the facility. She has been evaluated by the RN. Her NSA and behavior plans have been updated to reflect interventions to protect her from others.	
R 006	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 observations, interview and record review, it was determined the facility failed to protect 100% of residents from abuse, when they admitted and retained Resident #9 and Resident #6, who had documented histories of being sexually, physically or verbally abusive. The findings include: 1. According to his record, Resident #9 was a 61 year-old male admitted to the facility on 12/19/13, with diagnoses including Wernicke-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. Resident #9's record contained an "Admission History and Physical," dated 10/3/12, from Safe Haven Care Center, a skilled nursing facility. The history and physical documented the following: **This 59 year-old, Caucasian male is well known	R 006		

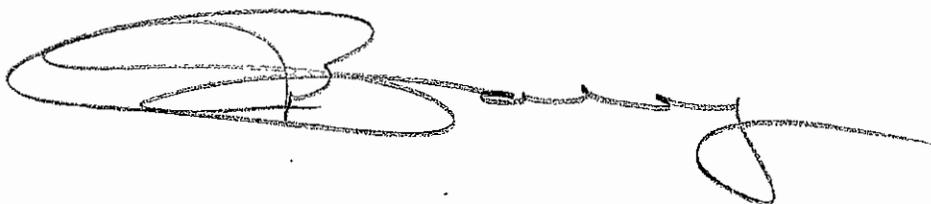


Residential Care/Assisted Living

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

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R 006	<p>Continued From page 2</p> <p>to me. He is a long term resident at Safe Haven skilled nursing facility and requires being kept on the locked unit because of behaviors that include inappropriate sexual behaviors. In fact this is the reason for his recent admission on 09/21/2013 to Safe Haven acute psychiatric hospital."</p> <p>*Resident #9 received medication every 2 weeks to "suppress sexually inappropriate behaviors."</p> <p>A Safe Haven Health Care "Inpatient Psychiatric Evaluation" report, dated 12/15/13, documented Resident #9 was transferred from Safe Haven of Lava after he demonstrated "increasing sexually inappropriate behavior." The report documented he grabbed and made sexually inappropriate comments to a female resident. The report documented, Resident #9 had resided at the Safe Haven skilled nursing "where records indicate he also demonstrated sexually inappropriate behavior."</p> <p>There was no documented evidence the facility requested information from Safe Haven in Lava to determine what "increasing sexually inappropriate behavior" Resident #9 exhibited while residing there.</p> <p>An NSA, dated 12/20/13, documented, "Due to history of being sexually inappropriate resident needs to be closely supervised." The NSA did not contain documentation the facility developed a plan to protect female residents from Resident #9's known inappropriate sexual behaviors, or how staff were to supervise him.</p> <p>A physician's report, dated 1/30/14, documented Resident #9 had a history of inappropriate sexual behavior and received medication every two weeks to suppress his "sexually inappropriate</p>	R 006	<p>100% of current resident and personnel could be affected by the same deficient practice.</p> <p>All residents have had their NSA's and behavior plans reviewed and revised (as needed to reflect the plans to protect them from others and provide appropriate supervision.</p> <p>The following measures have been put in place to ensure the deficient practice does not recur.</p>	



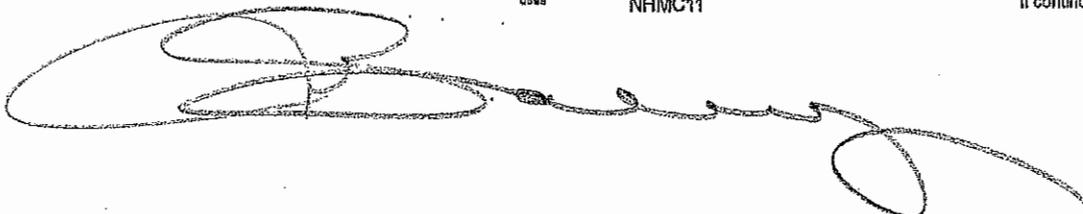
Residential Care/Assisted Living

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

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R 006	<p>Continued From page 3</p> <p>behavior."</p> <p>An UAI, dated 4/2/14, documented Resident #9 had "inappropriate sexual behaviors and takes hormone injections...."</p> <p>Resident #9's record contained at least five documents, including one developed by the facility, that referenced Resident #9's sexually inappropriate behaviors. Despite this documentation, there was no evidence the facility developed a plan to protect female residents from Resident #9's sexual abuse.</p> <p>A. First Known Incident of Sexual Abuse:</p> <p>According to her record, Resident #7 was 63 year-old female admitted to the facility on 8/11/14.</p> <p>An incident report, dated 8/22/14, documented Resident #7 stated Resident #9, "touched her by swatting bottom, then by grabbing her crotch...." The report documented Resident #7 reported the incident twice to the administrator of Safe Haven of Gooding, Kathy Adams, who was driving her to a physician's appointment. The report documented the RN was notified and he told staff to keep Resident #9 away from Resident #7. There was no documentation of what action the facility implemented to protect Resident #7, or other female residents, from Resident #9's inappropriate sexual behaviors.</p> <p>On 8/22/14 at 1:18 PM, Kathy Adams, the administrator of the Safe Haven of Gooding, documented the following information:</p> <p>*Resident #7 told her (Kathy Adams) two times that Resident #9, "swatted her on the bottom and then grabbed her between the legs and fondled</p>	R 006	<p>Staff inservice related to the Abuse Policy Prevention, Notification and reporting guidelines. Abuse Policy and Procedure has been posted for all staff and Outside Agencies. Staff inservice related to Incident-Accident Policy reporting and documentation. Staff was trained regarding allegations of neglect and abuse Gathering statements and implementation of protecting Resident and Staff.</p>	

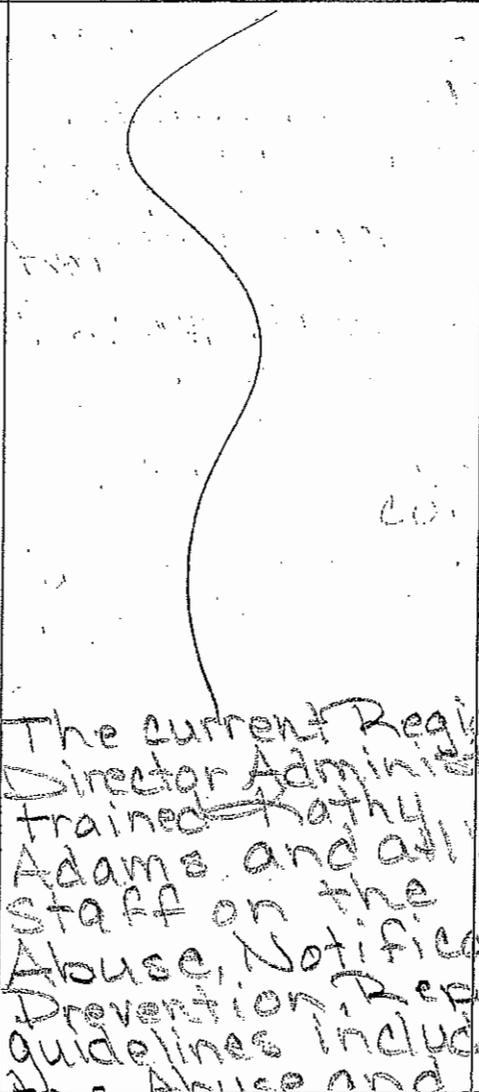


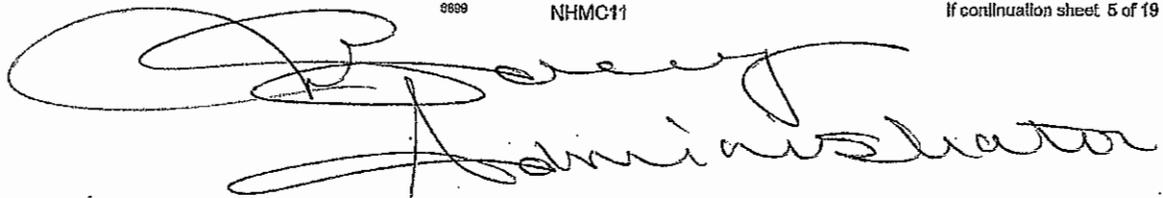
Residential Care/Assisted Living

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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 006	<p>Continued From page 4</p> <p>her...."</p> <p>*Resident #7 stated she reported the incident to a caregiver who told her, "...she had talked to the male resident and he denied doing it" and the caregiver said, "well I believe him, so this never happened."</p> <p>*When they arrived at the physician's office, Resident #7 repeated the "whole story" crying "alligator tears the whole time."</p> <p>*She (Kathy Adams) stood behind Resident #7 and "shook" her head "no" as the resident told the nurse about the incident.</p> <p>*After they left the physician's office, Resident #7 started to tell the "story" again, so she (Kathy Adams) asked the resident if she wanted a "treat," and took her out for "fries and a soda."</p> <p>Kathy Adams, the administrator from Safe Haven of Gooding also documented, on 8/22/14, the Safe Haven of Wendell administrator, Larry Gilley, requested that she investigate the incident between Resident #9 and Resident #7. The investigation report documented Kathy Adams escorted Resident #7 around the facility to identify the male resident. Kathy Adams documented when Resident #7 saw Resident #9, she "pushed back" in her wheelchair and said, "that's him."</p> <p>There was no documentation interventions were implemented to protect Resident #7, or other female residents, from Resident #9. Additionally, there was no documentation indicating that other residents were interviewed to determine if Resident #9 had abused other residents.</p>	R 006	 <p>The current Regional Director Administrator trained Kathy Adams and all her staff on the Abuse, Notification, Prevention, Reporting guidelines including the Abuse and Neglect Policy.</p>	
	<p>There was no documentation the administrator,</p>			



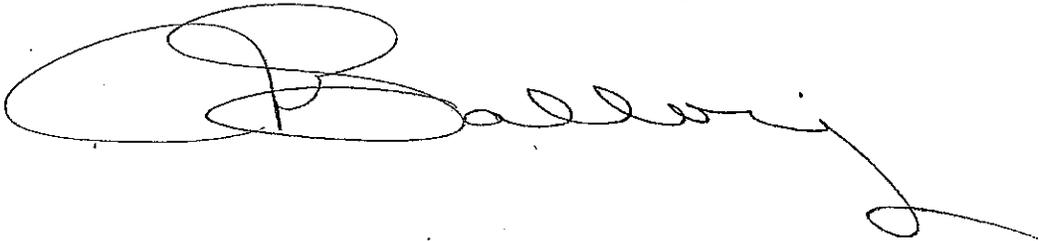
Administrator

Residential Care/Assisted Living

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R 006	<p>Continued From page 5</p> <p>Larry Gilley, conducted an investigation, reviewed the investigation conducted by Kathy Adams, or implemented interventions to protect female residents from Resident #9.</p> <p>The facility nurse documented on 8/22/14, Resident #7 made an allegation that Resident #9 inappropriately touched her. The note documented he was advised Resident #9 was placed on "one to one" with staff and he was to be discharged to a psychiatric hospital.</p> <p>B. Second Known Incident of sexual abuse, one day later:</p> <p>According to her record, Resident #4 was a 46 year-old female admitted to the facility on 7/31/14.</p> <p>An incident report, dated 8/23/14, documented Resident #4 was standing by the medication room and was approached by Resident #9. Resident #4 turned around and Resident #9 "grabbed her breasts with both hands and fondled her." There was no documentation on the incident report what the facility was going to do to protect Resident #4.</p> <p>There was no documentation the administrator, Larry Gilley, conducted an investigation of the incident or implemented interventions to protect female residents from Resident #9.</p> <p>A note, signed and dated 8/23/14, by Resident #4, documented she was standing at the medication door. It further documented, as she turned around, Resident #9 grabbed her breasts. The note documented she immediately reported the assault to the facility staff.</p> <p>According to documentation, Resident #9 was</p>	R 006	<p>Administrator will be notified of Abuse Allegations. The Regional will participate in the investigative process.</p> <p>The Regional will Review Admission with the Admission team prior to acceptance to ensure compatibility and the appropriate behavior management risk assessment are implemented prior to or upon admission.</p> <p>Compliance will be met by Nov 7, 2014 in regards to ROOU protect from Abuse.</p>	

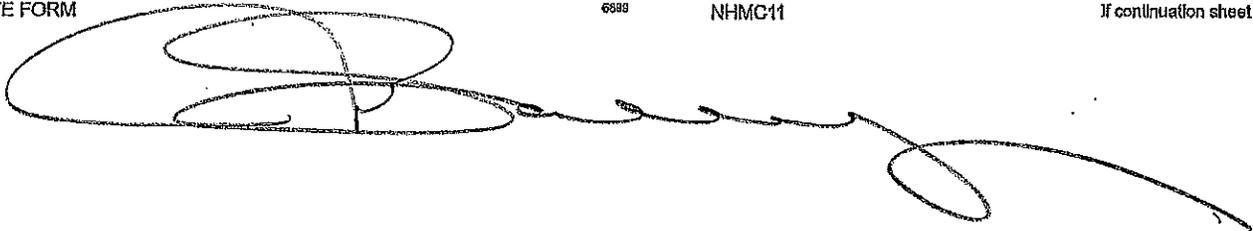


Residential Care/Assisted Living

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 09/11/2014
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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 006	<p>Continued From page 6</p> <p>suppose to be placed on 1:1 supervision after the incident, on 8/22/14, where he inappropriately touched and "grabbed" Resident #7.</p> <p>On 9/10/14, between 8:30 AM and 3:00 PM, five employees stated Resident #9 was not on 1:1 supervision until 8/25/14.</p> <p>On 9/10/14 the facility's August "as-worked" schedule was reviewed. The schedule documented the 1:1 supervision was not implemented until 8/25/14, three days after the first allegation of sexual abuse.</p> <p>An "Incident/RN Assessment," dated 8/24/14, documented Resident #4 had her breasts grabbed by another resident. The assessment further documented the "alleged assailant was put one on one and is being moved out to a psych hospital. No further follow up needed." Additionally, the assessment documented to keep the "pt away from alleged assailant."</p> <p>Care notes documented the following:</p> <p>*8/23/14, the facility nurse received a phone call from staff. Staff informed the nurse about Resident #4 getting her breasts grabbed by another resident. The facility nurse was to follow up on the incident.</p> <p>*8/24/14, the facility nurse documented, "F/U with pt. Pt stated the resident grabbed her breasts with both hands and she backed up and went straight to staff and reported it...The resident that did it is moving out to the psych hospital and a one to one was put on him until he moved out..."</p> <p>*8/25/14, the facility nurse documented, "received notice today that pt called police on sat [sic]"</p>	R 006	<p>The following corrective action have been put in place.</p> <p>Resident #6 and Resident #9 were discharged from the facility prior to survey.</p> <p>All resident may be affected.</p> <p>Residents have been reviewed for diagnosis, current behaviors and placement within the facility. Alternative arrangement have been sought for some residents due to incompatibility with others.</p>	

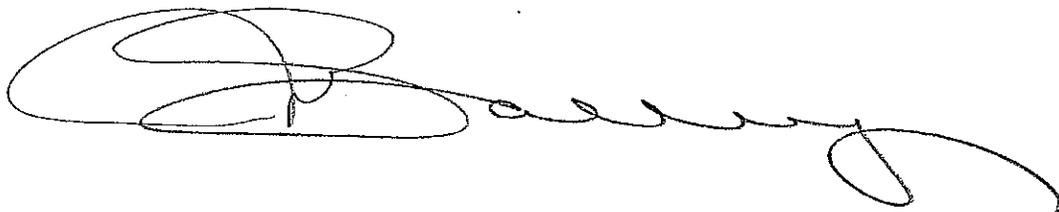


Residential Care/Assisted Living

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R 006	<p>Continued From page 7</p> <p>8-23-14 and reported that she was touched by [Resident #9's name]. I'll follow up with this...."</p> <p>There was no other documentation in the care notes that Resident #4 was protected or that 1:1 supervision was implemented for Resident #9 until 8/25/14. There was no documentation the administrator, Larry Gilley, developed and implemented interventions to protect female residents after Resident #9 sexually assaulted Resident #7 and Resident #4.</p> <p>An "Admission and Discharge Face Sheet," dated 8/26/14, documented Resident #9 was discharged to a psychiatric hospital due to "negative (unacceptable) behaviors."</p> <p>On 9/10/14, between 8:30 AM and 3:00 PM, five employees stated they were told during a staff meeting on 8/25/14, that Resident #9 should be on 1:1. All stated that prior to the staff meeting Resident #9 was not on 1:1 supervision.</p> <p>On 9/10/14 at 11:47 AM, the facility nurse stated he was told that Resident #9 had been placed on 1:1 supervision. He confirmed that he had not come to the facility to ensure the intervention had actually been implemented.</p> <p>On 9/10/14 at 1:35 PM, the former administrator, Larry Gilley, stated he was surprised that Resident #9 had "acted out" sexually towards other residents. He stated he asked the administrator of Safe Haven of Gooding to conduct the investigation of the incident. However, he stated the administrator from Gooding did not believe the sexual abuse had really happened. He stated he was under the impression that 1:1 had been implemented. However, he stated he made an assumption it</p>	R 006	<p>The following measures have been put into place</p> <p>The Administrator, Assistant Administrator, RN and House Manager have all reviewed IDAPA 16.03.22.152.05 related to acceptable admission/retention criteria.</p> <p>A review of current Residents diagnosis/behaviors has been conducted in addition to placement within the facility. If compatibility issues were noted, changes were made within the limits of the facility capabilities</p>	

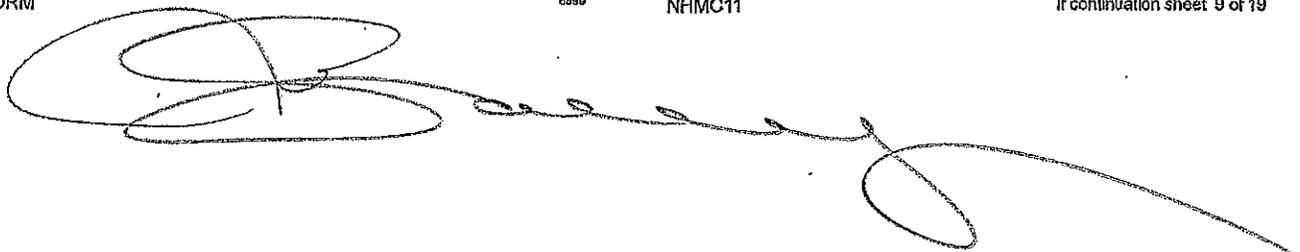


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R 006	<p>Continued From page 8</p> <p>was started, but later found out it had not been.</p> <p>The facility failed to develop a plan to protect female residents from sexual abuse when they admitted Resident #9, who had a documented history of inappropriate sexual behaviors towards others. Additionally, the facility failed to protect female residents from sexual abuse when they did not implement interventions after Resident #9 sexually abused two female residents. Thus, the facility failed to ensure that policies and procedures were implemented to ensure that all residents were free from abuse.</p> <p>2. According to his record, Resident #6, was a 46 year-old male, admitted to the facility on 8/13/14, with diagnoses including bipolar disorder, schizophrenia, psychosis and drug abuse.</p> <p>Hospital paperwork, dated 8/4/14, contained documentation from a physician "...While I was at the facility and prior to my arrival, patient very intrusive, very poor boundaries. Patient actually hypersexual and in fact grabbed the nurse, well tried to grab the nurse's breast. The patient also grabbing or trying to grab other people..."</p> <p>Resident #6's record documented he was discharged from a psychiatric hospital to the facility on 8/13/14. The discharge paperwork documented Resident #6 had "psychosis" and should seek immediate medical care if "severe psychotic symptoms present a safety issue (such as an urge to hurt yourself or others.)"</p> <p>Resident #6's record did not contain an NSA, interim care plan, a behavior management plan, or a plan on how to protect other residents at the facility from Resident #6.</p>	R 006	<p>Due to the need to share bathrooms, gender must be considered in addition to age/diagnosis. Care needs when determining placement.</p> <p>Pre screening includes a record review by the Facility RN and Admission team. If available a visit to the potential Resident by the RN, Administrator or member of the Admission team. Prior to admission may take place. Additional information if available will be sought from previous facility.</p>	



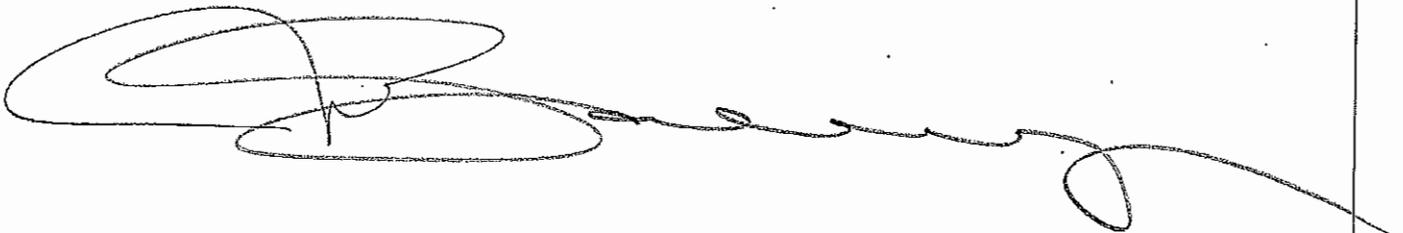
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R 006	<p>Continued From page 9</p> <p>A nursing assessment, dated 8/11/14, documented "Please follow NSA" and "Watch for s/s of drug abuse. Pt has sever [sic] meth addiction."</p> <p>Resident #6's UAI, dated 8/21/14, documented "Client was observed ambulating around the facility on the day of the interview, intrusive and not aware of personal boundaries...Judgement is always poor. Cannot make appropriate decisions for self or makes unsafe decision and needs intense supervision (Intense supervision is needed to prevent danger to self or others)...Client confrontational with others due to paranola, intrusive and not aware of personal boundaries, demanding...Current or history of occasional combative or destructive behaviors..."</p> <p>There was no evidence the facility developed a plan to guide staff if Resident #6 became physically or verbally abusive toward other residents.</p> <p>Resident #6's record contained the following documentatton from August 2014:</p> <p>*8/22 (am): "Res very inappropriate verbally & sexually. He is getting into peoples rooms. Getting into peoples faces. Yelling & screaming at staff & residents. He is backing me up against the wail outside threatening to punch me in the face. He chased [elderly woman's name] down yelling and cursing at her. Him and [random resident's name] got into a physical fight. Cops called out twice."</p> <p>*8/23, 4:30 AM: "...wanted to touch staffs' boobs."</p> <p>*8/23, 5:15 AM: "...went down to a resident's room pounding on the door wanting to bum a</p>	R 006	<p>The acceptable admission/retention requirements will be reviewed by the Admission Team to consider compatibility with current resident census.</p> <p>Initial Functional Risk Assessment has been created and will be completed at the time of admission as part of the interim plan of care for any at Risk behaviors. The Care at a Glance has also been created and will be used to guide staff in the care needs of the residents. The Interim care Plan, Risk assessment,</p>	



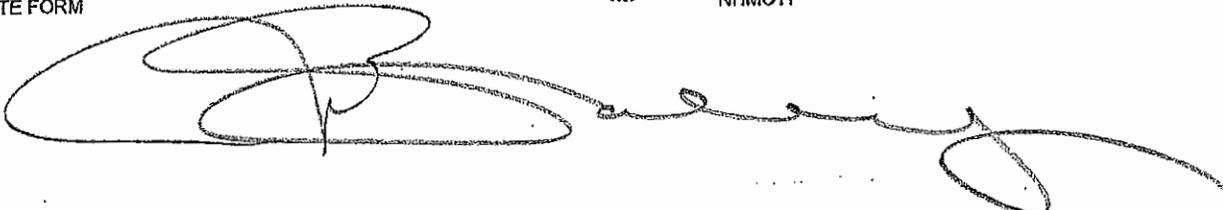
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R 006	<p>Continued From page 10</p> <p>cigarette. He then went down to another resident's room pounding on the door so they could go fishing. He got mad at staff because they had no cigs for him. He proceeded to call staff names cunt, bitch."</p> <p>*8/23, 6:30 AM: "...going in rooms"</p> <p>*8/23, 7:00 AM: "1st big behavior outside."</p> <p>*8/23, 7:30 AM: "Rude remarks."</p> <p>*8/23, 8:00 AM: "2nd big behavior in dining room."</p> <p>*8/23, 9:00 AM: "Cops called out talking to him."</p> <p>*8/23, 9:30 AM: "back outside yelling at people."</p> <p>*8/23, 10:00 AM: "incident with [elderly resident's name] and [random resident]. Cops called back out."</p> <p>*8/23, 12:30 PM: "ate lunch starting to get rude again."</p> <p>*8/23, 1:00 PM: "yelling at staff, following staff."</p> <p>There was no documentation the administrator, Larry Gilley, implemented interventions to ensure residents' or staffs' safety after Resident #6 demonstrated aggressive behaviors.</p> <p>A handwritten note from the house manager, dated 8/22/14, documented she took Resident #6 to the hospital for a psychiatric evaluation "due to his behaviors." She documented she was told by a counselor "...due to paperwork and it was a Friday, could we keep him over the weekend til someone comes on Monday to pick him up." She documented the resident was returned to the</p>	R 006	<p>behavior care plan and care at a glance will all be used to assist staff and Management team to develop the NSA and meet the needs of all residents.</p> <p>A weekly stand-up meeting is scheduled to occur in the facility which will include a discussion of care and behavioral concerns. Admission Retention guidance from the AL rules will be reviewed to ensure care and or behavioral concerns are compatible</p> <p>The corrective actions will be monitored to ensure that the deficient</p>	



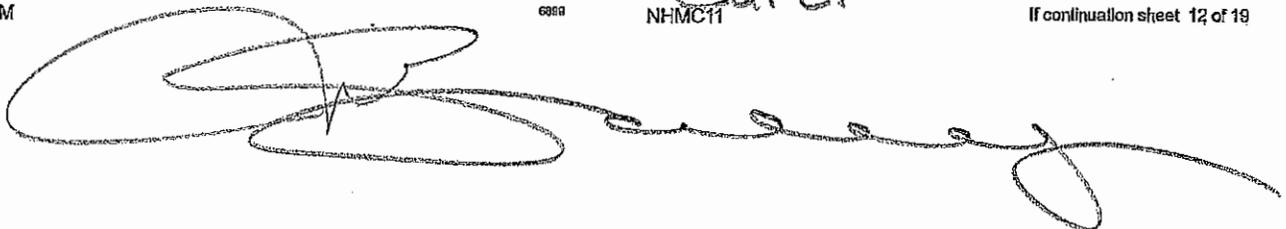
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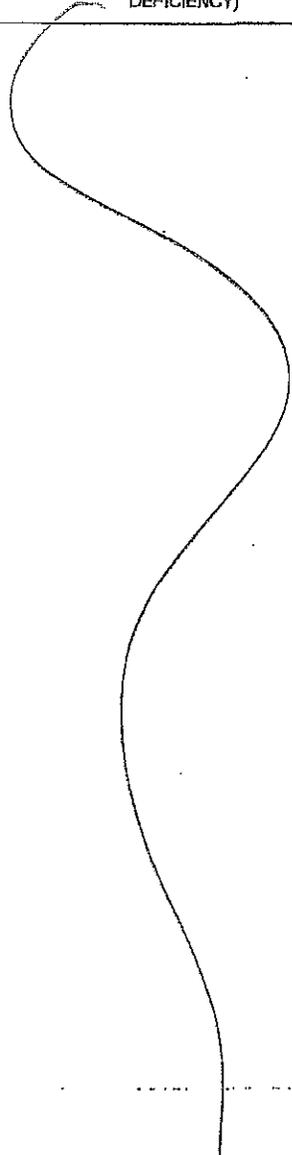
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R 006	Continued From page 11 facility on 8/23/14. She documented day shift staff called, and stated his "behaviors were worsening" and 911 was called for the aggressive behaviors. She documented, "The police told [staff's name] that they were tired of being called for this place and we bring these kind of people here we should be able to control them..." A handwritten note from a caregiver, dated 8/23/14, documented Resident #6 "got right up" in the face of an elder female resident yelling, "whose the fxxking bxxch now cxxt, over and over again. Getting louder and closer." She documented she tried to get Resident #6 away from the elder female resident "but he wouldn't back up." She documented another female resident drew Resident #6's attention away from the elder resident, and they "started throwing fists." She documented law enforcement was notified, and later she was able to calm him down. There was no documentation the administrator, Larry Gilley, conducted an investigation of the incident or implemented interventions to protect residents from Resident #6 after he demonstrated aggressive and threatening behaviors. Nursing notes documented the following: *8/22: "Received a call from staff stating pt eloped and is having s/s of anxiety....Pt states he needs meth to take care of his problems. Pt stated he will refuse to take all medications...he is mentally unstable...Pt will in fact be going back to [behavioral hospital] on Monday. Until then, I've instructed staff to continue giving him his medications as scheduled and do frequent checks on him and continue to try to redirect him..." There was no documentation indicating	R 006	will not recur. The Administrator RN, Assistant Administrator and House Manager will review potential admits with the Corp. Office, Regional Director and Admission team prior to move in. The facility map, placement of Residents and notes from weekly standup, will be reviewed monthly by the Regional or another member from the Corporate office. Compliance will be met by November 7, 2014 in regards to R006 inadequate	

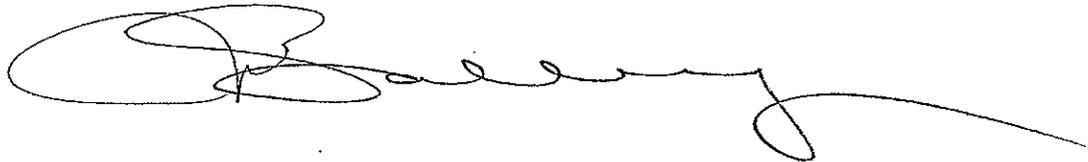


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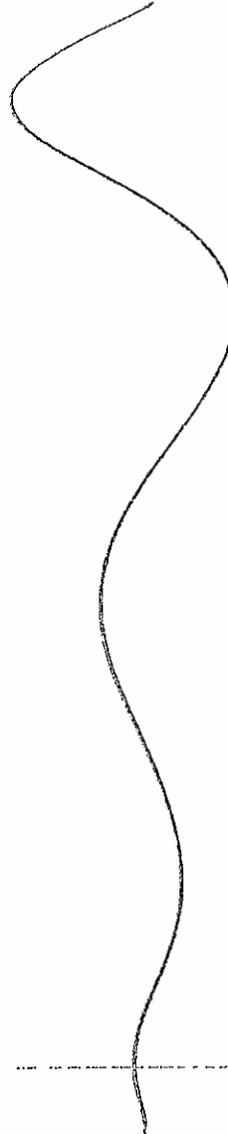
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R 006	<p>Continued From page 12</p> <p>how staff were to redirect him, or that extra staff were scheduled to supervise him.</p> <p>*8/23: "Received a call from staff stating pt is cornering staff members and yelling at them and threatening them. Pt is also yelling at other residents and going into their rooms. I instructed staff to give him his PRN Haldol. Staff stated he will not take his medications. I instructed staff to call 911 and have him removed immediately because he is a risk to himself and others....officers stated it is our problem..."</p> <p>*8/24: "...Called staff late in the evening. Staff states pt is manageable but he is showing s/s of agitation such as pacing, and going into others rooms and starting to be verbally aggressive again. Instructed staff to give him a dose of his Haldol and report back to me if things don't change..."</p> <p>*8/25: "...pt still isn't moved out..."</p> <p>*8/26 : "pt broke through a window and climbed out..."</p> <p>*8/27: "...Pt was moved to a psych hospital..."</p> <p>On 9/8/14 at 3:35 PM, a caregiver stated Resident #6 would "act out and get in your face. He would bug residents for smokes." She further stated, he had a physical altercation with a resident, but "a shadow" was implemented only after he went through a window several days later.</p> <p>On 9/9/14 at 11:00 AM, a caregiver stated Resident #6's "meds stopped working. He was all over the facility verbally aggressive to residents and staff. He would scream at us, I want a</p>	R 006		

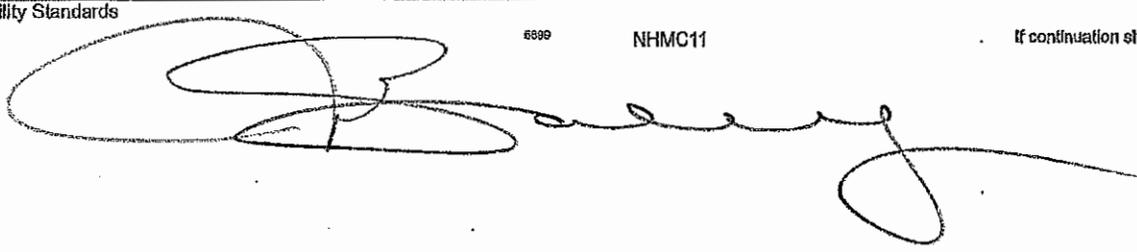


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R 006	<p>Continued From page 13</p> <p>sandwich, get your ass up now." She further stated, he would "argue" with other residents when he was out of cigarettes. She stated, he pushed one staff member against the wall and got "in a fight" with another resident. She stated, one staff member was "scared of him" and the staff member stated "if he keeps being the way he is, I will walk out." She further stated, staff were unable to supervise him. She stated, one to one staffing was not implemented until he broke through a window, several days after the behaviors began.</p> <p>On 9/9/14 at 11:10 AM, a caregiver stated Resident #6 was up a lot during the night, wanting cigarettes and beer. She stated, one night he left the facility, went to a bar and was begging people to buy him cigarettes and drinks. She further stated, Resident #6 had been "yelling a lot and screaming at the birds." She stated, she was told that "we needed to be watching him" but stated 1:1 staffing was not added until the few hours prior to him being discharged.</p> <p>On 9/9/14 at 11:50 AM, the facility RN stated when Resident #6's behaviors began escalating and after "he cornered staff," he instructed staff to call the police and tell them the resident was endangering others' lives. He stated, the police were unwilling to intervene, so he told the former administrator "to get rid of him ASAP." He stated, "nothing could be done over the weekend." He stated, he was told extra staff were in place. He further stated, "I thought they moved him out, and was not aware he was still at the facility until I got a call that he went through the window." He stated, when he kept stating the resident needed moved out, he was told staff "were working on it."</p> <p>On 9/9/14 at 2:45 PM, a caregiver stated,</p>	R 006		



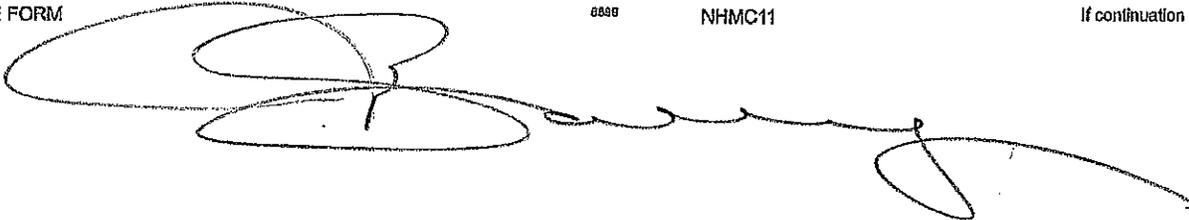
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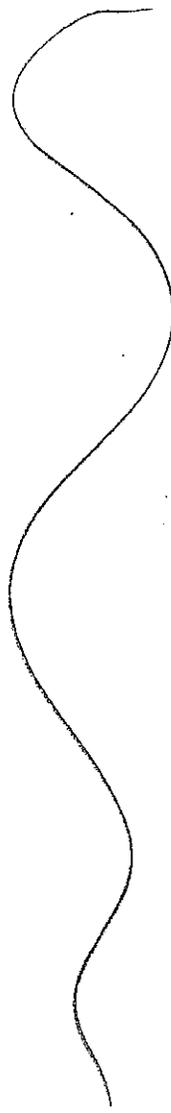
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R 006	<p>Continued From page 14</p> <p>Resident #6 would get "very violent, yell and hit people." She further stated, he got in a physical fight with one resident and went after another elderly resident. She stated, other residents were afraid of him, but one random resident would intervene and "stand up for people he would go after." She further stated, she was unaware of what staff were instructed to do to protect other residents and stated, "extra staff was only added after he eloped." She stated, she was asked to come in and provide 1:1 after Resident #6 eloped a second time, but she declined stating, "I did not want my life to be at risk."</p> <p>On 9/10/14 at 10:25 AM, a resident stated she got in a fight with Resident #6. She stated, he came after an elderly woman at the facility, and was calling her names. She stated, when he would not stop, she intervened and got in a physical fight with him.</p> <p>On 9/10/14 at 10:30 AM, another resident stated Resident #6 liked to "bug" the female residents and he "would try to protect them." He stated, he recalled Resident #6 stating, "just take care of your own problems" when he would try to intervene. He further stated, "a lot of things happened when staff were not around."</p> <p>On 9/10/14 at 10:45 AM, a caregiver stated many residents were "afraid of him and whether he would flip his last cookie." She further stated, he would "get right in your face" and made many staff uncomfortable. She stated, there was not enough staff to supervise him "especially on days when he would wake up needing constant attention. He was hot on your heels." She further stated, he would approach people and say random things such as "I am a murderer, lets go do drugs." She stated, when staff confronted him,</p>	R 006		

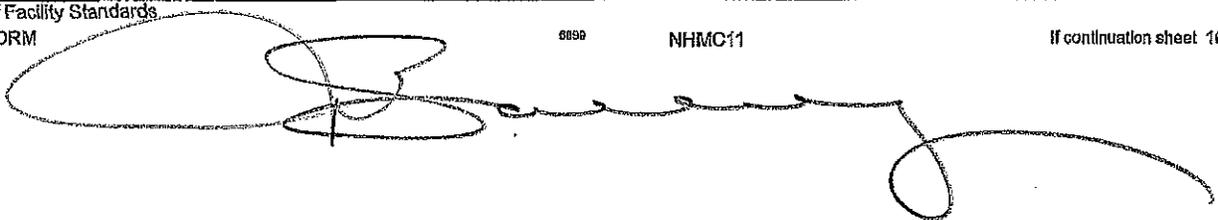


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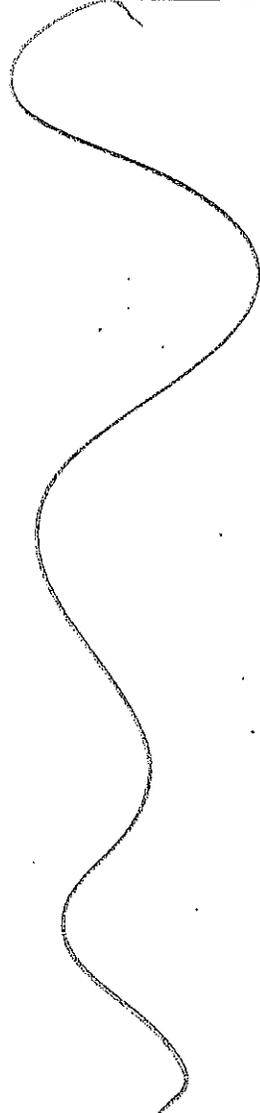
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R 006	<p>Continued From page 15</p> <p>he would sometimes experience remorse and "slap himself."</p> <p>On 9/10/14 at 1:45 PM, the former administrator, Larry Gilley, stated when Resident #6 began showing behaviors "PRN meds were set up to help." He further stated, we were trying to figure out how to get him help. I felt like he should not be in the building." He further stated he was not aware of any behaviors where he hurt himself or others, or that some staff were afraid of the resident.</p> <p>The facility failed to develop plans to protect residents from sexual, verbal or physical abuse when they admitted Residents #9 and #6, who had documented histories of inappropriate sexual behaviors or violence towards others. Additionally, the facility failed to protect residents from abuse when they did not implement interventions to protect the other residents at the facility. These failures resulted in abuse.</p>	R 006		
R 008	<p>16.03.22.520 Protect Residents from Inadequate Care.</p> <p>The administrator must assure that policies and procedures are implemented to assure that all residents are free from inadequate care.</p> <p>This Rule is not met as evidenced by: IDAPA 16.03.22.011.08 - Inadequate Care. When a facility...takes residents who have been admitted in violation of the provisions of Section 39-3307 (See IDAPA 16.03.22.152)</p> <p>Based on observation, interview and record review, it was determined the facility admitted and</p>	R 008		

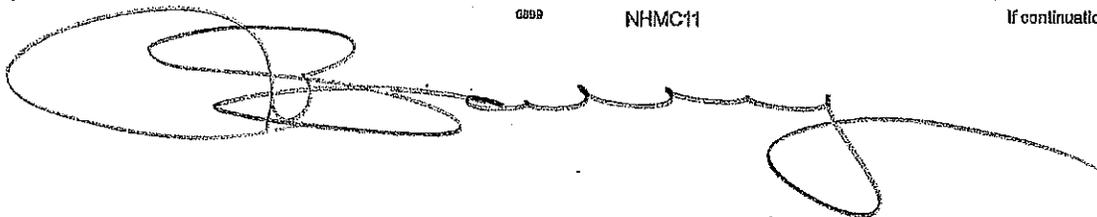


Residential Care/Assisted Living

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 09/11/2014
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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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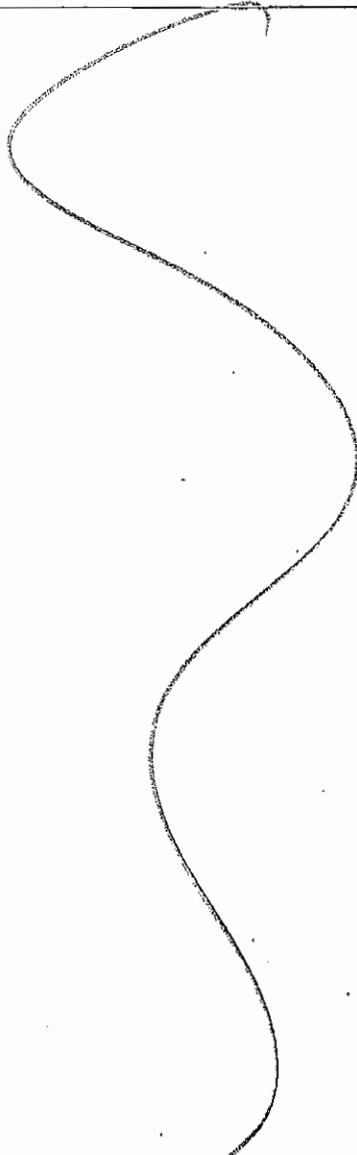
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETE DATE
R 008	<p>Continued From page 16</p> <p>retained residents who were not compatible with other residents and were violent and a danger to others.</p> <p>IDAPA 16.03.22.152.05,d - e, documents that residents will not be admitted or retained who has physical, emotional, or social needs that are not compatible with other residents in the facility, or is violent or a danger to themselves or others.</p> <p>I. Violent or danger to others</p> <p>Please refer to the R006 abuse tag for further information regarding this portion of the deficiency.</p> <p>II. Incompatibility of residents</p> <p>On 9/8/14, the facility was observed to be a 37 bed-facility, with two wings, which were separated by a dining room and a common area. The wings were not visible when in the dining room, common area, or front office area. Two caregivers were scheduled for each shift.</p> <p>On 9/8/14 through 9/11/14, a mix of elderly and young residents were observed in the facility.</p> <p>The roster of residents who resided at Safe Haven of Wendell facility at the time of survey on 9/8/14, documented the following:</p> <ul style="list-style-type: none"> * There were twenty-six residents residing at the facility. * Seventeen residents had diagnoses of mental illness. * Four residents had diagnoses of dementia. 	R 008		

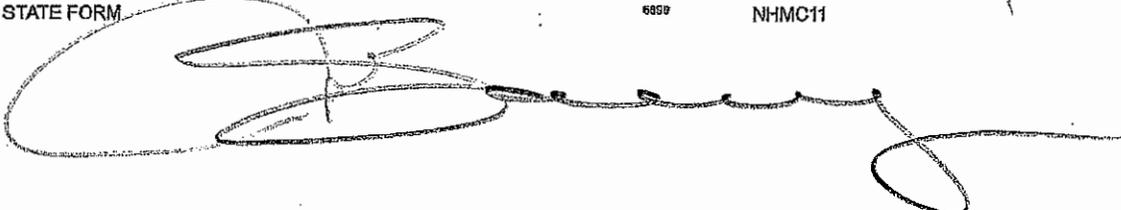


Residential Care/Assisted Living

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 09/11/2014
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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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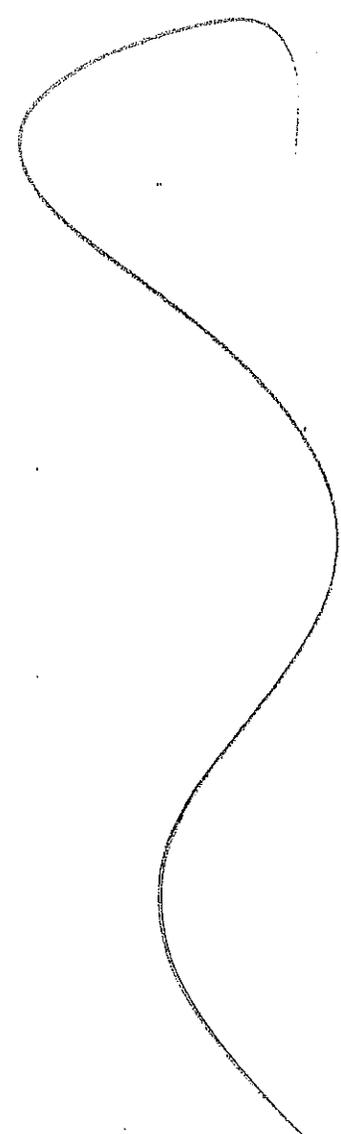
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R 008	<p>Continued From page 17</p> <ul style="list-style-type: none"> * Two residents had diagnoses of traumatic brain injury. * One resident had a diagnosis of developmental disability. <p>On 9/18/14, the facility provided the Department with an untitled document, which listed the ages of the residents. The residents' ages ranged from 25 to 95 years of age, twelve were aged 70 or above and of those, two were over 90 years of age.</p> <p>Following are examples of incompatibility identified during the survey:</p> <ul style="list-style-type: none"> * A 25 year-old with a diagnosis of mental illness, who was independent with all care needs, was a roommate with a 95 year-old with severe dementia who was totally dependent for all of her needs. * A 61 year-old with an extensive history of sexual inappropriateness. * The resident's room with extensive history of sexual inappropriateness was near vulnerable female residents. * An elderly female resident, with dementia and extensive needs, was in a room next to a 46 year-old male with violent tendencies. * An elderly female resident was physically and verbally threatened by a 46 year-old male resident. <p>The facility admitted and retained residents who were not compatible with other residents and who were violent and a danger to others. This resulted</p>	R 008		

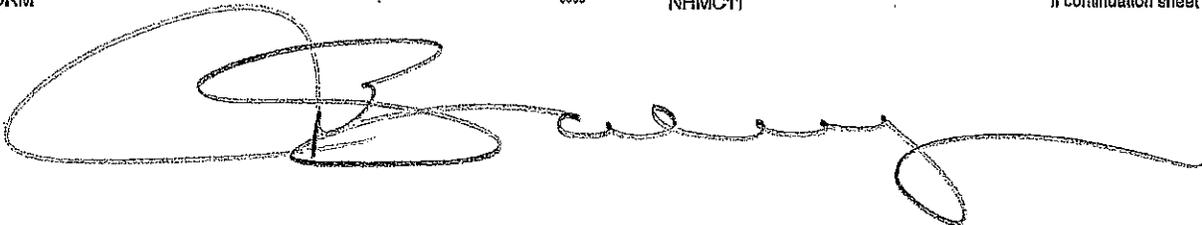


Residential Care/Assisted Living

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 09/11/2014
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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 008	Continued From page 18 in inadequate care.	R 008		





Facility CAREFIX - SAFE HAVEN HOMES OF WENDELL - MAGIC VALLEY	License # RC-932	Physical Address 210 NORTH IDAHO	Phone Number (208) 536-6623
Administrator Jodi Galloway	City WENDELL	ZIP Code 83355	Survey Date September 11, 2014
Survey Team Leader Gloria Keathley	Survey Type Complaint Investigation	RESPONSE DUE: October 11, 2014	
Administrator Signature 	Date Signed 9-11-2014		

NON-CORE ISSUES

Item #	IDAPA Rule # 16.03.22.	Description	Department Use Only	
			EOR Accepted	Initials
1	009.06.c	One of seven employee records did not contain an Idaho State Police background check.	10-16-14	gk
2	215	The facility did not have an administrator at all times.	10-16-14	gk
3	215.02	The previous administrator was not on site sufficiently to ensure that residents received safe and adequate care.	10-16-14	gk
4	215.05	The previous administrator did not ensure that residents were appropriate for admission or retention.	10-16-14	gk
5	215.08	The previous administrator did ensure the facility's abuse policy was implemented, such as interviewing residents for possible abuse.	10-16-14	gk
6	225.01	The facility did not evaluate Resident #6, #9 and #12's behaviors. ***Previously cited on 2/20/14***	11-4-14	gk
7	225.02	The facility did not develop interventions for Resident #6, #9 and #12's behaviors. ***Previously cited on 2/20/14***	11-4-14	gk
8	260.06	The facility did not provide adequate cleaning to ensure there were no offensive odors present and carpets were clean.	10-16-14	gk
9	300.02	The facility did not ensure Resident #1 and #2's physicians' orders were implemented as ordered.	10-20-14	gk
10	305.02	Resident #5's record did not contain all physician's orders.	10-16-14	gk
11	305.05	The facility RN did not follow-up to ensure Resident #2's sutures were removed in a timely manner. ***Previously cited on 8/28/13 and 2/20/14***	10-20-14	gk
12	320	Resident #6 and #9's records did not contain an interim plan of care.	10-20-14	gk
13	320.01	The facility did not implement Resident #2, #5 and #8's NSA to include assistance with toileting and hygiene.	10-20-14	gk
14	350.01	The administrator was not notified of all incidents and complaints.	10-20-14	gk
15	350.02	The previous administrator did not investigate all incidents and complaints.	10-16-14	gk
16	350.03	The facility did implement interventions to ensure residents were protected after an allegation of abuse.	10-20-14	gk
17	350.05	Adult Protection was not notified after a second allegation of abuse.	10-20-14	gk
18	350.06	The facility failed to take immediate corrective actions to ensure that abuse did not reoccur.	10-20-14	gk



Facility CAREFIX - SAFE HAVEN HOMES OF WENDELL - MAGIC VALLEY	License # RC-932	Physical Address 210 NORTH IDAHO	Phone Number (208) 536-6623
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Survey Team Leader Gloria Keathley	Survey Type Complaint Investigation	RESPONSE DUE: October 11, 2014	
Administrator Signature 	Date Signed 9-11-2014		

NON-CORE ISSUES

Item #	IDAPA Rule #	Description	Department Use Only	
			EOR Accepted	Initials
19	600.05	The previous administrator did not ensure that staff were performing their assigned duties, such as assisting residents with ADLs.	10-20-14	JK
20	711.08.c	The facility did not document all unusual events.	10-20-14	JK
21	711.08.e	Facility staff did not document when they notified the facility RN of residents' changes of condition.	10-20-14	JK
22	711.11	Facility staff did not document the reason why medications were not given.	10-20-14	JK
23	711.13	All nursing assessments were not maintained in residents' records.	10-20-14	JK
24	711.14	Required discharge information was not contained in all applicable resident records.	10-20-14	JK
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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 26, 2014

Jodie Galloway, Administrator
Carefix-Safe Haven Homes of Wendell-Magic Valley Manor
210 North Idaho
Wendell, Idaho 83355

Provider ID: Rc-932

Ms. Galloway:

An unannounced, on-site complaint investigation was conducted at Carefix-Safe Haven Homes of Wendell-Magic Valley Manor between September 8, 2014 and September 11, 2014. During that time, observations, interviews, and record reviews were conducted with the following results:

Complaint # ID00006482

Allegation #1: Staff did not treat residents with dignity and respect.

Findings #1: Substantiated. However, the facility was not cited as they responded appropriately by terminating the staff who had not treated residents with dignity and respect.

Allegation #2: Residents were not appropriately assisted for toileting needs.

Findings #2: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.320.01 for not implementing residents' Negotiated Service Agreements for assistance with toileting. Additionally, the facility was issued a deficiency at IDAPA 16.03.22.600.05 for the administrator not supervising staff and ensuring all tasks were completed. The facility was required to submit evidence of resolution within 30 days.

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

Sincerely,

GLORIA KEATHLEY, LSW
Health Facility Surveyor
Residential Assisted Living Facility Program

GK/sc

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



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September 26, 2014

Jodie Galloway, Administrator
Carefix-Safe Haven Homes of Wendell-Magic Valley Manor
210 North Idaho
Wendell, Idaho 83355

Provider ID: RC-932

Ms. Galloway:

An unannounced, on-site complaint investigation was conducted at Carefix-Safe Haven Homes of Wendell-Magic Valley Manor between September 8, 2014 and September 11, 2014. During that time, observations, interviews, and record reviews were conducted with the following results:

Complaint # ID00006588

Allegation #1: Residents were verbally threatened by staff.

Findings: Substantiated. However, the facility was not cited as they had terminated the staff who verbally threatened residents.

Allegation #2: Residents were not being assisted with their toileting needs.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.320.01 for not implementing residents' Negotiated Service Agreements for assistance with toileting and hygiene. The facility was required to submit evidence of resolution within 30 days.

Allegation #3: The facility did not schedule sufficient staff to meet residents' care needs.

Findings: Substantiated. However, the facility was not cited as they acted appropriately by adding additional staff. Seven current staff members stated staffing patterns were adequate. Seventeen residents were interviewed and stated current staff assisted them with what they required.

Allegation #4: Medications were not being appropriately monitored

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.300.02 for not ensuring physicians' orders were implemented and at 16.03.22.711.11 for not documenting reasons why medications were not given. The facility was required to submit evidence of resolution within 30 days.

Jodie Galloway, Administrator

September 26, 2014

Page 2 of 2

Allegation #5: Residents were not appropriately supervised.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.520 for not providing appropriate supervision to residents. The facility was required to submit a plan of correction.

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,



GLORIA KEATHLEY, LSW

Health Facility Surveyor

Residential Assisted Living Facility Program

GK/sc

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



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September 26, 2014

Jodie Galloway, Administrator
Carefix-Safe Haven Homes of Wendell-Magic Valley Manor
210 North Idaho
Wendell, Idaho 83355

Provider ID: RC-932

Ms. Galloway:

An unannounced, on-site complaint investigation was conducted at Carefix-Safe Haven Homes of Wendell-Magic Valley Manor between September 8, 2014 and September 11, 2014. During that time, observations, interviews, and record reviews were conducted with the following results:

Complaint # ID00006589

Allegation #1: The facility did not appropriately supervise residents.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.520 for not providing supervision to residents. The facility was required to submit a plan of correction.

Allegation #2: The facility did not assist residents with activities of daily living (ADLs).

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.320.01 for not implementing residents' Negotiated Service Agreements for assistance with toileting and hygiene. The facility was required to submit evidence of resolution within 30 days.

Allegation #3: Medications were not appropriately monitored.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.300.02 for not ensuring physicians' orders were implemented and at 16.03.22.711.11 for not documenting a reason why medications were not given. The facility was required to submit evidence of resolution within 30 days.

Allegation #4: Residents were not protected from abuse.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.510 for residents not being protected from abuse. The facility was required to submit a plan of correction.

Jodie Galloway, Administrator

September 26, 2014

Page 2 of 2

Allegation #5: The facility administrator was not at the facility sufficiently to provide oversight.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.600.05 for the administrator not being present to ensure staff were performing their assigned duties, such as assisting residents with their activities of daily living. The facility was required to submit evidence of resolution within 30 days.

Allegation #6: Residents were being exploited when staff borrowed money.

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

Allegation #7: Residents were not compatible.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.520 for retaining a resident who was harmful to other residents. The facility was required to submit a plan of correction.

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,



GLORIA KEATHLEY, LSW
Health Facility Surveyor
Residential Assisted Living Facility Program

GK/sc

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



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September 26, 2014

Jodie Galloway, Administrator
Carefix-Safe Haven Homes of Wendell-Magic Valley Manor
210 North Idaho
Wendell, Idaho 83355

Provider ID: RC-932

Ms. Galloway:

An unannounced, on-site complaint investigation was conducted at Carefix-Safe Haven Homes of Wendell-Magic Valley Manor between September 8, 2014 and September 11, 2014. During that time, observations, interviews, and record reviews were conducted with the following results:

Complaint # ID00006646

Allegation #1: The facility did not protect residents from sexual abuse.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.510 for not protecting residents from abuse. The facility was required to submit a plan of correction.

Allegation #2: The facility did not assist residents with activities of daily living (ADLs).

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.320.01 for not implementing residents' Negotiated Service Agreements for assistance with toileting and hygiene. The facility was required to submit evidence of resolution within 30 days.

Allegation #3: The facility did not supervise residents' medical needs.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.305.05 for not following up on residents' medical needs in a timely manner. The facility was required to submit evidence of resolution within 30 days.

Allegation #4: Residents were not treated with dignity and respect.

Findings: Substantiated. However, the facility was not cited as they had terminated staff who did not treat residents with dignity and respect prior to the complaint investigation.

Jodie Galloway, Administrator
September 26, 2014
Page 2 of 2

Allegation #5: The facility did not appropriately supervise residents.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.520 for not providing appropriate supervision of residents. The facility was required to submit a plan of correction.

Allegation #6: Nursing assessments were not in residents' records.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.711.13 for not having nursing assessments in the residents' records. The facility was required to submit evidence of resolution within 30 days.

Allegation #7: The facility did not report an allegation of sexual abuse to Adult Protection.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.350.05 for not reporting an allegation of abuse to Adult Protection. The facility was required to submit evidence of resolution within 30 days.

Allegation #8: The facility administrator was not at the facility sufficiently enough to supervise staff.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.600.05 for the administrator not being present to ensure staff were performing their assigned duties, such as assisting residents with their activities of daily living. The facility was required to submit evidence of resolution within 30 days.

Allegation #9: The facility administrator did not follow the facility's policy and conduct a thorough investigation of an allegation of sexual abuse.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.215.08 for not ensuring the facility's abuse policy was implemented, when there was an allegation of abuse. The facility was required to submit evidence of resolution within 30 days.

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

Sincerely,



GLORIA KEATHLEY, LSW
Health Facility Surveyor
Residential Assisted Living Facility Program

GK/sc

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