



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: 208-364-1862
FAX: 208-364-1888

October 18, 2013

CERTIFIED MAIL #: 7012 1010 0002 0836 0256

Carissa Bullets, Administrator
Friends And Family Living Center
185 Constellations Rd
Idaho Falls, ID 83402

Dear Ms. Bullets:

On September 27, 2013, a Complaint Investigation survey was conducted by our staff at Friends & Family Living Center - Tierragold Assisted Living Center, LLC. The facility was cited with three core issue deficiencies for: failure to protect residents from abuse, failure to protect residents from inadequate care, and failure to protect residents from neglect.

These core issue deficiencies substantially limit the capacity of Friends & Family Living Center - Tierragold Assisted Living Center, LLC, to provide for residents' basic health and safety needs. The deficiencies are described on the enclosed Statement of Deficiencies.

BACKGROUND:

On May 12, 2011, the facility was issued core level deficiencies for failure to protect residents from abuse and failure to protect residents from inadequate care.

PROVISIONAL LICENSE:

As a result of the survey findings, the Department is issuing the facility a provisional license, effective October 18, 2013, through April 18, 2014. The following administrative rule for Residential Care or Assisted Living Facilities in Idaho (IDAPA 16.03.22) give the Department the authority to issue a provisional license:

935. ENFORCEMENT REMEDY OF PROVISIONAL LICENSE.

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

The conditions of the provisional license are as follows:

1. **The facility will maintain, on an ongoing basis, the deficient areas in a state of compliance in accordance with the submitted Plan of Correction;**

2. A provisional license is issued which is to be prominently displayed in the facility. Upon receipt of this provisional license return the full license, currently held by the facility.

3. **PLAN OF CORRECTION:**

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.

4. **EVIDENCE OF RESOLUTION:**

Fourteen (14) 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.

Two (2) of the fourteen (14) non-core issue deficiencies were identified as repeat punches.

All fourteen (14) punches 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 27, 2013**.

5. When the administrator believes the facility is in full compliance, she will notify the Department and a follow-up survey will be conducted.

ADMINISTRATIVE REVIEW

Please be advised that you may contest these decisions by filing a written request for administrative review pursuant to IDAPA 16.05.03.300. no later than twenty-eight (28) days after this notice was mailed. Any such request should be addressed to:

**Tamara Prisock, Administrator
Division of Licensing and Certification
Department of Health and Welfare
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009**

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

INFORMAL DISPUTE RESOLUTION

You have available the opportunity to question cited deficiencies through an informal dispute resolution process. If you disagree with the survey report findings, you may make a written request to the Supervisor of the Residential Care Program for a Level 1 IDR meeting. The request for the meeting must be made within ten (10) business days of receipt of the Statement of Deficiencies (October 31, 2013). The specific deficiencies for which the facility asks reconsideration must be included in the written request, as well as the reason for the request for reconsideration. The facility's request must include sufficient information for Licensing and Certification to determine the basis for the provider's appeal. If your request for informal dispute resolution is received after October 31, 2013, your request will not be granted. Your IDR request must be made in accordance with the Informal Dispute Resolution Process. The IDR request form and the process for submitting a complete request can be found at www.assistedliving.dhw.idaho.gov under the heading of Forms and Information.

FOLLOW-UP SURVEY

If, at the follow-up survey, it is found that the facility is not in compliance with the rules and standards for residential care or assisted living facilities, the Department will have no alternative but to initiate an enforcement action against the license held by Friends & Family Living Center - Tierragold Assisted Living Center, LLC. Enforcement actions could include:

- a. Continuation of the provisional license
- b. Limitations of admissions to the facility
- c. Hiring a consultant who submits periodic reports to Licensing and Certification
- d. Civil monetary penalties

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

Sincerely,



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

MH/tp

cc: Medicaid Notification Group



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RESIDENTIAL ASSISTED LIVING FACILITY PROGRAM
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: 208-334-6626
FAX: 208-364-1888

November 15, 2013

Carissa Bullets, Administrator
Friends And Family Living Center
185 Constellations Rd
Idaho Falls, ID 83402

License #: Rc-977

Dear Ms. Bullets:

On September 27, 2013, a Complaint Investigation survey was conducted at Friends & Family Living Center - Tierragold Assisted Living Center, Llc. 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 Matt Hauser, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 364-1962.

Sincerely,

Matt Hauser
Team Leader
Health Facility Surveyor

mlh/mlh

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

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R977	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/27/2013
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NAME OF PROVIDER OR SUPPLIER FRIENDS & FAMILY LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 165 + 175 + 185 + 195 CONSTELLATIONS ROAD IDAHO FALLS, ID 83402
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R 000	<p>Initial Comments</p> <p>The following deficiencies were cited during a complaint investigation survey conducted from 9/25/2013 through 9/27/13 at your residential care/assisted living facility. The surveyors conducting the survey were:</p> <p>Matt Hauser, QMRP Team Leader Health Facility Surveyor</p> <p>Karen Anderson, RN Health Facility Surveyor</p> <p>Maureen McCann, RN Health Facility Surveyor</p> <p>Abbreviations:</p> <p>ACT team = Assertive Community Treatment team; provides services to individuals with severe and persistent mental illness (not a medical emergency response team). @ = at & = and ADLs = Activities of Daily Living DC'd = discontinued C/O = complain of MARs = medication assistance records mg = milligram NA = not applicable NSA = negotiated service agreement (care plan) PSR = Psychosocial rehabilitation PTSD = post traumatic stress disorder Res = resident temp = temperature</p>	R 000	<p>R006 The facility did not protect Resident #2 and potentially 100% of the residents from abuse.</p> <p>What Corrective actions will be accomplished for the specific resident affected.</p> <p>1) Adult Protection was notified on 10/29/13.</p> <p>2) Facility nurse conducted a full head to toe exam of Resident #2 on 10/29/13.</p> <p>3) Staff involved in allegation no longer works at Friends and Family as of 7/12/13.</p> <p>How will you identify other residents that may be affected by the same deficient practice and what corrective action will be taken?</p> <p>1) All residents could be affected at any time. A mandatory in service will be held 11/5/2013 informing staff the need to report any allegation or actual abuse to the Administrator or Designee immediately. Administrator will notify RN if necessary to assist with</p>	
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RECEIVED
10/15/2013
FACILITY

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

Causa Bulleto

TITLE

Administrator

(X5) DATE

Bureau of Facility Standards

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R 006 R 006	<p>Continued From page 1</p> <p>16.03.22.510 Protect Residents from Abuse.</p> <p>The administrator must assure that policies and procedures are implemented to assure that all residents are free from abuse.</p> <p>This Rule is not met as evidenced by: Based on record review and interview, it was determined the facility failed to implement policies and procedures to protect 1 of 10 sampled residents (Resident #2) and potentially 100% of the residents from abuse. The findings include:</p> <p>IDAPA 16.03.22.153.01 documents, "The facility must develop policies and procedures to assure that allegations of abuse, neglect and exploitation are identified, reported, investigated, followed-up with interventions to prevent reoccurrence and assure protection, and documented."</p> <p>IDAPA 16.03.22.520 documents, "The administrator must assure that policies and procedures are implemented to ensure that all residents are free from abuse."</p> <p>Idaho Statute 39-5303 requires that a residential care facility, serving vulnerable adults, must immediately report information to the Idaho Commission on Aging (Adult Protection/APS) when there is reasonable cause to believe that a resident had been abused.</p> <p>The facility's Abuse Policy documented, "...If a staff member or contractor...is suspected of abuse of any kind the staff member will be immediately suspended without pay...Administrator will oversee a complete investigation of the allegation. The investigation will be completed in a timely fashion. The results</p>	R 006 R 006	<p>the investigation.</p> <p>what measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</p> <p>1) The abuse policy has been revised and is posted in every building for staff as reminders.</p> <p>2) Staff will be educated on the abuse policy 11/5/13 including the need to notify the administrator or Designee immediately and how to handle an allegation or actual abuse case.</p> <p>3) Testing about abuse will be given on 11/5/13 and added into employee packets for new employees.</p>	

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R 006	<p>Continued From page 2</p> <p>will be reported to the appropriate officials."</p> <p>Resident #2 was a 26 year-old female, admitted to the facility on 9/27/11, with a diagnosis of schizoaffective psychosis.</p> <p>On 9/25/13 at 11:00 AM, Resident #2 was observed standing in the living room conversing with other residents. Upon introduction, Resident #2 stepped behind other residents and said "hi." The resident's demeanor appeared to be shy and reserved.</p> <p>Resident #2's NSA, dated 2/7/13, documented she was independent with all ADLs but required assistance with her medications. According to her NSA, the resident's personality was documented as being "generally pleasant and cooperative."</p> <p>An Incident/Accident Report, dated 4/1/13, documented when Caregiver B arrived to work on 3/31/13 at 11:30 PM, the evening caregiver told her about an incident involving Caregiver A and Resident #2. The evening caregiver told Caregiver B, that Resident #2 had a bruise on her right upper arm caused by Caregiver A pulling on her arm to get her out of bed. The incident report documented, Resident #2 showed Caregiver B the bruise and stated Caregiver A pulled her arm to get her out of bed. The incident report further documented, Caregiver B took the resident to the administrator's office the next morning to inform her of the incident.</p> <p>None of the caregivers who had worked on 3/31/13, reported the incident to the administrator or completed an incident report until the following morning.</p> <p>A communication note, signed and dated on</p>	R 006	<p>How will the corrective action be monitored and how often will monitoring occur to ensure the deficient practice will not recur?</p> <p>1) Shift supervisors will read staff communication notes and resident case notes weekly for any documented abuse or allegations. If any documentation is found, the Administrator or Designee will be notified immediately and appropriate actions taken.</p> <p>2) Staff in service/education will be held on 11/5/2013. A "what to do in the event of Abuse/Allegation" will be posted in all buildings for staff to refer to.</p>	

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R 006	<p>Continued From page 3</p> <p>4/1/13, by the administrator, documented Resident #2 informed her of the incident involving Caregiver A. The administrator wrote, the resident stated Caregiver A grabbed and pulled on her arm because she did not want to get up out of bed to take her morning medications. The administrator documented, she observed the resident's bruise.</p> <p>An incident report, dated 4/1/13 at 5:00 PM, documented the administrator telephoned Caregiver A to come back to the facility and complete an incident report. The administrator documented Caregiver A told her that on the morning of 3/31/13, the resident was having a difficult time getting out of bed to take her medications and requested help. The administrator further documented, according to Caregiver A, Resident #2 stood up and started to fall, so he caught her by her upper arms.</p> <p>On 4/2/13 at 10:30 AM, the administrator's investigation documented, "[Caregiver A's name] did in fact try to awaken [Resident #2's name] by pulling her arm. After talking to both parties, it is believed that the bruising was from her near fall and [Caregiver A's name] grabbing to save her from falling...Staff was warned about grabbing/pulling on residents due to possible bruising and/or accusations that may arise from situations."</p> <p>On 9/26/13 at 3:40 PM, the administrator stated she did not follow the facility's abuse policy when she did not suspend Caregiver A and allowed him to work before completing a full investigation. She stated she did not interview other staff members or residents because she believed after talking to Resident #2 and Caregiver A, abuse had been ruled out. The administrator confirmed she did</p>	R 008	<p>What date will the corrective actions be completed by?</p> <p>Corrective actions will be completed by 11/5/13.</p>	

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R 008	Continued From page 4 not contact Adult Protection. The facility did not protect Resident #2 from abuse, when the administrator did not ensure an allegation of abuse was reported to Adult Protection and allowed a caregiver to continue having unsupervised access to residents, before an investigation was conducted.	R 008	R008 The facility failed to provide adequate care for 2 of 10 residents (#1, #7) The facility failed to provide assistance and monitoring of medication for Resident #1. The facility retained Resident #1 and #7 after they became a danger to themselves.	
R 008	16.03.22.520 Protect Residents from Inadequate Care. The administrator must assure that policies and procedures are implemented to assure that all residents are free from inadequate care. This Rule is not met as evidenced by: Based on record review, observation and interview, it was determined the facility failed to provide adequate care for 2 of 10 sampled residents (#1 and #7). The facility failed to provide assistance and monitoring of medication for Resident #1. Also, the facility retained Resident #1 and #7 after they became a danger to themselves. The findings include: 1) ASSISTANCE AND MONITORING OF MEDICATION IDAPA 16.22.03.08 defines inadequate care as: "When a facility fails to provide ...assistance and monitoring or medication..." Resident #1 was a 35 year-old male, admitted to the facility on 11/21/12, with a diagnosis of paranoid schizophrenia. A) Xarelo	R 008	What corrective actions will be accomplished for the specific residents affected? 1) Resident #1 no longer resides at the facility as of 10/2/13. 2) Resident #2 will be assessed by a Mental Health Professional to determine risk of danger to self or others. Assessment will be completed before 11/8/13	

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R 008	<p>Continued From page 5</p> <p>The following hospital discharge physician's order, dated 1/22/13, was found in the resident's record:</p> <p>* Xarello 15mg twice a day (an anticoagulant medication)</p> <p>There was no other documentation from the hospital found in the resident's record regarding the resident's hospitalization or why the resident required an anticoagulant.</p> <p>Resident #1's NSA, dated 11/12/12, documented the facility, "....will monitor and control all medication."</p> <p>Resident #1's February, March, April and May 2013 MARs documented the resident did not receive Xarello. The following note was handwritten on the June 2013 MAR: "Medical will not pay & Doctor will not DC'd [sic] it"</p> <p>"Skilled Nursing Assessment - 90 DAY" forms, dated 2/6/13, 5/4/13 and 8/6/13, and signed by the facility nurse were reviewed. The nurse did not document the resident had been hospitalized, the reason for the hospitalization, why Resident #1 required anticoagulant therapy or that the resident had not received the medication.</p> <p>There was no physician's order found in the resident's record to discontinue the Xarello.</p> <p>An incident report, dated 5/29/13, documented the resident had not received Xarello because it had not been available from the pharmacy. The form was signed by the administrator on 5/30/13 and by the facility nurse on 6/10/13, five months after the physician wrote the initial order.</p>	R 008	<p>How will you identify other residents that may be affected by the same deficient practice and what corrective action will be taken?</p> <p>1) All residents could be affected at any time. All residents will have a complete medication order review. MARs are currently being reviewed to assure all medications are available as ordered.</p> <p>2) If a medication is found unavailable, the facility nurse will be notified, who will document finding and contact the physician. If the pharmacy is unable to fill the medication, the nurse will request an order change or a temporary hold until the medication is available as ordered. Facility nurse will provide documentation about medication.</p>	

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R 008	<p>Continued From page 6</p> <p>On 9/26/13 at 10:25 AM, the administrator stated the resident still had not received the medication because his insurance would not pay for it and the doctor would not discontinue it. She stated she had been working with the ACT team to rectify the situation.</p> <p>There was no documentation in Resident #1's record why he required an anticoagulant or that he had been assessed by the nurse or physician for any complications related to not receiving the anticoagulant for 8 months. Further, there was no documentation the physician's order had been discontinued or that the facility was actively attempting to rectify the discrepancy.</p> <p>B) Oxygen</p> <p>On 9/25/13 at 10:25 AM, the resident's room was observed. When entering the room, a large liquid oxygen tank was observed on the floor. A small portable oxygen tank was on the floor next to the tank.</p> <p>The following hospital discharge orders, dated 1/22/13, were found in the resident's record:</p> <p>* Continuous oxygen at 2 liters</p> <p>Between 9/23/13 and 9/26/13, the resident was observed numerous times during the survey. The resident was either in the common areas, seated outside in the yard or asleep in his bedroom with the door open. The resident was not observed wearing oxygen during the survey. The facility staff were not observed to cue or assist the resident with his oxygen.</p> <p>Resident #1's NSA, dated 11/21/12, documented</p>	R 008	<p>3) Any resident harming themselves or others or who threatens harm to themselves or others will be sent out immediately to be assessed by a mental Health Professional.</p> <p>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</p> <p>1) The facility nurse will review every medication the facility is unable to obtain and will contact the physician. The nurse will request a supplement order or a hold order to avoid future medications being unavailable as ordered. The nurse will document all findings and requests.</p>	

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R 008	<p>Continued From page 7</p> <p>the facility would monitor and provide medication support for the resident. Under the heading, "Treatments - Oxygen", "NA" was documented.</p> <p>"Skilled Nursing Assessment - 90 DAY" forms, dated 2/6/13, 5/4/13 and 8/6/13, and signed by the facility nurse were reviewed. The nurse did not document the resident had been hospitalized, the reason for the hospitalization, why Resident #1 required oxygen therapy or that the resident had not been compliant wearing the oxygen.</p> <p>A "Resident Case Notes" form, dated 7/25/13, documented Resident #1 had returned from the hospital at 4:00 PM and had "...oxygen day & night."</p> <p>On 9/26/13, Resident #1's record was reviewed. There was no documentation the nurse had assessed the resident to determine if the resident experienced ill effects when he did not wear his oxygen. Further, there was no documentation the nurse or other staff had informed the resident of the consequences of not wearing his oxygen.</p> <p>On 9/26/13 at 10:25 AM, the administrator stated, Resident #1 only wore his oxygen when he was sleeping.</p> <p>Resident #1 was observed not wearing his oxygen or being cued or assisted with his oxygen, as ordered by his physician. Further, the resident had not been informed of the consequences of not wearing his oxygen.</p> <p>II) RETENTION</p> <p>IDAPA 16.03.22.152.05.b. & e documents, "No resident will be admitted or retained who requires ongoing skilled nursing or care not within the</p>	R 008	<p>2) Staff will be educated 11/5/2013 about following oxygen orders and prompting residents to use oxygen as ordered. Nurse will be notified if a resident fails to use oxygen as ordered. The nurse will provide documents.</p> <p>3) Facility nurse will conduct an assessment on all residents after a hospitalization.</p> <p>4) Staff will receive additional Mental Health, Crisis Intervention Training by a Mental Health Professional by 11/20/13.</p> <p>5) All staff and residents will be informed of the facility requirements if any resident is threatening harm to self or others they will be sent out for an evaluation and depending on the evaluation, they may or may not be permitted back at the facility.</p>	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R977	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/27/2013
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NAME OF PROVIDER OR SUPPLIER FRIENDS & FAMILY LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 165 + 175 + 185 + 195 CONSTELLATIONS ROAD IDAHO FALLS, ID 83402
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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 8</p> <p>legally licensed authority of the facility. Such residents include: A resident that is violent or a danger to himself or others;"</p> <p>A) Resident #7's record documented she was a 26 year-old female, who was admitted to the facility on 9/9/13. Her diagnoses included borderline personality disorder, PTSD, depression and developmental disabilities. Resident #7's record also documented, prior to being admitted to the facility, she had been hospitalized, on 9/1/13, in a psychiatric behavioral health unit for trying to harm herself.</p> <p>An incident report, dated 9/16/13, documented Resident #7 "...started crying, running to the phone emotionally picked up phone and called crisis line... she handed me the phone... the woman on the line, explained to me that [Resident #7's name] can be suicidal and that she had told her that she was gonna [sic] cut herself..." The incident report documented the staff member followed Resident #7 to her room and saw her shuffling through a box in her bathroom. The report stated, the staff member "asked her what are you looking for, she said I am gonna [sic] cut myself, I cannot find it." The report went on to document, the staff member told Resident #7 to calm down and gave the resident a hug and the resident "calmed down." The report further documented the staff member and the resident talked for a while and Resident #7 stated she felt "a lot better." Resident #7 was not assessed by a mental health professional, after the 9/16/13 incident, to determine if she was a danger to herself or others.</p> <p>The facility's policy, titled "Response of Staff to Emergencies," documented "In a psychiatric emergency, the staff will determine if the resident</p>	R 008	<p>How will the corrective actions be monitored and how often will monitoring occur to ensure the deficient practice will not recur?</p> <p>1) Shift supervisors will review MARS weekly for medications unavailable. Facility Nurse and Administrator will be notified of any medications unavailable. Facility Nurse will provide documentation and contact the physician for further directions.</p> <p>2) Shift supervisors will review staff communication notes and resident case notes weekly for documentation of residents threatening harm to self or others or actually harming themselves or others. Supervisors will notify Administrator immediately if anything is found and the resident</p>	

Bureau of Facility Standards

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R 008	<p>Continued From page 9</p> <p>is a danger to himself/herself or others." The policy further documented, "The staff will call an ambulance and inform the Administrator/Supervisor if it is determined the resident is not a danger to himself/herself or others." However, the staff had not been trained or licensed to assess if residents were a danger to themselves or others. Additionally, Resident #7 had not been assessed by a licensed mental health professional to determine if she was a danger to herself, after the incident.</p> <p>On 9/26/13 at 10:16 AM, the administrator stated she was not aware of the incident. However, she had signed the incident report on 9/16/13. She further stated, Resident #7 should have been evaluated by a mental health professional after the incident, but was not.</p> <p>Resident #7 became a danger to herself on 9/16/13, but was not assessed by licensed mental health professional.</p> <p>B) Resident #1 was a 35 year-old male, who was admitted to the facility on 11/21/12, with a diagnosis of paranoid schizophrenia.</p> <p>On 9/26/13 at 5:20 PM, the resident was observed waiting in line for dinner. He asked a surveyor if she knew how to "do heart and brain surgery." He stated, "We need someone here to do that. They need to hire someone that can."</p> <p>An incident report, dated 7/16/13, documented the resident went to a local gas station, filled a water bottle with gas and drank it. Shortly after the resident returned to the facility, the police arrived. The police stated staff at the gas station had called them. The police had already notified an ambulance and the resident was taken to an</p>	R 008	<p>will be sent out for a mental Health Evaluation.</p> <p>What date will the corrective actions be completed by?</p> <p>Corrective actions will be completed by 11/20/13</p>	

Bureau of Facility Standards

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R 008	<p>Continued From page 10</p> <p>emergency department. The resident was admitted to the hospital for 8 days.</p> <p>A hospital report documented Resident #1 was admitted and treated for for "acute hypoxemic respiratory failure with associated pneumonitis and developing pneumonia secondary to gasoline inhalation."</p> <p>A "Resident Case Notes" form, dated 7/25/13, documented Resident #1 had returned from the hospital at 4:00 PM and had "...oxygen day & night" and "has a nebulizer..."</p> <p>There was no documentation in the record the resident had been assessed to determine if he continued to be a danger to himself or was appropriate to be readmitted to the facility.</p> <p>The facility failed to provide adequate care when they did not appropriately assist and monitor medications for Resident #1 and retained Resident's #1 and #7, when they became a danger to themselves. This resulted in inadequate care.</p>	R 008	<p>R009 The facility failed to provide medical treatment in a timely manner for 1 of 10 residents. (Resident #1)</p> <p>What corrective actions will be accomplished for the specific resident affected?</p> <p>1) Resident #1 no longer resides at the facility as of 10/2/13.</p> <p>How will you identify other residents/personnel areas that may be affected by the same deficient practice and what corrective actions will be taken?</p>	
R 009	<p>16.03.22.525 Protect Residents from Neglect</p> <p>The administrator must assure that policies and procedures are implemented to assure that all residents are free from neglect.</p> <p>This Rule is not met as evidenced by: Based on observation, record review and interview, it was determined the facility failed to provide medical treatment in a timely manner for 1 of 10 sampled residents (Resident #1).</p>	R 009	<p>1) All residents could be affected. Staff was educated by the facility nurse 10/18/13 regarding change of condition with residents.</p>	

Bureau of Facility Standards

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R 009	<p>Continued From page 11</p> <p>IDAPA 16.22.03.08 defines neglect as, "Failure to provide... or medical care necessary to sustain the life and health of a resident."</p> <p>Resident #1 was a 35 year-old male, admitted to the facility on 11/21/12, with a diagnosis of paranoid schizophrenia.</p> <p>Resident #1's NSA, dated 11/21/12, documented the facility would provide nursing evaluations upon admission, quarterly and nursing would be notified of any changes and follow up promptly.</p> <p>1) JANUARY 2013</p> <p>The following was documented in "Resident Case Notes":</p> <ul style="list-style-type: none"> * 1/1/13 (7AM - 3PM). "Temp at 12:30 pm was 99.1. Says his throat hurts & he is coughing." * 1/2/13 (3PM - 11PM). "He was running a temp of 100.5 at 3pm, gave him Tylenol. Rechecked him at 5:30 and it had gone down to 99.0." * 1/2/13 (11PM - 7AM). "...he did c/o pain gave him ibuprofen at 12:25. Later he c/o headache gave him Tylenol at 5:15." * 1/4/13 (3PM - 11PM). The resident's "been coughing a lot today. Nose looks red too." * 1/4/13 (11PM - 7AM). "Res c/o being sick, coughing and chest pain. Took Tylenol at 12:50 am." * 1/5/13 (3PM - 11PM). "Resident coughing a lot." * 1/10/13 (3PM - 11PM). "C/o not feeling well still." 	R 009	<p>Staff will notify the nurse and submit a change of condition form for follow up and review by the nurse. Residents will be sent out for further treatment per direction of the facility nurse as needed.</p> <p>What measures will be put into place or what systemic changes will you make to ensure the deficient practice does not recur?</p> <p>1) Staff was educated 10/18/13 by facility nurse. Staff will contact the nurse for all medical questions or concerns. Change of condition forms will be submitted for review and follow up. Nurse will document findings on the change of condition form.</p>	

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER: **FRIENDS & FAMILY LIVING CENTER**
STREET ADDRESS, CITY, STATE, ZIP CODE: **165 + 175 + 185 + 195 CONSTELLATIONS ROAD IDAHO FALLS, ID 83402**

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R 009	<p>Continued From page 12</p> <p>* 1/10/13 (11PM - AM). "He was miserable all night. Cold moved down to his chest he went to bed @ 4:30 am."</p> <p>* 1/11/13 (3PM-11PM shift). "Resident was sick when I got here @ 3pm. Took his temp & it was 102.4. Gave him Tylenol rechecked his temp @ 4:20pm & it was 101.9. Gave him ibuprofen @ 6:15pm. Checked temp at 5:30 & it was 102.9. Gave him Tylenol @ 8:15pm. Called the ACT team at 3 pm to see if they could take him to the doctor. They were unable to." The case note further documented, the caregiver then called the administrator, who instructed caregivers to "push a lot of fluids & alternate the Tylenol and ibuprofen until his fever is down." However, the administrator was not a nurse and there was no documentation in the resident's record the nurse had been contacted or assessed the resident.</p> <p>* 1/11/13 (11PM -7AM shift). "Res is still sick. He threw up at about 12 am in his room."</p> <p>An incident report, dated 1/12/13, documented the resident had a temperature, was coughing, had a hard time breathing and "didn't have balance," so the facility called the ACT team, and was told the ACT team could not take the resident to the emergency room. The facility then called for an ambulance. The report also documented, when the ambulance arrived, the resident's oxygen saturation was 60%. The resident was hospitalized for the next 10 days.</p> <p>On 9/26/13 at 1:40 PM, the administrator stated the nurse was in the facility frequently, but she could not find any of the nurse's documentation.</p> <p>There was no nurse documentation in the month of January 2013 found in the resident's record</p>	R 009	<p>2) Shift supervisors will review resident case notes and staff communication notes weekly for signs of changes of conditions. Supervisors will report any documented concerns to the facility nurse and Administrator to cross check and assure the change of condition has been reported. If it is found that a staff has failed to report a change of condition, he/she will receive a written warning and one on one with the nurse and administrator.</p> <p>How will the corrective action be monitored and how often will monitoring occur to ensure that the deficient practice does not recur?</p> <p>1) Supervisors are reviewing resident case notes and staff communication notes weekly and will</p>	

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R 009	<p>Continued From page 13 regarding the resident's change in condition.</p> <p>The facility did not have Resident #1 assessed by a medical professional when a resident was ill, until 11 days after the symptoms began. This resulted in neglect.</p>	R 009	<p>continue to review weekly for signs of changes in condition.</p> <p>2) Supervisors will report any documented change of condition to the nurse and administrator to cross check and assure the change of condition has been reported.</p> <p>By what date will the corrective actions be completed by?</p> <p>1) Corrective actions will be completed by 11/10/13.</p>	



Facility Friends and Family Living Center	License # RC-977	Physical Address 165, 175, 185, 195, and 205 CONSTELLATIONS	Phone Number (208) 227-0804
Administrator Carissa Bullets	City IDAHO FALLS	ZIP Code 83402	Survey Date September 27, 2013
Survey Team Leader Matt Hauser	Survey Type Complaint Investigation and Follow-up	RESPONSE DUE: October 27, 2013	
Administrator Signature <i>Carissa Bullets</i>	Date Signed 9/27/13		

NON-CORE ISSUES

Item #	IDAPA Rule # 16.03.22.	Description	Department Use Only	
			EOR Accepted	Initials
1	210	The facility did not offer an activity program that assisted, encouraged and promoted residents to maintain and develop their highest potential for independent living.	10/29/13	<i>MB</i>
2	225.02	The facility did not develop an intervention for each behavioral symptom for Resident's #2, 5 and 6.	10/29/13	<i>MB</i>
3	250.10	A) The water temperatures in all buildings were not maintained between 105 and 120 degrees F. B) The water fountain was broken in building #1.	10/29/13	<i>MB</i>
4	260.06	The interior and exterior of the facility were not maintained in a safe, orderly manner. Such as: Several exit doors did not close properly causing gaps between the door and door jam, weather stripping was missing and automatic door closer was broken. Two residents' heaters were not working in Building #1, room #13 and building #2, room #1. No closet door in building #2, room #6. A strong urine odor was detected in building #2, room #8. Holes in walls and scraped, missing paint on walls were observed throughout the facility. The window blinds near the front door in building #4 were inoperable. The vinyl flooring was cracked in several areas throughout the facility. Toilet seats were loose in several bathrooms. Building #2 only had a table that sat 10 residents with only 7 chairs, although 14 residents resided in the building. Exterior gate doors were broken, missing or latches not working properly. Holes and cracks were observed in the siding throughout the facility. Two vehicles were parked in the parking lot that were inoperable; one was on jacks. Cigarette butts littered the parking lot.	10/29/13	<i>MB</i>
5	300.01	The facility nurse did not complete an assessment after Resident's #'s 1, 2, 3, 5, 7 and 9 had changes in condition. Such as: When Resident #9 had chest pain, Resident #7 had suicidal ideation, Resident #5 "blacked-out" twice, Resident #1 developed respiratory distress and Resident #2 burned herself with a cigarette and broke out in hives. ***Previously cited on 5/12/11***	10/29/13	<i>MB</i>
6	305.02	Medications for Resident's #1, #7 and #8 were not available as ordered by the physician.	10/29/13	<i>MB</i>
7	305.101.f	A caregiver did not observe a random resident swallow their medication in building #4.	10/29/13	<i>MB</i>
8	310.04.e	Behavioral updates were not provided to the physician for Resident's #'s 1, 2, 4 and 5.	10/29/13	<i>MB</i>
9	320.01	Resident #5's NSA was not developed for 4 months after admission. ***Previously cited on 5/12/11***	error	<i>MB</i>
10	320.08	Resident #1's and 2's NSAs were not updated after changes in conditions.	10/29/13	<i>MB</i>
11	350.02	The administrator did not complete an investigation for each, accident, incident and complaint.	10/29/13	<i>MB</i>



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Administrator Carissa Bullets	City IDAHO FALLS	ZIP Code 83402	Survey Date September 27, 2013
Survey Team Leader Matt Hauser	Survey Type Complaint Investigation and Follow-up		RESPONSE DUE: October 27, 2013
Administrator Signature <i>Carissa Bullets</i>	Date Signed 9/27/13		

NON-CORE ISSUES

Item #	IDAPA Rule # 16.03.22.	Description	Department Use Only	
			EOR Accepted	Initials
12	350.04	The administrator did not provide a written response to complainants within 30 days. ***Previously cited on 5/12/11***	10/29/13	ML
13	350.07	The facility did not report a resident to resident altercation to Licensing and Certification.	10/29/13	ML
14	405.03	The facility was storing and transferring liquid oxygen tanks in two residents' rooms.	10/29/13	ML
15	455	The facility did not maintain a supply of food to meet the menu. Such as: The facility ran out of milk 2 days in a row.	10/29/13	ML
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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
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RESIDENTIAL ASSISTED LIVING FACILITY PROGRAM
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Boise, Idaho 83720-0009
PHONE: 208-334-6626
FAX: 208-364-1888

October 17, 2013

Carissa Bullets, Administrator
Friends and Family Living Center
185 Constellations Rd
Idaho Falls, ID 83402

Dear Ms. Bullets:

An unannounced, on-site complaint investigation survey was conducted at Friends & Family Living Center - Tierragold Assisted Living Center, LLC between September 25 and September 27, 2013. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00005813

Allegation #1: The administrator threatened to evict residents who brought complaints to her attention.

Findings #1: Insufficient evidence was available at the time of the investigation and in records reviewed to substantiate this allegation.

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

Allegation #2: The exterior door latches did not work.

Findings #2: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.260.06 for not ensuring the exterior doors latched and the automatic door closers functioned on the doors. The facility was required to submit evidence of resolution within 30 days.

Allegation #3: The administrator did not investigate a complaint that residents were not treated with dignity and respect.

Findings #3: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.350.02 for not investigating each complaint/incident. The facility was required to submit a plan of correction within 10 days.

Allegation #4: Residents' visitation rights were violated.

Findings #4: On 9/26/13, thirty-seven residents were interviewed. All of the residents stated they were allowed to have visitors. None of the residents interviewed indicated their visitation rights had been violated.

From 9/25/13 through 9/26/13, twelve staff members were interviewed regarding residents' visitation rights. All of the staff members stated residents were allowed to have and receive visitors. Further, the staff members stated, there were no visitation restrictions.

On 9/25/13 at 11:45 AM, the administrator stated residents had no restriction on visitors.

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

Allegation #5: Residents were not assisted with their medications as ordered by their physicians.

Findings #5: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.305.02 for not having medications available as ordered by residents' physicians. The facility was required to submit evidence of resolution within 30 days.

Allegation #6: Residents' medications were stolen by staff.

Findings #6: Substantiated. However, the facility was not cited as they acted appropriately by investigating the stolen medications and reporting the stolen medications to the police. An investigation report documented a staff member reported to the administrator on 10/9/12 that a resident's narcotic medications had been removed from the bubble pack and replaced with another medication. The administrator documented the police were notified and came to the facility to investigate the missing medications. The administrator documented a staff member came to her and admitted she had taken the narcotics. The staff member was immediately terminated and the administrator reported what had occurred to the police.

Allegation #7: The facility did not notify the appropriate agencies or protect residents after allegations of abuse were made.

Findings #7: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.520 for failing to protect residents from abuse and failing to notify the appropriate agencies of the abuse allegation. The facility was required to submit a plan of correction within 10 days.

Allegation #8: The facility was not maintained in a clean and orderly manner.

Findings #8: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.260.06 for not maintaining the interior and exterior of the facility in a clean, safe and orderly manner. The facility was required to submit evidence of resolution within 30 days.

Allegation #9: The administrator did not respond in writing to complainants.

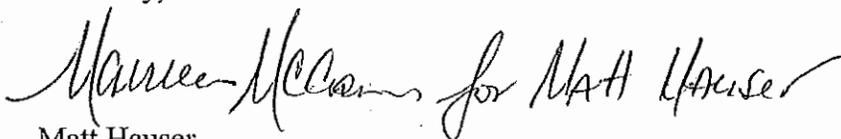
Findings #9: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.350.04 for not providing complainants with a written response to their complaint within 30 days. The facility was required to submit evidence of resolution within 30 days.

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

Please bear in mind that non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference, on **September 27, 2013**. The completed punch list form and accompanying evidence of resolution (e.g., receipts, pictures, policy updates, etc) are to be submitted to this office within thirty (30) days from the exit date.

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

Sincerely,



Matt Hauser
Health Facility Surveyor
Residential Assisted Living Facility Program

MH/TFP

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