



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

December 18, 2013

Jerry Bowlin, Administrator  
Wedgewood Terrace, Provident Foundation  
2114 Vineyard Avenue  
Lewiston, ID 83501

License #: Rc-588

Dear Ms. Bowlin:

On October 22, 2013, a Complaint Investigation survey was conducted at Wedgewood Terrace-Provident Resources Group, Inc. 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.

Your submitted plan of correction is 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 Rae Jean McPhillips, RN, BSN, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 364-1962.

Sincerely,

Rae Jean McPhillips, RN, BSN  
Team Leader  
Health Facility Surveyor

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



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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 13, 2013

**CERTIFIED MAIL #: 7007 3020 0001 4050 8166**

Jerry Bowlin  
Wedgewood Terrace, Provident Foundation  
2114 Vineyard Avenue  
Lewiston, ID 83501

Dear Ms. Bowlin:

Based on the Complaint Investigation survey conducted by Department staff at Wedgewood Terrace-Provident Resources Group, Inc between October 21, 2013 and October 22, 2013, it has been determined that the facility failed to protect residents from sexual abuse and retained residents who were a danger to themselves or others.

This core issue deficiency substantially limits the capacity of Wedgewood Terrace-Provident Resources Group, Inc to furnish services of an adequate level or quality to ensure that residents' health and safety are protected. The deficiency is described on the enclosed Statement of Deficiencies.

You have an opportunity to make corrections and thus avoid a potential enforcement action. Correction of this deficiency must be achieved by **December 6, 2013**. **We urge you to begin correction immediately.**

After you have studied the enclosed Statement of Deficiencies, please write a Plan of Correction by answering **each** of the following questions for **each** deficient practice:

- ◆ What corrective action(s) will be accomplished for those specific residents/personnel/areas found to have been affected by the deficient practice?
- ◆ How will you identify other residents/personnel/areas that may be affected by the same deficient practice and what corrective action(s) will be taken?
- ◆ What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?
- ◆ How will the corrective action(s) be monitored and how often will monitoring occur to ensure that the deficient practice will not recur (i.e., what quality assurance program will be put into place)?
- ◆ By what date will the corrective action(s) be completed?

Return the **signed and dated** Plan of Correction to us by **November 26, 2013**, and keep a copy for your

Jerry Bowlin  
November 13, 2013  
Page 2 of 2

records. Your license depends upon the corrections made and the evaluation of the Plan of Correction you develop.

In accordance with IDAPA 16.03.22.003.02, 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. See the IDR policy and directions on our website at [www.assistedliving.dhw.idaho.gov](http://www.assistedliving.dhw.idaho.gov). If your request for informal dispute resolution is not received within the appropriate time-frame, your request will not be granted.

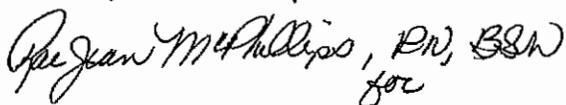
If, at the follow-up survey, the core deficiency still exists or a new core deficiency is identified the Department will have no alternative but to initiate an enforcement action against the license held by Wedgewood Terrace-Provident Resources Group, Inc.

Enforcement actions may include:

- imposition of civil monetary penalties;
- issuance of a provisional license;
- limitation on admission to the facility;
- requirement that the facility hire a consultant who submits periodic reports to Licensing and Certification.

Our staff is available to answer questions and to assist you in identifying appropriate corrections to avoid further enforcement actions. Should you have any questions, or if we may be of assistance, please contact us at (208) 334-6626 and ask for the Residential Assisted Living Facility program. Thank you for your continued participation in the Idaho Residential Care Assisted Living Facility program.

Sincerely,

 *Jamie Simpson, RN, BSN*  
for

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

JM/tm

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13R588</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/22/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>WEDGEWOOD TERRACE, PROVIDENT FOUNE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2114 VINEYARD AVENUE LEWISTON, ID 83501</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>Initial Comments</p> <p>The following deficiencies were cited during the complaint investigation conducted between October 21, 2013 and October 22, 2013 at your residential care/assisted living facility. The surveyors conducting the survey were:</p> <p>Rae Jean McPhillips, RN, BSN Team Leader Health Facility Surveyor</p> <p>Donna Henscheid, LSW Health Facility Surveyor</p> <p>Gloria Keathley, LSW Health Facility Surveyor</p> <p>Survey Definitions:</p> <p>@ = at &amp; = and ABH Gel = Ativan, Benadryl and Haldol - topical ointment used to decrease agitation BMP = Behavior Management Plan C/O = Complaints of EMT = Emergency Medical Technician FNP = Family Nurse Practitioner LPN = Licensed Practical Nurse MAR = Medication Assistance Record Med = Medication Med tech = Medication Technician Mg = milligram NSA = Negotiated Service Agreement PO = By Mouth RN = Registered Nurse Tx = Treatment X = Times</p>	R 000		

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DEC 13 2013  
FACILITY STANDARDS

Bureau of Facility Standards

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

TITLE

(X6) DATE

*[Signature]*

Executive Director 12-6-13

Bureau of Facility Standards

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R 006 R 006	Continued From page 1 16.03.22.510 Protect Residents from Abuse.  The administrator must assure that policies and procedures are implemented to assure that all residents are free from abuse.  This Rule is not met as evidenced by: Based on record review and interview it was determined the facility failed to protect 2 of 4 sampled male residents (#8 and #9) and random female and male residents from Resident #6's sexual abuse. This had the potential to place 100% of all residents at risk for abuse. The findings include:  The facility's abuse policy, dated 4/09, documented if an employee witnessed or had knowledge of abuse, they were required to immediately report it to their supervisor. The policy further documented, the administrator was to report the incident to the proper authorities immediately following the incident.  According to his record, Resident #6 was an 82 year-old male, admitted to the facility's memory unit, on 5/30/12, with a diagnosis of dementia.  Resident #6's NSA, dated 5/30/12, documented the resident could "be sexually aggressive...."  According to Resident #6's progress notes the resident's victims included:  *Resident #8, a 77 year-old male with a diagnosis of dementia *Resident #9, a 92 year-old male with a diagnosis of dementia *Unidentified female and male residents	R 006 R 006	State of Disclaimer Preparation and/ or execution of this plan of correction does not constitute the providers admission of or agreement with the facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared and executed solely because it is required by the provision of Idaho State law.  Corrective actions for this specific incident are that resident number 6 is no longer living at the facility. The RN and LPN who failed to report such incidents to adult protection and the facility administrator are no longer employed at Wedgewood Terrace.  In order to identify other residents/personnel/ areas that may be affected by the same deficient practice there will be proper reporting done by caregivers who observe such behaviors. The RN and/or facility administrator will then properly report to adult protection/correct agencies and corrective interventions will be implemented to ensure said resident(s) are free from abuse to self and others. NSA will be updated accordingly and personnel will be notified of changes that need to be made immediately. Provide one on one care 24 hours a day. If deemed necessary, said resident(s) will be given a immediate discharge notice/30 day notice and assistance will be provided to find different placement.  Measures that are being put into place that will ensure the deficient practice does not recur: - Extensive training is being scheduled for the carestaff that reinforce the facility abuse policy. Richard, from Adult Protection, is working on scheduling a class for December training that will go over elder abuse and reportable incidents. This training will be mandatory for all employees every six months and as deemed necessary.	

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R 006	<p>Continued From page 2</p> <p>Resident #6's progress note, dated 6/4/12, documented an aide reported to the facility RN that on 5/30/12, Resident #6 was found naked, standing over Resident #9, who was lying in bed. It further documented staff were to make sure Resident #6 was "not alone with other residents."</p> <p>There was no documentation the RN reported the incident to adult protection or to the facility administrator. The only intervention documented was to "not leave Resident #6 alone with other residents." This was documented in Resident #6's progress notes, which may or may not have been read by all the caregivers. Further, there was no documented evidence that an investigation of the incident was conducted.</p> <p>Resident #6's progress notes documented the following:</p> <p>*6/12/12 - The resident did not have any more "inappropriate undressing or touching" of other residents. However, the resident would occasionally, "lightly kiss" female caregivers on the cheek.</p> <p>*7/9/12 - The resident was standing over Resident #8 "groping" his "scrotal area" and appeared to be "caressing" the "peri area."</p> <p>*7/21/12 at 6:20 PM - The resident was trying to "kiss a female resident on the mouth in the dining room."</p> <p>*7/21/12 at 7:00 PM - Resident #6 was found in his bedroom with Resident #9 and a female resident. Resident #9 was laying on Resident #6's bed with his "pants open, attends down." Resident #6 was "stroking" Resident #9's penis. The female's pants "weren't on correctly" but the</p>	R 006	<p>- Facility RN and Resident Service Coordinator will perform Biweekly chart audits to monitor for any inappropriate behaviors that may have been documented on, but not reported to the correct authority or further investigated by RN and/or administrator.</p> <p>- The administrator will follow policies and procedures to identify, investigate and communicate to the commission on Aging Adult Protection any time the facility has reasonable cause to suspect abuse.</p> <p>The corrective actions for this specific resident/ area has been taken care of as stated above; this specific resident is no longer living at the facility and the RN and LPN who failed to report correctly are no longer employed at Wedgewood Terrace. All employees are aware that they are mandated to report any suspicion of neglect/abuse. This will be reinforced by the training of the facility's current abuse policy and the training that will be done by Adult Protection every six months and/or as needed.</p> <p>All corrected actions will be put in place before January 7, 2014.</p>	
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R 006	<p>Continued From page 3</p> <p>caregiver had not witnessed any inappropriate touching of the female resident.</p> <p>On 6/4/12, the RN documented in Resident #6's progress notes that caregivers were to ensure Resident #6 was not alone with other residents. However, during July 2012, caregivers documented in the resident's progress notes that he "groped" another male resident's "scrotal area," tried to kiss a female resident, and was found "stroking" the penis of another male resident while in the company of a female resident.</p> <p>Resident #6's progress note, dated 7/23/12, documented the RN faxed the resident's physician requesting a mental health consultation because of his sexual behaviors. Also, she again documented Resident #6 would be monitored at all times while awake and would "...not be alone with any resident, male or female."</p> <p>There was no documented evidence found in Resident #6's record the incidents were reported to adult protection or to the facility administrator. Additionally, there was no documentation that other interventions were put into place to protect other residents from Resident #6's sexual abuse.</p> <p>Resident #6's progress notes documented the following:</p> <p>*9/6/12 at 1:30 PM - Resident #6 was "groping a male resident." At 1:40 PM, another resident's family member reported to the caregiver the resident was seen "groping a female resident."</p> <p>*9/18/12 at 3:00 PM - It was reported to the RN that Resident #6 had "several episodes of inappropriate behaviors" toward staff and</p>	R 006		

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R 006	Continued From page 4  residents. The resident "slapped" a female caregiver's buttocks and twice had to be redirected from "rubbing" two male residents' heads.  *9/21/12 - The resident "grabbed" a caregiver's "rear end."  *9/30/12 - A caregiver found Resident #6 "touching" Resident #8's leg and "going toward the peri area."  *10/19/12 - A caregiver found the resident in the day room with Resident #8 and had "unbuttoned" his shirt and "was poking at him near private area."  *11/28/12 - The resident had two incidents of inappropriate touching.  *12/11/12 - The resident was seen by a caregiver kissing another resident.  *12/29/12 - Resident #6 was seen by a caregiver touching and trying to undress other male residents.  On 7/23/12, the RN documented in Resident #6's progress notes, the resident would be monitored at all times while he was awake and would not be left alone with other residents, male or female. However, from 9/6/12 until 12/29/12, there were eleven documented instances where Resident #6 was sexually inappropriate with other residents.  There was no evidence the facility's RN, LPN or caregivers, notified adult protection or the facility administrator of Resident #6's ongoing aggressive sexual behaviors. Further, interventions were not put into place to protect	R 006		

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R 006	<p>Continued From page 5</p> <p>other residents from Resident #6 sexual behaviors.</p> <p>On 10/21/13 at 3:58 PM, a caregiver stated she heard that Resident #6 had been inappropriate with other residents and staff, but she had not witnessed it.</p> <p>On 10/21/13 at 4:08 PM, another caregiver stated Resident #6 was sexually inappropriate with other male residents, but especially "targeted" Resident #9. She stated he would touch Resident #9's leg and then move his hands to Resident #9's genital area. She stated he would also touch other residents in a sexual way and try to kiss them.</p> <p>On 10/22/13 at 3:06 PM, a caregiver stated Resident #6 would try to touch other male residents in a sexual manner. She stated, "he seemed to like the men."</p> <p>On 10/22/13 at 4:15 PM, another caregiver stated she heard that Resident #6 was sexually inappropriate toward other male residents.</p> <p>On 10/22/13 at 4:35 PM, the administrator stated she was aware of only one instance when Resident #6 had been sexually inappropriate. She stated, she was told by the nurses that "they had taken care of it." She stated she was unaware of any other incidences when he was sexually inappropriate with other residents. She stated, she did not report the incident to adult protection, or initiate an investigation of the incident.</p> <p>For over six months, from 5/31/12 until 12/29/12, the facility failed to protect Residents' #8, #9 and other unidentified residents from Resident #6's sexual assaults. This failure resulted in abuse.</p>	R 006			

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R 008  R 008	<p>Continued From page 6</p> <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: Based on record review and interview, it was determined the facility retained 3 of 3 sampled Residents (#4, #6 and #7) who were physically and verbally aggressive towards staff and other residents. The findings include:</p> <p>According to IDAPA 16.03.22.152.05.e, a resident will not be admitted or retained who is violent or a danger to himself or others.</p> <p>1. According to his records, Resident #7, was an 85 year-old male, admitted to the facility's memory unit on 3/26/13, with a diagnosis of Alzheimer's type dementia.</p> <p>Resident #7's April 2013 progress notes documented the following behaviors:</p> <p>*4/1 - The resident was "aggressive" with staff and was "disturbing" other residents when "up and down" all night. Staff found the resident's shower running with the hose outside the shower and water all over the bathroom. The resident was standing in his bathroom voiding on the floor and had bowel movement (BM) on his bottom, hands, legs and arms. While attempting to clean him up, the resident "became aggressive. He hit one staff member and grabbed another staff member's wrist and would not let go when asked."</p>	R 008  R 008	<p>Corrective actions for this specific incident are that two of the three residents are no longer living at the facility. The third resident has been seen and is currently under treatment by a mental health physician; behaviors are stable at this time.</p> <p>In order to identify other residents/personnel/ areas that may be affected by the same deficient practice there will be proper behavior documents utilized for any resident who exhibits aggressive/ inappropriate behaviors and /or is on psychotropic medications. Proper reporting will be done by the caregivers who observe such behaviors. The RN and/or facility administrator will then properly report to appropriate agencies (mental health, primary care provider, adult protection, etc.) and corrective interventions will be placed to ensure said resident(s) are free from harm to self and others. NSA will be updated accordingly and personnel will be notified of any changes that are to be implemented. Provide one on one 24 hours a day. If deemed necessary, said resident(s) will be given a 30 day notice and /or immediate notice and assistance will be provided to find different placement.</p> <p>Measures that are being put into place that will ensure the deficient practice does not recur:</p> <ul style="list-style-type: none"> <li>- Training is being scheduled for the carestaff on Alzheimer's/ dementia care. This training will be mandatory for all employees every six months and as deemed necessary.</li> <li>- Facility RN and Resident Service Coordinator will perform bi-weekly chart audits to monitor for any aggressive/inappropriate behaviors that may have been documented, but not reported to the correct authority or further investigated by RN and/or administrator.</li> <li>- The administrator will follow policies and procedures to assure that all residents are free from inadequate care.</li> <li>- Rental agreements will be updated to include families awareness that any aggressive/ inappropriate behaviors will lead to a 30 day and/ or immediate notice for other placement.</li> </ul>	

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R 008	Continued From page 7  *4/1 - The nurse and med tech took the resident to clean him up. The resident was resistive, hitting and kicking and another aide was called in to help. The resident continued to hit staff.  *4/18 - The resident had incontinent BM and urinated "all around" the bathroom. He was "resistive to changing pants and peri-care, twisting staff hands and fingers."  *4/22 - Staff reported the resident had been aggressive and "refusing cares this week as well as today." He had "hit, scratched, kicked, grabbed and thrown objects at staff." It took 4 to 5 staff members to change him.  *4/24 - At 2:00 PM, the resident was hitting, kicking and punching staff when trying to get him into the shower.  *4/28 - Resident #7 went into another resident's room, who was on comfort care. A family member requested he be removed from the room. When staff approached to remove him, the resident threw himself back onto the resident in her bed and proceeded to punch and kick the med tech. It took four staff members to escort the resident out of the room.  *4/29 - The incident on 4/28/13 was reported to the RN. When staff attempted to assist the resident out of the other resident's room, he became "verbally and physically aggressive towards staff." He "kicked" the med tech in the abdomen five times and punched the other staff members. "He was yelling and hitting staff." The other resident's daughter was very concerned about the safety of her mother and the safety of the staff. The RN spoke to the administrator	R 008	The corrective actions for this specific resident/ area have been taken care of as stated above; two of the three residents are no longer living at the facility. The third resident has been seen and is currently under treatment by a mental health physician; behaviors are stable at this time. Behavior monitors are being used to document any aggressive/inappropriate behaviors and appropriate reporting will be performed. The mandatory training, biweekly chart audits, and updated rental agreements will ensure that the deficient practice does not recur.  All corrected actions will be put in place before January 7, 2014.		

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R 008	<p>Continued From page 8</p> <p>about Resident #7's increased behaviors and the "need to find him placement in a behavioral unit."</p> <p>Resident #7's April 2013 "Behavior/mood symptom monitoring record" documented the resident resisted care; hit, kicked, yelled and cursed at staff eight times. Additionally, on 4/28/13 he kicked, punched, slapped staff, threw himself back on another resident.</p> <p>Resident #7's May 2013 progress notes documented the following behaviors:</p> <p>*5/1 - The resident went into another resident's room and laid on her bed. When staff attempted to get him up, he swung at them with a cane or tried to hit them with a closed fist. After "about 10 minutes," he moved to the other resident's bed in the room.</p> <p>*5/3 - After breakfast the resident "threw himself" on the ground. He was assisted off the ground by four staff members while he was "hitting, kicking and pinching."</p> <p>*5/7 - While staff were assisting resident with his bath, he became increasingly "aggressive, hitting, kicking, biting staff. He made a fist and drew it back in an attempt to punch a staff member." It took four staff members to get him dressed.</p> <p>*5/7 - (late entry for 5/6) - Resident was up and walking around most of the night shift. During rounds, the resident was found in another resident's room taking a female resident's shirt off. It took two staff to "get him out" of the room. Resident #7 "refused food/coffee. Not redirectable." The resident took his clothes off and sat in the main lobby</p>	R 008			

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R 008	Continued From page 9  *5/7 - At 9:00 PM, it took four people to "get" Resident #7 showered and shaved. He was "hitting, kicking and yelling..."  *5/10 - It was reported the resident was up all night, wandering, dressing and undressing. The resident refused to leave the dining room and climbed on top of the table to sleep. "Assist of 3 to remove" him from the table, "kicking and striking out."  *5/14 - The resident climbed onto his nightstand over the weekend and refused to get off. Staff attempted to get him down and he began "kicking and yelling." The family was called and explained the resident did not meet criteria to remain at the facility. "We are seeing self-inflicted injuries because of his refusals of cares and a decline in his physical health, mental and health and weight."  *5/20 - The resident was moving dressers around in his room in the dark. Had a small skin tear.  *5/21 - At 9:00 PM, the resident refused most cares and was hitting and kicking when being toileted.  *5/28 - Resident #7 "...refused all p.o. meds, c/o back pain but spit med for pain on the floor. Refused nebulizer tx, slapping it away x 3." The resident became "combative" when staff attempted to take him to the dining room.  *5/30 - The caregivers reported to the RN the resident was found with a skin tear on his right forearm.  Resident #7's May 2013 "Behavior/mood symptom monitoring record" documented the	R 008			

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R 008	<p>Continued From page 10</p> <p>resident was resistive to care, hit, punched, pinched, kicked, squeezed hands and was verbally aggressive towards staff. Further, the monitoring form documented the following:</p> <p>*5/1 - hitting staff with cane in another resident's room</p> <p>*5/2 - sat on a female resident's legs and refused to move, he had to be physically removed and he punched the caregiver in her arm</p> <p>Resident #7's June 2013 progress notes documented the following:</p> <p>*6/2 - The medication technician and another staff member were putting the resident in the shower due to having bowel movement. While in the shower the resident was "hitting, kicking" and attempting to bite the medication technician. When walking the resident out of the shower room, the resident threw himself to the ground.</p> <p>*6/3 - The caregivers reported to the RN the resident was found with a skin tear on his upper left arm. While attempting to clean and bandage the skin tear, the resident bit a staff member in the upper left arm, breaking the skin and leaving a large 2 inch bruise. When the resident bit the staff member, she brought her right arm over his head in an attempt to get him to let go of her arm. When she did this, she "accidentally hit him in the back of the head" with her hand. The resident was noted to have "several large bruises" to bilateral arms related to "combative behaviors."</p> <p>An incident report, dated 6/3/13, documented Resident #7 was found bleeding from his left shoulder. The staff attempted to put the resident to bed, but he was "very combative." He bit a caregiver on her arm and refused to go to bed.</p>	R 008		

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R 008	<p>Continued From page 11</p> <p>"The caregiver hit him on the top of his head."</p> <p>A progress note, dated 6/4/13, documented the RN applied the ABH gel to Resident #7 while he was sleeping. At 7:00 AM, a caregiver found the resident laying on the floor at the foot of his bed with injuries. The EMTs were called and as the RN attempted to dress the resident's skin tears, he became "combative, striking out, kicking, grabbing at staff." The resident was transported to the hospital.</p> <p>On 10/21/13 at 3:45 PM, a caregiver stated Resident #7 was a "tough one to do cares for." The caregiver stated the resident was "very, very strong" and would hit and bite. The caregiver stated the resident "constantly" had bruises from "smacking" the caregivers. Further, the caregiver stated it took no less than two people to do his cares.</p> <p>On 10/22/13 at 9:55 AM, the administrator stated she was aware of Resident #7's behaviors as they were working with the son to get him moved to another facility.</p> <p>On 10/22/13 at 3:00 PM, when asked about Residents #7's behaviors a caregiver responded, "sure that's nothing, we have to take it...it's ok to be a punching bag." She stated Resident #7 hit and punched caregivers and "sometimes" it took four people to escort him to his room.</p> <p>On 10/22/13 at 3:12 PM, a caregiver stated she did not have problems with Resident #7, but did see bruises on other staff members where he had hit them. She stated, Resident #7 had "defined" arm muscles.</p> <p>On 10/22/13 at 4:15 PM, a caregiver stated</p>	R 008		
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R 008	<p>Continued From page 12</p> <p>Resident #7 was "a hand full." The caregiver stated, it took three to four staff members to do anything for him. When asked about his behaviors, she stated, "Just about everything, he did it. He was a hard person to handle."</p> <p>Five days after being admitted to the memory unit until he was discharged three months later, Resident #7 exhibited physically aggressive behaviors such as hitting, biting, punching and kicking at staff. Although the facility was unable to manage Resident #7's behaviors, they continued to retain him at the facility. This placed the resident, other residents and staff members at risk for injury.</p> <p>2. According to his record, Resident #6 was an 82 year-old male who was admitted to the facility's memory unit, on 5/30/12, with diagnoses that included dementia.</p> <p>Progress notes from 7/21/12 through 11/28/12 documented the following behaviors:</p> <p>*7/21 - Resident #6 became very angry and yelled "You're a piece of shit!!" when staff attempted to redirect him.</p> <p>*8/14 - The resident was verbally aggressive and threatened physical harm towards others.</p> <p>*9/2 - The resident tried to hit a caregiver in the stomach.</p> <p>*9/18 - The resident was "angry and began yelling at another resident. He stated 'he is just a pile of shit.' He was also yelling at a female resident. He was sitting in the common area and was yelling at anyone who walked by him. He was yelling at residents across the room."</p>	R 008			

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R 008	Continued From page 13  *9/21 - The resident was "aggressive, yelling @ other residents, staff, cussing, & grabbed my rear end. Growling, took a swing at me."  *9/22 - The resident "smacked" another resident on the head.  *10/21 - The resident was "very aggressive," swearing at staff, "lashing out" and yelling at other residents. Staff were unable to redirect him, and he would growl and point his finger in their faces.  *11/3 - Resident #6's behaviors were "more violent" and he was "very resistive" to cares. Two people were now required to assist him with cares because he would "punch & kick and swear." Additionally, "no amount of affection has worked on him for 2 days. We are to [sic] scared to get him ready for bed for 1 person..." and "...any intervention has no affect on him."  *11/28 - Resident #6 had "increased aggressive resistance" to caregivers when they tried to provide cares. He was "easily irritated" and the recent increase in his behavioral modifying medication was not effective.  Resident #6's Novemeber 2012 "Behavior/mood symptom monitoring record" documented the resident was verbally and physically aggressive thirteen times. Further, it documented he hit, kicked, bit and spat at staff and had socially inappropriate behaviors.  A progress note, dated 12/15/12, documented Resident #6's "...new med change has no effect on him, still very aggressive & combative. We have tried all means of caregiving, being really nice doesn't work, he swears at staff, bites, head	R 008		

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R 008	<p>Continued From page 14</p> <p>butts, punches and kicks."</p> <p>Resident #6's December 2012 "Behavior/mood symptom monitoring record" documented the resident hit staff five times. Additionally, the monitoring record documented the following:</p> <p>12/4 - taking his clothing off in the common area 12/10 - took his "attends" off, urinated on a chair in the common area, and tried to hit a caregiver 12/14 - "beating us up" 12/15 - "beating us up" 12/27 - "head butting" and pinching 12/29 - trying to touch and undress male residents in the common area</p> <p>A progress note, dated 1/29/13, documented Resident #6 was "combative" and aggressive, hitting, pinching, kicking and biting caregivers.</p> <p>Resident #6's January 2013 "Behavior/mood symptom monitoring record" documented he was physically aggressive three times and was resistive to cares twice.</p> <p>A March 2013 "Behavior/mood symptom monitoring record" documented he hit, slapped, kicked, punched and squeezed caregivers hands. Further, the record documented the following behaviors:</p> <p>3/18 - grabbed a caregiver by the throat, then punched her in the throat 3/20 - hitting two female residents 3/30 - hitting with silverware</p> <p>There were no care notes or behavioral monitoring forms found in Resident #6's record for April regarding the resident's behaviors.</p>	R 008		

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R 008	Continued From page 15  A progress note, dated 5/20/13, documented Resident #6 was hitting and yelling at caregivers.  Resident #6's May 2013 "Behavior/mood symptom monitoring record" documented he slapped a resident on the arm, bit, hit and kicked staff.  Resident #6's June 2013 "Behavior/mood symptom monitoring record" documented he hit another resident. Further, he hit and bit caregivers.  A progress note, dated 6/18/13, documented Resident #6 had been transferred from the facility on 6/21/13, due to a decline in his physical condition.  The facility retained Resident #6 for four months, after he began hitting other residents and biting, punching, head-butting and kicking staff members numerous times. This placed Resident #6, the staff and other residents at risk for injury.  3. According to her record, Resident #4, was a 94 year-old female, admitted to the facility on 3/14/13, with a diagnosis of Alzheimer's dementia and was transferred to the memory unit on 7/14/13.  A "Quarterly Nursing Health Assessment" for Resident #4, dated 6/18/13, documented the resident had an increase in verbal and physical aggression.  A fax to the physician regarding Resident #4, dated 6/18/13, documented the resident was demonstrating increased confusion and aggression.	R 008		

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R 008	<p>Continued From page 16</p> <p>Resident #4's June 2013 progress notes documented the following:</p> <p>*6/17 at 3:00 PM - Staff found Resident #4 out in the parking lot. She was trying to get into the parked cars. When staff tried to redirect her, she became verbally aggressive and was swinging her cane.</p> <p>*6/19 at 11:30 AM - The resident was having hallucinations and delusions.</p> <p>*6/29 at 12:30 PM - Resident #4 was hitting staff with her cane. She was also trying to bite staff and was verbally aggressive towards them.</p> <p>Resident #4's June 2013 "Behavioral/mood symptom monitoring record," dated 6/29/13, documented the resident was hitting with a cane, pinching, biting, hitting and getting into vehicles in the parking lot.</p> <p>A "Behavior Management Plan" for Resident #4, dated 7/1/13, documented the resident had verbal aggression, physical aggression and refused cares.</p> <p>A Fax to Resident #4's physician, dated 7/11/13, documented the resident had increased confusion and was having verbal and physical aggression towards staff.</p> <p>Resident #4's July 2013 progress notes documented the following:</p> <p>*7/11 at 2:00 PM, the resident was outside trying to get into a truck. Four staff members attempted to re-direct her back inside. She refused to go in and was "verbally abusive" to staff. Further, she was " hitting, kicking, and stepping on staff toes."</p>	R 008		

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R 008	<p>Continued From page 17</p> <p>A staff member went and got a wheelchair. Two staff continued to stay with the resident and she "began hitting the staff with a cup." She was assisted to the wheelchair to be taken to the memory unit and was "hitting and kicking at staff."</p> <p>*7/12 at 2:30 PM - Four staff members assisted Resident #4 to the memory unit. She was "both physically &amp; verbally abusive" toward staff. She punched the RN in the right lower jaw. She further "kicked, scratched, pinched all four staff members."</p> <p>*7/14 at 1:00 PM - The resident became verbally aggressive. She attempted to hit three staff members when they tried to redirect her. She became "physically and verbally abusive" towards staff. The resident "kicked, hit, scratched, pinched, punched all staff." Additionally, she bit one staff on the arm.</p> <p>*7/14 at 6:00 PM - The resident told another resident he was being poisoned. Staff tried to redirect her, but she became verbally aggressive towards them. Additionally, the resident slapped a staff member.</p> <p>July 2013, "Incident Reports" for Resident #4 documented the following:</p> <p>*7/14 at 12:30 PM - The resident was disruptive at lunch. She began taking other residents' plates and telling them not to eat. Staff attempted to redirect her and she became verbally and physically aggressive. She was kicking, biting, scratching, pinching and punching staff. One staff was bit on the forearm, scratched and hit on the arms. Another staff was hit, scratched and kicked. The last staff member was scratched, pinched on the left hand and kicked in the legs.</p>	R 008		

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R 008	<p>Continued From page 18</p> <p>*7/14 at 6:30 PM - The resident became upset at dinner. She attempted to take a sandwich away from another resident. She told him the sandwich was poisoned. The resident became verbally and physically aggressive when staff tried to redirect her. The resident was removed from the dining room.</p> <p>An incident report, dated 7/15/13 at 12:15 PM, documented Resident #4 was being redirected by a caregiver. The resident punched the caregiver in her right shoulder. When she did this she fell over the arm of a chair. She refused to allow the RN to assess her.</p> <p>Resident #4's July 2013's progress notes documented the following:</p> <p>*7/17 at 10:30 AM - The resident "hit, kicked, punched, and pinched" staff. All staff members involved received some form of physical abuse from the resident.</p> <p>*7/17 at 11:30 AM - Staff tried to redirect the resident to her room when she was trying to push a wheelchair bound resident. "She refused to let go of the wheelchair and began spinning him around. She shoved the wheelchair bound resident into a lounge chair, hitting his shins and feet into the chair." Resident #4 was taken to her room by three staff members as she "hit, kicked, yelled, bit" and "punched" at them. She additionally, bent a caregiver's fingers back. The administrator was told about the incident.</p> <p>*7/17 at 12:15 PM - Staff walked with the resident to the dining room. The resident went towards another resident's chair, as she walked by the RN, she punched the RN. The administrator and</p>	R 008		

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R 008	<p>Continued From page 19</p> <p>family were notified.</p> <p>An incident report, dated 7/17/13 at 6:00 AM, documented, Resident #4 refused cares for three days. She punched the RN four times in her right forearm. The resident hit, kicked, slapped and pinched four caregivers. Additionally, Resident #4 pushed a wheelchair bound resident around when he did not want to be pushed.</p> <p>Resident #4's July's progress notes documented the following:</p> <p>*7/18 at 11:15 AM - The administrator spoke with a family member and issued a 30 day notice of intent to discharge the resident.</p> <p>*7/18 at 4:30 PM - The resident's physician's office requested Resident #4 be sent to a local hospital for a mental health evaluation.</p> <p>A "medical clinic note," dated 7/18/13, documented the Resident #4's family called the clinic to have the resident evaluated by mental health, because her behaviors "had changed" over the last month and she had become more "violent."</p> <p>A "History and Physical Report" for Resident #4 from a local emergency room, dated 7/18/13, documented the resident was seen for "behavioral problems." Resident #4 refused to go back to the facility because they "were keeping her a prisoner" in the memory unit. Eventually, the resident agreed to return to the facility.</p> <p>A fax to Resident #4's physician, dated 7/18/13, documented the resident had bruised several staff members and was also directing her aggression towards other residents.</p>	R 008		
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R 008	<p>Continued From page 20</p> <p>Resident #4's July's progress notes documented the following:</p> <p>*7/19 at 12:20 PM - The resident returned from the hospital and was very combative and resistive to cares.</p> <p>*7/19 at 5:00 PM - The resident tried to get other residents to assist her by "grabbing their hands or pushing their wheelchairs." Staff tried to intervene and the resident began hitting and kicking. She kicked one staff in the knee.</p> <p>*7/22 at 10:25 AM - Staff were leaving the unit and the resident tried to exit with them. When staff tried to redirect her back inside, the resident began hitting staff and grabbed one staff member's wrist which caused the staff member's bracelet to dig into her arm.</p> <p>An incident report, dated 7/22/13 10:25 AM, documented Resident #4 tried to exit the unit when a staff member left. When the resident was redirected, she hit the caregiver and grabbed the caregiver's wrist and caused the caregiver's bracelet to dig into her arm.</p> <p>A fax to Resident #4's physician, dated 7/23/13, documented the resident was having increased behaviors such as "biting, kicking, hitting, refusing care and not eating."</p> <p>A progress note, dated 7/26/13 at 4:45 PM, documented Resident #4 walked into another resident's room. Staff tried to redirect her, but she slapped the other resident. There were "no marks" on the other resident.</p> <p>On 8/5/13 at 2:30 PM, the RN documented in</p>	R 008		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13R588</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/22/2013</b>	
NAME OF PROVIDER OR SUPPLIER  <b>WEDGEWOOD TERRACE, PROVIDENT FOUNC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2114 VINEYARD AVENUE LEWISTON, ID 83501</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 008	<p>Continued From page 21</p> <p>Resident #4's progress notes the resident was placed on new medications and would not have to be discharged.</p> <p>On 10/22/13 at 9:55 AM, the administrator stated Resident #4 started going outside, getting into vehicles and was "too combative to live over there [assisted living side]" so she was moved to the memory care unit.</p> <p>On 10/22/13 at 2:35 PM, a caregiver stated Resident #4 hit, kicked, bit and slapped. It would take four caregivers to redirect her. She further stated, two caregivers placed the resident in a wheelchair using arm under arm and the other caregivers held her feet. The resident would kick and try to bite while doing this.</p> <p>On 10/22/13 at 3:00 PM, a caregiver stated Resident #4 hit and kicked caregivers. However "we would just have to take it."</p> <p>On 10/22/13 at 4:15 PM, another caregiver stated Resident #4 hit and kicked out at staff. She further stated, the resident exited the building and it took three to four caregivers to bring her back inside. Additionally, the caregiver stated they placed her in a wheelchair and two of the caregivers would hold her feet up while being transported to her room. She was placed in her room to "cool down."</p> <p>On 10/22/13 at 3:35 PM, the administrator stated she was aware of Resident #4's aggression towards staff and other residents. Additionally, the administrator stated the resident had kicked her once.</p> <p>Resident #4's behaviors increased in June 2013, so the facility moved the resident to the memory</p>	R 008		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13R588	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 10/22/2013
NAME OF PROVIDER OR SUPPLIER  WEDGEWOOD TERRACE, PROVIDENT FOUN		STREET ADDRESS, CITY, STATE, ZIP CODE 2114 VINEYARD AVENUE LEWISTON, ID 83501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 008	Continued From page 22  unit in July 2013. The resident continued to be both physically and verbally abusive towards staff and other residents.  The facility retained Resident #4 for five months, while she was hitting, kicking, biting and demonstrating other aggressive behaviors staff were not able to manage. This placed Resident #4, the staff and other residents at risk for injury.  The facility retained Residents #4, #6 and #7, who were a danger to themselves and others. All three residents had aggressive behaviors such as hitting, kicking, punching, pinching or head-butting which the staff were unable to manage. At times, they were also physically aggressive or threatening to other residents. This failure resulted in inadequate care.	R 008		



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

C.L. "BUTCH" OTTER -- GOVERNOR  
RICHARD M. ARMSTRONG -- DIRECTOR

TAMARA PRISOCK -- ADMINISTRATOR  
DIVISION OF LICENSING & CERTIFICATION  
JAMIE SIMPSON -- PROGRAM SUPERVISOR  
RESIDENTIAL ASSISTED LIVING FACILITY PROGRAM  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: 208-334-6626  
FAX: 208-364-1888

November 12, 2013

Jerry Bowlin, Administrator  
Wedgewood Terrace, Provident Foundation  
2114 Vineyard Avenue  
Lewiston, ID 83501

Dear Ms. Bowlin:

An unannounced, on-site complaint investigation survey was conducted at Wedgewood Terrace-Provident Resources Group, Inc between October 21, 2013 and October 22, 2013. During that time, observations, interviews or record reviews were conducted with the following results:

**Complaint # ID00006052**

**Allegation #1:** The facility retained residents who were a danger to themselves and others.

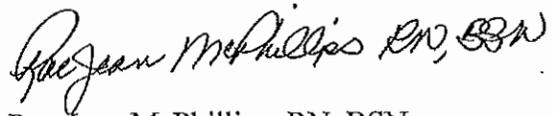
**Findings #1:** Substantiated. The facility was issued a core deficiency at IDAPA 16.03.22.520 for retaining residents who were a danger to themselves and others. The facility was required to submit a plan of correction within 10 days.

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

If you have questions or concerns regarding our visit, please call us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Jerry Bowlin, Administrator  
November 12, 2013  
Page 2 of 2

Sincerely,

A handwritten signature in cursive script that reads "Rae Jean McPhillips RN, BSN".

Rae Jean McPhillips, RN, BSN  
Health Facility Surveyor  
Residential Assisted Living Facility Program

RM/rm

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



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FAX: 208-364-1888

November 12, 2013

Jerry Bowlin, Administrator  
Wedgewood Terrace, Provident Foundation  
2114 Vineyard Avenue  
Lewiston, ID 83501

Dear Ms. Bowlin:

An unannounced, on-site complaint investigation survey was conducted at Wedgewood Terrace-Provident Resources Group, Inc between October 21, 2013 and October 22, 2013. During that time, observations, interviews, and record reviews were conducted with the following results:

**Complaint # ID00006069**

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

**Findings #1:** Unsubstantiated. Although the allegation may have occurred, it could not be determined during the complaint investigation.

**Allegation #2:** The facility staff were not trained to provide cares to residents with behaviors in the memory care unit.

**Findings #2:** Unsubstantiated. However, the facility was issued a core deficiency for retaining residents who had behaviors that were a danger to themselves and other residents. The facility was required to submit a plan of correction within 10 days.

**Allegation #3:** The facility inappropriately discharged residents.

**Findings #3:** Unsubstantiated.

Jerry Bowlin, Administrator

November 12, 2013

Page 2 of 2

As no deficiencies were cited as a result of our investigation, no response is necessary to this report. Thank you to you and your staff for the courtesies extended to us on our visit.

Sincerely,



Rae Jean McPhillips, RN, BSN

Health Facility Surveyor

Residential Assisted Living Facility Program

RM/rm

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



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November 12, 2013

Jerry Bowlin, Administrator  
Wedgewood Terrace, Provident Foundation  
2114 Vineyard Avenue  
Lewiston, ID 83501

Dear Ms. Bowlin:

An unannounced, on-site complaint investigation survey was conducted at Wedgewood Terrace-Provident Resources Group, Inc between October 21, 2013 and October 22, 2013. During that time, observations, interviews or record reviews were conducted with the following results:

**Complaint # ID00006170**

- Allegation #1:** Residents were not assessed by the facility nurse when they had a change in condition.
- Findings #1:** Unsubstantiated. Although the allegation may have occurred, it could not be determined during the complaint investigation.
- Allegation #2:** The facility did not report sexual abuse to adult protection or take adequate steps to protect residents from further abuse.
- Findings #2:** Substantiated. The facility was issued a core deficiency at IDAPA 16.03.22.510 for not reporting sexual abuse to adult protection and not implementing interventions to protect residents from sexual abuse. The facility was required to submit a plan of correction within 10 days.

Jerry Bowlin, Administrator  
November 12, 2013  
Page 2 of 2

Allegation #3: The facility retained residents who had behaviors they did not have the capacity to care for.

Findings #3: Substantiated. The facility was issued a core deficiency at IDAPA 16.03.22.520 for retaining residents who were a danger to themselves and others. The facility was required to submit a plan of correction within 10 days.

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

If you have questions or concerns regarding our visit, please call us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,



Rae Jean McPhillips, RN, BSN  
Health Facility Surveyor  
Residential Assisted Living Facility Program

RM/rm

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



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November 12, 2013

Jerry Bowlin, Administrator  
Wedgewood Terrace, Provident Foundation  
2114 Vineyard Avenue  
Lewiston, ID 83501

Dear Ms. Bowlin:

An unannounced, on-site complaint investigation survey was conducted at Wedgewood Terrace-Provident Resources Group, Inc from October 21, 2012 to October 22, 2013. During that time, observations, interviews, and record reviews were conducted with the following results:

**Complaint # ID00006182**

**Allegation #1:** The facility did not investigate a complaint regarding staff stealing residents' pain medications in July 2013.

**Findings #2:** Unsubstantiated. Although the allegation may have occurred, it could not be determined during the complaint investigation.

**Allegation #2:** The facility administrator did not investigate or respond to a resident's complaint regarding treatment by a caregiver.

**Findings #2:** Unsubstantiated. Although the allegation may have occurred, it could not be determined during the complaint investigation.

Jerry Bowlin, Administrator  
November 12, 2013  
Page 2 of 2

As no deficiencies were cited as a result of our investigation, no response is necessary to this report.  
Thank you to you and your staff for the courtesies extended to us on our visit.

Sincerely,



Rae Jean McPhillips, RN, BSN  
Health Facility Surveyor  
Residential Assisted Living Facility Program

RM/rm

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