



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 13, 2013

Rebecca Kohlwey, Administrator
Willows, The-Blackfoot Operations, LLC
898 South Meridian
Blackfoot, ID 83221

License #: RC-912

Dear Ms. Kohlwey:

On November 8, 2013, a Complaint Investigation was conducted at Willows, The-Blackfoot Operations, LLC. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level:

- Non-core issues, which are described on the Punch List, and for which you have submitted evidence of resolution.

Your submitted evidence of resolution 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 Donna Henscheid, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 364-1962.

Sincerely,

Donna Henscheid
Team Leader
Health Facility Surveyor

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



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P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: 208-334-6626
FAX: 208-364-1888

November 15, 2013

Rebecca Kohlwey, Administrator
The Willows, Blackfoot Operations, Llc
898 South Meridian
Blackfoot, ID 83221

Dear Ms. Kohlwey:

An unannounced, on-site complaint investigation survey was conducted at The Willows, Blackfoot Operations, LLC between November 4, 2013 and November 8, 2013. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00006172

- Allegation #1:** The facility did not schedule enough staff to supervise the residents.
- Findings #1:** Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.600.06 for the facility administrator not scheduling adequate staffing to ensure residents were supervised during the evening shifts. The facility was required to submit evidence of resolution within 30 days.
- Allegation #2:** Residents' incidents and accident were not investigated.
- Findings #2:** Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.350.02 for the administrator not conducting an investigation of all incidents. The facility was required to submit evidence of resolution within 30 days.
- Allegation #3:** The facility did not follow physician's orders regarding treatments for residents' whirlpools and physical therapy.
- Findings #3:** Unsubstantiated. Insufficient evidence was available at the time of the investigation to substantiate this allegation.
- Allegation #4:** The facility did not respond to complainants in writing.

Rebecca Kohlwey, Administrator
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Findings #4: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.350.04 for not providing a written response to complainants. The facility was required to submit evidence of resolution within 30 days

Allegation #5: The facility did not report all falls with injuries to Licensing and Certification.

Findings #5: Unsubstantiated. Insufficient evidence was available at the time of investigation to substantiate this allegation.

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 **November 8, 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) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,



Donna Henscheid
Health Facility Surveyor
Residential Assisted Living Facility Program

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



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November 15, 2013

Rebecca Kohlwey, Administrator
The Willows, Blackfoot Operations, LLC
898 South Meridian
Blackfoot, ID 83221

Dear Ms. Kohlwey:

An unannounced, on-site complaint investigation survey was conducted at The Willows, Blackfoot Operations, LLC between November 4, 2013 and November 8, 2013. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00006198

- Allegation #1:** The facility nurse did not assess residents when they had changes of condition.
- Findings #1:** Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.305.03 for the facility nurse not assessing residents when they had changes of condition. The facility was required to submit evidence of resolution within 30 days.
- Allegation #2:** Caregivers assisted residents with medications without physicians' orders.
- Findings #2:** Unsubstantiated. Insufficient evidence was available at the time of the investigation to substantiate this allegation.
- Allegation #3:** The facility did not follow physician's orders to obtain stool and blood samples.
- Findings #3:** Unsubstantiated. Insufficient evidence was available at the time of the investigation to substantiate this allegation.
- Allegation #4:** The facility did not follow the dietitian planned menu.
- Findings #4:** Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.451.01.d

for the facility not documenting substitutions made to the approved menu. The facility was required to submit evidence of resolution within 30 days.

Allegation #5: The facility cook touched ready-to-eat food with his bare hands.

Findings #5: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.450 for the cook not following the Idaho Food code when he touched ice cubes with his bare hands. The facility was required to submit evidence of resolution within 30 days.

Allegation #6: The facility did not practice proper infection control.

Findings #6: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.335.03 for not providing paper towels and liquid handsoap in residents' rooms to promote good infection control. The facility was required to submit evidence of resolution within 30 days.

Allegation #7: The facility did not assist residents with bathing.

Findings #7: Unsubstantiated. Insufficient evidence was available at the time of the investigation to substantiate this allegation.

Allegation #8: Call lights were not answered in a timely manner.

Findings #8: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.600.06 for the facility administrator not scheduling adequate staffing to ensure call lights were answered in a timely manner. The facility was required to submit evidence of resolution within 30 days.

Allegation #9: The facility was not maintained in a clean, safe and orderly manner.

Findings #9: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.260.06 for not maintaining the facility in a clean and orderly manner. The facility was required to submit evidence of resolution within 30 days.

Allegation #10: Staff did not document when they assisted with medications.

Findings #10: Unsubstantiated. Insufficient evidence was available at the time of the investigation to substantiate this allegation.

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 **November 8, 2013**. The completed punch list form and accompanying evidence of resolution (e.g., receipts, pictures, policy updates, etc) are to be

Rebecca Kohlwey, Administrator
November 15, 2013
Page 3 of 3

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) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,

A handwritten signature in cursive script that reads "Donna Henscheid".

Donna Henscheid
Health Facility Surveyor
Residential Assisted Living Facility Program

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



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November 15, 2013

Rebecca Kohlwey, Administrator
Willows, The-Blackfoot Operations, LLC
898 South Meridian
Blackfoot, ID 83221

Dear Ms. Kohlwey:

An unannounced, on-site complaint investigation survey was conducted at The Willows, Blackfoot Operations, LLC between November 4, 2013 and November 8, 2013. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00006225

- Allegation #1:** There was not sufficient staff scheduled to ensure call lights were answered in a timely manner.
- Findings #1:** Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.600.06 for the facility administrator not scheduling adequate staffing to ensure call lights were answered in a timely manner. The facility was required to submit evidence of resolution within 30 days.
- Allegation #2:** Staff did not protect residents' private information.
- Findings #2:** Substantiated. However, not cited as the facility identified the problem prior to the complaint investigation and had conducted training with staff on 10/25/13, regarding the importance of not discussing resident information at the front desk and in front of others. Further, the administrator and the resident care coordinator stated they provided on-going coaching to staff, if they were heard openly discussing resident information.

- Allegation #3: Staff did not treat residents with dignity and respect.
- Findings #3: Unsubstantiated. Insufficient evidence was available at the time of the investigation to substantiate this allegation.
- Allegation #4: The food was inedible.
- Findings #4: Unsubstantiated. Insufficient evidence was available at the time of the investigation to substantiate this allegation.
- Allegation #5: Staff did not respond to resident to resident altercations in an appropriate manner.
- Findings #5: Unsubstantiated. Insufficient evidence was available at the time of the investigation to substantiate this allegation.
- Allegation #6: The facility retained residents who are not compatible with others.
- Findings #6: Unsubstantiated. Insufficient evidence was available at the time of the investigation to substantiate this allegation.
- Allegation #7: The facility nurse was not available to address residents' medical concerns.
- Findings #7: Unsubstantiated. Insufficient evidence was available at the time of the investigation to substantiate this allegation.
- Allegation #8: The administrator did not respond to complainants in writing.
- Findings #8: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.350.04 for not providing a written response to complainants. The facility was required to submit evidence of resolution within 30 days.
- Allegation #9: Staff were not trained to provide care to the residents.
- Findings #9: Unsubstantiated. Insufficient evidence was available at the time of the investigation to substantiate this allegation.
- Allegation #10: The facility was not maintained in a clean and sanitary manner.

Rebecca Kohlwey, Administrator
November 15, 2013
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Findings #10: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.260.06 for not maintaining the facility in a clean and orderly manner. The facility was required to submit evidence of resolution within 30 days.

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 **November 8, 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) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,



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

DH/rm

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

Facility WILLOWS, THE - BLACKFOOT OPERATIONS, LLC	License # RC-912	Physical Address 898 SOUTH MERIDIAN	Phone Number (208) 782-1478
Administrator Rebecca Kohlewey	City BLACKFOOT	ZIP Code 83221	Survey Date November 8, 2013
Survey Team Leader Donna Henscheid	Survey Type Complaint Investigation and Follow-up	RESPONSE DUE: December 8, 2013	
Administrator Signature <i>Rebecca J Kohlewey</i>	Date Signed 11-8-13		

NON-CORE ISSUES

Item #	IDAPA Rule # 16.03.22.	Description	Department Use Only	
			EOR Accepted	Initials
1	152.05.b.iii	Four residents had rails attached to their beds.	12/9/13	DH
2	250.13.L	There were no dividers to separate residents' clothing in shared closets. **Previously cited 5/11/11**	12/9/13	DH
3	260.06	The facility was not maintained in a clean and orderly manner. For example: Environment - Several rooms had strong urine odors. The carpets were dirty, spotted or littered with debris in residents' rooms and common areas. Room #8 had several bottles of unknown substances on the floor and the room was cluttered and dirty. The kitchen walk-in cooler had blood on the floor. The kitchen floors, cabinets, shelves, stove, and can opener were dirty and covered with a film. Maintenance - There was wallpaper ripped off the wall in the hallways. Window blinds had missing or broken slats. Heating units in residents' rooms had broken vents. In one room the heating unit was missing and the hole was partially covered with cardboard. There were holes in closet doors and paint chipped in several rooms and throughout the facility. Soap dispensers were broken. A phone jack was hanging off the wall in the unit. A drawer was missing in the cabinet in the unit. The carpet was frayed, worn and buckled throughout the facility. Several rooms had missing outlet covers. **Previously cited 5/11/11**	1/16/14 error DH 12/9/13	DH DH
4	305.03	The facility nurse did not document an assessment had been conducted when residents' had changes of condition. For example: Resident #1 and #2's pressure ulcers and Resident #3's swollen legs.	12/13/13	DH
5	305.06	Resident #3 was not assessed by the facility nurse to self-administer medications. **Previously cited on 5/11/11**	12/13/13	DH
6	335.03	The facility did not provide paper towels and liquid handsoap in residents' rooms. **Previously cited on 5/11/11**	12/9/13	DH
7	350.02	The administrator did not document an investigation was conducted on all incidents.	12/13/13	DH
8	350.04	There was no evidence the administrator provided written responses to complainants.	12/13/13	DH
9	405.05	The ice machine was not clean and was leaking. The walk-in seals around the doors in both the freezer and refrigerator units were defective. Icicles were hanging from the pipes of the freezer unit and had dripped down into the food.	12/9/13	DH
10	450	The cook did not follow the Idaho Food Code when he touched ice cubes with his bare hands and placed ice out for public use without a scoop.	12/13/13	DH

