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

February 19, 2015

Ginger Price, Administrator
Malad Living Center/RCF
151 West 200 North
Malad, Idaho 83252

Provider ID: RC-463

Ms. Price:

On November 24, 2014, a state licensure/follow-up survey was conducted at Malad Living Center/RCF. 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 **(With the exception of 260.06 - Facility maintenance - Soffit and trim outside required repair and paint)** are being accepted by this office. Please ensure the corrections you identified are implemented for all residents and situations, and implement a monitoring system to make certain the deficient practices do not recur.

Thank you for your work to correct these deficiencies. Should you have questions, please contact Gloria Keathley, LSW, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 364-1962.

Sincerely,

GLORIA KEATHLEY, LSW
Team Leader
Health Facility Surveyor

GK/sc

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

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November 30, 2014

CERTIFIED MAIL #: 7007 3020 0001 4050 8647

Ginger Price
Malad Living Center/RCF
151 West 200 North
Malad, Idaho 83252

Provider ID: RC-463

Ms. Price:

Based on the state licensure/follow-up survey conducted by Department staff at Malad Living Center/RCF between November 20, 2014 and November 24, 2014, it has been determined that the facility failed to protect residents from abuse.

This core issue deficiency substantially limits the capacity of Malad Living Center/RCF 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 **January 8, 2015.** **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 **December 13, 2014,** and keep a copy for your records. Your license depends upon the corrections made and the evaluation of the Plan of Correction you develop.

Pursuant to IDAPA 16.03.22.003.02, you have available the opportunity to question the core issue deficiency through an informal dispute resolution process. If you disagree with the survey report findings, you may make a written request to the Supervisor of the Residential Assisted Living Facility Program for an IDR meeting. The request for the meeting must be in writing and must be made within ten (10) business days of receipt of the Statement of Deficiencies. The facility's request must include sufficient information for Licensing and Certification to determine the basis for the provider's appeal, including reference to the specific deficiency to be reconsidered and the basis for the reconsideration request. If your request for informal dispute resolution is received more than ten (10) days after you receive the Statement of Deficiencies, your request will not be granted. Your IDR request must be made in accordance with the Informal Dispute Resolution Process. The IDR request form and the process for submitting a complete request can be found at *www.assistedliving.dhw.idaho.gov* under the heading of Forms and Information.

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. Your evidence of resolution (e.g., receipts, pictures, policy updates, etc.) for each of the non-core issue deficiencies is to be submitted to this office by **December 24, 2014**.

Four (4) of the eighteen (18) non-core deficiencies cited were identified as repeat punches. Please be aware, any non-core deficiency which is identified on three consecutive surveys will result in a civil monetary penalty.

Also, be aware that any variance allowing the administrator to serve over other facilities is revoked as of the date of the exit conference. The facility must now employ a single, licensed administrator who is not serving as administrator over any other facilities. Failure to do so within thirty (30) days of the date of the exit conference will result in a core issue deficiency.

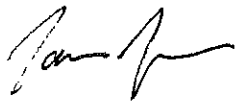
If, at the follow-up survey, the core deficiency still exists or a new core deficiency is identified, or if any of the repeat non-core punches are identified as still out of compliance, the Department will have no alternative but to initiate an enforcement action against the license held by Malad Living Center/rcf.

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) 364-1962 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, MBA, QMRP
Program Supervisor
Residential Assisted Living Facility Program

JS/sc

Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	13R463		11/24/2014

NAME OF PROVIDER OR SUPPLIER: MALAD LIVING CENTER/RCF

STREET ADDRESS, CITY, STATE, ZIP CODE: 151 WEST 200 NORTH, MALAD, ID 83252

(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	Initial Comments The following deficiency was cited during the licensure survey conducted between 11/20/14 and 11/24/14 at your residential care/assisted living facility. The surveyors conducting the survey were: Gloria Keathley, LSW Team Coordinator Health Facility Surveyor Donna Henscheid, LSW Health Facility Surveyor Rae Jean McPhillips, RN, BSN Health Facility Surveyor Karen Anderson, RN Health Facility Surveyor	R 000	Corrective Action for Malad Living Center Regarding these rules: IDAPA 16.03.22.510 Corrective Action for Malad Living Center Regarding these rules: IDAPA 16.03.22.510 Protect Residents from Abuse What corrective action will be accomplished for those specific areas found to have been affected by the deficient practice? **The administrator will ensure that if there is any complaints/incidents of any kind regarding staff To resident altercation a thorough investigation will be completed** **Policy and procedures reviewed and revised to increase personal hiring process screening.** **Employee Training on abuse policy and resident Complaints** **All employees are trained to encourage all residents to complete a complaint forms to the Administrator so an investigation can be done**	
R 006	16.03.22.510 Protect Residents from Abuse. The administrator must assure that policies and procedures are implemented to assure that all residents are free from abuse. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to protect 4 of 8 sampled residents (#1, #3, #7 and #8) from physical and verbal abuse. The findings include: IDAPA 16.02.33.510 documents, "The administrator must assure that policies and procedures are implemented to assure that all residents are free from abuse." The facility's abuse policy documented, "If there is any reason to believe abuse to any resident	R 006		

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Chuci TITLE administratu (X6) DATE Submitted 12/22/14 1/13/15

Residential Care/Assisted Living

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R 006	Continued From page 1 caused by an employee(s), that empolyee(s) will be on an unpaid suspension until there is a full investigation completed. It is the policy of Malad Assisted Living Center to be as fair as possible in all matters. All decisions regarding staff and consumers will be made considering the residents as top priority." *According to his employment record, Caregiver A worked at the Malad Living Center from 4/16/14 until 9/6/14. 1. According to his records, Resident #8 was a 31 year old male, admitted to the facility on 5/27/14, with a diagnosis of an anxiety disorder. A "Complaint Form," dated 7/10/14, documented Resident #8 approached Caregiver A with a concern and Caregiver A used "very uncalled for langage [sic] and told me to get the f*** out of the kitchen." It further documented, Caregiver A "pulled" Resident #8 into the hall and yelled at him, "When I tell you to get the f*** out of my kitchen, then you get the f*** out of my kitchen." The complaint also documented the names of four residents who heard the verbal altercation. It further documented, the resident "exaggerated" the incident and the employee would be warned. There was no further documentation regarding this incident. The as-worked schedule for July 2014, documented Caregiver A was not suspended from work. Further, there was no documentation an investigation had been conducted to include interviews with the four other residents or employees. On 11/20/14 at 4:35 PM, a resident stated, Resident #8 went up to Caregiver A to request a	R 006	How will you identify other residents/personnel/areas that may be affected by the same deficient practices and what corrective action(s) will be taken **I will ensure that all complaints of staff verbal emotion and physical abuse are investigated and more thoroughly documented while staff is on temporary suspension.** What measures will be put into place or what systemic changes will you make to ensure that deficient practice does not recur? **More thorough reference checks and interview. Administrator will speak to the residents on a day to day basis to insure staff are treating them with respect and dignity** **The facility will document all warnings verbal and written in the employee file And maintain more thorough investigation**	

Residential Care/Assisted Living

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R 006	Continued From page 2	R 006		
	medication. He stated, Caregiver A yelled at Resident #8 that he was too busy to help him. He stated Resident #8 started to walk away when Caregiver A "grabbed" him. He stated Caregiver A was an "a**h***" when he was doing medications and did not like being interrupted. On 11/20/14 at 4:55 PM, a current caregiver stated he had never witnessed Caregiver A be verbally abusive to residents, but stated five different residents, including Resident #8, complained to him about Caregiver A's behaviors. The caregiver stated he notified the administrator of the residents' concerns about Caregiver A prior to the incident when Caregiver A was fired. On 11/20/14 at 2:33 PM, the administrator stated, Resident #8's parole officer and a staff member from a mental health counseling clinic, investigated the incident and felt the resident was exaggerating about Caregiver A. The administrator stated she had no further documentation regarding the incident. On 11/20/14 at 5:38 PM, the administrator stated the current caregiver had talked to her about Caregiver A, but she could not recall what she was told. On 11/24/14, at 10:25 AM, the administrator stated, Resident #8 "threw" his complaint under the office door. She stated, the mental health counselor told Resident #8's parole officer about it. The administrator stated, Resident #8 reported "a lot of false stuff." She confirmed she had not talked to other residents about this incident nor had she conducted an investigation. 2. Resident #3's record documented she was a 59 year-old female admitted to the facility on		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) **Upon application and hiring process New employment hire checklist will be implemented and completed.** By what date will the corrective actions be completed? **12/22/2014**	

Residential Care/Assisted Living

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R 006	Continued From page 3 12/2/13 with diagnoses including schizophrenia. On 11/20/14 at 4:25 PM, Resident #3 stated she had a verbal and physical altercation with Caregiver A sometime in August. She stated, she had asked him for a medication and he started to yell at her. She stated, when she turned to walk away from him, he followed her down the hallway yelling, "Don't you walk away from me!" She stated, when she continued to walk away, Caregiver A "grabbed her arm and swung her around." She stated Caregiver A said, "I don't care what they teach you at [name of mental health clinic], I don't give a damn!" She stated, she reported the altercation to her mental health counselor and parole officer, who called the facility and discussed it with the administrator. She stated her parole officer told her to avoid Caregiver A. On 11/24/14 at 9:57 AM, Resident #3's parole officer confirmed Resident #3 reported a verbal and physical altercation with Caregiver A on 8/5/14. He stated he called the facility administrator and Caregiver A to discuss the incident. He stated Caregiver A's story was different from Resident #3's. He said Caregiver A "seemed believable, he was apologetic about it." He stated, he told Resident #3 to stay away from Caregiver A and "don't cause problems." He stated he had not talked to any other residents to prove or disprove Resident #3's version of the altercation. On 11/24/14 at 10:28 AM, the administrator stated she spoke to Resident #3's parole officer, the mental health counselor and another employee about the incident. The administrator confirmed she had not suspended Caregiver A, had not interviewed other residents or conducted	R 006		

Residential Care/Assisted Living

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R 006	Continued From page 4 an investigation. The administrator stated, the residents "all hated" Caregiver A. She stated, "He was authoritative and not sweet like the other girls." 3. According to Resident #1's record, she was a 61 year old female, admitted to the facility on 8/13/14 with a diagnosis of developmental disability. A handwritten resident statement, dated 9/6/14, documented Resident #1 reported Caregiver A yelled at her when she asked for a cigarette at 3:00 PM. It documented Resident #1 was told by Caregiver A she could not have a cigarette until 4:30 PM. The statement documented Resident #1 began to cry and Caregiver A told her to "Shut the f*** up" or he would write her up for crying. The letter further documented, Resident #1 told Caregiver A that she had some sores on her back and wanted him to look at them. Caregiver A told her "no" and yelled at Resident #1 again and said, "go to bed and stop that crying." There was no further documentation at the facility regarding this incident. On 11/20/14 at 3:30 PM, a current caregiver stated he was aware of the incident that occurred between Caregiver A and Resident #1, but did not think too much about the interaction because Resident #1 had a behavior of crying. On 11/20/14 at 4:20 PM, Resident #1 stated, Caregiver A "was horrible and yelled at all the residents." She stated, "If I cried, [Caregiver A's name] would yell at me and tell me he was going to write me up for crying." On 11/20/14 at 5:38 PM, the administrator stated	R 006		

Residential Care/Assisted Living

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R 006	Continued From page 5 she did not follow-up on the incident, because she knew Resident #1 had a behavior of crying. 4. According to Resident #7's record, she was a 48 year old female, admitted to the facility on 8/13/14 with a diagnosis of mental illness. On 11/20/14 at 4:52 AM, Resident #7 stated, she had asked Caregiver A to not yell at her and "he wouldn't listen" and continued to yell back. Resident #7 stated, Caregiver A yelled at her to "hit me, hit me, I know you want to hit me you prison thug." Resident #7 stated she tried to get out of the kitchen to get to a phone to call for help, but Caregiver A would not let her get past him. She stated, Caregiver A "pushed" her, she fell and banged her head against the wall in the dishwashing area. Resident #7 stated, Caregiver A told her, if she called for help, he would say the incident was her fault and she would be taken back to prison. She stated, Caregiver A threatened other residents by telling them they would go back to jail if they told anyone. Resident #7 stated there was another incident where Caregiver A grabbed a male resident by his arm. "This was not the first time" Caregiver A "grabbed residents." She stated, Caregiver A knew he had control over the residents and he "could get away with yelling profanities, grabbing and pushing us around." He threatened to call the parole officer and tell him "we broke our parole agreement, so we would go back to jail." Written statements by residents for the Sheriff's department, dated 9/6/14, documented the following regarding the altercation between Resident #7 and Caregiver A: *Caregiver A "got in my face and started yelling. I told him to get out of my face and quit	R 006		

Residential Care/Assisted Living

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R 006	Continued From page 6 yelling....He started to push me a [sic] told him I will call Tanya and Dr. Patty or Ginger." Caregiver A told Resident #7 to go wash her plate and then "trapped" her in the "dish pit, calling her a "F*** Bitch." When the resident tried to get by Caregiver A, he pushed her back and she hit her head on the door to the dishwashing room. *"...I heard [Caregiver A's name] start yelling at [Resident #7's name]. It escalated quickly. He told her to, 'hit me, hit me' and continued yelling." Resident #7 went into the dish room and Caregiver A followed her "still yelling." Caregiver A blocked her in the dish area and when Resident #7 tried to get past him, he "made her bump her head on the door frame." After Resident #7 got past Caregiver A, she went to grab a phone to call 911. Caregiver A was "still yelling, wouldn't let the call go through..." *Resident #7 was getting yelled at by Caregiver A for not rinsing her plate off. When she was on her way to do so, Caregiver A "got into her face." Resident #7 said to Caregiver A "you need to get out of my face." Caregiver A kept "getting closer yelling at her, calling her a 'punk bitch, Just hit me, come on hit me already. Big bad prison thug wants to hit me.' [Caregiver A's name] then cornered her in the dish room" and Caregiver A "pushed her and her head had hit the wall." *Caregiver A "kept yelling" and asked her, "What do you think you are, some prisson [sic] thug?" *Caregiver A "yelled at her for not cleaning her dish...called her a stuped [sic] bitch." Caregiver A was "scaring me cause he was yelling, 'hit me, you stuped [sic] dum [sic] bitch." Caregiver A told Resident #7 to give him the phone stating, 'Your [sic] not calling anybody'..."	R 006		

Residential Care/Assisted Living

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R 006	Continued From page 7 On 11/20/14 at 4:35 PM, a resident stated Caregiver A came up to Resident #7 and yelled, "give me the phone." He stated Resident #7 refused to give the phone to Caregiver A and attempted to get up off the couch. He stated Caregiver A "pushed" Resident #7 back down onto the couch. He said Resident #7 got off the couch and went into the kitchen, where Caregiver A "pinned" her in. He stated when Resident #7 was attempting to leave the kitchen, Caregiver A "hipped" her causing her to strike her head. He stated Resident #7 was able to call the police who came to the facility and stopped the altercation. On 11/20/14 at 5:15 PM, a resident stated she witnessed Caregiver A "verbally abuse" Resident #7. She stated Caregiver A was "up in" Resident #7's face, screaming, "Hit me, I know you want to hit me." The resident further stated, Caregiver A "blocked" Resident #7 in the kitchen, he "pushed" her and Resident #7 "hit her head against the wall." On 11/20/14 at 5:00 PM, Resident #7 stated after Caregiver A was fired he came back to the facility one day because he wanted to apologize and wanted his job back. The resident stated, the administrator asked her how she felt about Caregiver A coming back to work. She stated, "I told Ginger that it was not my decision to make, but if she was asking for my opinion, I would say no!" On 11/20/14 at 5:35 PM, the administrator stated when she arrived at the facility, Caregiver A was told to leave. She stated, she had not previously interviewed residents about Caregiver A, but realized the night of this incident, she should have. Further, the administrator confirmed	R 006		

Residential Care/Assisted Living

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R 006	Continued From page 8 Caregiver A came back to the facility to "apologize" to Resident #7, but she said she told staff to get him out of there. On 11/20/14, between 4:00 PM and 6:30 PM, during interviews, residents stated the following regarding Caregiver A's overall behaviors: *Caregiver A had "grabbed" at least 5 residents that he knew of. *Caregiver A was nice to her, but yelled at the other residents a lot. *Caregiver A was "mean to residents!" She stated, he was "nice to me, but he made me feel like a bar slut." She stated she felt uncomfortable about some of the questions he asked her. She stated, when Caregiver A asked her "weird questions" she replied, "Why are you asking me this stuff? You have a girlfriend." She further stated, "His comments made me feel like he was hitting on me." *Caregiver A "yelled at me because I locked the door to our room." She stated she and her roommate told Caregiver A they wanted the door locked because there had been some problems with theft. Caregiver A told the residents to unlock the door and yelled, "I don't give a f***, I told you not to lock your bedroom door." *Caregiver A was "fair to some, but a dick to others. He was fair to guys, but hated the girls." He stated Caregiver A swore "a lot" and was "angry all the time." Further, he stated, Caregiver A hated to cook and if the residents did not wash off their dishes properly, he yelled at them like they were "f***in kids." He stated he told a current caregiver about Caregiver A's behaviors prior to	R 006		

Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	13R463		11/24/2014

NAME OF PROVIDER OR SUPPLIER
MALAD LIVING CENTER/RCF

STREET ADDRESS, CITY, STATE, ZIP CODE
151 WEST 200 NORTH
MALAD, ID 83252

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 006	Continued From page 9 the incident with Resident #7. *Caregiver A "was abusive to everyone here, screaming at us." The resident stated, he had a manner of correcting people that was not professional, "yelling at us for not rinsing out dishes. He used the f-word. He screamed at me for locking my door." *Caregiver A "didn't have much patience and was pretty rude to people." The resident stated, Caregiver A would "lash out" at the residents, especially during medication pass. He stated Caregiver A would yell, "I ain't got f***ing time for this." The resident said, "I think he was hired for a job he didn't like. I talked to [current caregiver's name] about him. A lot of people acknowledged problems with Caregiver A before the incident with Resident #7. *Caregiver A would "get very upset," especially when handing out medications. She stated Caregiver A "verbally pushed" people around and had a "hard time with some people, but not me." Caregiver A was "normally just angry. Too many people for him to take care of. Meals were hard for him. He didn't like working here." On 11/20/14 at 5:30 PM, the administrator stated "[Caregiver A's name] had me fooled. I thought he was doing a good job because he followed the rules and was firm with the residents." She stated Caregiver A had a "loud boisterous voice that could sound abrasive," but she did not think think he was being abusive. The administrator stated, "I told him a few times about his behavior with residents." The administrator stated she "couldn't remember" if she had reported any of the allegations of abuse to Adult Protection.	R 006		

Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	13R463		11/24/2014

NAME OF PROVIDER OR SUPPLIER
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STREET ADDRESS, CITY, STATE, ZIP CODE
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R 006	Continued From page 10 In July Resident #8 reported Caregiver A had been verbally abusive to him. In July, Resident #3 reported verbal and physical abuse by the same caregiver. After both reports, the administrator failed to suspend Caregiver A as outlined in the facility's policy, failed to report to Adult Protection and failed to conduct an investigation. On 9/6/14, Resident #1 filed a report of verbal abuse by Caregiver A with her mental health counseling center. Later the same day, there was a verbal and physical altercation between Caregiver A and Resident #7. For over two months, the facility failed to protect Residents #1, #3, #7 and #8 from physical and verbal abuse.	R 006		

IDAHO DEPARTMENT OF HEALTH & WELFARE

DIVISION OF LICENSING & CERTIFICATION
P.O. Box 83720
Boise, ID 83720-0036
(208) 364-1962 Fax: (208) 364-1888

ASSISTED LIVING
Non-Core Issues Punch List

Facility	License #	Physical Address		Phone Number
MALAD LIVING CENTER/RCF	RC-463	151 WEST 200 NORTH		(208) 766-4724
Administrator	**City**		**ZIP Code**	**Survey Date**
Ginger Price	MALAD		83252	November 24, 2014
Survey Team Leader	**Survey Type**			**RESPONSE DUE:**
Gloria Keathley	Licensure and Follow-up			December 24, 2014
Administrator Signature	**Date Signed**			

NON-CORE ISSUES

Item #	IDAPA Rule # 16.03.22.	Description	Department Use Only: EOR Accepted	Initials
1	152.05.d	There were residents admitted and retained who were not compatible with other residents.	2-17-15	[illegible]
2	153.01	The facility's abuse policy did not correctly reflect when to call Adult Protection.	1-12-15	[illegible]
3	225	The facility did not develop behavior management plans for residents with behaviors. **Previously cited 3/30/11**	2-17-15	[illegible]
4	225.02	The facility did not develop interventions specific to residents' behaviors.	2-17-15	[illegible]
5	260.06	The facility was not maintained in a clean, safe and orderly manner. For example: There were closet doors missing or off the track, curtain rods and blinds were broken, curtains were worn and torn, walls were gouged and had paint chipped off, window screens were bent, the carpet was dirty and worn throughout the building, pillow cases were dirty and thread-bare, there were urine odors in some rooms, wallpaper was torn by the sink in a room, outside gutters were full of leaves, cords were hanging from the roof, there was a bedframe and other debris outside the building, the soffit and trim outside required repair and paint, light bulbs were burned out, lighting was poor in the shared bathroom, a vent in a bathroom was not working and the dining room light cover was missing. **Previously cited on 3/30/11**	exceed soffit 2-17-15	[illegible]
6	305.03	There was no documentation the facility nurse assessed residents after they had changes of condition. For example following hospital stays and injuries requiring stitches. Further, the facility nurse did not document on the status of a resident's wounds.	2-17-15	[illegible]
7	310.01.f	The caregiver did not watch a resident take his medication.	1-12-15	[illegible]
8	320.01	Resident #1 did not have a developed NSA since her admission on 8/13/14.	2-17-15	[illegible]
9	335.03	Not all bathrooms had paper towels and hand soap available.	2-17-15	[illegible]
10	350.02	The administrator did not conduct thorough investigation for all incidents, accidents and complaints and provide a written report of the findings within 30 days. **Previously cited on 3/30/11.**	2-17-15	[illegible]
11	625	Six of seven staff did not have documented evidence of orientation training, to include infection control.	2-17-15	[illegible]
12	630.02	Six of seven staff did not have documentation of mental illness training.	2-17-15	[illegible]
13	630.03	Six of seven staff did not have documentation of developmental disability training.	2-17-15	[illegible]
14	630.04	Six of seven staff did not have documentation of traumatic brain injury training.	2-17-15	[illegible]
15	711.01	The facility did not track residents' behaviors to include the behavior exhibited, the intervention used and the effectiveness of the intervention.	2-17-15	[illegible]

IDAHO DEPARTMENT OF HEALTH & WELFARE

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ASSISTED LIVING
Non-Core Issues Punch List

Facility	License #	Physical Address		Phone Number
MALAD LIVING CENTER/RCF	RC-463	151 WEST 200 NORTH		(208) 766-4724
Administrator	**City**		**ZIP Code**	**Survey Date**
Ginger Price	MALAD		83252	November 24, 2014
Survey Team Leader	**Survey Type**			**RESPONSE DUE:**
Gloria Keathley	Licensure and Follow-up			December 24, 2014
Administrator Signature	**Date Signed**			

NON-CORE ISSUES

Item #	IDAPA Rule # 16.03.22.	Description	Department Use Only: EOR Accepted	Department Use Only: Initials
16	711.08	Caregivers did not document the care they provided to residents.	1-12-15	[illegible]
17	711.08.c	Unusual events were not documented. For example: seizures, altercations, wounds, etc.	1-25-15	[illegible]
18	711.08.e	There was no documentation the facility nurse was notified of residents' changes of condition.	2-17-15	[illegible]
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Date 11-24-14 Page 2 of 2

IDAHO DEPARTMENT OF HEALTH & WELFARE

Food Establishment Inspection Report

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

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

Establishment Name: Malad Living	Operator: Ginger Bailey
Address: 151 West 200 North	Malad 83252
County: Oneida Estab #: EHS/SUR #: 20828	Inspection time: Travel time:
Inspection Type: Risk Category: High	Follow-Up Report: Date: OR On-Site Follow-Up: Date:

Items marked are violations of Idaho's Food Code, IDAPA 16.02.19, and require correction as noted.

RISK FACTORS AND INTERVENTIONS (*Idaho Food Code* applicable sections in parentheses)

The letter to the left of each item indicates that item's status at the inspection.

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

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

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

Item/Location	Temp	Item/Location	Temp	Item/Location	Temp	Item/Location	Temp
Cheesy Potato	38.5	Fish Sticks	170°	Green beans	175°		
		Cheesy Potato	180°				

GOOD RETAIL PRACTICES (☒ = not in compliance)

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

OBSERVATIONS AND CORRECTIVE ACTIONS (CONTINUED ON NEXT PAGE)

Person in Charge (Signature) Ginger (Print) Ginger Price Title Admin Date 11/24/14

Inspector (Signature) Karen Anderson (Print) KAREN Anderson Date 11/24/14

Follow-up: (Circle One) Yes No

IDAHO DEPARTMENT OF HEALTH & WELFARE

Food Establishment Inspection Report

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

Date 11-24-14

Establishment Name	Operator
Malad Living Center	Ginger Bailey
Address: 151 W. 200 North	Malad 83252
County Estab # / EHS/SUR.# 20828	License Permit #

OBSERVATIONS AND CORRECTIVE ACTIONS (Continuation Sheet)

#6: A Kitchen Staff member prepared and served food and did not wash her hands after touching the lid to the trash can.

COS: Education provided to all staff who work in the kitchen the need to wash their hands each time they remove the garbage can lid and then prepare or served food, or to leave the lid off the trash can while prepping, plating and serving food.

#15: Kitchen staff were not aware of proper cooking time and food temperatures.
COS: Staff provided education and given a guide on proper cooking temperatures to help avoid food borne illness.

#16: Kitchen staff were not aware of proper temperature when reheating food.
COS: Staff were provided education for re-heating all food to 165°F

Person in Charge	Date	Inspector	Date
Chris	11-24-14	Karen Anderson	11-24-14

Technical Assistance List

Facility: Malad Living Center	Exit Date: 11/24/14

Item #	Technical Assistance Provided:
1.	Hot water needs to be maintained between 105 to 120 degrees.
2.	Portable heaters cannot be used in an assisted living facility.
3.	Please review admission agreements and make sure they are signed by all parties.
4.	Please be sure to document on the NSA who is payee for the resident.
5.	Records should be congruent and in order.
6.	Be sure an assessment is completed on residents that need a transfer or repositioning device to get out of bed.
7.	Be sure all NSAs are signed and dated.
8.	White out should not be used on legal documents.
9.	Be sure when House Rules are updated that all residents are aware of the changes. Also, eviction requires a 30 day notice unless the person is a danger to themselves or others.
10.	Be sure all medication orders are current for each resident.
11.	Be sure there are written parameters for BGs and vitals.
12.	Be sure all beds are in good repair.
13.	Make sure you have a copy of the RN's license.
14.	Be sure to document all continuing education for your staff.