



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 2, 2013

Kathy Adams, Administrator
Carefix-Safe Haven Homes Of Gooding
745 California Avenue
Gooding, ID 83330

License #: RC-930

Dear Ms. Adams:

On August 30, 2013, a State Licensure and Complaint Investigation survey was conducted at Carefix Management & Consulting Inc, Dba Safe Haven Homes Of Gooding. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level(s):

- Core issues, which are described on the Statement of Deficiencies, and for which you have submitted a Plan of Correction.
- Non-core issues, which are described on the Punch List, and for which you have submitted evidence of resolution.

Your submitted plan of correction and evidence of resolution are being accepted by this office. Please ensure the corrections you identified are implemented for all residents and situations, and implement a monitoring system to make certain the deficient practices do not recur.

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

Sincerely,

Gloria Keathley, LSW
Team Leader
Health Facility Surveyor

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

September 20, 2013

CERTIFIED MAIL #: 7012 1010 0002 0836 0218

Scott Burpee
Carefix-Safe Haven Homes of Gooding
c/o Carefix Management & Consulting, Inc.
705 South 4th Street
Pocatello, ID 83201

Dear Mr. Burpee:

Based on the complaint investigation, state licensure survey conducted by Department staff at Carefix Management & Consulting Inc, dba Safe Haven Homes of Gooding between August 28 and August 30, 2013, it has been determined that the facility failed to protect residents from inadequate care.

This core issue deficiency substantially limits the capacity of Carefix Management & Consulting Inc, dba Safe Haven Homes of Gooding to provide for residents' basic health and safety needs. 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 **October 15, 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?

Scott Burpee
September 20, 2013
Page 2 of 2

Return the **signed** and **dated** Plan of Correction to us by **October 3, 2013**, and keep a copy for your 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. If your request for informal dispute resolution is not received within the appropriate time-frame, your request will not be granted.

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. Three (3) of the twenty (20) non-core deficiencies cited were identified as repeat punches. 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 **September 29, 2013**.

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 Carefix Management & Consulting Inc, dba Safe Haven Homes of Gooding.

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.

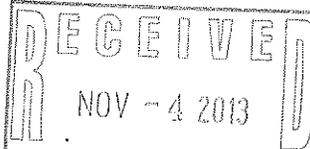
Our staff is available to answer questions and to assist you in identifying appropriate corrections to avoid further enforcement actions. Should you have any questions, or if we may be of assistance, please contact us at (208) 364-1962 and ask for the Residential Assisted Living Facility program. Thank 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

GK/ftp



PRINTED: 08/16/2013
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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R930	(X2) MULTIPLE CONSTRUCTION A. BUILDING: <u>RALF</u> B. WING: _____	(X3) DATE SURVEY COMPLETED 08/30/2013
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NAME OF PROVIDER OR SUPPLIER
 CAREFIK-SAFE HAVEN HOMES OF GOODING

STREET ADDRESS, CITY, STATE, ZIP CODE
 745 CALIFORNIA AVENUE
 GOODING, ID 83330

(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 deficiency was cited during the licensure survey, follow-up and complaint investigation conducted between 8/28/2013 and 8/30/2013 at your residential care/assisted living facility. The surveyors conducting the survey were:</p> <p>Gloria Keathley, LSW Team Leader Health Facility Surveyor</p> <p>Donna Henscheid, LSW Health Facility Surveyor</p> <p>Karen Anderson, RN Health Facility Surveyor</p> <p>Abbreviations used in this report: Accucheck = Blood glucose checks ASAP = as soon as possible BID = two times daily BG = blood glucose CHF = congested heart failure C/O = complained of Furosemide = generic name for Lasix which is a medication used to reduce swelling and fluid retention Glucometer = A device used to determine blood glucose levels HS = at bedtime MARs = medication assistance records MD = medical doctor med = medication mg = milligram Metolazone = a medication used to reduce swelling and fluid retention NSA = Negotiated Service Agreement PRN = As needed</p>	R 000	<p>We have hired a new full time administrator effective Oct. 19th 2013. We will notify BFS with all changes. A staff meeting is scheduled on Oct 21, 2013 for all staff. A flyer will also be mailed out to all Residents and family with the New Administrator information. Staff meeting being held today 10-4-13 announcing changes to all staff.</p>	

Signature of Facility Director or Laboratory Director or Provider/Supplier Representative's Signature

TITLE

(X6) DATE

STATE FORM

857811

10-4-13

If continuation sheet 1 of 10

Scott G. [Signature]
 CEO

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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R580	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/30/2013
NAME OF PROVIDER OR SUPPLIER GAREFIX-SAFE HAVEN HOMES OF GOODING		STREET ADDRESS, CITY, STATE, ZIP CODE 745 CALIFORNIA AVENUE GOODING, ID 83220		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	Continued From page 1 RN = registered nurse SQ = subcutaneous	R 000	<p>A staff meeting was held on 9-4-13 at 10:30A</p> <p>Basic principles of Documentation, Abuse Neglect Policy, Medication Assistance and what task can be delegated.</p> <p>The Administrator has been trained on proper hiring process. Requirement before working on the floor unsupervised.</p> <p>New facility oversight has been hired effective Oct 5, 13</p>	
R 008	16.03.22.520 Protect Residents from Inadequate Care. The administrator must assure that policies and procedures are implemented to assure that all residents are free from inadequate care. This Rule is not met as evidenced by: Based on observations, interview and record review, it was determined the administrator failed to provide appropriate supervision to ensure the facility staff provided safe and adequate care of the residents to include assistance and monitoring of medications for 4 of 8 sampled Residents (#1, #4, #6 and #7) and emergency services for 1 of 8 sampled Residents (#4). The findings include: On 8/28/13, a facility file review was conducted at the Licensing and Certification Department office. Scott Burpee was on file as the administrator from 6/20/12 and 7/6/13. Lang Hansen was on file as the administrator from 7/10/13 to 8/19/13. On 8/19/13, Lang notified Licensing and Certification that he no longer worked for the company and was removing his license from the facility. Scott Burpee's administrator's license expired on 8/9/13, so there was no licensed administrator listed at the facility. On 8/28/13 at 12:10 PM, an unannounced licensure survey and complaint investigation was conducted. When surveyors entered the facility, one caregiver was observed in the building. The caregiver was asked to contact the administrator,	R 008		

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If continuation sheet 2 of 19

[Handwritten Signature]

10-4-13

Scott Burpee CEO

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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X4) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R930	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/30/2013
NAME OF PROVIDER OR SUPPLIER CAREFIX-SAFE HAVEN HOMES OF GOODING		STREET ADDRESS, CITY, STATE, ZIP CODE 745 CALIFORNIA AVENUE GOODING, ID 83330		
(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 2</p> <p>The caregiver stated she would call Kathy Adams. When told Kathy Adams was not the administrator, the caregiver responded, "All I know is she's my boss."</p> <p>Lang Hansen's administrator's license was observed attached to the facility's license. The caregiver stated she did not know who Lang Hansen was. When asked if she knew Scott Burpee, the caregiver stated she met him once, but it was at another facility.</p> <p>A facility organizational chart found in a resident's record, dated 5/10/13, documented that Kathy Adams was the administrator and the first in charge after the corporate person. Kathy Adams was on record as the administrator of another facility in Wendell and was not authorized to be over more than one facility.</p> <p>The facility's "Admission Agreement" documented the following staffing patterns:</p> <p>"Administrator arrives at 9:00 AM and is available to assist as needed. "Administrator leaves for the day at 6:00 PM.</p> <p>The August "as worked staff schedule" documented there was one caregiver scheduled per shift. The schedule also included Kathy Adams' name as administrator, but there were no hours documented for her to work.</p> <p>On 8/28/13 at 1:30 PM, Resident #4 stated he "wasn't sure" who the administrator was. He thought it was the "long-haired lady" who was at the facility. (The person he identified was an employee from a sister facility.)</p> <p>On 8/29/13 at 10:45 AM, another caregiver was</p>	R 008	<p>Rn will be in to delegate all appropriate staff.</p> <p>Per Medication Policy. All staff will be trained on Diabetic Management on Oct 8 & 9, 2013.</p> <p>New Rn will assess all resident & determine if Residents are Capable to self administer and interpret sliding scale and/or insulin doses.</p> <p>If Residents are not capable a home health</p>	

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 Scott Duple CEO

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If continuation sheet 3 of 10

10-4-13

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R330	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/30/2013
NAME OF PROVIDER OR SUPPLIER CAREFIX-SAFE HAVEN HOMES OF GOODING		STREET ADDRESS, CITY, STATE, ZIP CODE 745 CALIFORNIA AVENUE GOODING, ID 83330	
(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)
R.008	<p>Continued From page 3</p> <p>asked who the administrator was. She stated she had just learned that day the Scott Burpee was the administrator.</p> <p>8/29/13 at 3:00 PM, another employee stated she learned yesterday that Scott Burpee was the administrator. However, Mr. Burpee legally could not be the administrator because his license had expired.</p> <p>A. ASSISTANCE & MONITORING OF MEDICATIONS</p> <p>The facility's admission agreement documented under medications, "All medications are locked in a centralized cabinet room at the facility and controlled by trained staff. Residents are assisted and supervised in taking medications in the facility...A licensed nurse monitors medications in the facility..."</p> <p>On 8/29/13, employees' records were reviewed for nursing delegation regarding medication assistance. One caregiver had documentation medication certification was completed on 5/15/13. However, on 5/10/13, the nurse delegated medication assistance, which was five days before the employee had taken the class to learn how to assist with medications. Further, one employee stated she did not receive any training from the facility nurse regarding medication assistance.</p> <p>On 8/28/13 at 12:14 PM, a caregiver was observed to approach an unlocked medication cart. The caregiver pulled out two insulin pens and two glucometers. The caregiver placed the needles on the insulin pens. She then proceeded to take the insulin pens and glucometers down the hall to two residents' rooms. Another resident</p>	R.008	<p>ORDER will be obtained if applicable to provide Diabetic Management/Education</p> <p>If this can not be obtained and the facility RN is not capable of meeting these needs the Resident will receive a discharge notice due to beyond level of care.</p> <p>New Administrator will be trained on all policies and procedures including Medication policy How and when to implement orders</p>

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If continuation sheet 4 of 10

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 Scott Lyle CEO

10-4-13

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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(01) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R030	(02) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(03) DATE SURVEY COMPLETED 08/30/2013
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NAME OF PROVIDER OR SUPPLIER
 CAREFIX-SAFE HAVEN HOMES OF GOODING

STREET ADDRESS, CITY, STATE, ZIP CODE
 746 CALIFORNIA AVENUE
 GOODING, ID 83330

(04) 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)	(05) COMPLETE DATE
R 008	<p>Continued From page 4</p> <p>was observed sitting alone in a recliner in his room. He had an insulin vial sitting on the nightstand and a syringe laying on the arm of the chair. The resident had a glucometer in his hands. The resident was asked what type of insulin was in the vial and he responded, "I don't know." There was no caregiver in the room to observe the resident self-inject his insulin to ensure he administered the medication correctly.</p> <p>1. Resident #4, an 81 year old male, was admitted to the facility on 4/25/13 with diagnoses including Type II diabetes and dementia.</p> <p>An NSA, dated 5/8/13, documented the resident required extensive assistance with medications and would forget his routine medications, but was able to take them with assistance.</p> <p>a. Insulin</p> <p>A physician's order, dated 5/21/13, documented Resident #4 was to receive Humalog insulin 5 units twice daily and Lantus insulin 14 units at bedtime. In addition to the 5 units routine dose of Humalog insulin, the physician ordered Humalog insulin to be used on a sliding scale basis three times a day.</p> <p>The June 2013 MAR, documented Resident #4 received "Humalog 5 units twice daily at 8:00 AM and 6:00 PM," plus a sliding scale based on blood glucose (BG) levels. A routine dose of Lantus 14 units at bedtime was also documented as given.</p> <p>Resident #4's physician orders, dated 5/21/13, documented sliding scale insulin was to be given based on Resident #4's blood glucose checks.</p> <p>Blood Glucose Parameters to determine sliding</p>	R 008	<p>Auditing of Mar Reporting Incidents</p> <p>Appropriate Documentation</p> <p>6 month medication reviews. Auditing medication orders as needed.</p> <p>Staff training on 10-8 & 10-9 will include shadowing by the RN, Regional Director of medication passes. How to receive medication changes, who to notify with all changes, and when orders should be implemented</p> <p>all correction</p>	

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 CEO

10/12/11

If continuation sheet 2 of 10

10-4-13

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(01) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R930	(02) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(03) DATE SURVEY COMPLETED 08/30/2013
NAME OF PROVIDER OR SUPPLIER CAREFIX-SAFE HAVEN HOMES OF GOODING		STREET ADDRESS, CITY, STATE, ZIP CODE 745 CALIFORNIA AVENUE GOODING, ID 83330		
(04) ID PREFIX TAG R 008	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG R 008	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(05) COMPLETE DATE
	<p>Continued From page 5</p> <p>scale insulin dose:</p> <p>80 - 149 = 0 unit 150 - 199 = 1 unit 200 - 249 = 2 units 250 - 299 = 3 units 300 - 349 = 4 units 350 - 400 = 5 units</p> <p>The June 2013 MAR, documented Resident #4 was given Humalog 17 times at bedtime. There was no bedtime order for sliding scale Humalog. Resident #4 received too much insulin 55 times during the month of June. The following Humalog errors were identified:</p> <p>Before breakfast dose = 13 times - 6/3, 6/6, 6/9, 6/10, 6/11, 6/12, 6/13, 6/14, 6/16, 6/19, 6/20, 6/22 and 6/30</p> <p>Before lunch dose = 12 times - 6/1, 6/2, 6/3, 6/5, 6/8, 6/11, 6/12, 6/19, 6/20, 6/21, 6/26, and 6/29</p> <p>Before supper dose = 13 times - 6/1, 6/2, 6/5, 6/7, 6/9, 6/10, 6/17, 6/18, 6/21, 6/22, 6/23, 6/28 and 6/29</p> <p>Bedtime dose = 17 times he got sliding scale insulin at bedtime when he should have only received lentus - 6/3, 6/4, 6/5, 6/14, 6/15, 6/18, 6/20, 6/21, 6/22, 6/23, 6/24, 6/25, 6/26, 6/27, 6/28, 6/29 and 6/30</p> <p>The July 2013 MAR, documented Resident #4 was to be given "Novolog" 5 units twice daily before meals. Medication aides documented the resident received the incorrect dose of sliding scale insulin 30 times.</p> <p>Before breakfast dose = 6 times - 7/1, 7/9, 7/12,</p>		<p>are and will be implemented by Oct 15, 2013 New Administrator will take over on Oct. 19th 2013.</p>	

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If continuation sheet 6 of 10

10-4-13

[Handwritten Signature]
 Scott Dwyer CFO

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 12R020	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/30/2013
NAME OF PROVIDER OR SUPPLIER CAREPIX-SAFE HAVEN HOMES OF GOODING		STREET ADDRESS, CITY, STATE, ZIP CODE 745 CALIFORNIA AVENUE GOODING, ID 83820		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROMOTOR'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 008	<p>Continued From page 6</p> <p>7/18, 7/26 and 7/27</p> <p>Before lunch dose = 10 times - 7/10, 7/11, 7/14, 7/15, 7/18, 7/24, 7/25, 7/26, 7/27 and 7/30</p> <p>Before supper dose = 14 times - 7/2, 7/5, 7/7, 7/8, 7/11, 7/12, 7/18, 7/20, 7/24, 7/26, 7/28, 7/29, 7/30 and 7/31</p> <p>A blood glucose tracking sheet for July 2013, documented Resident #4, refused his BG checks and insulin 10 times. There was no documented evidence the facility RN or physician were notified of the resident's refusals.</p> <p>The August 2013 MAR, documented the resident received the incorrect dose of sliding scale insulin 82 times.</p> <p>Before breakfast = 17 times - 8/1, 8/2, 8/3, 8/4, 8/7, 8/9, 8/10, 8/11, 8/16, 8/18, 8/20, 8/21, 8/22, 8/23, 8/24, 8/26 and 8/29</p> <p>Before lunch = 20 times - 8/1, 8/3, 8/5, 8/8, 8/7, 8/6, 8/9, 8/11, 8/12, 8/13, 8/14, 8/18, 8/19, 8/21, 8/23, 8/24, 8/26, 8/27, 8/28 and 8/29</p> <p>Before supper = 25 times - 8/1, 8/2, 8/3, 8/4, 8/5, 8/6, 8/7, 8/8, 8/9, 8/10, 8/11, 8/12, 8/13, 8/15, 8/16, 8/18, 8/19, 8/21, 8/22, 8/23, 8/24, 8/25, 8/26, 8/27 and 8/28</p> <p>There was no documented evidence, the facility RN, had reviewed the June, July or August 2013 MARS to ensure accuracy.</p> <p>The facility's RN assessment, dated 7/10/13, documented Resident #4's medications were congruent with physician's orders.</p>	R 008		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 18R030	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/30/2013
NAME OF PROVIDER OR SUPPLIER CAREFIX-SAFE HAVEN HOMES OF GOODING		STREET ADDRESS, CITY, STATE, ZIP CODE 746 CALIFORNIA AVENUE GOODING, ID 83330		
(X4) ID PREFIX TAG R 008	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG R 008	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	<p>Continued From page 7</p> <p>The facility's RN assessment, dated 8/23/13, documented the resident was able to self-inject "insulin only" but required assistance to "correctly identify the proper dose of insulin." The facility RN documented, Resident #4's medications were congruent with the current "med system."</p> <p>On 8/26/13 at 12:15 PM, a caregiver was observed to drop off Resident #4's insulin pen and leave it on top of his dresser in his room. The resident was observed laying in bed when the caregiver quickly said, "Here is your insulin pen." She left the room without observing the resident dial his insulin pen. The resident was observed coming out of his room with his glucometer and insulin pen and told the caregiver that his BG reading was 194, and that he took 10 units of Humalog. The correct insulin dose, according to physician's orders were 5 units of Novolog plus 1 unit of sliding scale insulin, for a total of 6 units of insulin. Resident #4 received 4 units more of insulin than ordered.</p> <p>On 8/29/13 at 10:05 AM, the on-call agency RN stated the caregivers were not communicating with their agency, so they were not aware of all the insulin errors. She further stated, she was not able to find the insulin order when Humalog was changed to Novolog in July. The nurse stated the sliding scale insulin was to be used before meals depending on the outcome of the resident's BG, and the resident should not be receiving sliding scale insulin before bed.</p> <p>On 8/29/13 at 10:05 AM, an employee from a sister facility, stated she was not able to find a current physician's order for Resident #4's insulin.</p> <p>On 8/29/13 at 11:45 AM, Resident #4 was observed in his room when the medication aide</p>			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R030	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/30/2013
NAME OF PROVIDER OR SUPPLIER CAREFIX-SAFE HAVEN HOMES OF GOODING			STREET ADDRESS, CITY, STATE, ZIP CODE 745 CALIFORNIA AVENUE GOODING, ID 83330		
(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 8</p> <p>brought his glucometer and insulin pen to him. The resident was able to perform his BG check. His BG level was 308. The resident, stated to the medication aide, "I should take 10 units of insulin." The caregiver told the resident, "Really, you only should have 9 units." After the resident injected himself with the insulin, the caregiver left his room. Resident #4 stated, "I just always take 10 units because it doesn't really matter if it is exact." He confirmed he did not understand how the sliding scale worked, so he just "goes with 10 units."</p> <p>b. Lasix</p> <p>Resident #4's physician's order, dated 9/7/12, for "Furosemide 40 mg 3 tabs bid" for diagnoses including CHF, edema and recurrent lower leg venous insufficiency ulcers.</p> <p>Review of the June, July and August 2013 MAFs, documented the resident was not assisted with his Furosemide 17 times - 6/1, 6/15, 6/16, 6/28, 6/29, 7/6, 7/7, 7/11, 7/12, 7/14, 7/15, 7/19, 7/21, 7/23, 7/28, and on 8/25 both doses were circled as not given.</p> <p>A Monthly/Quarterly Nursing Assessment, dated 7/10/13, documented the resident's weight was 190 pounds and his weight remained "stable."</p> <p>A Physician's Progress Note, dated 7/23/13, documented the skin on Resident #4's legs had "...broken open again...and he c/o increased swelling and gaining weight. His weight today is 218 and it was 195 at his last visit a month ago..."</p> <p>A Monthly/Quarterly Nursing Assessment, dated 8/23/13, documented the resident's weight was 191 pounds and he had not had a weight loss or</p>	R 008			

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Bureau of Facility Standards				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(01) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R820	(02) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(03) DATE SURVEY COMPLETED 08/30/2013
NAME OF PROVIDER OR SUPPLIER CAREPIX-SAFE HAVEN HOMES OF GOODING		STREET ADDRESS, CITY, STATE, ZIP CODE 745 CALIFORNIA AVENUE GOODING, ID 83330		
(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 9</p> <p>gain of more than 3 pounds since the last assessment dated 7/10/13.</p> <p>On 8/29/13 at 10:07 AM, an agency RN stated caregivers were not communicating with their agency, so they were not aware of Resident #4 refusing or not being assisted with his Furosemide as ordered.</p> <p>On 8/29/13 at 12:10 PM, the facility RN stated he thought Resident #4's weight had been stable and he was not aware of any missed Furosemide doses.</p> <p>Resident #4 missed 17 doses of Furosemide, possibly contributing to a weight gain of 23 pounds from 7/23/13 to 8/29/13. The facility nurse failed to assess Resident #4 to ensure he received Furosemide as ordered, and failed to monitor and assess his weight fluctuations.</p> <p>c. Metolazone</p> <p>Resident #4's physician's order, dated 7/23/13, for "metolazone 2.5 mg" to take 1 tablet on Mondays, Wednesdays and Fridays in addition to the Lasix to remove excess fluids.</p> <p>The July 2013 MAR, documented Resident #4 did not begin receiving "metolazone" as ordered until 7/26/13.</p> <p>A physician's order, dated 8/20/13, for "metolazone 2.5 mg" was changed to take 1 tablet on "Mondays and Fridays" twice weekly.</p> <p>The August 2013 MAR, documented the resident was assisted with metolazone 2.5 mg on Mondays, Wednesdays and Fridays until 8/28/13. The correct order had not been implemented until</p>	R 008		

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Bureau of Facility Standards				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 12R930	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/30/2013
NAME OF PROVIDER OR SUPPLIER CAREFIX-SAFE HAVEN HOMES OF GOODING		STREET ADDRESS, CITY, STATE, ZIP CODE 745 CALIFORNIA AVENUE GOODING, ID 83330		
(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 10</p> <p>8/29/13, nine days after the order changed.</p> <p>A physician's assessment, dated 8/20/13, documented, the resident had "lost 20 pounds since July 23." The resident continued to lose weight after receiving one additional dose every week.</p> <p>On 8/29/13 at 3:10 PM, an observation was made of the bubble pack of metolazone 2.5 mg. The bubble pack was filled by the pharmacy and contained the correct dose. The house manager stated, the pharmacy must have sent the wrong dose as the physician's order was for three days a week, instead of two. The house manager requested a medication clarification from the physician. The physician, faxed the current order confirming the medication order had changed on 8/20/13 to twice weekly.</p> <p>On 8/29/13 at 3:15 PM, an agency RN stated she was not aware the metolazone order had been changed to Mondays and Fridays only.</p> <p>Resident #4's MAFs for June, July and August 2013, documented a total of 181 insulin errors. Resident #4 was not assisted with his Furosemide 17 times. Review of a physician's documented examination, the resident had a weight gain of 23 pounds in one month. A physician's order for "metolazone 2.5 mg" was ordered in addition to the Lasix in July. The order was changed on 8/20/13, to be given on Mondays and Fridays. However, the resident continued to receive the medication three days a week with continued weight loss.</p> <p>2. Resident #7, a 70 year old male, was admitted to the facility, on 8/2/10, with a diagnosis of diabetes.</p>	R 008		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R930	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/30/2013
NAME OF PROVIDER OR SUPPLIER CARFEX-SAFE HAVEN HOMES OF GOODING		STREET ADDRESS, CITY, STATE, ZIP CODE 746 CALIFORNIA AVENUE GOODING, ID 83330			
(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 11</p> <p>On 8/29/13 at 12:15 PM, the caregiver was observed to bring Resident #7 a insulin pen and a glucometer. The caregiver left the resident's room and did not stay to observe the resident take the medication. The caregiver stated Resident #7 monitored his own blood glucose levels, self-administered the insulin and reported the numbers to the staff.</p> <p>An NSA, dated 7/10/13, documented the resident was "not always compliant with medications, does not know routine for medication."</p> <p>A nursing assessment, dated 8/19/13, documented the resident's medication orders were current and the resident was able to self-administer insulin dosages only.</p> <p>Physicians' orders documented the resident was to receive the following medications:</p> <p>*5/30/12 - Lantus - 34 units in the AM and 26 units at HS</p> <p>Novolog - 7 units just before meals plus sliding scale</p> <p>Sliding scale Humalog Kwikpen/Novolog Flex - Inject SQ per sliding scale in addition to routine.</p> <p>80 - 149 = 0 units 150 - 199 = 1 unit 200 - 249 = 2 units 250 - 299 = 3 units 300 - 349 = 4 units >350 = 5 units then notify MD ASAP</p> <p>*8/8/13 - Lantus 32 units in the AM and 24 units at HS</p>	R 008			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R930	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/30/2013
NAME OF PROVIDER OR SUPPLIER CAREPIX-SAFE HAVEN HOMES OF GOODING		STREET ADDRESS, CITY, STATE, ZIP CODE 745 CALIFORNIA AVENUE GOODING, ID 83330		
(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 12</p> <p>*8/21/13 - Lantus 34 units in the AM and 19 units at HS Novolog - 4 units before breakfast and lunch</p> <p>The following insulin errors were documented on the August 2013 MAR:</p> <p>*Novolog 7 units was crossed out and 6 units was handwritten in. (There was no order found in the record for 6 units of Novolog.)</p> <p>*Lantus was not self-administered 10 times and there was no explanation why.</p> <p>*According to the two Novolog orders for sliding scale insulin, Resident #7 reported to staff he had taken an incorrect amount of Novolog 63 times and 7 times there was no documentation it was self-administered at all. Further, the resident continued taking a sliding scale dose of Novolog at supper, when the order was for breakfast and lunch only.</p> <p>Facility staff did not supervise Resident #7 while he self-administered medications to ensure the resident received the appropriate dose of sliding scale insulin.</p> <p>3. Resident #7, an 89 year old female, was admitted to the facility on 8/1/12, with diagnoses including Type II diabetes and dementia.</p> <p>An NSA, dated 8/1/12, documented the resident required extensive assistance with medications. If further documented, the resident "would not remember if she has taken her meds."</p> <p>A nursing assessment, dated 8/28/12, documented the resident was not a</p>	R 008		

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Bureau of Facility Standards		STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R920	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/30/2013
NAME OF PROVIDER OR SUPPLIER CAREFOX-SAFE HAVEN HOMES OF GOODING			STREET ADDRESS, CITY, STATE, ZIP CODE 745 CALIFORNIA AVENUE GOODING, ID 83330			
(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 13</p> <p>self-medicator and "blood sugars done by daughter..."</p> <p>A physician's order, dated 7/24/13, documented the resident was to receive Aspirin one 81 mg tablet every day.</p> <p>A physician's order, dated 8/18/13, documented the resident was to have accuchecks done four times a day.</p> <p>A physician's order, dated 8/24/13, documented the resident was to receive Metformin 500 mg, one tablet twice a day for a total of 1000 mg. per day.</p> <p>The August 2013 MAR documented the following errors:</p> <ul style="list-style-type: none"> *Metformin 500 mg. was received only once a day on 8/26 and 8/27. *Aspirin 81 mg was not given for 11 days and there was no documentation why. <p>There was no documentation on the August MAR that accuchecks were being done four times a day as ordered. A separate BG log had blood glucose values written down twice a day starting on the 8/22 and not four times a day as ordered.</p> <p>The August 2013 MAR had the following medications listed twice on the MAR and signed by the caregivers as given in both places:</p> <ul style="list-style-type: none"> *Docusate 100 mg, one capsule twice a day - duplicate signed for 9 days *ferrous gluconate, 324 mg, one tablet every day - duplicate signed for 9 days *Multivitamin with minerals, one table every day - both signed as given every day but two. 	R 008				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R030	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/30/2013
NAME OF PROVIDER OR SUPPLIER CAREPIX-SAFE HAVEN HOMES OF GOODING		STREET ADDRESS, CITY, STATE, ZIP CODE 745 CALIFORNIA AVENUE GOODING, ID 83330		
(X4) ID PREFIX TAG R 008	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG R 008	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	<p>Continued From page 14</p> <p>It was unclear if the resident was receiving double doses of these medications.</p> <p>On 8/29/13, a caregiver stated Resident #1's family came to the facility twice a day to check her BG levels, because the resident could not do them and neither could staff. She stated the family reported them to the staff and they wrote the values down. Further, the caregiver stated the family had not been in this afternoon, because they "probably decided" the resident's BG levels were "okay" this morning.</p> <p>The facility did not ensure Resident #1 received accuchecks and medications as ordered by the physician.</p> <p>4. Resident #8 was a 76 year-old female who was admitted to the facility on 2/5/11 with diagnoses that included insulin dependent, Type II diabetes and developmental disabilities.</p> <p>The August 1, 2013 through August 31, 2013, MARs documented Resident #8's insulin dosage of Novolog was 62 units in the morning and 60 units of Novolog in the evening.</p> <p>Resident #8's "Negotiated Service Agreement," dated 1/5/13, documented the resident did not know route or routine of medications. The NSA further documented the resident required supervision/cueing and "must be reminded to take medications."</p> <p>A "Monthly/Quarterly Nursing Summary," dated 8/23/13, documented under the recommendations, to continue insulin injection oversight, as needed. The nursing summary further documented the resident could do her</p>			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R930	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/30/2013
NAME OF PROVIDER OR SUPPLIER QAREFIX-SAFE HAVEN HOMES OF GOODING		STREET ADDRESS, CITY, STATE, ZIP CODE 745 CALIFORNIA AVENUE GOODING, ID 83330		
(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)	DD COMPLETE DATE
R 008	Continued From page 16 insulin dosing. A "Resident Events-Change of Shift Report," dated 7/19/13, documented the resident's sister wanted to make sure that staff were looking at the resident's BG number, as the resident could not read it. A "Resident Events-Change of Shift Report," dated 8/14/13, documented the resident's BG was low and not to "give her" the insulin. The shift report did not document who instructed to hold the insulin or if the RN was notified. On 8/29/13 at 10:20 AM, Resident #6 stated the staff "dropped off" her insulin pen and blood glucometer. She stated she gave herself the insulin injection by "clicking" the pen 60 times, two times per day. She additionally stated she took 60 units of insulin in the morning and took 60 units in the evening. She stated she told the staff her blood glucose level, so they could write it down. She further stated, "staff usually came back" to check on her when she was "poking" her finger. On 8/29/13 at 10:30 AM, an employee from a sister facility, stated she was not aware the staff were leaving residents' insulin pens, blood glucometers with the residents and not observing them during the process. On 8/29/13 at 10:45 AM, a caregiver stated staff stayed with Resident #6 while she gave her insulin. She further stated the resident did not know her units right off, but the resident could dial her insulin pen. The caregiver then proceeded to leave a random resident's medication on the table in front of her and walk away.	R 008		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(01) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 12R990	(02) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(03) DATE SURVEY COMPLETED 08/30/2013
NAME OF PROVIDER OR SUPPLIER CAREFIX-SAFE HAVEN HOMES OF GOODING			STREET ADDRESS, CITY, STATE, ZIP CODE 745 CALIFORNIA AVENUE GOODING, ID 83330		
(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 16</p> <p>Facility staff did not supervise Resident #6 while she dialed her insulin pen and injected the insulin to ensure the resident received the appropriate dose.</p> <p>B. MEDICAL EVALUATION & INTERVENTION</p> <p>Resident #4, an 81 year old male, was admitted to the facility on 4/25/13 with a diagnosis of dementia.</p> <p>A fax to a physician, dated 7/29/13, documented an order for "Hydrocodone 10/325" 1 tablet every 4 hours for chronic pain PRN." The physician documented the pharmacy could dispense 90 tablets.</p> <p>A hand written note on the bottom of the fax, (undated) by Kathy Adams (the administrator of a facility in a different town), documented, "Please do not let [Resident #4's name] get orders & fill them." She documented they found 3 bottles in his room and he was "only taking 3 or 4 at a time."</p> <p>An incident report, dated 7/29/13 at 9:00 PM, documented Resident #4 informed the caregiver on duty that he had money that was missing out of his room. The caregiver documented the Lang Hansen was notified, along with Kathy Adams, the facility RN, and the police. The incident report was not signed by the administrator, but was signed by a caregiver from a sister facility, on 7/29/13.</p> <p>A caregiver from a sister facility documented the following information regarding the incident on 7/29/13: "When searching [Resident #4's name] room we discovered 2 bottles of hydrocodone and we removed them. While talking to [Resident</p>	R 008			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R030	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/30/2013
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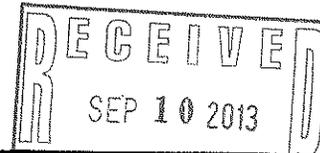
NAME OF PROVIDER OR SUPPLIER: CAREFIX-SAFE HAVEN HOMES OF GOODING
 STREET ADDRESS, CITY, STATE, ZIP CODE: 746 CALIFORNIA AVENUE GOODING, ID 83320

(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 17</p> <p>#4's name] he kept falling asleep - he could not or would not say how many he had taken." The incident report was signed by the caregiver from the sister facility and Kathy Adams.</p> <p>There was no documentation from the facility nurse that he had been notified of the hydrocodone incident.</p> <p>On 8/29/13 at 10:15 AM, an interview was conducted with an employee from a sister facility, Kathy Adams and the facility RN. The employee from the sister facility stated, the resident was lethargic and kept falling asleep. She stated, the RN was not notified of the incident. She stated 10 Hydrocodone from the 90 tablets supply were missing when counted. Kathy Adams stated, the resident "goes on his own to the physician and gets narcotics and then hides them in his room, so we were not aware he had 3 bottles of hydrocodone in his room."</p> <p>On 8/29/13 at 10:30 AM, the facility RN stated he was not informed of the hydrocodone incident or that Resident #4 was lethargic and was not able to stay awake. The facility RN confirmed he had not assessed the resident and was not aware the resident had not been medically evaluated. The facility RN stated, Resident #4 should have been evaluated and should have received medical attention.</p> <p>Resident #4 did not receive appropriate medical intervention after he took an unknown amount (possibly 10 tablets) of a narcotic medication. He had signs and symptoms of an overdose and was not medically evaluated.</p> <p>The administrator was not available to provide oversight to ensure the facility RN and staff were</p>	R 008		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R930	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/30/2013
NAME OF PROVIDER OR SUPPLIER CAREPIX-SAFE HAVEN HOMES OF GOODING		STREET ADDRESS, CITY, STATE, ZIP CODE 746 CALIFORNIA AVENUE GOODING, ID 83330		
(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 18 trained to provide appropriate monitoring and assistance with medications and emergency response. Due to the lack of oversight, Residents #1, #4, #6 and #7 did not receive medications as ordered and Resident #4 did not receive medical intervention after consuming an unknown amount of a narcotic medication. This resulted in inadequate care.	R 008		



Facility Safe Haven Homes of Gooding	License # RC-930	Physical Address 745 CALIFORNIA	By RALF	Phone Number (208) 934-5506
Administrator Scott Burpee - Licensee	City GOODING	ZIP Code 83330	Survey Date August 30, 2013	
Survey Team Leader Gloria Keathley	Survey Type Licensure and Complaint Investigation	RESPONSE DUE: September 29, 2013		
Administrator Signature 	Date Signed 9-10-13			

NON-CORE ISSUES

Item #	IDAPA Rule #	Description	Department Use Only	
			EOR Accepted	Initials
1	16.03.22. 009.06.c	One of two staff members did not have a state police background check. **Previously cited on 12/14/11**	10/30/13	W/12 ✓
2	210	No activities were observed to be offered or provided during the survey.	10/30/13	8 ✓
3	215	The facility did not have a licensed administrator from 8/19/13 to present.	10/15/13	8 ✓
4	250.10	The water temperature temped at 135.3 degrees which exceeded 120 degrees F. **Previously cited on 12/14/11**	10/15/13	8 ✓
5	260.06	The facility was not maintained in a safe and orderly manner. For example: The door with the wander guard system was not closing properly. The two rooms to the right of the front entry had a very strong urine odor from the floors, furniture and bedding. Four rooms had dirty toilets. In one room the bathroom sink had rust around the drain. Another room had dirty, worn caulking around the toilet. Trash cans were full. A soiled incontinence pad was laying on the floor. One resident's room had dead skin tissue and other debris on the carpet, dried urine around the base of the toilet and dried blood on the sheet and pillow case.	10/30/13	8 ✓
6	300.01	Resident #4 was not assessed by the facility nurse after he ingested an unknown amount of a narcotic medication. Three residents were not assessed by the facility nurse when they had complaints of dizziness, nausea, fever and vomiting. Further, the facility nurse delegated medication assistance prior to the employee obtaining medication certification.	10/30/13	8 ✓
7	310.01.a	Medications were observed left unsecured on the counter, in residents' rooms and on the medication cart.	10/15/13	8 ✓
8	310.01.f	Residents were not observed taking their medications by the caregiver.	10/15/13	8 ✓
9	320.03	The administrator did not sign NSAs.	10/15/13	8 ✓
10	335.03	The facility did not provide paper towels in the rooms of residents who required assistance with personal care. A caregiver was observed walking into the kitchen with a soiled incontinent pad, to the laundry room and proceeded to assist with medications without washing her hands. Bloody tissues were observed on a resident's dresser.	10/20/13	8 ✓
11	350.02	The administrator did not complete investigations and provide a written report of all accidents and incidents.	10/16/12	8 ✓



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

Establishment Name <u>Carelix-Safe Haven-Cooding</u>		Operator <u>Scott Burpee</u>	
Address <u>745 California Ave</u>		<u>Cooding 83330</u>	
County <u>Cooding</u>	Estab #	EHS/SUR #	Inspection time: _____ Travel time: _____
Inspection Type: <u>High</u>	Risk Category: <u>High</u>	Follow-Up Report: OR	On-Site Follow-Up: _____
Date: _____		Date: _____	

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

# of Risk Factor Violations <u>3</u>	# of Retail Practice Violations _____
# of Repeat Violations _____	# of Repeat Violations _____
Score <u>3</u>	Score _____
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

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.

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

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

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

Item/Location	Temp	Item/Location	Temp	Item/Location	Temp	Item/Location	Temp
<u>Fish / Oven</u>	<u>165</u>	<u>Egg Salad / Fridge</u>	<u>44</u>				
<u>(Orange) / Fridge</u>	<u>43</u>	<u>Ice cream / Fridge</u>	<u>44</u>				

GOOD RETAIL PRACTICES (input checked = not in compliance)

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

OBSERVATIONS AND CORRECTIVE ACTIONS (CONTINUED ON NEXT PAGE)

Person in Charge (Signature) <u>Scott Burpee</u>	(Print) <u>Scott F. Burpee</u>	Title <u>CFO</u>	Date <u>8-29-13</u>
Inspector (Signature) <u>[Signature]</u>	(Print) <u>Gina Keathly</u>	Date <u>8-29-13</u>	Follow-up: (Circle One) <u>Yes</u> <u>No</u>



Food Protection Program, Office of Epidemiology
450 West State Street, Boise, Idaho 83702
208-334-5938

Page 2 of 2
Date 8-29-13

Establishment Name Caretix - State Haven - Gardeng			Operator Scott Burpee
Address 745 California Ave			City/Zip Candle 83330
County Canyon	Estab #	EHS/SUR #	License Permit #

OBSERVATIONS AND CORRECTIVE ACTIONS (Continuation Sheet)

#11 - Eggs stored above food/liquids - COS - Facility educated on the importance of separating and protecting foods from contamination.

#12 - The facility used dish soap to clean counter tops and tables. COS - Staff were educated on sanitizing surfaces that food is coming in contact with - Staff made up a bleach spray to sanitize in the future.

#19 - Food temp at 44° - Egg salad was discarded by staff. COS - Staff turned fridge down and will monitor temperature each shift - a new thermometer will also be purchased.

Person in Charge Scott Burpee	Date 8-29-13	Inspector [Signature]	Date 8-29-13
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IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

September 20, 2013

Scott Burpee
Safe Haven Homes of Gooding
c/o Carefix Management & Consulting, Inc.
705 South 4th Street
Pocatello, ID 83201

Dear Mr. Burpee:

An unannounced, on-site complaint investigation survey was conducted at Carefix Management & Consulting Inc, dba Safe Haven Homes of Gooding between August 28 and August 30, 2013. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00005906

Allegation #1: The facility did not provide appropriate supervision of staff to ensure residents received appropriate care.

Findings #1: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.520 for not providing appropriate supervision of staff to ensure residents received appropriate care. The facility was required to submit a plan of correction, within 10 days.

Allegation #2: The administrator was not available to oversee the daily operations of the facility.

Findings #2: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.215 for not having a licensed administrator available at all times to oversee the daily operations of the facility. The facility was required to submit evidence of resolution within 30 days. The facility was also issued a deficiency at IDAPA 16.03.22.520 and was required to submit a plan of correction within 10 days.

Allegation #3: The facility was not maintained in a clean, safe and orderly manner.

Findings #3: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.260.06 for not maintaining the facility in a safe and orderly manner. The facility was required to submit evidence of resolution within 30 days.

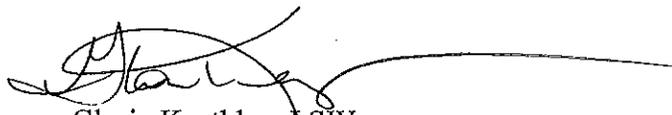
Scott Burpee
September 20, 2013
Page 2 of 2

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.

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 **August 30, 2013**. The completed punch list form and accompanying evidence of resolution (e.g., receipts, pictures, policy updates, etc) are to be submitted to this office within thirty (30) days from the exit date.

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

Sincerely,

A handwritten signature in black ink, appearing to read 'Gloria Keathley', with a long horizontal line extending to the right.

Gloria Keathley, LSW
Health Facility Surveyor
Residential Assisted Living Facility Program

GK/tfp

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