PLAN OF CORRECTION

Whispering Pines Assisted Living Center
351 E Center St
Downey ID 83234

Provider ID: RC-1229

On 04/13/2023, a Health Care Licensure and Follow-Up survey was conducted by Department staff at Whispering Pines Assisted Living Center. As a result of the survey, core issue deficiencies were cited with the following plan of correction.

Rule Violation .550.04.d. Personal Possessions.

Describe what corrective actions will be accomplished for those residents/personnel/area found to have been affected by the deficient practice.

The personal lock boxes have been ordered and will be here by 4/24/2023. They will be installed in every room by 5/22/2023.

Describe how the provider will identify other residents/personnel/areas having the potential by the same deficient practice and what corrective action(s) will be taken.

All rooms will have secured lock boxes that will be monitored to make sure they are secured properly and the resident is able to access the lock box.

Describe how the corrective action will be monitored to ensure the deficient practice does not recur (QA program).

I, Brie Moore, the facility administrator will ensure to go around and check that all lock boxes are properly secured every month and ensure that no residents have shared access to their personal lock box within the facility.

Date when corrective action will be completed.

May 22, 2023

Program Comments

NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
Whispering Pines Assisted Living Center	RC-1229	351 E Center St	208-897-5683
Administrator	City	Zip Code	Survey Date
Brie Moore	Downey	83234	04/13/2023
Survey Team Leader	Survey Type		Response Due
Walker, Jenny	Health Care Licensure and Follow-Up		05/13/2023

Item #	Rule (16.03.22)	Description
1	.009.06.c. Use of Previous Criminal History and Background Check.	One of one staff members, whose personnel files were reviewed and required an Idaho State Police background check, did not have documentation of an Idaho State Police background check in their record within thirty (30) days of obtaining the previous criminal history and background check results. Upon interview with the administrator it was confirmed the ISP background check was not completed.
2	.050.01. Temporary Variance	The facility did not request for a variance in writing for Resident #2's closet doors to be removed. The administrator stated she was not aware she had to request a variance for closet doors to be removed to Licensing and Certification.
3	.215.01. Administrator Responsibility.	The facility's abuse/neglect/exploitation policy did not include all elements required. For example, the policy did not contain the phone number for adult protection or law enforcement; how residents, family, and visitors would be educated regarding abuse/neglect/exploitation; specific directions for residents and visitors to immediately contact the administrator; directions to report to adult protection when there is an alleged incident; specific directions for the administrator or

		designee to contact law enforcement within four hours in the event the alleged abuse includes: sexual assault or results in the death or serious physical injury that jeopardizes the life, health or safety of the resident; forms/systems used to document the incidents/allegations/investigations of abuse/neglect/exploitation; the steps to be taken by the administrator to investigate the allegation; what to do if the administrator/staff/visitor is the suspected alleged abuser; procedures to ensure that allegations of abuse/neglect/exploitation are documented; procedures to ensure that allegations of abuse/neglect/exploitation are investigated; and ensure interventions to prevent further abuse/neglect/exploitation are implemented. The facility was previously provided technical assistance regarding their abuse/neglect/exploitation policy. The administrator stated she would update the policy according to the checklist provided. Additionally, IDAPA rule 16.03.22.550.04.d and the facility's resident rights policy was not implemented when residents were not provided a locked drawer or cabinet in their rooms. The administrator stated residents did not have a locking drawer or cabinet in their rooms.
4	.260.06. Toxic Chemicals.	The facility was not maintained in a clean, safe and orderly manner. For example: the flooring under the kitchen prep sink was rotting and had water damage, several areas on the kitchen counters were damaged and worn, making them an uncleanable surface, the tile on the kitchen counter was damaged and worn, making it an uncleanable surface, multiple tables in the dining room were damaged and/or broken, the tan sofa in the living room was torn and damaged, the sofa in the sitting room near room 13 had a worn armrest, there was an exposed fly stick in the sitting room near room 13, the faucet in the bathroom near room 13 was broken, the sink in room 12 was clogged and the sink itself was disintegrating, room 9 had multiple holes in the walls, the sink, toilet and

		shower had dark stains that were unable to be cleaned, there was chipped paint and trim throughout the facility, walls and door frames throughout the facility had gouges and scrapes, carpet throughout the facility had stains and dirt on it, window screens were missing on most resident rooms, a lawn mower was left outside uncovered in the exterior courtyard, another lawn mower and other trash and debris was left outside near the smoking area at the rear of the building, the asphalt in the rear of the building was damaged and breaking apart, and deep tire tracks were in the lawn at the rear of the building. ***Previously cited on 6/24/21***
5	.310.01.c. Medication Distribution.	The facility did not maintain the medication refrigerator, which contained insulin, in temperature range between 38 and 45 degrees F. In February 2023 temperatures were documented below 38 degrees seven times, in March 2023 seven times, and in April 2023 six times. The administrator stated the temperatures should have been more closely monitored. ***Previously cited on 6/24/21***
6	.310.02. Discontinued and Expired Prescriptions.	The facility did not document the method of disposal and signatures of responsible facility personnel and witness for medication destructions. The residential care manager stated the method and signatures were not documented. ***Previously cited on 6/24/21***
7	.310.04.a. Behavior Modifying Medication.	The facility did not attempt non-drug interventions prior to requesting medications to manage resident behaviors. Resident #2 was prescribed routine Caplyta once a day for anxiety and aripiprazole twice a day for mood and did not have a behavior management plan in place. Resident #4 was prescribed routine quetiapine three times a day for behavioral disturbance and did not have a behavior management plan in place. The administrator confirmed neither resident had a behavior management plan in place.
8	.310.04.e. Psychotropic or Behavior Modifying Medication.	Resident #1 was taking divalproex (Depakote), escitalopram (Lexapro), and clozapine, and Resident #3 was taking clozapine

		and lorazapam. Neither resident had six month psychotropic medication reviews that included behavioral updates. The residential care manager stated they were not completed. ***Previously cited on 6/24/21***
9	.320.08. Periodic Review.	Residents #1, #2, and #3's NSAs were not reviewed every 12 months. Resident #4's NSA was reviewed on 2/23/23 and was due to be reviewed on 7/23/22. The administrator stated the facility was behind on reviewing and updating the NSAs.
10	.330.06.a. Behavior Documentation*	The facility did not evaluate Resident #4's behaviors of yelling/cussing at staff, swinging at staff, and refusals of care nor Resident #2's behaviors of swearing/yelling at staff and residents and destruction of their own property. The administrator confirmed the facility had not completed evaluations for Resident #2 or #4's maladaptive behaviors. ***Previously cited on 6/24/21***
11	.330.06.b. Behavior Documentation*	The facility did not develop interventions after residents engaged in maladaptive behaviors. See non-core deficiency 330.06.a for examples. ***Previously cited on 6/24/21***
12	.330.14. As Worked Schedules.	The facility's as-worked schedule did not document the exact times the facility nurse worked at the facility nor positions of all the staff listed on the schedule.
13	.403. FIRE AND LIFE SAFETY STANDARDS FOR EXISTING BUILDINGS LICENSED FOR THREE THROUGH SIXTEEN RESIDENTS.	The facility kitchen had two gas-fired cooktops that required an applicable hood system(s) in accordance with NFPA 101, Chapter 33, Section 33.3.3.8. The facility kitchen hood was not operational and there was no suppression system. Multiple kitchen staff stated the kitchen hood had been inoperable over two years. ***Previously cited on 12/5/22 and 11/4/21***
14	.600.04.b. Sufficient Personnel.	Five of five caregivers, whose personnel files were reviewed and worked alone, did not have current first aid training certifications. One of five caregivers, whose personnel file was reviewed and worked alone, did not have current CPR training certification. The residential care manager stated the staff did not have current first aid and CPR certifications.
15	.630. TRAINING REQUIREMENTS FOR FACILITIES ADMITTING	Four of five staff members, whose personnel files were

	RESIDENTS WITH A DIAGNOSIS OF DEMENTIA, MENTAL ILLNESS, DEVELOPMENTAL DISABILITY, OR TRAUMATIC BRAIN INJURY.	reviewed, did not contain evidence of specialized training for how to care for and serve residents with a mental illness and a traumatic brain injury. The facility roster provided to surveyors at entrance documented the facility retained residents with these diagnoses. The administrator stated the staff members had not received these specialized trainings.
16	.640. CONTINUED TRAINING REQUIREMENTS.	Two of two staff members, whose personnel files were reviewed, did not contain job related continued training. The administrator and the two staff members stated the training was not completed.

CORE ISSUES

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Item #	Rule (16.03.22)	Description
2	.550.04.d. Personal Possessions.	Based on observations, record reviews, and interviews, it was determined the facility failed to protect the rights of 4 of 4 sampled residents (Resident #1, #2, #3, and #4), as well as the rights of all other residents residing in the facility. The findings include: IDAPA 16.03.22.010.20.d. A core issue is defined as "Inadequate care." IDAPA 16.03.22.011.05, documents Inadequate Care. When a facility...engages in violations of resident rights... IDAPA 16.03.22.215.01 documents, the facility's administrator is responsible for ensuring that policies and procedures are developed and implemented to fulfill the requirements in Title 39, Chapter 33, Idaho Code and IDAPA 16.03.22. IDAPA 16.03.22.520 documents, the administrator must ensure that policies and procedures are developed and

		implemented to ensure that all residents are free from inadequate care... IDAPA 16.03.22.550 documents, REQUIREMENTS FOR RESIDENTS' RIGHTS. The administrator must ensure that policies and procedures are developed and implemented to ensure that residents' rights are observed, promoted, and protected. IDAPA 16.03.22.550.04.d documents, residents are to "Be provided a separate storage area in their own living area and at least one (1) locked cabinet or drawer for keeping personal property." The facility's Residents' Rights policy documented each resident will "be provided a separate storage area in his/her own living area and at least one locked cabinet or drawer..." During the previous licensure survey on 6/24/21, the facility was given technical assistance to provide each resident with a locking drawer or cabinet for their personal property. During the initial tour between 4/11/23 and 4/13/23, there were no locking drawers or cabinets observed in resident rooms for all 16 residents residing in the facility. Between 4/11/23 and 4/12/23, ten residents who wanted a locking drawer or cabinet, stated they were not provided with a locked drawer or cabinet for keeping personal property. One resident stated they bought their own locked safe for their personal property. On 4/12/23, three staff members stated residents' rooms did not have a locked drawer or cabinet.

		On 4/12/23 at 2:15 PM, the administrator stated none of the residents residing at the facility had a locking cabinet or drawer for their personal belongings. The facility failed to provide 14 out of 14 current residents with a separate locking cabinet or drawer for protecting their personal property. This resulted in a violation of their rights.