PLAN OF CORRECTION

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

Provider ID: RC-1229

On 07/26/2024, 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 .215.03. Lapse of Administrator.

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

I have paid for my administrator license to be reinstated, and now just waiting.

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.

I will be making sure that this does not happen again now that I know they expire.

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

I will check my expiration date to insure that it does not happen again. I will also be setting a reminder in my phone and writing it on my calendar as reminders.

Date when corrective action will be completed.

September 04, 2024

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	07/26/2024
Survey Team Leader	Survey Type		Response Due
Perry, Bradley	Health Care Licensure and Follow-Up		08/25/2024

Item #	Rule (16.03.22)	Description
1	.215. REQUIREMENTS FOR A FACILITY ADMINISTRATOR.	The facility operated without a licensed administrator from 8/26/23 through 7/23/24. According to The Division of Professional and Occupational Licenses website, Brie Moore, Residential Assisted Living Facilities Administrator's license expired on 8/25/23, for a total of 333 days.
2	.260.06. Toxic Chemicals.	The facility was not maintained in a clean, safe and orderly manner. For example: Several areas in the kitchen were missing back splashes exposing the drywall, making it an uncleanable surface; the faucet in room 8 was broken; room 7 had multiple dead bugs smashed on the walls; there was chipped paint and trim throughout the facility; walls and door frames throughout the facility had gouges and scrapes; window screens were missing on most resident rooms and had been replaced with unsightly particle board; there were weeds growing on all sides of the building; the sidewalk on the right side had multiple chunks of concrete missing; linoleum in room 2 was missing; the front entrance walkway and door had bird droppings covering them; there was a red paint stripe on the wall in room 9; there was damaged and/or missing baseboards throughout and there were several doors with gouges in them.

		The facility manager and administrator stated the maintenance staff had not had time to fix the issues in question due to a conflicting schedule. They stated the owner had placed the particle board in lieu of window screens following the previous survey on 6/30/23. ***Previously cited on 6/24/21, 4/13/23 and 6/30/23***
3	.300.02. Licensed Nurse.	The facility nurse did not consistently review and implement residents' medication orders and did not contact outside providers after residents repeatedly refused their medications. For example, Resident #1 refused multiple medications daily between 6/1/24 to 7/22/24. Resident #3's provider had ordered Ingrezza for tardive dyskinesia on 6/6/24 was not implemented until 6/11/24 by the facility manager. Resident #3's order for Austedo XR was to be replaced with the Ingrezza order and the June and July 2024 medication administration record (MAR) documented the facility was "out" of the medication. The facility manager stated she never received a discontinued order for the Austedo order and the nurse was not involved with medication order changes or implementation. The facility nurse stated she was not aware she needed to implement new medication orders and was not made aware of new medication orders or changes with residents. She stated the facility manager and pharmacy was inputting new medication orders into the system for new orders and medication changes. The facility nurse stated she was not aware Resident #1 refused multiple medications daily between 6/1/24 to 7/22/24, and had not contacted their provider regarding these refusals.
4	.310.01.c. Medication Distribution.	The facility did not maintain the medication refrigerator temperatures, which stored residents' insulin and other medications, between 38 and 45 degrees F. The temperatures of the facility's medication refrigerator in the kitchen to the right was out of range 42 times between 5/1/24 to 7/22/24, and the left medication refrigerator was out of range three

		times between 5/1/24 to 7/22/24 with no corrective action taken. The facility manager stated she was unaware the medication refrigerators temperatures were out of range.
5	.630. TRAINING REQUIREMENTS FOR FACILITIES ADMITTING RESIDENTS WITH A DIAGNOSIS OF DEMENTIA, MENTAL ILLNESS, DEVELOPMENTAL DISABILITY, OR TRAUMATIC BRAIN INJURY.	Four of five staff members, whose personnel files were reviewed, did not have specialized training for mental illness, and five of five did not have specialized training for traumatic brain injury. The facility manager confirmed the staff members had not received these specialized trainings, and the facility maintained residents with these diagnoses.

CORE ISSUES

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Administrator	City	Zip Code	Survey Date
Brie Moore	Downey	83234	07/26/2024
Survey Team Leader	Survey Type		Response Due
Perry, Bradley	Health Care Licensure and Follow-Up		08/05/2024

Item #	Rule (16.03.22)	Description
2	.215.03. Lapse of Administrator.	Based on record review and interviews, it was determined the facility failed to retain a licensed administrator for the day-to-day operations of the facility for a period greater than 30 days. The findings include: IDAPA 16.03.22.010.20.e defines a core issue as the following: "A situation in which the facility has operated for more than thirty (30) days without a licensed administrator overseeing the day-to-day operations of the facility." IDAPA 16.03.22.100.04 documents, "Each facility must have an administrator." IDAPA 16.03.22.215 documents, “Under Section 39-3321, Idaho Code, each facility must have one (1) licensed administrator assigned as the person responsible for the day-to-day operation of the facility.” IDAPA 16.03.22.215.03 documents, “If the facility operates for

		more than thirty (30) days without a licensed administrator, it will result in a core issue deficiency." According to the Facility Licensing and Certification database (FLARES), Brie Moore, RCA-2582 has been the facility's administrator since 04/04/2022. According to The Division of Professional and Occupational Licenses website, Brie Moore, Residential Assisted Living Facilities Administer license expired on 8/25/23. On 7/23/24 at 10:05 AM, Brie Moore stated she was unaware that her license had expired. The facility operated without a licensed administrator from 8/25/23 to present. For 333 days there was no licensed administrator at the facility responsible to oversee the day-to-day operations. This resulted in a core deficiency.