PLAN OF CORRECTION

Pomerelle Place
1301 Bennett Avenue
Burley ID 83318

Provider ID: RC-1302

On 12/03/2024, a Health Care Complaint Investigation survey was conducted by Department staff at Pomerelle Place. 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.

Vanessa Ortega-Arteaga passed her exam and received her license. As of 12/18/2024, her license will be on the building.
Information has been posted in the community.
Betty will continue to support Vanessa after her she receives her license, as needed.

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.

Regional Director and Administrator will ensure a licensed administrator oversees day-to-day at the community.
Administrator Designee has been appointed in the event Vanessa Ortega-Arteaga is gone for training purposes.
This information is posted in the community.

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

Regional Director will oversee that a licensed person is in the building for day-to-day operations at all times.

Date when corrective action will be completed.

December 18, 2024

Program Comments

NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
Pomerelle Place	RC-1302	1301 Bennett Avenue	(208) 677-8212
Administrator	City	Zip Code	Survey Date
Betty Aberg	Burley	83318	12/03/2024
Survey Team Leader	Survey Type		Response Due
Walker, Jenny	Health Care Complaint Investigation		01/02/2025

Item #	Rule (16.03.22)	Description
1	.215. REQUIREMENTS FOR A FACILITY ADMINISTRATOR.	The facility did not have a licensed administrator overseeing the day-to-day operations of the facility. According to a communication in the FLARES portal, the previous administrator's last day was 7/15/24, and there had not been a licensed administrator overseeing the day-to-day operations at the facility since that date, for a total of 141 days. Several staff, residents, family members, and outside agency staff stated they did not know who the administrator was.
2	.305.02.b. Quarterly Nursing Assessments.	The facility did not ensure residents received medications as ordered. For example: Resident #3 did not receive their Montelukast Sodium nine times in November 2024 and Bisoprolol-Hydrochlorothiazide two times in November 2024; and Resident #3 had a physician's order, dated 8/26/24, Clobetasol Propionate foam to be applied to affected skin areas twice a day for two weeks, however, they received the medication from 8/26/24 to 11/26/24, for a total of 152 additional doses than prescribed. The facility's nurse stated the physician's orders had not been followed.

CORE ISSUES

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Betty Aberg	Burley	83318	12/03/2024
Survey Team Leader	Survey Type		Response Due
Walker, Jenny	Health Care Complaint Investigation		12/13/2024

Item #	Rule (16.03.22)	Description
2	.215.03. Lapse of Administrator.	Based on observations, interviews, and record review, 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.”

		The facility's undated administrator policy documented, "The facility's administrator must be on-site sufficiently to ensure safe and adequate care of the residents." According to the FLARES database, the facility did not have a licensed administrator who oversaw the day-to-day operations of the facility from 7/15/24 to current. The FLARES database documented Lisa Junod was the administrator from 2/5/24 until 7/15/24, and then Betty Aberg was the licensed administrator for the building from 8/12/24 to current. From 12/2/24 to 12/3/24, multiple residents, staff, family members, and outside agency staff stated they either did not know who the administrator was or stated the assistant administrator was the current administrator. On 12/2/24 at 2:20 PM, the assistant administrator stated she was the administrator designee for Betty Aberg who had her "license on the building" for several months until she passed her administrator's test. She stated the licensed administrator conducted weekly video calls and was also available by phone when she had questions, but was not in facility conducting day-to-day operations because the licensed administrator lived in Washington state. The assistant administrator stated she had not been delegated in writing by the administrator. A FLARES communication from the licensing project coordinator, dated 9/18/24, documented Betty Aberg was to be the licensed administrator starting on 9/12/24. A second FLARES communication from the licensing project coordinator, dated 9/19/24, documented she had made a typo on the 9/18/24 communications and Betty Aberg was to be the licensed administrator starting on 8/12/24.

		On 12/3/24 at 10:45 AM, the licensed administrator stated she lived in Washington state and had her name on the facility as the licensed administrator as of 9/12/24. She stated she had not been in the facility to oversee the day-to-day operations since her license had been put on the facility. She stated she had verbally delegated the assistant administrator but had not put it in writing as the rule required. The facility operated without a licensed administrator from 7/16/24 to present. For 141 days there was no licensed administrator at the facility responsible to oversee the day-to-day operations. This resulted in a core deficiency.