IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
RICHARD M. ARMSTRONG – Director

DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@idhw.state.id.us

July 31, 2006

FILE COPY

Leslie Erfurth, Administrator
Hawthorne Assisted Living
1836 S Curtis Rd
Boise, ID 83705

License #: Rc-805

Dear Ms. Erfurth:

On June 7, 2006, a state licensure survey was conducted at Hawthorne Assisted Living. 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.

This office is accepting your submitted plan of correction and evidence of resolution.

Should you have questions, please contact Patrick Hendrickson, R.N., Health Facility Surveyor, Residential Community Care Program, at (208) 334-6626.

Sincerely,

for

PATRICK HENDRICKSON, R.N.
Team Leader
Health Facility Surveyor
Residential Community Care Program

PH/slc

c: Jamie Simpson, BS, QRMP, MBA, Supervisor, Residential Community Care Program

IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
KARL B. KURTZ – Director

DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@idhw.state.id.us

June 12, 2006

CERTIFIED MAIL #: 7003 0500 0003 1967 1695

Leslie Erfurth, Administrator
Hawthorne Assisted Living
1836 S Curtis Rd
Boise, ID 83705

FILE COPY

Dear Ms. Erfurth:

Based on the standard health care survey conducted by our staff at Hawthorne Assisted Living on **June 7, 2006,** we have determined that the facility failed to maintain an operating sprinkler system and failed to ensure that residents were able to self-evacuate.

This core issue deficiency substantially limits the capacity of Hawthorne Assisted Living to furnish services of an adequate level or quality to ensure that residents' health and safety are safe-guarded. 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 **July 24, 2006.** **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)?
- What date will the corrective action(s) be completed by?

Return the **signed** and **dated** Plan of Correction to us by **June 25, 2006,** 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 Informational Letter #2002-16 INFORMAL DISPUTE RESOLUTION (IDR) PROCESS, 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 Chief of the Bureau of Facility Standards 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 (**June 25, 2006**). The specific deficiencies for which the facility asks reconsideration must be included in the written request, as well as the reason for the request for reconsideration. The facility's request must include sufficient information for the Bureau of Facility Standards to determine the basis for the provider's appeal. If your request for informal dispute resolution is received after **June 25, 2006,** 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. The completed punch list form and accompanying proof of resolution (e.g., receipts, pictures, policy updates, etc.) are to be submitted to this office by **July 7, 2006**.

If, at the follow-up survey, it is found that the facility is not in compliance with the rules and standards for residential care or assisted living facilities, the Department will have no alternative but to initiate an enforcement action against the license held by Hawthorne Assisted Living.

Should you have any questions, or if we may be of assistance, please call our office at (208) 334-6626.

Sincerely,

VIRGINIA LOPER, R.N.
Supervisor
Residential Community Care Program

VL/slc

Enclosure

c: Debra Ransom, R.N., R.H.I.T., Chief, Bureau of Facility Standards
Virginia Loper, Program Manager, Regional Medicaid Services, Region IV - DHW

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13R805		06/07/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAWTHORNE ASSISTED LIVING	3210 NORTH HAWTHORNE DRIVE BOISE, ID 83703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 standard survey conducted at your residential care/ assisted living facility on June 7, 2006. The surveyors conducting the survey were: Frutoso Gonzalez, RN Team Leader Health Facility Surveyor Patrick Hendrickson, RN Health Facility Surveyor Survey Definitions: NSA = Negotiated Service Agreement UAI = Uniform Assessment Instrument	R 000	RECEIVED JUN 30 2006 FACILITY STANDARDS	
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 observation, interview, and record review, it was determined the facility failed to ensure residents were not admitted and retained who were unable to self evacuate in the case of a fire for 1 of 3 sampled Residents (#1). The findings include:	R 008	R008 Residents who can not self evacuate during a fire will not be admitted OR retained in our building because of no fire supression system. TO ensure this, we will use a "self evacuation" assessment to identify current residents and future residents. Those residents identified as needing assistance will be discharged	

LA[illegible]ATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: RN — (X6) DATE: 6/28/06

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R805	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/07/2006
NAME OF PROVIDER OR SUPPLIER HAWTHORNE ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 3210 NORTH HAWTHORNE DRIVE BOISE, ID 83703		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 1 On 6/7/06 at 8:10 a.m., the facility was observed to have no fire sprinkler system. On 6/7/06 at 8:40 a.m., the owner confirmed the facility had only smoke detectors and no fire suppression system, which included sprinklers. Review of Resident #1's record on 6/7/06 revealed the resident was admitted on 12/2/04 with diagnoses which included cerebral palsy, congestive heart failure, and cervical stenosis. Further review of the resident's record revealed a combination UAI/NSA dated 4/25/06 which documented the resident was able to move inside the facility with the assistance of mobility devices either a wheelchair or a front wheel walker. Additionally, the facility documented the resident required the assistance of a single person as needed. The facility documented the resident may require staff assistance to respond to emergency situations. Resident #1's record contained a home health plan of care with a certification period from 4/25/06 to 6/23/06. The care plan documented the resident was diagnosed with muscle weakness and an unsteady gait. Physical therapy was provided to increase the resident's strength and improve his gait. Further review of the resident's record revealed physical therapy visit notes dated 5/23/06, 5/25/06, 5/30/06, 6/2/06, and 6/5/06. The notes documented the resident required moderate assistance with transfers, had an unstable gait and required the assistance of another to ambulate. On 6/7/06 at 8:10 a.m., Resident #1 was	R 008		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13R805		06/07/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAWTHORNE ASSISTED LIVING	3210 NORTH HAWTHORNE DRIVE BOISE, ID 83703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 2 observed sitting in a wheelchair at the dining room table. At 8:30 a.m., the resident was assisted to his room by a caregiver who pushed his wheelchair. The resident made no effort to move the wheelchair on his own. On 6/7/06 at 9:05 a.m., the facility owner, who was a licensed nurse, stated he was aware Resident #1 had "good days and bad days." "Good days" were days where the resident could transfer himself without assistance and when he could use his walker to ambulate. "Bad days" were days when the resident was weaker and required the assistance of caregivers to transfer and ambulate. He said the resident's mobility and transfer needs could not be consistently predicted. On 6/7/06 at 9:20 a.m., Resident #1's guardian stated he did not think the resident could safely exit the facility without assistance in case of an emergency. He said the resident's endurance was poor and he had noticed the resident tired easily. On 6/7/06 at 10:10 a.m., a caregiver stated Resident #1 could transfer independently "sometimes." She said she did not feel the resident could transfer out of bed into his wheelchair or use his walker without assistance to exit the facility in case of an emergency. The facility, without a fire sprinkler system, failed to assure resident safety when they admitted and retained Resident #1 who was not able to leave the building without one-on-one or hands on assistance. This failure resulted in inadequate care.	R 008	OR not admitted. TO ensure this defiency does not recur, the residents will be observed during scheduled fire drills & reassessed with NSA updates. Resident #1 has been given notice of discharge and has been asked to leave our building by July 3, 2006. We have obtained a bid for a fire sprinkler system and are currently seeking funding.	

IDAHO DEPARTMENT OF
HEALTH & WELFARE

BUREAU OF FACILITY STANDARDS
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-6626 fax: (208) 364-1888

ASSISTED LIVING
Non-Core Issues
Punch List

Facility Name	Physical Address	Phone Number
Hawthorne Assisted Living	3210 North Hawthorne Drive	336-6868
Administrator	**City**	**ZIP Code**
Leslie Erfarth	Boise	83703
Survey Team Leader	**Survey Type**	**Survey Date**
Frutoso Gonzalez RN	Standard Survey	6-7-06

NON-CORE ISSUES

ITEM #	RULE #	DESCRIPTION	DATE RESOLVED
1	16.03.22.250.15	The Facility call System did not include the Resident Bathing or toilet area.	6/8/06
2	16.03.22.260.04	Spiders were noted to be in the ceiling of the Hallway	7/4/06
3	16.03.22.310.01a	All medications need to be kept in a locked area.	7/4/06 + 6/13/06
4	16.03.22.310.01.d	Assistance with medication must comply with the Board of nursing requirements.	7/12/06

RECEIVED
JUL 10 2006
FACILITY STANDARDS

Response Required Date	Signature of Facility Representative
July 7, 2006	[signature]