



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

July 1, 2015

Joseph Huskinson, Administrator  
Lincoln Court Retirement Community  
850 Lincoln Drive  
Idaho Falls, Idaho 83401

Provider ID: RC-1020

Mr. Huskinson:

On May 1, 2015, a state licensure/follow-up survey and complaint investigation were conducted at Lincoln Court Retirement Community. 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 Donna Henscheid, LSW, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 364-1962.

Sincerely,

DONNA HENSCHIED, LSW  
Team Leader  
Health Facility Surveyor

DH/sc

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



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P.O. Box 83720  
Boise, Idaho 83720-0009  
EMAIL: ralf@dhw.idaho.gov  
PHONE: 208-364-1962  
FAX: 208-364-1888

May 20, 2015

**CERTIFIED MAIL #: 7007 3020 0001 4050 8906**

Joseph Huskinson, Administrator  
Lincoln Court Retirement Community  
850 Lincoln Drive  
Idaho Falls, Idaho 83401

Mr. Huskinson:

On May 1, 2015, a state licensure/follow-up survey and complaint investigation were conducted by Department staff at Lincoln Court Retirement Community. The facility was cited with a core issue deficiency for failing to protect residents from inadequate care.

This core issue deficiency substantially limits the capacity of Lincoln Court Retirement Community to provide for residents' basic health and safety needs. The deficiency is described on the enclosed Statement of Deficiencies.

**PROVISIONAL LICENSE:**

As a result of the survey findings, a provisional license is being issued effective May 20, 2015 and will remain in effect until the a follow-up survey is conducted to verify that the facility is back in compliance. The following administrative rule for Residential Care or Assisted Living Facilities in Idaho (IDAPA 16.03.22) gives the Department the authority to issue a provisional license:

***935. ENFORCEMENT REMEDY OF PROVISIONAL LICENSE.***

*A provisional license may be issued when a facility is cited with one (1) or more core issue deficiencies, or when non-core issues have not been corrected or become repeat deficiencies. The provisional license will state the conditions the facility must follow to continue to operate. See Subsections 900.04, 900.05 and 910.02 of these rules.*

The conditions 1- 6 of the provisional license are as follows:

**CONSULTANT:**

- 1. A licensed residential care administrator or RN consultant, with at least three years' experience**

working as an administrator or RN for a residential care or assisted living facility in Idaho, shall be obtained and paid for by the facility, and approved by the Department. This consultant must have an Idaho Residential Care Administrator's license or properly licensed through the Board of Nursing and may not also be employed by the facility or the company that operates the facility. The purpose of the consultant is to assist the facility in identifying and implementing appropriate corrections for the deficiencies. Please provide a copy of the enclosed consultant report content requirements to the consultant. The consultant shall be allowed unlimited access to the facility's administrative, business and resident records and to the facility staff, residents, their families and representatives. The name of the consultant with the person's qualifications shall be submitted to the Department for **approval no later than May 26, 2015.**

2. **A weekly written report** must be submitted by the Department-approved consultant to the Department commencing on **May 29, 2015.** The reports will address progress on correcting the core deficiency identified on the Statement of Deficiencies as well as the non-core deficiencies identified on the punch list. When the consultant and the administrator agree the facility is in full compliance, they will notify the Department and request a follow-up survey be scheduled. **The consultant will continue visiting the facility weekly and submitting weekly reports until the follow-up survey is completed.**

#### **PLAN OF CORRECTION:**

3. 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?

An acceptable, **signed** and **dated** Plan of Correction must be submitted to the Division of Licensing and Certification within **ten (10) calendar days of your receipt of the Statement of Deficiencies.** You are encouraged to immediately develop and submit this plan so any adjustments or corrections to the plan can be completed prior to the deadline.

#### **EVIDENCE OF RESOLUTION:**

4. 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 following administrative rule for Residential Care or Assisted Living Facilities in Idaho (IDAPA 16.03.22) describes the requirements for submitting evidence that the non-core issue deficiencies have been resolved:

**910. Non-core Issues Deficiency.**

**01. Evidence of Resolution.** *Acceptable evidence of resolution as described in Subsection 130.09 of these rules, must be submitted by the facility to the Licensing and Survey Agency. If acceptable evidence of resolution is not submitted within sixty (60) days from when the facility was found to be out of compliance, the Department may impose enforcement actions as described in Subsection 910.02.a through 910.02.c of these rules.*

The twenty-six (26) non-core issue deficiencies must be corrected and evidence (including but not limited to receipts, pictures, completed forms, records of training) must be submitted to this office by **May 31, 2015.**

**ADMINISTRATIVE REVIEW**

You may contest the provisional license and the requirement for a consultant by filing a written request for administrative review pursuant to IDAPA 16.05.03.300, which states: **the request must be signed by the licensed administrator of the facility, identify the challenged decision, and state specifically the grounds for your contention that this decision is erroneous.** The request must be received **no later than twenty-eight (28) days after this notice was mailed.** Any such request should be addressed to:

**Tamara Prisock, Administrator**  
**Division of Licensing and Certification - DHW**  
**3232 Elder Street**  
**P.O. Box 83720**  
**Boise, ID 83720-0036**

Upon receipt of a written request that meets the requirements specified in IDAPA 16.05.03.300, an administrative review conference will be scheduled and conducted. The purpose of the conference is to clarify and attempt to resolve the issues. A written review decision will be sent to you within thirty (30) days of the date of the conclusion of the administrative review conference.

If the facility fails to file a request for administrative review within the above specified time period, this decision shall become final.

**INFORMAL DISPUTE RESOLUTION**

Pursuant to IDAPA 16.03.22.003.02, you have available the opportunity to question the core issue deficiency 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 Assisted Living Facility Program for an IDR meeting. The request for the meeting must be in writing and must be made within ten (10) business days of receipt of the Statement of Deficiencies. The facility's request must include sufficient information for Licensing and Certification to determine the basis for the provider's appeal, including reference to the specific deficiency to be reconsidered and the basis for the reconsideration request. If your request for informal dispute resolution is received more than ten (10) days after you receive the Statement of Deficiencies, your request will not be granted. Your IDR request must be made in accordance with the Informal Dispute Resolution Process. The IDR request form and the process for submitting a complete request can be found at [www.assistedliving.dhw.idaho.gov](http://www.assistedliving.dhw.idaho.gov) under the heading of Forms and Information.

## **FOLLOW-UP SURVEY**

An on-site, follow-up survey will be scheduled after the administrator and consultant submit a letter stating that all deficiencies have been corrected and systems are in place to assure the deficient practices remain corrected. If at the follow-up survey, the core issue deficiency still exists, a new core issue deficiency is identified, non-core deficiencies have not been corrected, or the facility has failed to abide by the conditions of the provisional license, the Department will take further enforcement action against the license held by Lincoln Court Retirement Community. Those enforcement actions will include one or more of the following:

- Revocation of the Facility License
- Summary Suspension of the Facility License
- Imposition of Temporary Management
- Limit on Admissions
- Civil Monetary Penalties

Division of Licensing and Certification staff is available to assist you in determining appropriate corrections and avoiding further enforcement actions. Please contact our office at (208) 364-1962 if we may be of assistance, or if you have any questions.

Sincerely,



JAMIE SIMPSON, MBA, QMRP  
Program Supervisor  
Residential Assisted Living Facility Program

JS/sc

Enclosures

PRINTED: 05/19/2016  
FORM APPROVED

Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13R1020	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  05/01/2015
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NAME OF PROVIDER OR SUPPLIER  
**LINCOLN COURT RETIREMENT COMMUNITY**

STREET ADDRESS, CITY, STATE, ZIP CODE  
**850 LINCOLN DRIVE  
IDAHO FALLS, ID 83401**

(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 deficiencies were cited during the licensure survey and complaint investigation conducted April 27, 2015 through May 1, 2015 at your residential care/assisted living facility. The surveyors conducting the survey were:</p> <p>Donna Henschel, LSW Team Coordinator Health Facility Surveyor</p> <p>Maureen McCann, RN Health Facility Surveyor</p> <p>Gloria Keathley, LSW Health Facility Surveyor</p> <p>Rae Jean McPhillips, RN, BSN Health Facility Surveyor</p> <p>Abbreviations:</p> <p>AM = morning ETOH = alcohol LPN = licensed practical nurse MAR = medication assistance record mg = milligram NSA = negotiated service agreement PM = evening PRN (prn) = as needed QHS = at bedtime rehab = rehabilitation RN = registered nurse TID (tid) = three times daily</p>	R 000	<p>This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies imposed on Lincoln Court during a survey conducted April 27th-May 1st 2015. Rather, it is submitted as confirmation of our ongoing efforts to comply with all statutory and regulatory requirements. In this document, we have outlined specific actions in response to each allegation or finding. We have not presented contrary factual or legal arguments, nor have we identified mitigating factors.</p> <p>Residents three, and eight the following has been implemented:</p> <p>Resident three: medication error report will be implemented on the medication issues, medications will be reviewed for accuracy, and any changes needed will be made. The licensed nurse will review med orders before the medications are given. Psychotropic medications on the MAR will include side effects. Behavioral plan and tracking will be implemented to include interventions to be used prior to medications. The NSA will be updated on the changes in care if identified.</p> <p>Resident eight: medication error report will be implemented on the medication issues, medications will be reviewed for accuracy and any changes needed will be made. The Registered nurse will review med orders before the medication is given or held.</p>	06/30/2015
R 008	<p>18.03.22.520 Protect Residents from Inadequate Care.</p> <p>The administrator must assure that policies and</p>	R 008		

Bureau of Facility Standards  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*Joe Harrison*

*Executive Director*

*5/29/15*

PRINTED: 05/19/2015  
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## Residential Care/Assisted Living

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NAME OF PROVIDER OR SUPPLIER  LINCOLN COURT RETIREMENT COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 850 LINCOLN DRIVE IDAHO FALLS, ID 83401		
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R 008	<p>Continued From page 1</p> <p>procedures are implemented to assure that all residents are free from inadequate care.</p> <p>This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide assistance and monitoring of medications for 2 of 10 sampled Residents (#3 and #8). These findings include:</p> <p>1. According to her record, Resident #3 was an 87 year-old female, who was admitted to the facility on 12/0/12 with diagnoses including Alzheimer's disease and congestive heart failure.</p> <p>On 4/28/15 at 2:15 PM, Resident #3 was observed in her room seated in a motorized scooter. The resident stated "I got an overdose of my medication when I first got here and I had to go to the hospital." The resident could not remember when this incident occurred and thought it was at least a year ago.</p> <p>IDAPA 16.03.22.225 documents, "The facility must identify and evaluate behavioral symptoms that are distressing to the resident..."</p> <p>A "90 DAY RN ASSESSMENT," dated 2/10/15, documented the resident had seen a physician for "hallucinations." The assessment did not document any behaviors.</p> <p>Two NSAs, dated 2/26/15 and 4/28/15, documented Resident #3 had been placed on a behavior plan based on the need for prn psychotropic medications. The behaviors included "aggression, defensive behavior, hitting, hostility, maladaptive, manipulative, self-destructive, smoking, violence,</p>	R 008	<p>Current resident records will be reviewed and changes made for identified issues with, medications to include, psychotropics, side effects on the MAR, behavioral observation/tracking/ changes/interventions to be used prior to medications, and if identified, these will be added to the NSA.</p> <p>Policies and procedures will be reviewed and updated if applicable to include new systems and forms to support compliance with medication occurrences, receiving/reviewing/monitoring medications, behavioral monitoring with interventions to be used prior to medications, and updating the NSA. The policies and procedures and any new changes to include forms on medication occurrences, receiving/reviewing/monitoring medications, behavioral monitoring with interventions to be used prior to medications, and updating the NSA, will be reviewed and the staff will be educated in an in-service dated the week of June 8th.</p> <p>Checklists and continuing education in-services will be developed and implemented to track medication occurrences, receiving/reviewing/monitoring medications, behavioral monitoring with interventions to be used prior to medications and updating the NSA. These checklists will be monitored weekly until compliance is attained, then they will be monitored on an ongoing basis to support compliance.</p>	

Residential Care/Assisted Living

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R 008	<p>Continued From page 2</p> <p>wellness-seeking, ETOH abuse." However, none of these behaviors were documented anywhere else in Resident #3's record. The NSA did not document Resident #3 had hallucinations.</p> <p>Between 4/28/15 and 4/30/15, six staff members stated they did not remember Resident #3 having behaviors. They stated they remembered Resident #3 experiencing hallucinations at night when she thought people were looking in her window or hiding in her room or closet.</p> <p>On 4/30/15 at 10:35 PM, the facility nurse stated there was no behavior management plan for Resident #3 or documentation regarding the resident exhibiting behaviors.</p> <p>Although Resident #3's NSA documented the resident had a behavior plan based on the need for prn psychotropic medications, there was no documentation or clear description of what behaviors Resident #3 was exhibiting. Further, there was no documentation of a written behavior plan regarding what non-drug interventions staff were to try when Resident #3 exhibited behaviors.</p> <p>IDAPA 16.03.22.310.04.a documents, "Psychotropic or behavior modifying medication intervention must not be the first resort to address behaviors. The facility must attempt non-drug interventions to assist and redirect the resident's behavior."</p> <p>Resident #3's January 2015 MAR documented the resident had routinely received, an anti-psychotic medication, Seroquel 100 mg by mouth each evening for "mood." Further, the resident had an anti-anxiety medication, Xanax 0.5 mg (1/2 tab), available every 8 hours "as needed" for anxiety. The January MAR further</p>	R 008		

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R 008	<p>Continued From page 3</p> <p>Indicated Resident #3 received Xanax five out of a possible 63 times for "anxiety." Resident #3's February MAR documented the resident did not receive the prn Xanax.</p> <p>A fax, dated 2/9/15, to Resident #3's physician from the facility LPN, documented, "request to add Risperdal 0.5 mg QHS due to behaviors and anxiety with insomnia and request for Haldol 5 mg TID PRN hallucinations."</p> <p>On 4/30/15 at 10:35 PM, the facility nurse stated she requested the antipsychotic medications for Resident #3 because the night staff told her the resident was up at night and thought men were in her room or were outside her room at her window "with ladders."</p> <p>There was no documentation in Resident #3's record describing the resident's "hallucinations" or regarding the resident's insomnia or anxiety. Further, there was no documentation why the resident required a new medication for anxiety when she already had an anti-anxiety medication available and had only used it five times in January and not at all in February.</p> <p>Resident #3's February 2015 MAR documented the resident was to receive Haldol 5 mg three times a day. However, the physician's order documented the resident was only to receive the medication if needed. Therefore, due to this transcription error, Resident #3 received the Haldol nine times for an unknown reason on the following dates:</p> <p>*2/10/15 at 9:00 PM *2/11/15 at 8:00 AM, 1:00 PM and 9:00 PM *2/12/15 at 8:30 AM, 1:00 PM and 9:00 PM *2/13/15 at 8:30 AM and 1:00 PM</p>	R 008		

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R 008	<p>Continued From page 4</p> <p>Resident #3's February 2015 MAR also documented the resident had received Risperdal 0.5 mg and Seroquel 100 mg, per the physician's orders, on:</p> <p>*2/10/15 at 9:00 PM *2/11/15 at 9:00 PM *2/12/15 at 9:00 PM</p> <p>The facility LPN requested two additional anti-psychotic medications and Resident #3 received all three anti-psychotic medications simultaneously, without any documentation as to why the resident required these medications. Further, there was no documentation to explain why Resident #3 required another medication for anxiety when she had only used the anti-anxiety medication she already had available, five out of a possible 63 times in January.</p> <p>IDAPA 16.03.22.301.04.d documents, Psychotropic or Behavior Modifying Medication: "The facility will monitor the resident for any side-effects that could impact the resident's health and safety."</p> <p>According to Lippincott's "Nursing 2015 Drug Handbook," Seroquel, Haldol and Risperdal are anti-psychotic medications. The handbook also documented the side-effects of each of these medications, individually, include "somnolence or sedation."</p> <p>There was no documentation found in Resident #3's record that staff were instructed to monitor Resident #3 for somnolence or sedation while receiving three anti-psychotic medications simultaneously.</p>	R 008		

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R 008	<p>Continued From page 5</p> <p>On 4/30/15 at 2:50 PM, a family member stated another family member told her the following: She went to the facility to visit Resident #3 on 2/13/15 at 11:00 AM and found the resident was "still in bed. She could not function; she could not dress herself...and could not feed herself." At that time, other family members arrived at the facility, saw that Resident #3 was not able to function and thought the resident "looked like" she had experienced a stroke. The family transported the resident to the hospital where the emergency room physician told them Resident #3 had been over-medicated. The interviewed family member stated they were all surprised the facility had given Resident #3 additional anti-psychotic medications without their knowledge. She stated the family met with the administrator and the LPN after this incident. There was no documentation found in the facility regarding this incident or this meeting.</p> <p>On 4/29/15, the survey team requested Resident #3's records from a local hospital as there were none found in the facility. A hospital history and physical, dated 2/14/15, documented the resident was admitted to the hospital with "hypersomnolence" believed to be secondary to "overmedication."</p> <p>An "RN Nursing Assessment for Change in Condition," dated the day the resident returned to the facility on 2/26/15, documented the resident had seen a physician while "in rehab" but did not document why the resident had been in rehab or that Resident #3 had been in the hospital. The assessment further documented the resident's Risperdal and Haldol had been discontinued, but no explanation was made for the medication change.</p>	R 008		

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NAME OF PROVIDER OR SUPPLIER  LINCOLN COURT RETIREMENT COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 880 LINCOLN DRIVE IDAHO FALLS, ID 83401		
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R 008	<p>Continued From page 6</p> <p>Between 2/28/15 and 2/30/15, six staff members were interviewed. Five of the staff members stated they did not know why Resident #3 went to the hospital. One staff member stated, "There was a mix up with her medication," but did not recall any details.</p> <p>On 4/30/15 at 10:36 PM, the facility LPN stated she heard Resident #3 had been taken to the hospital because she was "over-sedated." She further stated she did not know the resident had been over-sedated until the resident was admitted to the hospital.</p> <p>On 4/30/15 at 2:15 PM, the administrator stated he could not recall why Resident #3 went to the hospital.</p> <p>The facility failed to address multiple issues with the assistance and monitoring of medication they provided to Resident #3. These issues were:</p> <ul style="list-style-type: none"> <li>*The facility did not clearly identify Resident #3's behaviors or ensure non-drug interventions were implemented and shown ineffective, before using anti-psychotic medications to control the behaviors.</li> <li>*A transcription error resulted in Resident #3 receiving a medication 9 times within 72 hours, that the resident was supposed to receive only if needed for hallucinations. There was no evidence the facility had investigated these errors or taken actions to ensure such errors would not occur.</li> <li>*There was no indication the facility monitored for or identified somnolence or sedation in Resident #3. However, family members immediately recognized something was wrong with the resident and took her to the emergency</li> </ul>	R 008		

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(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 7</p> <p>room. There was no evidence the facility was monitoring for side-effects or had a system in place to direct staff on what to do if adverse reactions were observed.</p> <p>2. According to her record, Resident #8 was an 82 year-old female, admitted to the facility on 7/16/13 with diagnoses including dementia and atrial fibrillation.</p> <p>According to the "2015 Nursing Drug Handbook," Coumadin is a drug used to prevent blood coagulation or clotting. It is typically used for pulmonary embolism, deep vein thrombosis, heart attack and chronic atrial fibrillation.</p> <p>A physician's order from the hospice agency, dated 2/13/15, documented to increase Resident #8's dose of Coumadin to 4.5 mg daily. The order was signed by the hospice nurse on 2/13/15 and by the facility RN and LPN on 2/16/15.</p> <p>A physician's recapitulation order, dated 3/3/15, documented Resident #8's dose of Coumadin was 4.5 mg daily. This was signed off by the facility RN on 3/3/15.</p> <p>February, March and April 2015 MARs, documented Resident #8 received only 0.5 mg of Coumadin instead of the 4.5 mg as ordered for a total of 71 days.</p> <p>A fax to Resident #8's physician, dated 4/17/15, documented a "clarification" regarding the resident being given 0.5 mg daily for the "past month." The physician responded to restart the Coumadin at 4.5 mg daily. The fax was signed off by the RN on 4/20/15. However, the order change was not implemented until 4/28/15, another 6 days after the order was clarified. There was no</p>	R 008		

PRINTED: 05/19/2015  
FORM APPROVED

Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13R1020	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  05/01/2015
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NAME OF PROVIDER OR SUPPLIER  LINCOLN COURT RETIREMENT COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 850 LINCOLN DRIVE IDAHO FALLS, ID 83401
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(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>further documentation found in Resident #8's record regarding the medication error. There was no investigation of the incident and no documented plan put into place to prevent the error from recurring.</p> <p>On 4/29/15 at 3:15 PM, the facility LPN stated the error with the Coumadin was corrected on 4/26/15. She confirmed there was no further documentation regarding the incident. She stated the facility was making changes to ensure medication assistance was more efficient for staff, but they had not implemented all the changes yet.</p> <p>The facility nurses had two opportunities, on 2/13/15 and 3/3/15, to rectify Resident #8's Coumadin order with the actual dose that was being given, but failed to get the dose corrected. After discovering the error, it took the facility 5 days to get the correct dose implemented. Resident #8 received an incorrect dose of Coumadin for 71 days, which included the additional 6 days after error was discovered and the order clarified with the physician. This had the potential to cause serious harm due to the risk for blood clots.</p> <p>The facility failed to provide adequate assistance and monitoring of medication for Resident's #3 and #8. These failures resulted in inadequate care.</p>	R 008		



Facility LINCOLN COURT RETIREMENT COMMUNITY	License # RC-1020	Physical Address 850 Lincoln Drive	Phone Number (208) 529-3456
Administrator Joseph Huskinson	City Idaho Falls	ZIP Code 83401	Survey Date May 1, 2015
Survey Team Leader Donna Henscheid, LSW	Survey Type Licensure and Complaint Investigation	RESPONSE DUE: May 31, 2015	
Administrator Signature 	Date Signed 5/8/15		

**NON-CORE ISSUES**

Item #	IDAPA Rule #	Description	Department Use Only	
			EOR Accepted	Initials
1	009.01	The facility did not have evidence that criminal history and background checks were conducted on 1 of 10 employees.	6/8/15	DH
2	009.06.c	The facility did not have evidence that Idaho State police background checks had been conducted for 4 employees.	6/8/15	DH
3	225.01	The facility did not evaluate behaviors for Residents #1, 3, 4, 7 and 8.		
4	225.02	The facility did not develop interventions for residents' behaviors. (#1, 3, 4, 7 and 8)	6/23/15	DH
5	260.06	Ten residents' rooms were not maintained in a clean and sanitary manner. For example: rooms had urine or other odors, toilets required cleaning, carpets/floors were dirty, a room had trim broken off the bathroom door, and carpet was peeling off a bathroom wall. Additionally, there was a large water stain in the dining room above the fireplace.	6/8/15	DH
6	305.02	The facility did not ensure residents' medications were current. For example: Resident #5's Coumadin order was not clarified, there were medications without orders and physicians' orders without medications. Further, nursing assessments did not contain pertinent medical information, such as diabetes, wounds, suprapubic catheters and ability to self-administer medications. **Previously cited on 9/27/12**	6/8/15	DH
7	305.03	The facility nurse did not document the status of residents' wounds or when residents had changes of condition. **Previously cited on 6/13/13**	6/22/15	DH
8	310.01.f	Staff did not observe residents take their medications.	6/8/15	DH
9	310.04.a	Psychotropic medications were used as a first resort to address behaviors.	6/8/15	DH
10	310.04.d	The facility did not monitor residents for side-effects of psychotropic medications that impacted residents health and safety.	6/23/15	DH
11	320.03	NSAs were not signed and dated by all parties. **Previously cited on 6/13/13**	6/25/15	DH
12	320.08	Residents' NSAs were not updated to reflect current needs or changes of condition. **Previously cited on 9/27/12**	6/25/15	DH
13	330.02	The facility did not maintain residents' records for three years. **Previously cited on 6/13/13**	6/22/15	DH
14	350.02	The administrator did not conduct investigations of all accidents, incidents and complaints.	6/23/15	DH



Facility LINCOLN COURT RETIREMENT COMMUNITY	License # RC-1020	Physical Address 850 Lincoln Drive	Phone Number (208) 529-3456
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Survey Team Leader Donna Henscheid, LSW	Survey Type Licensure and Complaint Investigation	RESPONSE DUE: May 31, 2015	
Administrator Signature 	Date Signed 5/8/15		

**NON-CORE ISSUES**

Item #	IDAPA Rule #	Description	Department Use Only	
			EOR Accepted	Initials
15	350.04	The administrator did not provide a written response to complainants.	6/22/15	DH
16	620	The facility did not have evidence of the number of orientation training hours provided to employees.	6/23/15	DH
17	630.01	8 of 10 employees did not have evidence of dementia training.	6/22/15	DH
18	630.02	9 of 10 employees did not have evidence of mental illness training. **Previously cited on 9/27/12**	6/22/15	DH
19	630.03	9 of 10 employees did not have evidence of developmental disability training. **Previously cited on 9/27/12**	6/22/15	DH
20	630.04	10 of 10 employees did not have evidence of traumatic brain injury training.	6/22/15	DH
21	711.04	There was no documentation Resident #10 had been informed of the consequences of refusing a medication, nor was the resident's physician notified of the refusals for over two months. **Previously cited on 9/27/12**	6/25/15	DH
22	711.07	The facility did not have current care plans for residents' outside services.	6/23/15	DH
23	711.08.c	Facility staff did not document all unusual events such as incidents, accidents, and behaviors. **Previously cited on 9/27/12**	6/23/15	DH
24	711.08.e	Facility staff did not document when they had notified the nurse.	6/25/15	DH
25	711.08.f	Residents' records did not contain current care notes from outside agencies.	6/8/15	DH
26	730.02.a	Work records did not include the days and hours the facility nurses worked.	6/8/15	DH
27				
28				
29				
30				
31				
32				



# 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>Linnell Court Retirement</u>		Operator <u>Joseph Hustinson</u>	
Address <u>950 Linnell Dr</u>		<u>ED Falls 83401</u>	
County <u>Latah</u>	Estab #	EHS/SUR #	Inspection time: _____ Travel time: _____
Inspection Type:		Risk Category: <u>High</u>	Follow-Up Report: OR On-Site Follow-Up: Date: _____ Date: _____

# of Risk Factor Violations <u>0</u>	# of Retail Practice Violations <u>1</u>
# of Repeat Violations _____	# of Repeat Violations _____
Score <u>0</u>	Score <u>1</u>
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

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

### 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"/>
	<b>Employee Health (2-201)</b>		
<u>Y</u> N	2. Exclusion, restriction and reporting	<input type="checkbox"/>	<input type="checkbox"/>
	<b>Good Hygienic Practices</b>		
<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"/>
	<b>Control of Hands as a Vehicle of Contamination</b>		
<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"/>
	<b>Approved Source</b>		
<u>X</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 (N/A)	10. Records: shellstock tags, parasite destruction, required HACCP plan (3-202 & 3-203)	<input type="checkbox"/>	<input type="checkbox"/>
	<b>Protection from Contamination</b>		
<u>Y</u> N (N/A)	11. Food segregated, separated and protected (3-302)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N (N/A)	12. Food contact surfaces clean and sanitized (4-5, 4-6, 4-7)	<input type="checkbox"/>	<input type="checkbox"/>
<u>X</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 (N/O) (N/A)	15. Proper cooking, time and temperature (3-401)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N (N/O) (N/A)	16. Reheating for hot holding (3-403)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N (N/O) (N/A)	17. Cooling (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
<u>X</u> N (N/O) (N/A)	18. Hot holding (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
<u>X</u> N (N/O) (N/A)	19. Cold Holding (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N (N/O) (N/A)	20. Date marking and disposition (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N (N/O) (N/A)	21. Time as a public health control (procedures/records) (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
	<b>Consumer Advisory</b>		
<u>Y</u> N (N/A)	22. Consumer advisory for raw or undercooked food (3-603)	<input type="checkbox"/>	<input type="checkbox"/>
	<b>Highly Susceptible Populations</b>		
<u>Y</u> N (N/O) (N/A)	23. Pasteurized foods used, avoidance of prohibited foods (3-801)	<input type="checkbox"/>	<input type="checkbox"/>
	<b>Chemical</b>		
<u>X</u> N (N/A)	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"/>
	<b>Conformance with Approved Procedures</b>		
<u>Y</u> N (N/A)	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>Pork / Fried</u>	<u>37</u>	<u>Turkey / Ham / Ham</u>	<u>177</u>				
<u>Beef / Fried</u>	<u>35</u>	<u>Beef / Ham / Ham</u>	<u>177</u>				

### GOOD RETAIL PRACTICES (input X = 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 checked="" 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>Joe Hustinson</u>	(Print) <u>Joe Hustinson</u>	Title <u>ED/AM</u>	Date <u>5/1/15</u>
Inspector (Signature) <u>Colvin Keith</u>	(Print) <u>Colvin Keith</u>	Date <u>4/30/15</u>	Follow-up: (Circle One) <u>Yes</u> No



Residential Assisted Living Facility Program, Medicaid L & C  
3232 W. Elder Street, Boise, Idaho 83705  
208-334-6626

Page 2 of 2  
Date 4-30-15

Establishment Name <u>Lincoln Court Retirement</u>		Operator <u>Joseph Huskanson</u>
Address <u>750 Lincoln Court Dr. ID Falls</u>		
County Estab # <u>Bonneville</u>	EHS/SUR.#	License Permit #

OBSERVATIONS AND CORRECTIVE ACTIONS (Continuation Sheet)

# 3# - there was not a lunch gap between a drain and a sink in the kitchen.

Person in Charge <u>[Signature]</u>	Date <u>5/1/15</u>	Inspector <u>[Signature]</u>	Date <u>4-30-15</u>
--	-----------------------	---------------------------------	------------------------



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

May 20, 2015

Joseph Huskinson, Administrator  
Lincoln Court Retirement Community  
850 Lincoln Drive  
Idaho Falls, Idaho 83401

Provider ID: RC-1020

Mr. Huskinson:

An unannounced, on-site complaint investigation was conducted at Lincoln Court Retirement Community between April 27, 2015 and May 1, 2015. During that time, observations, interviews, and record reviews were conducted with the following results:

**Complaint # ID00006768**

Allegation #1: The facility did not investigate accidents or incidents.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.350.02 for the facility administrator not conducted an investigation of all incidents or accidents. The facility was required to submit evidence of resolution within 30 days.

Allegation #2: The facility did not follow their policy by notifying residents' family members of incidents or accidents.

Findings: Substantiated. However, the facility was not cited for the delay in notifying the identified resident's family member. The facility administrator was provided with written technical assistance to ensure the facility's policy, regarding notifying residents' families of emergencies, be implemented in a timely manner.

Allegation #3: The facility did not respond to complainants in writing.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.350.04 for not providing complainants with a written response. The facility was required to submit evidence of resolution within 30 days.

Joseph Huskinson, Administrator

May 20, 2015

Page 2 of 2

Allegation #4: The facility did not report incidents to Licensing and Certification.

Findings: Unsubstantiated. The resident was hospitalized in July for an insertion of a pain pump which is not a reportable incident.

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 cursive script that reads "Donna Henscheid".

DONNA HENSCHIED, LSW  
Health Facility Surveyor  
Residential Assisted Living Facility Program

DH/sc

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



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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P.O. Box 83720  
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FAX: 208-364-1888

May 20, 2015

Joseph Huskinson, Administrator  
Lincoln Court Retirement Community  
850 Lincoln Drive  
Idaho Falls, Idaho 83401

Provider ID: RC-1020

Mr. Huskinson:

An unannounced, on-site complaint investigation was conducted at Lincoln Court Retirement Community between April 27, 2015 and May 1, 2015. During that time, observations, interviews, and record reviews were conducted with the following results:

**Complaint # ID00006961**

Allegation #1: The facility was not maintained in a clean and orderly manner.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.260.06 for residents' rooms not being maintained in a clean and orderly manner. The facility was required to submit evidence of resolution within 30 days.

Allegation #2: The activity director passed medications without medication certification.

Findings: On 4/29/15 at 4:10 PM, the activity director stated she had assisted with medications in the past when needed. She further stated, she was able to "help" with medication assistance because she had medication certification.

On 4/30/15, the activity director's employee record was reviewed. The record contained a copy of the employee's medication certification. Additionally, there was documentation the facility nurse had delegated the activity director to pass medications.

Unsubstantiated.

Joseph Huskinson, Administrator

May 20, 2015

Page 2 of 2

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 cursive script that reads "Donna Henscheid".

DONNA HENSCHIED, LSW  
Health Facility Surveyor  
Residential Assisted Living Facility Program

DH/sc

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



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

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P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: 208-364-1962  
FAX: 208-364-1888

May 20, 2015

Joseph Huskinson, Administrator  
Lincoln Court Retirement Community  
850 Lincoln Drive  
Idaho Falls, ID 83401

Provider ID: RC-1020

Mr. Huskinson:

An unannounced, on-site complaint investigation survey was conducted at Lincoln Court Retirement Community between April 27, 2015 and May 1, 2015. During that time, observations, interviews, and record reviews were conducted with the following results:

**Complaint # ID00006896**

**Allegation #1:** The facility did not evaluate residents' behaviors and implement behavior plans for residents displaying behaviors.

**Findings:** Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.225.a for not evaluating residents' behaviors and implementing behavior plans. The facility was required to submit evidence of resolution within 30 days.

**Allegation #2:** The facility implemented behavior modifying medications as a first resort when residents displayed behaviors.

**Findings:** Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.310.04.a, for requesting behavior modifying medications for an identified resident, before attempting non-pharmaceutical interventions. The facility was required to submit a plan of correction within 30 days.

**Allegation #3:** Caregivers did not document they had contacted the facility nurse when residents experienced changes in their condition.

Joseph Huskinson, Administrator

May 20, 2015

Page 2 of 2

Findings: Substantiated. The facility was issued deficiency at IDAPA 16.03.22.711.08.e, for caregivers not documenting they had contacted the facility nurse when residents experienced changes in their condition. The facility was required to submit evidence of resolution within 30 days.

Allegation #4: The facility did not monitor residents for side-effects after behavior modifying medications were implemented.

Findings: Substantiated. The facility was issued core deficiency at IDAPA 16.03.22.520, inadequate care, for not adequately monitoring and assisting residents with their medications. The facility was required to submit a plan of correction within 10 days.

Further, the facility was issued a non-core deficiency at IDAPA 16.03.22.310.04.d for the facility not monitoring an identified resident for side-effects when the resident simultaneously received three (3) behavior modifying medications. The facility was required to submit evidence of resolution within 30 days.

Allegation #5: The facility did not assist residents with medications as ordered by their physicians.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.305.02 for not following physicians' orders when assisting residents with their medications. The facility was required to submit evidence of resolution within 30 days.

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,



DONNA HENSCHIED, LSW  
Health Facility Surveyor  
Residential Assisted Living Facility Program

DH/sc

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