



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: 208-364-1886

October 20, 2015

Desiree Johnson, Administrator  
Lark's Haven on Honeysuckle  
11950 North Thames Court  
Hayden, Idaho 83835

Provider ID: RC-1084

Ms. Johnson:

On 05/15/2015, an initial state licensure survey and complaint investigation were conducted at Lark's Haven on Honeysuckle. 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 Maureen McCann, RN, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 364-1962.

Sincerely,

MAUREEN MCCANN, RN  
Team Leader  
Health Facility Surveyor

MM/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: rali@dhw.idaho.gov  
PHONE: 208-364-1962  
FAX: 208-364-1888

June 9, 2015

CERTIFIED MAIL #: 7007 3020 0001 4050 8913

Jenna Gove, Administrator  
Lark's Haven on Honeysuckle  
11950 Thames Court  
Hayden, Idaho 83835

Ms. Gove:

On May 15, 2015, an initial state licensure survey and complaint investigation were conducted by Department staff at Lark's Haven on Honeysuckle. The facility was cited with a core issue deficiency for failing to protect residents from inadequate care. The facility failed to protect three sampled residents from chemical restraints. Further the facility failed to provide assistance and monitoring of medications for one sampled resident. Finally, the facility failed to coordinate care for one sampled resident who received outside services.

This core issue deficiency substantially limits the capacity of Lark's Haven on Honeysuckle 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 June 9, 2015. The provisional license will remain in effect until the facility is back in substantial compliance with administrative rule for Residential Care or Assisted Living Facilities in Idaho. Please return the license currently held by the facility. 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- 4 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 be 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 June 15, 2015.**
2. **A weekly written report** must be submitted by the Department-approved consultant to the Department commencing on **June 19, 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 nineteen (19) 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 **June 14, 2015**.

**ADMINISTRATIVE REVIEW**

You may contest the provisional license or 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 Lark's Haven on Honeysuckle. 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 or Ban 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

Enclosure

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13R1084	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  05/16/2015
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NAME OF PROVIDER OR SUPPLIER: LARK'S HAVEN ON HONEYSUCKLE  
STREET ADDRESS, CITY, STATE, ZIP CODE: 1027 EAST HONEYSUCKLE HAYDEN, ID 83835

(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 deficiency was cited during the initial licensing survey and complaint investigations conducted between 5/12/15 and 5/16/15 at your residential care/assisted living facility. The surveyors conducting the survey were:</p> <p>Maureen McCann, RN Team Coordinator Health Facility Surveyor</p> <p>Karen Anderson, RN Health Facility Surveyor</p> <p>Abbreviations used in this report:</p> <p>&amp; = and 1:1 = one on one @ = at ADL = activities of daily living ASAP = as soon as possible AM = morning cont. = continuous HS = bedtime INR = international normalized ratio, related to the results of a PT lab test MAR = medication assistance record mg = milligrams NSA = negotiated service agreement PM (pm) = evening PRN (prn) = as needed PT = profime, a laboratory test RN = registered nurse W/C (w/c) = wheelchair</p>	R 000		

Bureau of Facility Standards  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Johnson RN* TITLE: *8/19/15* (X6) DATE

Bureau of Facility Standards

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R 008 R 008	<p>Continued From page 1</p> <p>16.03.22.520 Protect Residents from Inadequate Care.</p> <p>The administrator must assure that policies and 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, record review and interview it was determined the facility failed to protect 3 of 4 sampled residents (Resident #1, 2 &amp; 3's) right to be free of chemical restraints, and 1 of 4 sampled residents (Resident #1's) right to be free of physical restraints. Further, the facility failed to assist and monitor medications for 1 of 4 sampled residents (#2). Finally, the facility failed to coordinate care for 1 of 4 sampled residents (#1) who received outside services. The findings include:</p> <p>I. Resident Rights to be free of Chemical Restraints</p> <p>According to IDAPA 16.03.22.010.16, a chemical restraint is defined as: A medication used to control behavior or to restrict freedom of movement and is not a standard treatment for the resident's condition.</p> <p>According to The Nursing 2014 Drug Handbook, Depakote is used as an "Anticonvulsant and Mania." Signs and symptoms to monitor for drug side effects was "Somnolence."</p> <p>1. According to Resident #3's record, he was a 76 year-old male, admitted to 5/4/15, with a diagnoses of dementia and a history of falls. The resident was initially admitted to a sister facility, on 2/12/15.</p>	R 008 R 008	<p><b><i>I. Resident Rights to be free of Chemical Restraint. ADAPA 16.03.22.010.16</i></b></p> <p>A. Resident # 3 still resides in the facility and is now on hospice. Current dose of Depakote has been reduced and resident #3 was monitored for 30 days for adverse side effects by facility nurse. NSA and Behavior Management Plan have been reviewed and updated. Resident #3 has current physician orders.</p> <p>B. Resident #1 no longer resides in the facility.</p> <p>C. Resident # 2 no longer resides in the facility.</p> <p>D. To identify other residents that may be affected by the same deficiency, a review will be done of residents' medications, NSAs, Behavior Management Plans, and Physician orders. If a deficiency is found, the corrective action will be to update NSA, contact the resident's provider regarding medications, update</p>	

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STREET ADDRESS, CITY, STATE, ZIP CODE  
1027 EAST HONEYSUCKLE  
HAYDEN, ID 83835

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R 008	<p>Continued From page 2</p> <p>The administrator did not develop an NSA for Resident #3, when he was admitted on 5/4/15. Resident #3's environment changed significantly when he moved from an environment of younger residents, with primary diagnosis of developmental disabilities, to elderly residents' with primary diagnosis of dementia.</p> <p>The NSA from the "sister" facility, dated 2/11/15, documented the following care needs.</p> <p>* Resident required a 2 person assistance for mobility, transfers and dressing, due to being a "very high fall risk." * Resident was "anxious or aggressive depending on what was taking place in his environment."</p> <p>The facility did not have current physician orders for Resident #3. Physician orders from the "sister facility", dated 3/10/15, documented the resident was prescribed "Depakote 125 mg" 1 tablet, 3 times daily, for a total daily dose of 375 mg.</p> <p>Resident #3's record contained a fax, sent to the resident's physician on 3/10/15, from the "sister" facility, requesting an order to "increase" Depakote to 4 times a day instead of 3 times a day. The documented reason for the request was "The resident was very impulsive and getting up more. Resident is able to brush his teeth, eat, drink, walk approx 100 ft with staff assisting.</p> <p>Resident #3's physician documented an order, on 3/11/15, for staff to "Please keep written record of patient's behavior that needs redirecting and what redirection techniques were tried and if effective."</p> <p>The facility did not clearly identify Resident #3's behaviors or ensure non-drug interventions were</p>	R 008	<p>behavior management plans and interventions, and to obtain current physician orders.</p> <p>E. Measures to be put into place to ensure the deficiency does not occur are as followed;</p> <ol style="list-style-type: none"> <li>1. Prior to admit from the community, a sister facility, or outside source, physician orders will be obtained. During the residents stay in the facility, the facility will have physician orders sent to the resident's provider for review every 90 days.</li> <li>2. On admission an interim plan of care will be developed and the NSA will be complete by the 14<sup>th</sup> day after admission. NSA will continue to be updated if there is a change in condition or at least annually.</li> <li>3. Behavior Management Plans will be developed upon admission if a resident is on a psychotropic medication, or if a resident is prescribed a</li> </ol>	



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R 008	<p>Continued From page 4</p> <p>* 5/3/15, Resident "seemed to be out of it today."</p> <p>On 5/12/15 at 9:35 AM, Resident #3 was observed laying in bed sleeping. A caregiver stated the resident preferred to sleep in, but he would be getting up soon to eat breakfast.</p> <p>On 5/12/15 at 10:10 AM, Resident #3 was observed sitting in his wheelchair at the kitchen counter. The resident was observed sleeping in his wheelchair at the kitchen counter until 12:30 PM.</p> <p>On 5/12/15 at 12:35 PM, the administrator stated Resident #3 was transferred from the "sister" facility because she believed he would benefit from living in a calmer environment.</p> <p>On 5/13/15 at 8:45 AM, Resident #3 was observed sitting in his wheelchair sleeping at the kitchen counter, with his breakfast in front of him. The resident was observed to continue sleeping while he remained in his wheelchair until 10:27 AM, when he was assisted by 2 caregivers from his wheelchair into a recliner.</p> <p>On 5/13/15 at 11:00 AM, Resident #3's spouse stated she was concerned about her husband being "so sedated." She stated, "I came yesterday on (5/12/15), around lunch time. The resident's spouse said, "I could not get him to wake up long enough to eat his lunch." She stated, "I talked to the administrator about my husband being overly sedated, and requested his evening dose of Depakote be held."</p> <p>On 5/13/15 from 11:00 AM until 5:00 PM, four caregivers from the day and evening shift stated, Resident #3 had been asleep in the recliner for 6 hours.</p>	R 008	<p>7. If a nurse is contacted regarding side effects of a psychotropic medication, the nurse will assess the resident and contact the resident's provider as needed.</p> <p>8. The facility every 6 months will be send Psychotropic Reviews to the resident's provider.</p> <p>F. The corrective action will be monitored by the following;</p> <ol style="list-style-type: none"> <li>1. Prior to admission the Administrator will review admission check list to ensure there are current physician order, current H&amp;P, interim plan of care and behavior plan with interventions.</li> <li>2. The facility nurse will review physician orders prior or on the day of admission and make recommendations to the administrator.</li> <li>3. By the 14th day of admission, the Administrator will review the resident's chart to</li> </ol>	

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R 008	<p>Continued From page 5</p> <p>On 5/13/15 at 5:00 PM, a caregiver stated he observed Resident #3 sleeping in the recliner when he arrived at 2:00 PM. The caregiver stated he had taken care of the resident when he lived at the "sister" facility. He said, it was not that long ago, when Resident #3 was more alert, talking, walking and would sometimes dance with his wife. The caregiver stated, the resident had been "very lethargic" lately. He stated, the resident has had a decline in his energy level since he moved to the facility.</p> <p>On 5/13/15 at 5:06 PM, another caregiver stated, she had worked with Resident #3, when he lived at the "sister" facility. The caregiver stated, "I don't know what has happened" to Resident #3. She stated, Resident #3 had been "very sedated" lately, and no longer walked or talked like before.</p> <p>On 5/14/15 from 8:22 AM until 10:40 AM, Resident #3 was observed sitting in his wheelchair at the kitchen counter, sleeping with his breakfast meal in front of him.</p> <p>On 5/15/15 at 12:45 PM, Resident #3 was observed eating his lunch with his wife in the dining room. The resident was observed awake and visiting with his wife. The resident's wife stated, her husband was more alert since the facility held his dose of Depakote the past 2 nights.</p> <p>The facility continued to give Resident #3 his daily dose of Depakote, despite the resident exhibiting signs and symptoms of being "very lethargic, drooling and leaning to one side." The facility RN did not assess Resident #3 upon admission or since his medication was increased in March 2015, or when he had a significant change in his</p>	R 008	<p>ensure the NSA is complete and to review the behavior plan and update as needed.</p> <p>4. The Facility nurse at the 90 days assessment or change of condition will review the resident's NSA, behavior plan, medication changes, Psychotropic review and physician orders.</p> <p>G. To be completed by 08/31/2015.</p>	

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R 008	<p>Continued From page 6</p> <p>mental and health status. The facility failed to document Resident #3's behaviors and continued to use an antipsychotic medication that was sedating to the resident.</p> <p>B. Resident #1's record, documented he was a 62 year-old male, admitted to the facility on 8/29/14, with a diagnoses of renal failure and a right leg amputation.</p> <p>Resident #1's NSA, dated 8/29/14, documented he was alert and oriented, and had periods of confusion, and significant pain issues. The facility did not update the resident's NSA, when he experienced significant changes in his health status.</p> <p>On 9/15/14, the administrator faxed the following request to Resident #1's physician.</p> <p>The resident was "still having difficult nights. He Does NOT Sleep at all. He was up all night long last night. Could you please prescribe something for HS so he can get some sleep please." The physician faxed an order to give "Seroquel 60 mg" every night for "insomnia."</p> <p>On 9/15/14, the facility requested a medication to help Resident #1 sleep at night. However, there was no documented evidence found in the resident's record, the facility had evaluated the resident to rule out other possible reasons the resident was awake all night.</p> <p>On 3/13/15, a facility nurse, documented in Progress Notes, Resident #1 had new orders to increase the dose of Seroquel from 60 mg to 100 mg at night. There was no documentation by the facility nurse why Resident #1's dose of Seroquel was doubled. The nurse could not be interviewed</p>	R 008		

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NAME OF PROVIDER OR SUPPLIER  LARK'S HAVEN ON HONEYSUCKLE		STREET ADDRESS, CITY, STATE, ZIP CODE 1027 EAST HONEYSUCKLE HAYDEN, ID 83835		
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R 008	<p>Continued From page 7</p> <p>during the survey as she no longer worked for the facility and could not be reached by telephone.</p> <p>On 3/23/15, a night shift caregiver documented in Progress Notes, Resident #1 was requiring "extensive cont. 1:1 attention tonight. Also increased need for night cares, dressing, undressing, transferring...I took him back to his room &amp; into bed as he was disturbing other resident's sleep...."</p> <p>On 5/12/15 from 10:00 AM until 11:30 AM, Resident #1 was observed sleeping in his wheelchair for 1 hour and 30 minutes, with his head on the kitchen counter, and his breakfast untouched.</p> <p>On 5/12/15 at 11:30 AM, the medication aide and a caregiver were observed to assist the resident from his wheelchair into bed. Resident #1 was observed in his bed until 5:15 PM.</p> <p>On 5/12/15 at 5:17 PM, caregivers were observed to assist him from bed into his wheelchair for dinner. Both caregivers confirmed the resident had been in bed, sleeping off and on, from 11:30 AM until 5:17 PM, and had not eaten.</p> <p>On 5/13/15 at 8:25 AM, the administrator stated she faxed Resident #1's physician, as it became apparent to her and the caregivers, the resident was over sedated.</p> <p>On 3/13/15, the facility requested an order, from Resident #1's physician, to increase his dose of Seroquel. There was no documentation the facility identified or evaluated the resident's behavioral symptoms or tried non-drug interventions prior to requesting an order to double the dose of Seroquel for sleep.</p>	R 008		

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

LARK'S HAVEN ON HONEYSUCKLE 1027 EAST HONEYSUCKLE HAYDEN, ID 83836

(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>C. According to Resident #2's record, he was an 71 year-old male, who was admitted to the facility on 3/25/15, with diagnoses including dementia.</p> <p>On 5/12/15, the following was observed:</p> <p>*9:00 AM, Resident #2 was seated in a wheelchair asleep at the kitchen counter with his head hung down toward his chest, within inches of his breakfast plate. The resident kept falling asleep. For the next 30 minutes, the resident remained in that position without prompting or cueing from facility staff.</p> <p>*10:20 AM, Resident #2 slid from his wheelchair to the floor in the living room. Five minutes later, a caregiver assisted the resident back into his wheelchair. Once back in the wheelchair, the resident's head again hung down toward his chest and he fell asleep.</p> <p>*10:30 AM, The resident stood up from his wheelchair and with his eyes barely open, took a few steps while grabbing onto the back of a couch. The resident's gait was very unsteady and he swayed as he stood or attempted to walk. The resident had difficulty staying awake.</p> <p>*10:45 AM, a caregiver assisted the resident in his wheelchair, to a table where an activity was about to begin. Resident #2 sat at the table with his head hung down toward his chest and appeared to have fallen asleep.</p> <p>During the day shift, between 5/12/15 and 5/14/15, Resident #2 was observed asleep in a wheelchair in the living room or dining area most of the day. When he did get up from the wheelchair, he walked with his head hung down,</p>	R 008		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13R1084	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  05/15/2015
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NAME OF PROVIDER OR SUPPLIER: LARK'S HAVEN ON HONEYSUCKLE  
STREET ADDRESS, CITY, STATE, ZIP CODE: 1027 EAST HONEYSUCKLE HAYDEN, ID 83635

(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 9</p> <p>eyes partially opened, with an unsteady gait. As the resident ambulated, he often was observed grabbing onto his wheelchair or other furniture and appeared to be sleepy. The resident did not make eye contact or lift his head when spoken to and he was unable to carry on an intelligible conversation. He could answer simple questions such as, "Are you hungry?" However, he did not know the date, time or where he was.</p> <p>According to the "2014 Nursing Drug Handbook:"</p> <ul style="list-style-type: none"> <li>* Olanzapine is a medication classified as an anti-psychotic and has many potential side effects including sedation, insomnia and dizziness.</li> </ul> <p>A physician's order, dated 3/25/15, documented Resident #2 was to receive:</p> <ul style="list-style-type: none"> <li>* olanzapine 7.5 mg twice daily and 5 mg as needed every 4 hours</li> <li>* Temazepam, is a medication classified as a hypnotic and used for insomnia, has many potential side effects including, complex sleep-related behaviors, drowsiness, dizziness, lethargy, disturbed coordination, daytime sedation, confusion, weakness, and anxiety.</li> </ul> <p>Facility "Progress Notes" dated 3/25/15 through 4/16/15 and March and April 2015 MARs; documented the following:</p> <ul style="list-style-type: none"> <li>* 3/25, Resident #2 was admitted to the facility and "He is pretty independent but needs to be watched. Has a history of combative behavior."</li> <li>* 3/27 (night shift), The resident tried to go out the back door and was redirected by staff.</li> </ul>	R 008		

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NAME OF PROVIDER OR SUPPLIER: LARK'S HAVEN ON HONEYSUCKLE  
STREET ADDRESS, CITY, STATE, ZIP CODE: 1027 EAST HONEYSUCKLE HAYDEN, ID 83835

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R 008	<p>Continued From page 10</p> <p>* 3/28 (night shift), The resident was up, wandering around the facility until about 11 PM.</p> <p>* 4/1 (night shift), The resident did not sleep last night. The April 2015 MAR documented the resident received prn temazepam at 9:44 PM.</p> <p>* 4/2, The resident had a new prn medication, "temazepam 15 mg." The resident's record contained a physician's order, dated 3/30/15, for temazepam 15 mg to be given by mouth, prn for insomnia.</p> <p>* 4/5, "About 11 pm," the resident was "plunging the toilet. There was nothing in the toilet and the bathroom looked like it had been ransacked." The note further documented the resident had fallen and was found in the bathroom "against the wall." The April 2015 MAR documented the resident received prn temazepam at 9:42 PM. There was no documentation in the resident's record explaining why the resident received this prn medication.</p> <p>The April 2015 MAR documented Resident #2 was out of the facility between 4/16/15 and 4/22/15.</p> <p>A physician's order, dated 4/17/15, documented Resident #2 was to receive:</p> <ul style="list-style-type: none"> <li>* olanzapine 10 mg twice daily</li> <li>* olanzapine 5 mg as needed every 4 hours</li> </ul> <p>Between 4/22/15 and 5/11/15 (18 days), Resident #2's "Progress notes" and April and May 2015 MARs documented the the following:</p>	R 008		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13R10B4	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  05/15/2015
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NAME OF PROVIDER OR SUPPLIER: LARK'S HAVEN ON HONEYSUCKLE  
STREET ADDRESS, CITY, STATE, ZIP CODE: 1027 EAST HONEYSUCKLE HAYDEN, ID 83835

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R 008	<p>Continued From page 11</p> <p>* Resident #4 received his routine olanzapine at 8:30 AM and 9:00 PM daily.</p> <p>* 4/22/15, "...was having a hard time staying awake." The April 2015 MAR documented the resident received prn olanzapine at 4:18 PM, prn temazepam at 8:18 PM. There was no documentation in the resident's record explaining why the resident received the prn medications.</p> <p>* 4/23/15, "...keeps wanting to lay down on floor." The April 2015 MAR documented the resident received prn olanzapine at 10:01 AM. There was no documentation in the resident's record explaining why the resident received this prn medication.</p> <p>* 4/25/15, the MAR documented the resident received prn olanzapine at 4:57 PM. There was no documentation in the resident's record explaining why the resident received this prn medication.</p> <p>* 4/27/15 at 5:30 AM, "...heard a loud bang." Resident #2 was found "on the floor."</p> <p>* 4/29/15, The administrator documented, "As long as we follow the Dr's orders as he was getting at the hospital then he should be very calm and less agitated...When he is getting too agitated then we need to use the prn's that the Dr. has prescribed for these times." The April 2015 MAR documented the resident received prn olanzapine at 11:45 AM. There was no documentation in the resident's record explaining why the resident received this prn medication.</p> <p>* 4/29/15 (evening shift), "did not have behaviors this evening. In &amp; out of w/c. Gave prn olanzapine @ 4 pm....tamazepam @ 8:15 pm." The April</p>	R 008		

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NAME OF PROVIDER OR SUPPLIER . . . STREET ADDRESS, CITY, STATE, ZIP CODE  
LARK'S HAVEN ON HONEYSUCKLE 1027 EAST HONEYSUCKLE  
HAYDEN, ID 83835

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R 008	<p>Continued From page 12</p> <p>2015 MAR documented the resident received prn olanzapine at 4:35 PM, prn temazepam at 8:26 PM and his routine olanzapine at 8:28 PM. There was no documentation in the resident's record explaining why the resident received the prn medication.</p> <p>* 4/30 "Had a good evening." The April 2015 MAR documented the resident received prn temazepam at 9:25 PM. There was no documentation in the resident's record explaining why the resident received this prn medication.</p> <p>* 5/3/15 (day shift), "walking around very stable. No behaviors, prn olanzapine." The May 2015 MAR documented the resident received prn olanzapine at 12:08 PM. There was no documentation in the resident's record explaining why the resident received this prn medication.</p> <p>* 5/5/15 (evening shift), "...had a few bites of dinner, but a good day." The May 2015 MAR documented the resident received prn olanzapine at 4:20 PM. There was no documentation in the resident's record explaining why the resident received this prn medication.</p> <p>* 5/6/15 (evening shift), "...had a good evening." The May 2015 MAR documented the resident received prn olanzapine at 4:26 PM. There was no documentation in the resident's record explaining why the resident received this prn medication.</p> <p>A behavior plan, dated 4/21/15, documented Resident #2's behavior was, "Unable to follow direction from care staff." The plan further documented a behavior plan was needed because the resident, undressed in inappropriate places, wandered into other residents' rooms, did</p>	R 008		

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R 008	<p>Continued From page 13</p> <p>not sleep through the night, got agitated about 3:00 PM or had "a hard time conforming to the rules" of the facility.</p> <p>Behavior tracking sheets for April and May 2015 were reviewed. Only four entries were documented: "Staggered out into the hallway and other bedrooms...Not really behavior but hanging off of his bed...Undergarment off and found lying on floor under his bed...Unsure if he fell, denies falling however."</p> <p>On 5/12/15 at 6:00 PM, a caregiver stated when Resident #2 was first admitted to the facility, two months earlier, he was "fully functioning, could hold a conversation, was oriented, could shower himself. He was very much there mentally." She further stated Resident #2 "now needs to be checked every two hours to see if he is wet...he no longer can safely ambulate unassisted and he crawls on the ground a lot."</p> <p>On 5/14/15 at 10:45 AM, the administrator stated she observed Resident #2 and said he appeared to be very sleepy. "I assumed he was declining." She stated the resident was more alert when he was admitted to the facility a few months earlier and she had not considered an increase in psychotropic medications could effect his daytime alertness.</p> <p>On 5/15/15 at 8:35 AM, the facility nurse stated after Resident #2 had an aggressive incident with staff, he was sent to the hospital where his olanzapine dosage was increased. She stated the resident had not had any aggressive behaviors since returning from the hospital and could not explain why caregivers were giving Resident #2 prn olanzapine. She further stated there were no nursing assessments of Resident #2 for potential</p>	R 008		

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R 008	<p>Continued From page 14</p> <p>side-effects when the caregivers had documented he began falling, was found crawling around on the floor several times and was unsteady on his feet.</p> <p>Between 4/22/15 and 5/11/15, caregivers gave Resident #2, eleven prn doses of an anti-psychotic medication without first attempting non-drug interventions. Also, Resident #2 received prn temazepam, a hypnotic, five times without documentation the resident had complained of difficulty sleeping. Further, on 5/5/15, prn temazepam was given to the resident at 4:42 PM in the afternoon, even though the medication was to be used for insomnia. Between 5/12/15 and 5/14/15, Resident #4 was observed to be asleep in his wheelchair more than he was awake.</p> <p>The facility did not clearly identify Resident #2's behaviors or ensure non-drug interventions were implemented and shown ineffective, before using anti-psychotic medications to control behaviors.</p> <p><b>II. Resident's Right to be free from physical restraints</b></p> <p>According to IDAPA 16.03.22.550.10, each resident must have the right to be free from physical or chemical restraints.</p> <p>IDAPA 16.03.22.012.04, defines physical restraints as "Any device or physical force that restricts the free movement of, normal functioning of, or normal access to a portion or portions of an individual's body except for treatment of a medical condition."</p> <p>According to Resident #1's record he was a 62 year-old male who was admitted to the facility on</p>	R 008	<p><b>II. Resident Right to be free from physical restraints. ADAP 16.03.22.550 &amp; ADAPA 16.03.22.012.04</b></p> <p>A. Resident #1 no longer resides at our facility.</p> <p>B. To identify other resident who may be affected by this deficiency, each resident will be evaluated to make sure they are free from physical restraints relating to their function and level of care needs. If a resident is identify as being restrained, the administrator and/or facility nurse will evaluate and determine the best alternatives to keep resident free of restraints.</p> <p>C. Measures to be put into place to ensure the deficiency does not occur are as followed:</p> <p>1. Staff to be educated on ways to prevent physical restraints on 08/26/2015.</p>	

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R 008	<p>Continued From page 15</p> <p>8/29/14, with a diagnosis of renal failure and right leg amputation at the hip.</p> <p>Resident #1's NSA, dated 8/29/14, documented he was alert and oriented and had periods of confusion. The NSA documented the resident required extensive assistance to meet his mobility and transferring needs.</p> <p>On 5/12/15 at 9:45 AM, Resident #1 was observed in the living room, sitting in a recliner with the foot-rest up. A home made wood-framed box, covered with foam and shag carpet was observed on the seat of the recliner. The resident was observed trying to push the box off the recliner, attempting to get out of the recliner, but was not successful.</p> <p>On 5/12/15 at 9:50 AM, Resident #1 was observed moaning while trying to adjust himself in the recliner. The resident stated he had been sitting in the recliner since 10:00 PM, the night before. He stated he had not been assisted to his bed or been repositioned during the 12 hour timeframe. Resident #1 stated he wanted to sleep in his bed last night.</p> <p>On 5/12/15 at 9:52 AM, the medication aide stated Resident #1 "sleeps in the recliner so he won't fall out of bed." She further stated, the resident has had multiple falls and the facility placed his mattress on the floor, but the resident refused to sleep on the floor and preferred to sleep in the recliner rather than the floor. She stated caregivers were instructed to keep him in the recliner to prevent him falling out of bed.</p> <p>On 5/12/15 at 9:57 AM, the medication aide stated the resident had not been assisted out of the recliner since her shift started at 6:00 AM,</p>	R 008	<p>2. Each resident's function and level of care will be evaluated by the facility nurse with the 90 day assessment or change of condition to ensure resident will be free from physical restraints.</p> <p>D. The corrective action will be monitored by the following:</p> <ol style="list-style-type: none"> <li>1. The administrator will make frequent rounds in the facility to ensure residents remain free from physical restraints.</li> <li>2. The facility nurse observe resident while in building to ensure residents remain free from restraints.</li> <li>3. The staff will have continued education on preventing restraint at least annually.</li> </ol> <p>E. To be completed by 08/31/2015.</p>	

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R 008	<p>Continued From page 16</p> <p>(approximately 4 hours.) She stated Resident #1 was not able to get out of the recliner without the assistance of 2 caregivers.</p> <p>On 5/12/15 from 10:00 AM until 11:30 AM, Resident #1 was observed to sit in his wheelchair for 1 hour and 30 minutes, sleeping while his breakfast sat in front of him. At 11:30 AM, the medication aide and a caregiver were observed to assist the resident from his wheelchair into his bed.</p> <p>On 5/12/15 at 12:40 PM, the administrator stated Resident #1 had 7 falls between April and the first part of May. She stated, "We took his mattress off his bed and put it on the floor to prevent him from getting up without assistance." The administrator stated, the resident has had multiple falls out of his wheelchair and bed. She stated caregivers were instructed to assist the resident to sit in the recliner or in bed, unless he was eating meals.</p> <p>On 5/12/15 at 5:00 PM, an evening shift caregiver stated, he was told by the day shift caregivers the resident had been in bed, sleeping off and on all day. The caregiver stated, Resident #1 had been in his room for approximately 6 hours.</p> <p>On 5/13/15 at 8:53 AM, Resident #1 was observed sitting in a recliner in the living room. He stated he had several falls while attempting to get out of bed. Resident #1 stated, his mattress was put on the floor to prevent him from falling. He stated, "I didn't like sleeping on the floor, so I agreed to sleep in a recliner so staff could watch me." Resident #1 further stated he was not able get up off the floor or the recliner without assistance.</p> <p>On 5/13/15 at 3:40 PM, Resident #1 returned to</p>	R 008		

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R 008	<p>Continued From page 17</p> <p>the facility after his dialysis treatment. A driver from a transportation company escorted the resident inside the front entry via his wheelchair. The resident was observed to be tied in his wheelchair by a gait belt to prevent him from falling. A caregiver, a medication aide and the administrator acknowledged Resident #1 had returned but the resident remained tied in his wheelchair until 4:14 PM.</p> <p>On 5/13/15 at 5:32 PM, another caregiver on the evening shift stated, Resident #1 preferred to sleep in the recliner over sleeping on his mattress on the floor. She stated the resident was not able to get up off the floor or out of the recliner without assistance. The caregiver stated, at night there was only 1 caregiver on duty, and he required 2 caregivers to assist him off the floor; should he fall.</p> <p>Incident Reports, dated from December 2014 through May 10, 2015, documented Resident #1 had 18 falls from his bed or wheelchair.</p> <p>An Incident Report, dated 4/17/15, documented Resident #1 had fallen out of bed. The administrator documented, Resident #1 was "very restless" and had incidents of falling or rolling out of bed. The administrator documented, "I believe the only thing we can do now is get a Dr's order for his bed to be put on the ground. His mattress on the floor."</p> <p>On 4/27/15, a fax was sent requesting permission from Resident #1's physician to allow the facility to take the resident's mattress off his bed and place it on the floor. The administrator documented she was requesting the mattress be placed on the floor because, "He is constantly rolling out of bed and the fall mat nor the alarm</p>	R 008		

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R 008	<p>Continued From page 18</p> <p>are helping."</p> <p>A Progress Note, dated 4/29/15, documented the resident "will be sleeping on the mattress on the floor. We have received a Dr's order for this and the incidents are just too many. Even though they may be non-injury, we still need to take precautions so he does not end up getting hurt." The progress note was not signed by the staff member who documented the entry.</p> <p>The facility violated Resident #1's rights to be free from physical restraints when they placed his mattress on the floor, and left him in a recliner, and restrained him in a wheelchair by a gait belt he could not get out of.</p> <p>III. Supervision or Assistance with medications:</p> <p>IDAPA 16.03.22.011.08 defines inadequate care as "When a facility fails to provide...assistance and monitoring of medications and coordination of outside services."</p> <p>According to Resident #4's record, he was an 81 year-old male, who was admitted to the facility on 10/17/14, with diagnoses including dementia with hallucinations, pulmonary embolus and blindness.</p> <p>On 5/12/15 at 9:35 AM, Resident #4 was observed sitting in a wheelchair at the kitchen counter. The resident was carrying on a lengthy animated conversation with someone only he could hear. The resident was pleasant when spoken to. He could appropriately answer simple questions, such as if he was thirsty, but did not know where he was. The resident's eyes remained closed but did turn his head toward the person speaking to him.</p>	R 008	<p><i>III. Supervision or Assistance with medications. IDAPA 16.03.22.011.08.</i></p> <p>A. Resident #1 no longer resides in our facility.</p> <p>B. To identify other resident who may be affected by the deficiency, residents' medication and labs will be reviewed. Upon identification of deficiency, the resident provider will be contact to obtain order for labs relating to medication. Once the order is obtained, a lab requisition will be filled out and faxed to PAML along with the order to schedule a lab draw for the resident. Once the lab is drawn, results will be faxed to PCP for further instruction.</p> <p>C. Measure put into place to ensure deficiency does not occur are as followed;</p> <p>1. Upon admission, and during Quarterly assessments, medication will be reviewed by the facility nurse to identify medication that</p>	

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NAME OF PROVIDER OR SUPPLIER: LARK'S HAVEN ON HONEYSUCKLE  
STREET ADDRESS, CITY, STATE, ZIP CODE: 1027 EAST HONEYSUCKLE HAYDEN, ID 83835

(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)	(X8) COMPLETE DATE
R 008	<p>Continued From page 19</p> <p>Physician's orders, dated 3/3/15, documented Resident #4 was to take Coumadin 2 mg daily "for blood thinner."</p> <p>Resident #4's record contained two nursing assessments dated 10/8/14 and 4/25/15. Neither assessment documented the resident received Coumadin. The 4/25/15 assessment documented the resident had the diagnosis of pulmonary embolus.</p> <p>An NSA, dated 11/28/14, documented the resident's medication regime included Coumadin 2 mg daily. The NSA further documented, Resident #2 was on a medication that required "frequent monitoring...PT/INR drawn as directed by provider." The NSA was signed by the facility nurse.</p> <p>Resident #4's April and May 2015 MAR's, documented the resident had been receiving Coumadin 2 mg each evening.</p> <p>The only laboratory report regarding Resident #4's Coumadin blood level found in the resident's record was dated 11/18/14.</p> <p>On 5/14/15 at 10:40 AM, the administrator confirmed no other laboratory tests for Coumadin had been completed on Resident #4 since his admission to the facility. She further confirmed the facility had not notified the resident's physician regarding the lack of laboratory requests for Coumadin blood levels.</p> <p>On 5/15/15 at 8:55 AM, the facility nurse stated "I missed that (Coumadin blood levels). I need to put that into place" for Resident #4. She further stated, she could not recall why the resident was taking Coumadin.</p>	R 008	<p>may need labs. Once identified, a fax will be sent to the resident's PCP to obtain orders relating to the medication. Once order are obtained, the facility will fill out a lab requisition and fax the requisition along with the order to PAML. Once results obtained, the provider will be faxed results. Any order relating to labs will be initiated:</p> <ol style="list-style-type: none"> <li>2. Any new orders received, the facility nurse will reviewed and determine if labs are needed.</li> <li>3. All residents taking warfarin will be monitored per MD order. A warfarin log will be kept and updated when new orders are received. When new orders are received the pharmacy will be faxed, a lab requisition will be filled out and faxed with the new order to PAML.</li> <li>4. Staff to be educated on the process of lab orders, filling out lab requisitions, faxing</li> </ol>	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13R1084	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  05/15/2015
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NAME OF PROVIDER OR SUPPLIER: LARK'S HAVEN ON HONEYSUCKLE  
STREET ADDRESS, CITY, STATE, ZIP CODE: 1027 EAST HONEYSUCKLE HAYDEN, ID 83835

(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 20</p> <p>Resident #4 was admitted to the facility taking Coumadin which requires periodic blood level monitoring. The facility had not notified the resident's physician that blood levels were not being completed or requested a clarification from the physician regarding the correct dose of Coumadin the resident was to take. This resulted in Resident #4 not having a Coumadin blood level completed between 11/28/14 and 5/14/15, approximately 5.5 months.</p> <p>IV. Coordination of Care</p> <p>a. Hospice Agency and a Dialysis Center</p> <p>According to Resident #1's record he was a 62 year-old male who was admitted to the facility on 8/29/14, with a diagnosis of renal failure and required dialysis.</p> <p>Resident #1's NSA, dated 8/29/14, documented he was alert, oriented and had periods of confusion. The NSA did not mention a dialysis treatment center he attended 3 times a week or hospice services. The facility did not have a copy of Resident #1's care plans from the hospice agency or the dialysis center.</p> <p>A Quarterly Nursing Assessment, dated 2/6/15, documented Resident #1 went to "dialysis 4 x week," had hospice care for "cardiac" and his skin appearance was "dusky." The nurse documented the resident wore oxygen only at dialysis.</p> <p>According to Progress Notes, caregivers documented Resident #1 received treatment from the dialysis center 3 times a week, even though the facility nurse documented the resident went to</p>	R 008	<p>requisitions and order to pharmacy, and faxing PCP with results on 8/26/2015.</p> <p>D. The corrective action will be monitored by the following;</p> <ol style="list-style-type: none"> <li>1. The facility nurse will review medications and labs at each 90 day assessment and or change of condition to make sure orders for labs are being followed.</li> <li>2. The Warfarin Log will be reviewed weekly by administrator and/or facility nurse to make sure labs are drawn according to physician orders.</li> </ol> <p>E. The corrective action will be complete by 08/31/2015.</p> <p>IV. Coordination of Care</p> <p>A. Hospice Agency and a Dialysis Center.</p> <ol style="list-style-type: none"> <li>1. Resident is no longer in the facility.</li> <li>2. To identify residents who may be affected by this deficiency, each resident on outside</li> </ol>	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13R1084	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  06/15/2015
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NAME OF PROVIDER OR SUPPLIER  
LARK'S HAVEN ON HONEYSUCKLE

STREET ADDRESS, CITY, STATE, ZIP CODE  
1027 EAST HONEYSUCKLE  
HAYDEN, ID 83835

(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 21</p> <p>dialysis 4 times a week. There was no documentation in the resident's record his physician ordered oxygen use during dialysis treatment.</p> <p>A Quarterly Nursing Assessment, dated 4/25/15, documented Resident #1 continued to receive nursing services by a hospice agency and noted he did not use oxygen.</p> <p>On 5/13/15 at 3:40 PM, Resident #1 returned to the facility after his dialysis treatment. The driver set the brakes on his wheelchair and announced to staff the resident had returned. Although caregivers acknowledged the resident returned they did not assist him out of his wheelchair into his bed or a recliner. The resident was observed to sit in his wheelchair, tied in by a gait belt to prevent him from falling out of his wheelchair. The resident was left slumped over the right side of his wheel, his skin was observed to be a gray/blue "dusky" color.</p> <p>On 5/13/15 from 3:40 PM until 3:52 PM, Resident #1 was observed to sleep in his wheelchair, tied by a gait belt, slumped over to the right side, with his right hand touching the floor. At 3:52 PM, the administrator was observed to escort Resident #1 via his wheelchair away from the front entrance, to her office. The resident's right hand was observed dragging over the carpet through the living room to the administrator's office.</p> <p>On 5/13/15 at 4:15 PM, Resident #1 was observed to be transferred by 2 caregivers from his wheelchair into a recliner. The resident's skin was observed to be a gray/blue "dusky" color.</p> <p>On 5/13/15 at 5:20 PM, a medication aide was observed to check Resident #1's vital signs. She</p>	R 008	<p>services will have chart reviewed to may sure the facility has a plan of care. NSA will be reviewed and update to reflect the resident is receiving outside services and what services are provided. Visit notes and orders to be reviewed by the facility nurse.</p> <p>3. Measure put into place to ensure deficiency does not occur are as followed;</p> <ol style="list-style-type: none"> <li>a. All resident who have an outside service ordered, the administrator and/or the facility nurse will obtain a plan of care and update the NSA as needed.</li> <li>b. The administrator and facility nurse will review all visit notes from the outside agency and update the NSA as needed.</li> </ol>	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13R1084	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  05/16/2015
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NAME OF PROVIDER OR SUPPLIER  LARIK'S HAVEN ON HONEYSUCKLE	STREET ADDRESS, CITY, STATE, ZIP CODE 1027 EAST HONEYSUCKLE HAYDEN, ID 83835
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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 22</p> <p>stated his oxygen saturation level registered 77% on room air. The medication aide said, a hospice nurse instructed caregivers to administer 2 liters of oxygen as needed, for low oxygen saturations. She further stated, "He doesn't have an order, but we use the concentrator." The medication aide, a caregiver and the administrator all stated there were no written care plans from the hospice agency or the dialysis agency. The administrator stated she would call the resident's hospice nurse to fax an order for Resident #1's oxygen use, and request a copy of the hospice agency and dialysis treatment center's care plans.</p> <p>On 5/14/15 at 8:55 AM, a hospice nurse stated Resident #1 had a physician's order for oxygen to be set at 2 to 4 liters flow rate. She stated caregivers were instructed to assist him with his oxygen when needed. The hospice nurse was not aware the facility did not have physician's order for oxygen. The hospice nurse stated she had never coordinated care with the facility nurse or the dialysis center, but stated she would send the facility the oxygen order and a hospice care plan.</p> <p>On 5/15/15 at 8:33 AM, the facility nurse stated, "I wasn't aware I needed to coordinate care with the hospice nurse and his dialysis center." She further stated she thought Resident #1 received oxygen when he was receiving dialysis. The facility nurse stated she had not talked to the hospice nurse or the dialysis center and had not seen a care plan from either agency.</p> <p>The facility failed to coordinate care with Residents #1's hospice agency and his dialysis treatment center. The lack of coordination resulted in the facility not having oxygen orders or care plans to help direct care to meet Resident #1's care needs.</p>	R 008	<p>c. The administrator and facility nurse will review all order received from the outside source and will update the mar and NSA to reflect changes.</p> <p>d. Administrator and/or facility nurse will meet with outside agency as needed to coordinate the care of the resident.</p> <p>4. The corrective action will be monitored by the following:</p> <p>a. One week after services are started, the administrator and/or facility nurse will review chart to make sure the plan of care is received. If the plan of care is not received the outside agency will be called to obtain.</p>	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13R1084	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  06/15/2015
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NAME OF PROVIDER OR SUPPLIER: LARK'S HAVEN ON HONEYSUCKLE  
STREET ADDRESS, CITY, STATE, ZIP CODE: 1027 EAST HONEYSUCKLE HAYDEN, ID 83835

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R 008	<p>Continued From page 23</p> <p><b>b. PRESSURE ULCERS:</b></p> <p>Resident #1's NSA, dated 8/29/14, documented the resident required extensive assistance for mobility and transferring. The NSA was not updated to include interventions to prevent skin breakdown related to the resident being chair and bed bound.</p> <p>A Quarterly Nursing Assessment, dated 2/6/15, documented Resident #1 had several recent falls and his skin color was "dusky." The facility nurse did not document whether or not the resident had skin breakdown.</p> <p>The National Pressure Ulcer Advisory Panel defines Stage II, III, IV and unstageable pressure ulcers as the following:</p> <p>*Stage II: "Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough...Presents as a shiny or dry shallow ulcer without slough or bruising...Bruising indicates suspected deep tissue injury."</p> <p>*Stage III: "Full thickness tissue loss...Slough may be present..."</p> <p>On 3/14/15 at 11:00 AM, a facility nurse documented in Progress Notes, the resident reported he had a "sore area on R buttock - staff to observe for breakdown. Resident instructed to keep pressure off area by repositioning himself in w/c." There was no further documentation the nurse had staged or measured Resident #1's pressure ulcer.</p> <p>On 3/29/15, a hospice nurse, documented in</p>	R 008	<p>b. Periodic reviews will be done to make sure facility is receiving visit notes from the outside agency.</p> <p>5. The corrective action will be complete by 08/31/2015</p> <p><b>B. Pressure Ulcers</b></p> <p>1. Resident # 1 no longer resides in the facility.</p> <p>2. To identify other resident who may be affect by this deficiency, skin to be observe during cares and bathing. If a skin issue is identified, the caregiver is to contact the nurse. At this time the facility is free from pressure ulcers.</p> <p>3. Measure put into place to ensure deficiency does not occur are as followed;</p> <p>a. Upon discovery of a skin issue, the caregivers will notify the administrator and facility nurse.</p>	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13R1084	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  05/15/2015
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NAME OF PROVIDER OR SUPPLIER: LARK'S HAVEN ON HONEYSUCKLE  
STREET ADDRESS, CITY, STATE, ZIP CODE: 1027 EAST HONEYSUCKLE HAYDEN, ID 83835

(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 24</p> <p>Progress Notes, the resident was getting out of bed, falling asleep in his wheelchair and had skin tears and abrasions. The hospice nurse further documented, the caregivers had been putting "barrier cream" on Resident #1's buttock sore.</p> <p>There was no documentation by the facility nurse or the hospice nurse they had coordinated care regarding Resident #1's skin tears, abrasions and pressure ulcer.</p> <p>A caregiver documented, in Progress Notes, dated 4/2/15, "Sore on bottom is not getting better. Hospice RN has taken a look at it. Sore has been covered with padded bandage."</p> <p>A Quarterly Nursing Assessment, dated 4/25/15, documented Resident #1's skin had "new and healing tears/bruises." The facility nurse did not document she had assessed Resident #1's pressure ulcer.</p> <p>On 5/12/15 at 11:30 AM, Resident #1's wound was observed when 2 caregivers assisted the resident with pericare. The resident's coccyx area was observed by a surveyor, to have a partial thickness tissue loss involving the epidermis and the dermis skin layers. According to The National Pressure Ulcer Advisory Panel, the sore on his coccyx would compare to the description of a Stage II pressure ulcer. Resident #1 was observed to have a nonblanchable erythema of intact skin that covered his buttocks. According to The National Pressure Ulcer Advisory Panel, the skin covering his buttocks would be defined as a Stage I. Both caregivers stated, the sore on his coccyx had never completely healed.</p> <p>On 5/12/15 at 2:45 PM, the administrator stated, Resident #1's skin was intact and his pressure</p>	R 008	<ul style="list-style-type: none"> <li>b. The facility nurse will assess the skin issue and contact the resident's provider and make recommendations.</li> <li>c. If an order for home health is received to evaluate and treat, the order will be faxed to the home health of the resident's or POA's choice.</li> <li>d. Once the skin issue has been evaluated by home health, a plan of care will be requested.</li> <li>e. The administrator and/or Facility nurse will review the plan of care and update the NSA as needed.</li> <li>f. The administrator and facility nurse will review visit notes and update NSA as needed.</li> </ul>	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13R1084	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  05/15/2015
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NAME OF PROVIDER OR SUPPLIER  
LARK'S HAVEN ON HONEYSUCKLE

STREET ADDRESS, CITY, STATE, ZIP CODE  
1027 EAST HONEYSUCKLE  
HAYDEN, ID 83835

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R 008	<p>Continued From page 25</p> <p>ulcer was healed.</p> <p>On 5/13/15 at 8:53 AM, another caregiver stated hospice was managing Resident #1's sore on his bottom. She stated a hospice nurse covered the area with a padded dressing and hospice was responsible to change the dressing.</p> <p>On 5/14/15 at 8:55 AM, Resident #1's hospice nurse stated, she assessed the pressure ulcer on 5/13/15, and determined the pressure ulcer was a Stage II. The hospice nurse additionally stated, the pressure ulcer had improved, and said the wound had progressed to a Stage III approximately a month ago. The hospice nurse stated the pressure ulcer would go from a Stage I to a Stage III, depending on how often the resident changed his position while sitting in his wheelchair and recliner or bed. Additionally, the hospice nurse stated she and the facility nurse had not coordinated care and they had never observed the pressure ulcer together or discussed the status of the resident's pressure ulcer.</p> <p>On 5/15/15 at 8:33 AM, the facility nurse stated, "I personally have not observed his wound." She stated, "I thought the hospice nurse was managing his wound." The facility nurse confirmed she was not aware Resident #1 had a Stage II pressure ulcer or that at one point had progressed to a Stage III.</p> <p>The facility failed to coordinate care with Residents #1's hospice agency, when he developed a Stage I pressure ulcer that eventually progressed to was a Stage III, pressure ulcer. These failures had the potential to affect 100% of the residents residing at the facility which resulted in inadequate care.</p>	R 008	<p>g. The facility nurse will assess wound bi-weekly for improvement.</p> <p>h. The administrator and/or facility nurse will meet with outside agency as needed to coordinate the care of the resident.</p> <p>4. The corrective action will be monitored by the following;</p> <p>a. One week after services are started, the administrator and/or facility nurse will review chart to make sure the plan of care is received. If the plan of care is not received the outside agency will be called to obtain.</p> <p>b. Periodic reviews will be done to make sure facility is receiving visit notes from the outside agency.</p>	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  19R1084	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  05/16/2015
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NAME OF PROVIDER OR SUPPLIER  LARK'S HAVEN ON HONEYSUCKLE	STREET ADDRESS, CITY, STATE, ZIP CODE 1027 EAST HONEYSUCKLE HAYDEN, ID 83835
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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
			5. The corrective action will be complete by 8/31/2015	

Facility LARK'S HAVEN ON HONEYSUCKLE	License # RC-1084	Physical Address 1027 EAST HONEYSUCKLE	Phone Number (208) 762-3828
Administrator Jenna Gove	City HAYDEN	ZIP Code 83835	Survey Date May 15, 2015
Survey Team Leader Maureen McCann, RN	Survey Type Initial Licensure and Complaint Investigation	RESPONSE DUE: June 14, 2015	
Administrator Signature <i>Jenna M Gove</i>	Date Signed <i>May 15, 2015</i>		

**NON-CORE ISSUES**

Item #	IDAPA Rule # 16.03.22.	Description	Department Use Only	
			EOR Accepted	Initials
1	009.06.c	The facility did not complete a state-only background check for 2 of 5 staff. <i>DMC JMC</i>		
2	153.03.c	The facility did not have a clear policy directing staff how to respond to a criminal situation.	<i>7/2/15</i>	<i>MC</i>
3	210	The facility did not provide activities to engage all residents.	<i>7/2/15</i>	<i>MC</i>
4	220.02	The facility and Resident #3 did not have a completed admission agreement prior to or on the day of admission.	<i>7/2/15</i>	<i>MC</i>
5	225.01	Resident #'s 1, 2, 3 & 4, were not evaluated to identify their specific behaviors.	<i>7/2/15</i>	<i>MC</i>
6	260.06	The facility was not maintained in a clean, safe and orderly manner. For example, vinyl flooring was torn throughout the facility, paint was worn and chipped throughout the facility, several bathroom floors were stained around the toilets, showers and tubs. Two residents' closets did not have doors. Carpets were stained and wrinkled creating a fall risk. Several air vents were rusted and covered in dust. A faucet was leaking in the laundry room and a bathroom sink drain was broken. A fabric easy chair was torn and had exposed wood and tacks sticking out.		
7	300.01	The facility RN did not complete an initial assessment when Resident #3 was admitted to the facility on 5/4/15.	<i>7/2/15</i>	<i>MC</i>
8	300.02	The facility RN did not review new orders for Resident #'s 1, 2, 3 & 4.	<i>7/1/15</i>	<i>MC</i>
9	305.01	The facility did not assess Resident #4's response to Coumadin.	<i>7/1/15</i>	<i>MC</i>
10	305.02	The facility nurse did not ensure physician's orders for Resident #1's oxygen were current.	<i>7/2/15</i>	<i>MC</i>
11	305.03	The facility nurse did not document an assessment when residents had a change of condition. Such as, Resident #1 & #4's wound status, Resident #1's hospital visits, or when he had an unresponsive episode or Resident #4's ankle edema.	<i>7/2/15</i>	<i>MC</i>
12	310.04.c	The facility nurse did not monitor Resident #'s 1, 2, 3 & 4, to determine the continued use of psychotropic medication based on the residents demonstrated behaviors.	<i>7/2/15</i>	<i>MC</i>
13	310.04.d	The facility nurse did not monitor Resident #'s 1, 2, 3 & 4's, potential side effects of psychotropic medications that could impact the residents health and safety.	<i>7/2/15</i>	<i>MC</i>
14	310.04.e	The facility did not provide behavioral updates to Resident #'s 1, 2, 3 & 4's physicians.	<i>7/2/15</i>	<i>MC</i>

Facility LARK'S HAVEN ON HONEYSUCKLE	License # RC-1084	Physical Address 1027 EAST HONEYSUCKLE	Phone Number (208) 762-3828
Administrator Jenna Gove	City HAYDEN	ZIP Code 83835	Survey Date May 15, 2015
Survey Team Leader Maureen McCann, RN	Survey Type Initial Licensure and Complaint Investigation	RESPONSE DUE: June 14, 2015	
Administrator Signature <i>Jenna M Gove</i>	Date Signed <i>May 15, 2015</i>		

**NON-CORE ISSUES**

Item #	IDAPA Rule #	Description	Department Use Only	
			EOR Accepted	Initials
15	320.01	The facility did not implement Resident #'s 1, 2, 3 & 4's NSAs to ensure they were provided assistance with eating, transferring, mobility and toileting needs.	7/2/15	AMC
16	320.08	Resident #'s 1, 2, 3 & 4's NSAs were not updated to reflect their current care needs.	7/2/15	AMC
17	405.05	Portable heaters are not allowed.	7/2/15	AMC
18	600.06.b	One of one staff did not have current CPR and first aide and worked alone on the night shift.	7/2/15	AMC
19	711.08.e	Staff did not document when they notified the facility RN.	7/1/15	AMC
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IDAHO DEPARTMENT OF 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>Yorks Haven on Homersuckle</u>		Operator <u>Janina Gore</u>	
Address <u>107 E. Homersuckle</u>		<u>Hailey ID 83835</u>	
County <u>Boole</u>	Estab # <u>700691</u>	EHS/SUR #	Inspection time: <u>11:00 - 12:00</u>
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>0</u>
# of Repeat Violations	<u>0</u>	# of Repeat Violations	<u>0</u>
Score	<u>0</u>	Score	<u>0</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"/>
	Employee Health (2-201)		
<u>Y</u> N	2. Exclusion, restriction and reporting	<input type="checkbox"/>	<input type="checkbox"/>
	Good Hygienic Practices		
<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"/>
	Control of Hands as a Vehicle of Contamination		
<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"/>
	Approved Source		
<u>Y</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"/>
	Protection from Contamination		
<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>Y</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/A	15. Proper cooking, time and temperature (3-401)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N (N/A)	16. Reheating for hot holding (3-403)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N (N/A)	17. Cooling (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N (N/A)	18. Hot holding (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N N/A	19. Cold Holding (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N N/A	20. Date marking and disposition (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N (N/A)	21. Time as a public health control (procedures/records) (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
	Consumer Advisory		
<u>Y</u> N N/A	22. Consumer advisory for raw or undercooked food (3-603)	<input type="checkbox"/>	<input type="checkbox"/>
	Highly Susceptible Populations		
<u>Y</u> N N/A	23. Pasteurized foods used, avoidance of prohibited foods (3-801)	<input type="checkbox"/>	<input type="checkbox"/>
	Chemical		
<u>Y</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"/>
	Conformance with Approved Procedures		
<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>cube steak</u>	<u>190°</u>	<u>Yogurt</u>	<u>34°</u>				
<u>potatoes</u>	<u>170°</u>	<u>Jack &amp; cheese</u>	<u>36°</u>				

GOOD RETAIL PRACTICES (input checked box = 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 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) Janina Gore (Print) Janina M. Gore Title Adm. Date 5/14/2015

Inspector (Signature) [Signature] (Print) Maureen Miller Date 5/14/15

Follow-up: (Circle One) Yes / No



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

June 9, 2015

Jenna Gove, Administrator  
Lark's Haven on Honeysuckle  
1027 East Honeysuckle  
Hayden, Idaho 83835

Provider ID: RC-1084

Ms. Gove:

An unannounced, on-site complaint investigation survey was conducted at Lark's Haven on Honeysuckle between May 12, 2015 and May 15, 2015. During that time, observations, interviews, and record reviews were conducted with the following results:

**Complaint # ID00006448**

**Allegation #1:** Residents were not assisted with activities of daily living such as assistance with mobility, transferring, toileting and eating as outlined in their negotiated service agreements.

**Findings:** Substantiated. The facility was issued a core deficiency at IDAPA 16.03.22.520 for inadequate care for failure to protect residents rights when one resident was physically restrained and three residents were chemically restrained. The facility was required to submit a plan of correction within 10 days.

Further, the facility was issued a non-core deficiency at IDAPA 16.03.22320.01 for failure to implement residents' negotiated service agreement's regarding their assistance with toileting and eating needs. The facility was required to submit evidence of resolution within 30 days.

**Allegation #2:** Residents were not assisted with monitoring and assistance of medications.

**Findings:** Substantiated. The facility was issued a core deficiency at IDAPA 16.03.22.520 for inadequate care for failure to monitor and assist a resident with his medications. The facility was required to submit a plan of correction in 10 days.

The facility was also issued a non-core deficiency at IDAPA 16.03.22.305.02 for failure to ensure a resident's medication orders were current. The facility was required to submit a plan of correction in 30 days.

**Allegation #3:** The facility did not provide activities to engage all residents.

**Findings:** Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.210 for not providing activities to engage all residents. The facility was required to submit evidence of resolution within 30 days.

Jenna Gove, Administrator

June 9, 2015

Page 2 of 2

**Allegation #4:** The facility did not reposition residents, and residents were left in the same positions for long periods of time.

**Findings:** Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.520 for inadequate care. The facility was required to submit a plan of correction within 10 days.

Further, the facility was issued a non-core deficiency at IDAPA 16.03.22320.01 for failure to implement residents' negotiated service agreement's regarding their needed assistance with positioning and transfers. The facility was required to submit evidence of resolution within 30 days.

**Allegation #5:** The facility did not provide copies of the admission agreement to the family.

**Findings:** Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.220.02 for the facility not completing admission agreements prior to or on the day of admission. The facility was required to submit evidence of resolution within 30 days.

**Allegation #6:** The facility staff did not meet the specific needs of residents with a dementia diagnosis.

**Findings:** Substantiated. The facility was issued a core deficiency at IDAPA 16.03.22.520 for inadequate care for chemically restraining residents' who had diagnosis of dementia. The facility was required to submit a plan of correction within 10 days.

**Allegation #7:** Staff did not complete dementia training.

**Findings:** On 5/14/15, five employee records were reviewed and all five employees had documented evidence they had completed dementia training within 30 days of being hired. Unsubstantiated.

However, the facility was issued a core deficiency at IDAPA 16.03.22.520 for inadequate care for chemically restraining residents' who had diagnosis of dementia. The facility was required to submit a plan of correction within 10 days.

**Allegation #8:** Residents were not assisted with eating.

**Findings:** Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.320.01 for not implementing NSAs to ensure residents were provided assistance with eating. 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,



MAUREEN MCCANN, RN  
Health Facility Surveyor  
Residential Assisted Living Facility Program

MM/sc

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



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June 9, 2015

Jenna Gove, Administrator  
Lark's Haven on Honeysuckle  
1027 East Honeysuckle  
Hayden, Idaho 83835

Provider ID: RC-1084

Ms. Gove:

An unannounced, on-site complaint investigation was conducted at Lark's Haven on Honeysuckle between May 12, 2015 and May 15, 2015. During that time, observations, interviews or record reviews were conducted with the following results:

**Complaint # ID00006525**

**Allegation #1:** The facility did not respond appropriately when an identified resident smoked an illegal substance in the facility.

**Findings:** Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.153.03.c for the facility not having a clear policy directing staff how to respond to a criminal situation. The facility was required to submit evidence of resolution within 30 days.

**Allegation #2:** The facility chemically restrained residents.

**Findings:** Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.520 for not protecting residents rights to be free from chemical restraints. The facility was required to submit a plan of correction within 10 days.

**Allegation #3:** The facility retained an identified resident who was violent and a danger to others.

**Findings:** Unsubstantiated.

**Allegation #4:** The facility did not notify Licensing and Certification of reportable incidents.

Jenna Gove, Administrator  
June 9, 2015  
Page 2 of 2

Findings: Unsubstantiated. Although the allegation may have occurred, it could not be determined during the complaint investigation.

Allegation #5: The facility did not provide timely medical treatment when residents had changes in their health status.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.305.03 for the facility nurse not documenting assessments when residents had changes in their health status. The facility was required to submit evidence of resolution within 30 days.

Allegation #6: The facility did not complete a proper admission for residents.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.220.02 for not completing admission agreements, prior to or on the day of admission. 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,



MAUREEN MCCANN, RN  
Health Facility Surveyor  
Residential Assisted Living Facility Program

MM/sc

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



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June 9, 2015

Jenna Gove, Administrator  
Lark's Haven on Honeysuckle  
1027 East Honeysuckle  
Hayden, Idaho 83835

Provider ID: RC-1084

Ms. Gove:

An unannounced, on-site complaint investigation was conducted at Lark's Haven on Honeysuckle between May 12, 2015 and May 15, 2015. During that time, observations, interviews, and record reviews were conducted with the following results:

**Complaint # ID00006645**

**Allegation #1:** Residents did not receive medications as ordered by their physicians.

**Findings:** Substantiated. The facility was issued a core deficiency at IDAPA 16.03.22.520 for inadequate care when they failed to monitor and assist residents' with their medications. The facility was required to submit a plan of correction in 10 days.

The facility was issued a deficiency at IDAPA 16.03.22.300.02 for the facility nurse not reviewing residents' medications. Additionally, the facility was issued a non-core deficiency at IDAPA 16.03.22.305.02 for not ensuring residents' medication orders were current. The facility was required to submit evidence of resolution within 30 days.

**Allegation #2:** The facility restrained residents.

**Findings:** Substantiated. The facility was issued a core deficiency at IDAPA 16.03.22.520 for inadequate care for failure to protect residents rights when residents were chemically and physically restrained. The facility was required to submit a plan of correction within 10 days.

Jenna Gove, Administrator

June 9, 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 black ink, appearing to read "Maureen McCann".

MAUREEN MCCANN, RN

Health Facility Surveyor

Residential Assisted Living Facility Program

MM/sc

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