IDAHO DEPARTMENT OF HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

LESLIE M. CLEMENT - Administrator
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888

November 5, 2010

CERTIFIED MAIL #: 7000 1670 0011 3315 2139

Robbe Redford, Administrator
Hearthstone Village, LLC
P.O. Box 418
Kootenai, ID 83840

Dear Mr. Redford:

Based on the state licensure and complaint investigation survey conducted by our staff at Hearthstone Village, LLC on **October 22, 2010,** we have determined that the facility failed to provide adequate supervision to residents.

This core issue deficiency substantially limits the capacity of Hearthstone Village, LLC0 to furnish services of an adequate level or quality to ensure that residents' health and safety are safe-guarded. The deficiency is described on the enclosed Statement of Deficiencies.

You have an opportunity to make corrections and thus avoid a potential enforcement action. Correction of this deficiency must be achieved by **December 6, 2010. We urge you to begin correction immediately.**

After you have studied the enclosed Statement of Deficiencies, please write a Plan of Correction by answering **each** of the following questions for **each** deficient practice:

- What corrective action(s) will be accomplished for those specific residents/personnel/areas found to have been affected by the deficient practice?
- How will you identify other residents/personnel/areas that may be affected by the same deficient practice and what corrective action(s) will be taken?
- What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?
- How will the corrective action(s) be monitored and how often will monitoring occur to ensure that the deficient practice will not recur (i.e., what quality assurance program will be put into place)?
- By what date will the corrective action(s) be completed?

Return the **signed** and **dated** Plan of Correction to us by **November 18, 2010,** and keep a copy for your records. Your license depends upon the corrections made and the evaluation of the Plan of Correction you develop.

You have available the opportunity to question cited deficiencies through an Informal Dispute Resolution (IDR) process. If you disagree with the survey report findings, you may make a written request to the supervisor of the Residential Assisted Living Facilities Program for a Level 1 IDR meeting. The request for the meeting must be made within ten (10) business days of receipt of the statement of deficiencies (**November 18, 2010**). The specific deficiencies for which the facility asks reconsideration must be included in the written request, as well as the reason for the request for reconsideration. The facility's request must include sufficient information for Licensing & Certification to determine the basis for the provider's appeal. If your request for IDR is received after **November 18, 2010,** your request will not be granted. Your IDR request must me 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 under the heading of Forms and Information.

Please bear in mind that non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference. The completed punch list form and accompanying proof of resolution (e.g., receipts, pictures, policy updates, etc.) are to be submitted to this office by **November 21, 2010**.

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

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

Sincerely,

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

JS/sm

Enclosure

PRINTED: 11/01/2010
FORM APPROVED

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13R922		10/22/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSTONE VILLAGE, LLC	402 3RD STREET KOOTENAI, ID 83840

(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	Initial Comments The following core deficiency was cited during the licensure, follow-up survey and complaint investigation conducted 10/20/2010 through 10/22/2010 at your residential care/assisted living facility. The surveyors conducting the survey were: Polly Watt-Geier, MSW Team Coordinator Health Facility Surveyor Maureen McCann, RN Health Facility Surveyor Rae Jean McPhillips, RN Health Facility Surveyor Gloria Keathley, LSW Health Facility Surveyor Survey Definitions: activity apron = an apron with various types of closures (zippers, buttons, etc.) BID = twice daily eval = evaluation Jan = January MD = physician meds = medications NSA = Negotiated Service Agreement res = resident	R 000	Information on this document is required by regulation for licensure. Any information provided is not to be construed as an admission of guilt or that the facility in any way agrees with the findings of the survey team. R008 A. Mealtime supervision. All staff will be retrained as to appropriate meal service supervision. This training will focus on supervision of residents and will cover the following: quantity of staff at meal times, assistance with dining, attentiveness to diner's needs, and seat positioning during meals. Resident #4 Staff will monitor meal process to ensure that he has food if desired until he is satisfied. Also when completed eating will remove bowl and remove from dining area. Staff will monitor at all times to ensure that he does not eat other residents' food or foods that are not within his dietary texture orders. . This information will be noted and ~~updated the resident's NSA.~~	
R 008	16.03.22.520 Protect Residents from Inadequate Care. The administrator must assure that policies and procedures are implemented to assure that all residents are free from inadequate care.	R 008		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 12/3/10

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R 008	Continued From page 1 This Rule is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to provide adequate supervision for 4 of 5 sampled residents (# 3, 4, 5 and 10) and 2 random residents (A & C), who required assistance during meal times. The facility further failed to provide adequate care for 4 of 5 sampled residents (#'s 4, 5, 6 and 10), who required therapeutic diets. Finally the facility failed to provide adequate care for 1 of 1 sampled residents (#4) who was in a reclined wheelchair for extended periods of time. The findings include: I. SUPERVISION: According to IDAPA 16.03.22.25, Supervision is defined as "A critical watching and directing activity which provides protection, guidance, knowledge of a resident's general whereabouts, and assistance with activities of daily living." The facility consisted of two buildings, referred to as Building A or B. The following report describes events that occurred in Building A unless otherwise noted. Building A's census during the survey was 10 residents. A. Meal Times: On 10/20/10 between 9:45 AM and 10:05 AM, the following was observed at the breakfast table. One caregiver was observed to supervise and assist the residents: * For 20 minutes, Resident #4 sat with an empty bowl, picking at the tablecloth. The caregiver did not offer the resident more food, remove his empty bowl or assist the resident from the table.	R 008	Resident #3 Staff will monitor for meal process and determine if additional help is needed. Staff will review to see if adaptive devices that may assist her meal process. Updates and assistance needs will be noted in the resident's NSA. Resident #5 Staff will monitor the resident's needs to assist with meal and to encourage non-playing in food. Staff will be available to assist residents at all times. These concerns will be noted on the resident's NSA. Resident #10 Staff will be aware of the this resident's needs for greater assistance with meals. This may include encouragement to eat, use of finger foods for easier dining, reheating of foods if become cold, and overall supervision of the dining process. This resident's particular dining needs will be updated as they change on the resident's NSA.	

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R 008	Continued From page 2 * Resident #5 was observed playing with a "soup-like consistency" food in her bowl splashing it with her hand throughout the meal. The caregiver periodically fed the resident from the same bowl, but did not redirect the resident from playing in her food. On two occasions the caregiver was also observed to spoon food into the resident's mouth without watching to ensure the food was secure in her mouth before removing the utensil. Both times the food was observed dripping down the resident's face and into her lap. * Resident #10 appeared restless, tapping her fingernails in circular motions around her plate which was full of food. The caregiver did not cue or assist the resident to eat until 9:52 AM. At that time, the caregiver approached Resident #10 and cued her to use a fork. The resident ate a bite of a waffle, but then sat from 9:52 AM until 10:05 AM tapping her plate with her fork while staring at her plate. The resident had eaten 1 bite of a waffle in 20 minutes, only after being cued to eat. The resident returned to tapping on the table or her plate and did not eat unless she was further cued. * Random Resident A sat with a "soup-like consistency" food dripping from her mouth and chin for 15 minutes. The caregiver did not assist the resident to wipe the food that dripped down her mouth and chin. On 10/20/10 between 12:45 PM and 1:40 PM, the following was observed at the lunch table. One caregiver was observed to supervise and assist the residents. During the meal, the caregiver left the dining room for approximately 15 minutes to assist a resident with toileting needs:	R 008	Resident A This resident will be monitored for cleanliness assistance while dining and remove from the table when completed. This resident becomes frustrated when given too much assistance, but staff will intervene as the resident allows to increase dignity during the meal process. This information will be updated on the resident's NSA. Resident C Staff assist resident with dining process. Adaptive plates or utensils will be reviewed to see if they are effective in assisting with the meals. If applicable this information will be added to the resident's NSA. All staff will be trained as all staff will focus on the dining experience. The Nurse, House Manager and the administrator will monitor for compliance.	

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R 008	Continued From page 3 * Random Resident D ate her jello salad and pushed the plate of food off to her right side. The resident had eaten 15% of her meal. The caregiver did not look into the reason why the resident only ate 15% of her meal. * Resident #4 had been served a pureed diet. Between 1:08 PM and 1:28 PM, the resident attempted to scoop food from his plate, but his plate was empty. He was then observed taking chunks of ham off of Random Resident D's plate several times. At 1:28 PM, when the caregiver removed the resident's plate from the table, the resident appeared to want more food and grabbed the plate. The resident sat at the table after he was finished eating for 32 minutes, during which time he was observed eating off of another resident's plate. The caregiver did not intervene when the resident ate off of another residents' plate, offer the resident more food or assist the resident from the table. * Resident #5 was slumped and leaning left in her chair. She had her hand in her bowl of rice and was tapping it to music playing in the background. The caregiver left the table to assist another resident with cares. When the caregiver returned to assist Resident #5 with eating, she did not reposition or redirect the resident from playing in her food. The resident sat for 55 minutes without being repositioned by the caregiver. * Resident #10 sat down at 1:05 PM with her arms folded across her chest staring out the window or at her plate. At 1:20 PM, the resident began to appear restless, tapping her feet on the floor and holding on to the edge of the tablecloth, but did not attempt to eat. At 1:22 PM the resident	R 008	B. Therapeutic Diets All residents have been reviewed for appropriate therapeutic diets. Requests were made for those without clear understanding of the physicians order for diet preference. Specific diet orders are located in each residents chart and posted in each kitchen for all the staff. Resident #10 Resident was re-evaluated to assess for appropriate eating process and appropriate texture. No pocketing of foods was present during evaluation, however staff will continue to monitor. Evaluation completed and order from doctor clarifying diet texture obtained. Staff have been updated as to current texture and to monitor and assist resident with pocketing of foods if needed. Information has been added to the residents NSA. Resident #5 Diet orders including texture have been obtained from the physician. Updates have been made to the NSA. Resident #6 Swallowing re-evaluations have been completed. Updated diet orders have	

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R 008	Continued From page 4 picked up her napkin and straightened it on the table, but still did not attempt to eat. At 1:26 PM, the caregiver approached the resident and handed her a fork. The resident began to eat independently. The resident sat for 21 minutes before eating, until the caregiver assisted her to eat. * Random Resident A sat with a "soup-like consistency" food dripping from her mouth and chin. While the resident was eating, the caregiver did not assist her to steady her spoon. When the resident was finished eating, she sat at the table for 32 minutes without the caregiver assisting her to wipe the food that had dripped down her mouth and chin or assisting the resident from the table. * Random Resident C attempted to stab rice with her fork, but was unable to get the rice onto her fork. She repeatedly lifted the empty fork up to her mouth. The caregiver seated at the table did not seem to notice the resident was struggling and the resident was not assisted with eating her rice. On 10/21/10 between 8:25 AM and 10:00 AM, the following was observed at the breakfast table. One caregiver was observed to supervise and assist the residents. During the meal, the caregiver left the dining room for 17 minutes to assist a resident with toileting needs: *Resident #3 was observed trying to cut up a fried egg with the side of her fork. Although the resident tried for 3 minutes, she was unsuccessful, so she began eating hash browns. After finishing her hash browns the resident again attempted to cut her egg. When she was not able to cut through the large piece of fried egg, she eventually held the entire piece to her mouth and	R 008	been received an implemented by the staff. The Residents NSA has been updated. Resident #4 Diet orders have been clarified by the physician. The resident's NSA has been updated. All staff will be trained as to which diet each resident is on and what the diet entails. Each staff member will be trained as to where to find information in the facility. The Nurse, House Manager and the administrator will monitor for compliance. C. Supervision of Resident in reclining wheelchair. Staff will be trained as to appropriate interventions with Resident #4 and all residents needing supervision. Alternative interventions such as distracting activities or cues for unmet care needs will be reviewed with staff. These will include activity materials (such as boards, kits, activity aprons, shredding paper, etc.), toileting, exercising, or repositioning. Administrator and House Manager will monitor for compliance.	

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	13R922		10/22/2010

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R 008	Continued From page 5 took small bites off of the large piece as it flapped from her fork. The caregiver seated at the table did not seem to notice the resident was struggling and the resident was not assisted in cutting her egg. *Resident #5 had been receiving assistance with eating, however the caregiver left the table at 9:10 AM to assist another resident. During that time, the resident was observed trying to retrieve pieces of hash browns out of her bowl with her hand. A few minutes later, the resident was observed to be asleep with her hand in her bowl. At 9:27 AM, the caregiver returned and assisted Resident #5 to finish eating. For 17 minutes, the resident was left unattended. * Resident #10 received her plate at 8:50 AM. She sat with her arms folded across her chest staring out the window or at her plate. At 9:03 AM, the resident appeared to become restless and pushed her plate back and forth on the table with her hand, but did not attempt to eat. At 9:05 AM, after the resident sat for 15 minutes staring at her full plate, the caregiver verbally cued the resident and she took a bite of her food. At 9:56 AM (1 hour and 6 minutes since the resident received her plate), the resident was still at the table with her plate 80% full. At 11:10 AM, the caregiver assisted the resident from the table (2 hours and 20 minutes since the resident received her plate). The resident's plate was 50% full. The caregiver asked the resident to spit into a paper towel as she was assisted from the table. The resident spit out food she had pocketed in her mouth. The caregiver assisted the resident to the couch and again asked the resident to spit food into a paper towel. The resident again spit out more food she had in pocketed in her mouth. During the 2 hours and 20 minutes the resident	R 008		

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R 008	Continued From page 6 sat the table, the caregiver was not observed to monitor the resident's intake nor offer to warm the resident's food. The caregiver only checked the resident for pocketing food as she assisted the resident from the table. * Random Resident A was observed feeding herself with a spoon, however the food was dripping out of her mouth and down her chin. The caregiver did not assist the resident to steady her spoon or wipe the food that dripped down her mouth and chin. Resident #3 was not given assistance when she struggled cutting up her egg. Resident #4 sat for extended periods of time after completing his meal and was not offered additional food although he attempted to obtain more food. He also was not monitored to ensure he ate appropriate foods. Resident #5 was not repositioned while eating nor was she redirected from playing in her food. Caregivers continued feeding the resident as she played in her food and as they fed her they did not ensure the food was secure in her mouth before removing the utensil. Resident #10 sat for extended periods at the table, appearing restless and not eating until cued by caregivers. She also was not monitored to prevent pocketing of food. Random Resident A sat for extended periods of time after completing her meal with food dripping down her chin. Further, she was not assisted to steady her spoon while eating. Finally, Random Resident C was not given assistance when she struggled getting rice onto her fork. B. Therapeutic Diets: 1. Resident #10 was admitted on 3/26/08 with diagnoses including dementia and macular	R 008		

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R 008	Continued From page 7 degeneration. There was no documented evidence of a physician's diet order in the resident's record. An NSA dated 1/19/10, documented, the resident "needs cueing and encouragement" when eating and "no pork." A sheet entitled, "Ways You Can Compensate for Swallowing Difficulties" was found in the front pocket of the residents' record. There was no date on the sheet. Handwritten on the form was the following: * "Cue [Resident #10's name] to take a bite & then a drink. * If difficulty with soft textures, trial puree." A progress note, dated 2/9/10, documented "(Per MD) res is now on mechanical soft diet, due to dental issues...resident has lost 2 pounds since Jan 16th per records. Appetite is fair per staff. feeds self. Soft diet being served." A nursing assessment, dated 7/29/10, documented the resident was "pocketing food and meds." A physician's order for a swallow evaluation was ordered on 7/30/10. There was no documented evidence of a subsequent swallow evaluation in the resident's record, nor was there further communication to the physician regarding the completion or results of a swallow evaluation. On 10/22/10 at 7:35 AM, the facility nurse stated, "I couldn't find diet orders for [Resident #10's name]." The nurse also stated she could not find the results of the physician ordered swallow evaluation for Resident #10.	R 008		

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R 008	Continued From page 8 Resident #10 was observed being served the following foods during the following meals: * cut up waffle with syrup and hash browns for breakfast on 10/20/10 * cut-up pieces of ham, whole canned beets and rice for lunch on 10/20/10 * scrambled eggs, hash browns and toast for breakfast on 10/21/10 On 10/21/10 between 8:10 AM and 11:35 AM, five staff members stated the resident was not to receive pork and was known to pocket food, but otherwise was not on a therapeutic diet. On 10/21/10 at 9:45 AM, the house manager confirmed there was no current list of residents' therapeutic diets in the facility. On 10/21/10 at 3:10 PM, the facility nurse confirmed there was no current list of residents' therapeutic diets in the facility. Resident #10's record did not contain a physician's diet order. The resident's NSA did not document a therapeutic diet, but directed staff that the resident needed cueing and encouragement when eating and was not to be served pork. All interviewed staff were aware the resident was not to be served pork; however, the resident was served ham for lunch on 10/21/10. An information sheet in the resident's record also directed staff to cue the resident to take a bite and then a drink. Staff were not observed to cue the resident to take a bite and then a drink during any of the 3 observed meals. A progress note informed staff the "res is now on mechanical soft diet, due to dental issues." The resident was observed being served a regular diet with cut-up ham and toast. The house manager and facility	R 008		

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R 008	Continued From page 9 nurse confirmed there was no current list of residents' therapeutic diets in the facility to guide staff when serving meals. Additionally, there was no follow-up on a physician's order for a swallow evaluation for Resident #10. 2. Resident #5 was admitted on 3/26/08 with diagnoses including dementia, hearing loss and right upper extremity amputation. A physician's order, dated 12/21/07, documented the following diet: "mechanical soft with thin liquids. no dairy, no wheat, 3 scoops of protein powder BID in Ensure." According to the Idaho Diet Manual, 9th Edition, a mechanical soft diet is "designed to provide a texture modification of the regular diet for patients with chewing or swallowing difficulty. Meats are ground and all raw and hard to chew foods are omitted." An NSA, dated 3/10/10, documented the resident "needs physical assistance with eating...no wheat...drinks soy milk...mechanical soft...increased protein." A note, attached to the front of the refrigerator, documented "Please make sure to cut [Resident #5's name] food into small pieces and use the sectional plate for her with every meal." Resident #5 was observed being served the following foods during the following meals: * soup-like consistency scrambled eggs for breakfast on 10/20/10 * cut-up pieces of ham, whole canned beets and rice for lunch on 10/20/10 * scrambled eggs, hash browns and toast for breakfast on 10/21/10	R 008		

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R 008	Continued From page 10 On 10/21/10 between 8:10 AM and 11:35 AM the following staff stated Resident #5 was on the following therapeutic diet: * a caregiver - lactose intolerant, no wheat or flour * a second caregiver - gluten and lactose free, but not a mechanical soft * a third caregiver - gluten and dairy free * a medication aide - mechanical soft, lactose intolerant, no wheat or flour * the house manager - mechanical soft Resident #5 was observed being served a mixture of a pureed, mechanical soft as well as a regular diet with cut-up meat and toast despite a physician's order for "mechanical soft with thin liquids." Of five staff interviewed, two answered mechanical soft, but the other three did not. The house manager and facility nurse confirmed there was no current list of residents therapeutic diets in the facility to guide staff when serving meals. 3. Resident #6 was admitted on 11/30/07 with diagnoses including dementia and left-sided weakness post cardiovascular accident. A physician's order, dated 7/19/10, documented the following diet: pureed diet but to "proceed with a dietary eval." There was no documented evidence of a subsequent dietary evaluation in the resident's record, nor was there further communication to the physician regarding the completion or results of a dietary evaluation. A 10/20/10 note, entitled "ATTENTION, STAFF" was observed taped to the refrigerator door. The note documented the following: * "Resident #6 - mechanical soft"	R 008		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R922	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/22/2010
NAME OF PROVIDER OR SUPPLIER HEARTHSTONE VILLAGE, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 402 3RD STREET KOOTENAI, ID 83840		

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R 008	Continued From page 11 Resident #6 was observed, in building B, being served the following foods during the following meals: * scrambled eggs and yogurt for breakfast on 10/21/10 * pureed food for lunch on 10/21/10 On 10/21/10 between 8:10 AM and 11:35 AM, the following staff stated Resident #6 was on the following therapeutic diet: * a caregiver - pureed * a medication aide - mechanical soft * the house manager "I think it has been changed from mechanical soft to pureed" Resident #6's physician's diet order for a pureed diet was not congruent with the scrambled eggs the resident was served on 10/21/10. The note on the refrigerator door documented the resident was on a mechanical soft diet. Of three staff interviewed, two answered with different diets and one was not sure. The house manager and facility nurse confirmed there was no current list of residents therapeutic diets in the facility to guide staff when serving meals. 4. Resident #4 was admitted to the facility on 03/11/10 with a diagnosis of dementia with hallucinations. A physician's order, dated 3/9/10, documented the following diet: a regular diet with thin liquids. An NSA, dated 3/25/10, documented the resident was on a mechanical soft diet. A note, entitled "ATTENTION, STAFF" was observed taped to the refrigerator door. The note documented Resident #4 was on a "puree diet."	R 008		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R922	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/22/2010
NAME OF PROVIDER OR SUPPLIER HEARTHSTONE VILLAGE, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 402 3RD STREET KOOTENAI, ID 83840		

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R 008	Continued From page 12 On 10/21/10 between 8:10 AM and 11:35 AM, the following staff stated Resident #4 was on the following therapeutic diet: * a caregiver - pureed * a second caregiver - pureed * a third caregiver - mechanical soft * a medication aide - pureed * the house manager - pureed Resident #4's physician diet order for a regular diet was not congruent with the resident's NSA of a mechanical soft diet or with the note on the refrigerator door of a pureed diet. Four staff interviewed thought the resident was on a pureed diet, but one caregiver thought the resident's diet was mechanical soft. The house manager and facility nurse confirmed there was no current list of residents' therapeutic diets in the facility to guide staff when serving meals. Resident #4 was observed being served a pureed diet during 3 meals. However, the resident was observed taking chunks of ham off of another resident's plate during a meal without staff intervention. C. Supervision of resident in reclining wheelchair Resident #4 was admitted to the facility on 03/11/10, with a diagnosis of dementia with hallucinations. On 10/20/10 at 8:05 AM, the resident was observed sitting in the living room in a low wheelchair. The back of the wheelchair could be positioned upright to a 90 degree angle or reclined between an 80 to 45 degree angle. At the above time, the resident's wheelchair was observed to be reclined to approximately a 60 degree angle. The caregiver was not observed in the common area, as she was assisting another	R 008		

Bureau of Facility Standards

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	13R922		10/22/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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	Continued From page 13 resident behind a closed door. The resident was observed trying to scoot his bottom forward in the wheelchair, but was unable to do so. Then he was observed to grab ahold of his armrests and shake them from side to side. Additionally, a tab alarm was observed on the back of the wheelchair, which was attached to the resident's clothing. At this time, the resident was observed to be confused and when asked, was unable to explain the reason why his wheelchair was in a reclined position. An incident report, dated 6/24/10 at 7:50 AM, documented the caregiver found the resident on the floor in the living room "in front of his wheelchair." The incident report documented the caregiver took the following actions, "checked to ensure fall alarm was on and tipped chair back further." On 10/20/10 at 9:27 AM, a caregiver was observed putting foot pedals on the resident's wheelchair. The wheelchair's back was observed to be at a 90 degree angle. On 10/20/10 at 10:55 PM, Resident #4's wheelchair was observed to be reclined at approximately a 70 degree angle. He leaned forward and his tab alarm sounded. A caregiver went over to the resident, said a few words and reclined the resident to approximately a 50 degree angle, re-attached the tab alarm and walked away. The caregiver was not observed to offer an alternative activity or engage the resident in conversation at this time. Approximately a minute later the alarm sounded a second time. Another caregiver came and assisted the resident to the bathroom. On 10/20/10 between 11:15 AM and 11:40 AM,	R 008		

Bureau of Facility Standards

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R 008	Continued From page 14 Resident #4 was observed sitting in his wheelchair in the living room. The wheelchair was reclined to approximately a 45 degree angle. The resident was observed attempting to scoot his bottom forward for approximately five minutes. After five minutes, the resident was observed to grab the armrests and shake and pull on them. The resident then tried to remove the duct tape off of one of the armrests. After a few minutes of shaking the armrests and pulling on the duct tape, the resident pulled his sock half-way off, then put the sock back on. Then he pulled his pant leg up to the middle of his thigh and again tried to pull the duct tape off of the armrests. After a few more minutes, the resident took off his sock and placed his right arm inside the sock. Then he tried to pull off the duct tape with his hand covered by the sock. During this observation, staff were not observed to check on the resident, offer alternative activities or engage the resident in conversation. On 10/20/10 at 3:11 PM, Resident #4 was observed sitting in his wheelchair in the living room. The wheelchair was reclined to approximately a 60 degree angle. He leaned forward and the tab alarm sounded. A caregiver replaced the tab alarm and walked away without talking to the resident. The resident leaned forward in the wheelchair and said, "What do I do?" Staff were not observed to respond to the resident's question, engage the resident in conversation or offer an alternative activity. On 10/20 at 3:24 PM, Resident #4's wheelchair was observed in a reclined position at approximately a 60 degree angle. The resident attempted to scoot forward in his chair. When he was unable to do so, he grabbed the armrest cover on the couch and moved it. Then he	R 008		

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R 008	Continued From page 15 grabbed the armrests on the wheelchair and began shaking them from side to side. Staff were not observed to check on the resident, offer alternative activities or engage the resident in conversation. On 10/21/10 at 8:00 AM, Resident #4 was observed sitting in his wheelchair in the living room at approximately a 60 degree angle. The resident removed his left shoe and dropped it on the floor beside his left foot. Staff were not observed to check on the resident, offer alternative activities or engage the resident in conversation. On 10/21/10 at 9:37 AM, Resident #4 was wheeled from breakfast at the dining table into the living room. The caregiver was observed to recline the resident's wheelchair, without informing the resident, to approximately a 60 degree angle and then walked away without engaging the resident in an activity. On 10/21/10 between 9:56 AM and 10:10 AM, Resident #4 was observed sitting in his wheelchair, which was reclined to approximately a 60 degree angle. The resident was picking at duct tape on the armrests, pulling then pushing on the armrests; attempting to straighten up the reclined chair. He pushed on the armrests with both hands slightly raising himself up to get out of the seat and wiggled the wheelchair back and forth in attempt to get out of the chair. Caregivers in the room did not acknowledge the resident verbally, assist the resident to reposition or provide the resident with an activity. On 10/21/10 at 10:05 AM, Resident #4 was brought back into the living room after being toileted. The caregiver reclined the resident's	R 008		

Bureau of Facility Standards

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	13R922		10/22/2010

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R 008	Continued From page 16 wheelchair, without informing the resident or involving the resident in an activity, to approximately a 60 degree angle and then walked away. On 10/21/10 at 10:20 AM, a caregiver was observed walking behind the resident and reclining his chair back from approximately a 60 degree angle to a 45 degree angle, without informing the resident. The caregiver was not observed to check on the resident when she reclined the wheelchair, offer alternative activities or engage the resident. On 10/21/10 at 10:26 AM, Resident #4 was observed removing his shoes and attempting to get up. He leaned forward and the alarm went off. The activity director re-attached the tab alarm and got the resident an activity apron. When the resident saw the apron, he immediately put his hands on the armrests and thumped the armrests up and down. When the apron was close to the resident, he grabbed the apron and immediately began zipping and unzipping the zipper on the apron. He was observed to be involved with the apron for approximately one minute and then he placed his right hand on his head and stared off into the distance. On 10/21/10 between 10:28 AM and 10:40 AM, the resident was observed shaking his armrests frequently. At 10:40 AM, the resident pulled his pant leg up to his right knee. He then was observed taking his sock off and then attempting to put it back on. The activity director came over and assisted the resident to put the sock back on. On 10/21/10 at 11:36 AM, a caregiver stated there was a "bucket of bolts" and other activity items for Resident #4 near the television.	R 008		

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R 008	Continued From page 17 On 10/21/10 at 11:35 AM, a caregiver stated she leaned the resident's wheelchair back because it was more comfortable for the resident. She stated that when he would shake the armrests it usually meant that he was restless and needed to go to the bathroom. If after going to the bathroom, the agitation was still being exhibited, the staff would get the resident a yogurt or a magazine to flip through. On 10/21/10 at 12:10 PM, the house manager stated the resident was a one to two person assist for transferring, but was not safe to walk because he would cross his legs in front of him when walking, increasing his fall risk. She stated the caregivers typically moved the resident from his wheelchair to a recliner in the living room approximately every two hours. She also stated when the resident shook his armrests it usually was because he was "worried about fixing something." When staff saw the shaking of the armrests, they would typically intervene by toileting the resident, offering snacks or by giving the resident blocks. "He has a bucket of items over there." Additionally, she stated the wheelchair was primarily used for safety and the resident had not had falls since the wheelchair had been put into place. She also stated the wheelchair was reclined when the resident became agitated or really active, because it would reassure him. On 10/21/10 at 4:14 PM, the resident was observed sitting in the living room with his wheelchair reclined to approximately a 45 degree angle. The resident was observed unbuttoning and unzipping his pants. An odor of a bowel movement was observed coming from the resident at this time.	R 008		

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R 008	Continued From page 18 On 10/21/10 at 4:24 PM, a caregiver stated she was waiting for the house manager, who was on break, to assist with toileting the resident. She stated he was combative at times and she wanted to make sure she had the help before taking the resident to the bathroom. Additionally, the caregiver stated if the resident's wheelchair was "straight" (at a 90 degree angle) the resident would get up and fall. On 10/22/10 at 8:10 AM, the administrator described an "activity bucket" containing items Resident #4 could rummage through, when he got restless. Throughout 10/20/10 and 10/21/10, Resident #4 was observed reclined in his wheelchair attempting to get out and shaking the armrests of the chair. Staff were not observed to verbally inform the resident of when he was being reclined, engage the resident in conversation or transfer the resident out of his wheelchair to the recliner. Additionally, although several staff referred to providing snacks or resident specific activity items when the resident was restless in his wheelchair, none of these interventions were observed during the two-day survey, except on one occasion when an activity apron was utilized. The facility failed to supervise Residents' #3, 4, 5, 10, A and C at the table to ensure they received the assistance they required. The facility further failed to monitor and therefore ensure Residents' #4, 5, 6 and 10 received the appropriate therapeutic diets. Finally the facility failed to supervise Resident #4 when he was reclined in his wheelchair. These failures lead to inadequate care.	R 008		

Bureau of Facility Standards

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IDAHO DEPARTMENT OF HEALTH & WELFARE

MEDICAID LICENSING & CERTIFICATION - RALF
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-6626 fax: (208) 364-1888

ASSISTED LIVING
Non-Core Issues Punch List

Facility Name	Physical Address	Phone Number
Hearthstone Village	402 3rd St.	(208) 255-4849
Administrator	**City**	**Zip Code**
Robbe Redford	Kootenai	83840
Team Leader	**Survey Type**	**Survey Date**
Polly Watt-Geier	Licensure, Follow-up and Complaint	10/22/10

NON-CORE ISSUES

Item #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	L&C USE
1	009.06.c	Three of three staff did not have the required state police background check.	11/19/2010	12/21/10 Pwg
2	152.05.b.iii	Three residents, who resided in Building B, had side rails on their beds.	11/19/2010	12/17/10 Pwg
3	210	There were no individual or group activities observed throughout the day on 10/20/2010.	11/5/10	11/29/10 Pwg
4	225.01	Resident #1 and #10's behavior management plans were not being implemented. (Repeat)	11/19/10	12/17/10 Pwg
5	250.013.l	~~Several~~ one residents' rooms in Building B did not have closet doors.	11/19/10	11/29/10 Pwg
6	260.04.a	Building A and B were observed to have unlocked chemicals in the laundry rooms.	COS 10/22/10	
7	260.05.d	The washing machine in Building B was not working properly.	11/8/10	11/29/10 Pwg
8	305.06	The facility RN did not assess Resident #3's ability to self-administer insulin. (Repeat)	COS 10-22-10	
9	310.01.d	A medication technician (MT) was observed to dial a random resident's insulin pen. Additionally, another MT was observed spooning	11/5/10	11/29/10 Pwg
		medications into residents' mouths, who were capable of feeding themselves the medications.		
10	320.01	Residents' #3, #4, #5, #6 and #10 NSAs did not clearly describe specific residents care needs in order to guide caregivers when providing	11/19/10	11/29/10 Pwg
		assistance to the residents. (Repeat)		
11	320.02.p	Resident #5's NSA did not describe home health services being provided. (Repeat)	11/19/10	11/29/10 Pwg
12	320.03	Resident #3, #6, #7's NSAs were not signed or dated by the resident, resident representative and administrator.	11/19/10	11/29/10 Pwg

Response Required Date	Signature of Facility Representative	Date Signed
11/21/10	[signature]	10-22-10

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Team Leader	**Survey Type**	**Survey Date**
Polly Watt-Geier	Licensure, Follow-up and Complaint	10/22/10

NON-CORE ISSUES

Item #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	L&C USE
13	335.03	Staff were observed exiting resident rooms and entering the kitchen wearing gloves they had worn while assisting residents	11/5/10	12/12/10 PWG
		with toileting. Additionally, not all staff rest rooms had liquid hand soap, paper towels or a garbage pail available.		
14	350.02	The administrator did not complete investigations on incident and accidents. (Repeat)	11/5/10	11/29/10 PWG
15	350.07	The facility did not report a bruise of an unknown origin for Resident #1 to Licensing and Certification. (Repeat)	11/5/10	11/29/10 PWG
16	405.05	The oven door hinge was broken in Building B.	11/8/10	11/29/10 PWG
17	430.05.g	The facility did not provide assistance and monitoring of medications when they allowed Resident #3's family member to administer	COS 10/22/10	
		an injectable medication.		12/10/10 PWG [illegible]
18	451.02	Snacks were not offered between meals or before bedtime.	11/5/10	11/29/10 PWG
19	625	The facility did not have documentation of orientation training for seven of seven staff.	11/19/10	12/17/10 PWG
20	625.03	There was no documentation of what training content was provided to staff during orientation.	11/19/10	12/17/10 PWG
21	625.03.d	Staff were observed using improper techniques during resident transfers.	11/5/10	11/29/10 PWG
22	630.01	Two of seven staff did not have specialized training for dementia. (Repeat)	11/19/10	12/17/10 PWG
23	630.02	Three of three staff, who worked in Building B, did not have specialized training for mental illness.	11/19/10	12/17/10 PWG
24	640	Three of three staff did not have eight hours of continuing education.	11/19/10	12/17/10 PWG
25	730.02	The facility did not maintain an as worked staff schedule that included all personnel.	COS 10-22-10	

Response Required Date	Signature of Facility Representative	Date Signed
11/21/10		10-22-10

Date 20 OCT 10 Page 1 of 2

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

Establishment Name: Northstone Village AL	Operator: Robbie Redford
Address: 403 W. Third St	City: Kootenai Zip: ID 83840
County Estab.#: Kootenai EHS/SUR.#	Inspection time: Travel time:
Inspection Type: Risk Category: high	Follow-Up Report: OR On-Site Follow-Up: Date: Date:

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

Critical Violations		Good Retail Practices	
# of Risk Factor Violations	2	# of Retail Practice Violations	0
# of Repeat Violations	0	# of Repeat Violations	0
Score	0	Score	0
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	

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

		COS	R
	Demonstration of Knowledge (2-102)		
(Y) N	1. Certification by Accredited Program or Approved Course; or correct responses; or compliance with Code	☐	☐
	Employee Health (2-201)		
(Y) N	2. Exclusion, restriction and reporting	☐	☐
	Good Hygienic Practices		
(Y) N	3. Eating, tasting, drinking, or tobacco use (2-401)	☐	☐
(Y) N	4. Discharge from eyes, nose and mouth (2-401)	☐	☐
	Control of Hands as a Vehicle of Contamination		
(Y) N	5. Clean hands, properly washed (2-301)	☐	☐
(Y) N	6. Bare hand contact with ready-to-eat foods/exemption (3-301)	☐	☐
(Y) N	7. Handwashing Facilities (5-203 & 6-301)	☐	☐
	Approved Sources		
(Y) N	8. Food obtained from approved source (3-101 & 3-201)	☐	☐
(Y) N	9. Receiving temperature / condition (3-202)	☐	☐
Y N (N/A)	10. Records: shellstock tags, parasite destruction, required HACCP plan (3-202 & 3-203)	☐	☐
	Protection from Contamination		
(Y) N N/A	11. Food segregated, separated and protected (3-302)	☐	☐
(Y) N N/A	12. Food contact surfaces clean and sanitized (4-5, 4-6, 4-7)	☐	☐
(Y) N	13. Returned / reservice of food (3-306 & 3-801)	☐	☐
(Y) N	14. Discarding / reconditioning unsafe food (3-701)	☐	☐

		COS	R
	Potentially Hazardous Food Time/Temperature		
(Y) N N/O N/A	15. Proper cooking, time and temperature (3-401)	☐	☐
Y N N/O (N/A)	16. Reheating for hot holding (3-403)	☐	☐
Y N N/O (N/A)	17. Cooling (3-501)	☐	☐
Y (N) N/O N/A	18. Hot Holding (3-501)	☐	☐
(Y) N N/O N/A	19. Cold Holding (3-501)	☐	☐
(Y) N N/O N/A	20. Date marking and disposition (3-501)	☐	☐
Y N (N/O) N/A	21. Time as a public health control (procedures/records) (3-501)	☐	☐
Y N N/O N/A	**Consumer Advisory**		
Y (N) N/A	22. Consumer advisory for raw or undercooked food (3-603)	☐	☐
	Highly Susceptible Populations		
(Y) N N/O N/A	23. Pasteurized foods used, avoidance of prohibited foods (3-801)	☐	☐
	Chemical		
(Y) N N/A	24. Additives / approved, unapproved (3-207)	☐	☐
(Y) N	25. Toxic substances properly identified, stored, used (7-101 through 7-301)	☐	☐
	Conformance with Approval Procedures		
Y N (N/A)	26. Compliance with variance and HACCP plan (8-201)	☐	☐

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
Yogurt in refrig	39.9	Kiwa out of oven	186.2+				
Milk in refrig	40.1	Rice on stove	188.6+				

GOOD RETAIL PRACTICES (☒ = not in compliance)

		COS	R			COS	R			COS	R
☐	27. Use of ice and pasteurized eggs	☐	☐	☐	34. Food contamination	☐	☐	☐	42. Food utensils/in-use	☐	☐
☐	28. Water source and quantity	☐	☐	☐	35. Equipment for temp. control	☐	☐	☐	43. Thermometers/Test strips	☐	☐
☐	29. Insects/rodents/animals	☐	☐	☐	36. Personal cleanliness	☐	☐	☐	44. Warewashing facility	☐	☐
☐	30. Food and non-food contact surfaces: constructed, cleanable, use	☐	☐	☐	37. Food labeled/condition	☐	☐	☐	45. Wiping cloths	☐	☐
☐	31. Plumbing installed; cross-connection; back flow prevention	☐	☐	☐	38. Plant food cooking	☐	☐	☐	46. Utensils & single-service storage	☐	☐
☐	32. Sewage and waste water disposal	☐	☐	☐	39. Thawing	☐	☐	☐	47. Physical facilities	☐	☐
☐	33. Sinks contaminated from cleaning maintenance tools	☐	☐	☐	40. Toilet facilities	☐	☐	☐	48. Specialized processing methods	☐	☐
					41. Garbage and refuse disposal	☐	☐	☐	49. Other	☐	☐

OBSERVATIONS AND CORRECTIVE ACTIONS (CONTINUED ON NEXT PAGE)

Person in Charge (Signature)	(Print) Robbie Redford	Title Mgr	Date 10/20/10
Inspector (Signature)	(Print) Martin Morris	Date 20 OCT 10	Follow-up: (Circle One) Yes No

IDAHO DEPARTMENT OF HEALTH & WELFARE

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

Food Establishment Inspection Report

Date 20 OCT 10

Establishment Name	Operator
Heartstone Village AL	Robbie Redford
Address 705. W. Third ST	Kootenai ID 83840
County Estab # Kootenai EHS/SUR.#	License Permit #

OBSERVATIONS AND CORRECTIVE ACTIONS (Continuation Sheet)

22. The facility cooks eggs to order and did not have an advisory available for residents. COS – Sign hung near kitchen in living room.

18. 2 breakfast plates were observed being held in the microwave for residents that did not get up for breakfast. COS – thrown away by caregiver.

Person in Charge	Date	Inspector	Date
[illegible]	10/20/10	[illegible]	20 OCT 10

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

LESLIE M. CLEMENT - Administrator
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888

December 29, 2010

Robbe Redford, Administrator
Hearthstone Village, LLC
Po Box 418
Kootenai, ID 83840

Dear Mr. Redford:

An unannounced, on-site complaint investigation survey was conducted by Polly Watt-Geier, MSW, Maureen McCann, RN, Rae Jean McPhillips, RN and Gloria Keathley, LSW at Hearthstone Village, LLC from October 20, 2010 to October 22, 2010. During that time, observations, interviews, and record reviews were conducted with the following results:

Complaint # ID00004483

Allegation #1: The facility did not hire certified nursing assistants to provide cares to the residents.

Findings #1: Substantiated. However, the facility was not cited as they are not required to hire certified nursing assistants to provide cares to the residents cares.

Allegation #2: The staff did not receive required orientation content training.

Findings #2: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.625 for not having documented orientation training and at IDAPA 16.03.22.625.03 for not documenting orientation content provided to caregivers during orientation. The facility was required to submit evidence of resolution within 30 days.

Allegation #3: The facility nurse was not available to assess residents' changes of condition.

Findings #3: Between 10/20 and 10/21/10, ten resident records were reviewed. The records documented the nurse followed-up on residents' changes of condition within a timely manner.

Between 10/20 and 10/21/10, seven family members were interviewed. They stated the nurse was available for changes in condition. They also stated the residents' received appropriate interventions when they had changes in

condition.

Between 10/20 and 10/21/10, three residents were interviewed. They stated the nurse came in and assessed them when they had changes in condition.

Between 10/20 and 10/21/10, the house manager and five staff members stated the facility nurse worked 40 hours a week, but not at set times. They stated she was always available by phone to call when there were changes in residents' conditions.

On 10/21/10 at 3:10 PM, the facility nurse stated when she was not in the facility, she was always available by phone. She stated the staff always called her with any resident changes, especially falls, injuries or illness.

Unsubstantiated. This does not mean the incident did not take place; it only means that the allegation could not be proven.

Allegation #4: The facility did not notify licensing and certification of reportable incidents.

Findings #4: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.350.07 for not reporting bruises of unknown origin to licensing and certification. The facility was required to submit evidence of resolution within 30 days.

Allegation #5: The facility administrator did not investigate all accidents and incidents and implement interventions to prevent a reoccurrence.

Findings #5: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.350.02 for the administrator not investigating incident and accidents. The facility was required to submit evidence of resolution within 30 days.

Allegation #6: The facility did not document all accidents and incidents.

Findings #6: Between 10/20/10 and 10/21/10, ten residents' records and incident reports were reviewed. The residents' care notes documented accidents/incidents that were congruent with the incident reports. No additional incidents were documented in the residents' records.

Between 10/20 and 10/21/10, the facility nurse, house manager and five staff members stated the staff would fill out an incident report when any incident or accident occurred.

Unsubstantiated. This does not mean the incident did not take place; it only means that the allegation could not be proven.

Allegation #7: The facility did not provide appropriate therapeutic diets.

Findings #7: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.520 for not providing supervision to ensure residents received appropriate therapeutic diets. The facility was required to submit a plan of correction.

Allegation #8: Residents were denied the right to watch television shows of choice based on the administrator's religious views.

Findings #8: Between 10/20 and 10/21/10, Building A and Building B television usage was observed. Residents were not observed to have inappropriate limitations on television programs being watched on the common use televisions.

Between 10/20 and 10/21/10, seven family members were interviewed. They stated they were not aware of the facility limiting television programs due to religious reasons.

Between 10/20 and 10/21/10, three residents were interviewed. They stated they were not limited on what programs they could watch on the common television.

Between 10/20 and 10/21/10, the house manager and five staff members stated television programs were not limited due to religious preferences of staff. They stated they did try to watch programs that were associated with the residents' generation and reduce violent programming that may upset the residents.

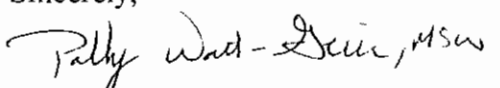
Unsubstantiated. This does not mean the incident did not take place; it only means that the allegation could not be proven.

Allegation #9: Snacks were not available or offerred to residents.

Findings #9: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.451.02 for not providing snacks in between meals and at bedtime. 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) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,



Polly Watt-Geier, MSW
Health Facility Surveyor
Residential Assisted Living Facility Program

IDAHO DEPARTMENT OF
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December 28, 2010

Robbe Redford, Administrator
Hearthstone Village, LLC
Po Box 418
Kootenai, ID 83840

Dear Mr. Redford:

An unannounced, on-site complaint investigation survey was conducted by Polly Watt-Geier, MSW, Maureen McCann, RN, Rae Jean McPhillips, RN and Gloria Keathley, LSW at Hearthstone Village, LLC from October 20, 2010 to October 22, 2010. During that time, observations, interviews, and record reviews were conducted with the following results:

Complaint # ID00004730

Allegation #1: Unlicensed caregivers were injecting an identified resident's insulin.

Findings #1: An identified resident's Negotiated Service Agreement documented a family member would give injections most of the time. There was no documented nursing assessment regarding the resident's ability to safely self-inject insulin.

On 10/20/10 at 10:30 AM, the house manager stated staff did not assist the identified resident with insulin. She stated the resident's family member came in and gave insulin injections nine out of ten times. She stated when the family member was unable to give the injection, the facility nurse would come in and give the injection.

On 10/20/10 at 12:55 PM, the facility nurse stated the resident's family member came in and gave the insulin injection 99% of the time. When they were not available, she would come in and give the injection.

On 10/20/10 at 1:57 PM, the identified resident's family member stated "I give her the shot."

Unsubstantiated. This does not mean the incident did not take place; it only means that the allegation could not be proven. However, the facility was issued

a deficiency at IDAPA 16.03.22.305.06 for the facility nurse not assessing a resident's capability to safely self-inject insulin. The facility was also issued a deficiency at IDAPA 16.03.22.430.05.g for the facility not providing assistance and monitoring of medications when they allowed a family member to administer an injectable medication. The facility was required to submit evidence of resolution within 30 days.

Allegation #2: An identified resident was being over-medicated.

Findings #2: On 10/21/10, the identified resident's closed record was reviewed. There was no documented evidence the resident had been over-medicated while at the facility. Nine other random resident records were reviewed and there was no documented evidence any of the residents had been over-medicated.

On 10/20/10, the facility's incident reports were reviewed. There was no documented evidence of medication errors, including incidents when the identified resident or other residents were over-medicated.

Between 10/20 and 10/21/10, residents were not observed to have symptoms of being over-medicated.

Between 10/20 and 10/21/10, seven family members were interviewed. They stated they had no concerns with medications and had not observed their loved ones exhibiting signs of being over-medicated.

Between 10/20 and 10/21/10, three residents were interviewed. They stated they had no concerns with medications and had not been over-medicated at any time.

Between 10/20 and 10/21/10, the facility nurse, house manager and five staff members stated they were not aware of a time when residents were over-medicated.

Unsubstantiated. This does not mean the incident did not take place; it only means that the allegation could not be proven.

Allegation #3: The facility was not maintained in a clean, safe, and orderly manner. There were broken pipes and mold under the kitchen sink in Building A.

Findings #3: Between 10/20 and 10/21/10, the facility was observed to be well maintained and clean. There were no foul odors present, no broken pipes or mold observed under the kitchen sink cabinet.

Between 10/20 and 10/21/10, seven family members were interviewed. They stated the facility was always well maintained.

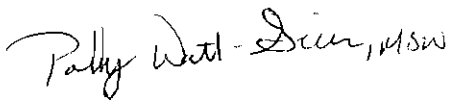
Between 10/20 and 10/21/10, three residents were interviewed. They stated they had no concerns with housekeeping and the facility was always well maintained.

Between 10/20 and 10/21/10, the facility nurse, house manager and five staff members stated the housekeeping duties were divided between the medication aides and the caregivers on the evening and night shifts. The house manager also did all of the vacuuming and assisted with areas that required additional cleaning. They all stated maintenance was taken care of promptly, unless they had to wait for parts to be delivered to fix appliances.

Unsubstantiated.

As no deficiencies were cited as a result of our investigation, no response is necessary to this report. Thank you to you and your staff for the courtesies extended to us on our visit.

Sincerely,



Polly Watt-Geier, MSW
Health Facility Surveyor
Residential Assisted Living Facility Program

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

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December 28, 2010

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Complaint # ID00004771

Allegation #1: Three caregivers worked without a completed criminal history background check.

Findings #1: Substantiated. However, the facility was not cited as they had identified and corrected the problem prior to the survey.

As no deficiencies were cited as a result of our investigation, no response is necessary to this report. Thank you to you and your staff for the courtesies extended to us on our visit.

Sincerely,

Polly Watt-Geier, MSW

Polly Watt-Geier, MSW
Health Facility Surveyor
Residential Assisted Living Facility Program