



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

August 6, 2014

Kimberly Johnson, Administrator
Bristol Heights Assisted Living
2220 West Prairie Avenue
Coeur d Alene, Idaho 83815

Provider ID: RC-1011

Ms. Johnson:

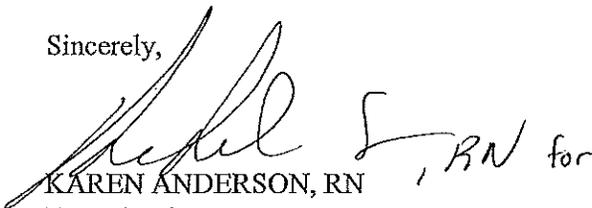
On June 20, 2014, a state licensure/follow-up survey was conducted at Bristol Heights Assisted Living. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level(s):

- Core issues, which are described on the Statement of Deficiencies, and for which you have submitted a Plan of Correction.
- Non-core issues, which are described on the Punch List, and for which you have submitted evidence of resolution.

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 Karen Anderson, RN, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 364-1962.

Sincerely,


KAREN ANDERSON, RN

Team Leader
Health Facility Surveyor

KA/sc

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



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June 25, 2014

CERTIFIED MAIL #: 7007 3020 0001 4050 8449

Kimberly Johnson
Bristol Heights Assisted Living
2220 West Prairie Avenue
Coeur d Alene, Idaho 83815

Provider ID: RC-1011

Ms. Johnson:

Based on the State Licensure survey conducted by Department staff at Bristol Heights Assisted Living between June 19, 2014 and June 20, 2014, it has been determined that the facility failed to protect residents from inadequate care.

This core issue deficiency substantially limits the capacity of Bristol Heights Assisted Living to furnish services of an adequate level or quality to ensure that residents' health and safety are protected. 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 **August 4, 2014**. **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?

Kimberly Johnson

June 25, 2014

Page 2 of 2

Return the **signed** and **dated** Plan of Correction to us by **July 8, 2014**, and keep a copy for your records. Your license depends upon the corrections made and the evaluation of the Plan of Correction you develop.

In accordance with IDAPA 16.03.22.003.02, you have available the opportunity to question cited deficiencies through an informal dispute resolution process. If you disagree with the survey report findings, you may make a written request to the Supervisor of the Residential Care 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. See the IDR policy and directions on our website at www.assistedliving.dhw.idaho.gov. If your request for informal dispute resolution is not received within the appropriate time-frame, your request will not be granted.

Please bear in mind that non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference. Your evidence of resolution (e.g., receipts, pictures, policy updates, etc.) for each of the non-core issue deficiencies is to be submitted to this office by **July 20, 2014**.

Also, be aware that any variance allowing the administrator to serve over other facilities is revoked as of the date of the exit conference. The facility must now employ a single, licensed administrator who is not serving as administrator over any other facilities. Failure to do so within thirty (30) days of the date of the exit conference will result in a core issue deficiency.

If, at the follow-up survey, the core deficiency still exists or a new core deficiency is identified, or if any of the repeat non-core punches are identified as still out of compliance, the Department will have no alternative but to initiate an enforcement action against the license held by Bristol Heights Assisted Living.

Enforcement actions may include:

- imposition of civil monetary penalties;
- issuance of a provisional license;
- limitation on admission to the facility;
- requirement that the facility hire a consultant who submits periodic reports to Licensing and Certification.

Our staff is available to answer questions and to assist you in identifying appropriate corrections to avoid further enforcement actions. Should you have any questions, or if we may be of assistance, please contact us at (208) 364-1962 and ask for the Residential Assisted Living Facility program. Thank you for your continued participation in the Idaho Residential Care Assisted Living Facility program.

Sincerely,



JAMIE SIMPSON, MBA, QMRP

Program Supervisor

Residential Assisted Living Facility Program

JS/sc

TIME RECEIVED July 30, 2014 2:03:21 PM MDT	REMOTE CSID 6355073	DURATION 67	PAGES 1	STATUS Received
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Jul 30 14 11:54a Bristol Heights 6355073 p.1

PRINTED: 06/23/2014
FORM APPROVED

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R1011	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/20/2014
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NAME OF PROVIDER OR SUPPLIER BRISTOL HEIGHTS ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 2220 WEST PRAIRIE AVENUE COEUR D ALENE, ID 83815
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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 000	<p>Initial Comments</p> <p>The following deficiency was cited during the licensure and follow-up survey conducted between June 19, 2014 and June 20, 2014, at your residential care/assisted living facility. The surveyors conducting the survey were:</p> <p>Karen Anderson, RN Team Leader Health Facility Surveyor</p> <p>Maureen McCann, RN Health Facility Surveyor</p> <p>Rachel Corey, RN, BSN Health Facility Surveyor</p> <p>Survey Definitions: @ = at hr = hour mcg = micrograms min = minute ml = milliliter</p>	R 000	<p>Administrator and House Manager assumed the pain pump was Sub-Q #2 is very private and we never looked ourselves. Facility RN assumed that Administrator obtained a variance for said pain pump. Facility House Manager and Administrator have repeatedly voiced to our hospice RN that the rule clearly states that ANY time an IV is being used that they must be in the facility the entire time.</p> <p>We are fully accepting responsibility for our lack of knowledge. Never again will the Administrator or House Manager allow any type of pump in our facilities without visually looking at it ourselves.</p> <p>Pain pump was inserted as Sub-Q as of 6/20/14 prior to noon.</p>	
R 008	<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, interview and record review it was determined the facility retained 1 of 1 sampled residents (#2) who had a continuous intravenous (IV) infusion. The findings include:</p>	R 008		

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Kimberly Johnson

Administrator

7/7/14

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R1011	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/20/2014
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NAME OF PROVIDER OR SUPPLIER BRISTOL HEIGHTS ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 2220 WEST PRAIRIE AVENUE COEUR D ALENE, ID 83815
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R 008	<p>Continued From page 1</p> <p>According to IDAPA 16.03.22.152.05.ii, a resident will not be admitted or retained to an assisted living facility who is receiving continuous IV therapy.</p> <p>Resident #2's record documented he was an 49 year-old male, who was admitted to the facility on 9/30/13, with a diagnosis of muscular dystrophy and he received hospice services.</p> <p>On 6/19/14 at 10:25 AM, a double lumen catheter was observed located in Resident #2's left arm. The catheter was connected to a medication pump located on the bedside table next to the resident. Resident #2 stated he had a intravenous line and a pain medicine pump which helped him manage his chronic pain.</p> <p>A "Progress Note", dated 9/30/13, documented Resident #2 was admitted with a pain medication pump which was maintained by the resident and a hospice nurse.</p> <p>Physician's orders, dated 6/18/14, documented, "FentaNYL...Continuous rate 110mcg/hr."</p> <p>On 6/19/14 at 2:45 PM, the facility nurse stated the resident had a continuous IV pump which delivered pain medication to the resident.</p> <p>On 6/19/14 at 3:15 PM, the administrator stated she "did not understand" that Resident #2 was receiving a continuous IV infusion.</p> <p>On 6/19/14 at 4:00 PM, the hospice nurse confirmed Resident #2 had a intravenous catheter and was receiving a continuous IV infusion of pain medication.</p>	R 008		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R1011	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/20/2014
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NAME OF PROVIDER OR SUPPLIER BRISTOL HEIGHTS ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 2220 WEST PRAIRIE AVENUE COEUR D ALENE, ID 83815
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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 2 The facility admitted and retained Resident #2 for 9 months with a continuous IV infusion. This resulted in inadequate care.	R 008		



Facility BRISTOL HEIGHTS ASSISTED LIVING	License # RC-1011	Physical Address 2220 WEST PRAIRIE AVENUE	Phone Number (208) 661-6173
Administrator Kimberly Johnson	City COEUR D'ALENE	ZIP Code 83815	Survey Date June 20, 2014
Survey Team Leader Karen Anderson	Survey Type Licensure and Follow-up	RESPONSE DUE: July 20, 2014	
Administrator Signature 	Date Signed 6-20-14		

NON-CORE ISSUES

Item #	IDAPA Rule #	Description	Department Use Only	
			EOR Accepted	Initials
1	300.02	The facility staff were not following the hypoglycemia protocol each time Resident #4 had low blood sugar. There was no documentation the nurse directed staff when the resident had low blood sugar. Previously cited on 11/30/11.	7/18/14	KA
2	305.06	Resident #4 was not assessed by the nurse to self inject his own insulin and Resident #7 was not assessed by the nurse to keep self administer medications at bedside.	7/18/14	KA
3	711.08.e	Facility staff did not notify the facility nurse each time residents had a change of condition.	7/18/14	KA
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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: Arise! Height CNA Operator: Kimberly Johnson
Address: 220 W. Prairie Ave COA 83815
County: Boone Estab #: 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.

# of Risk Factor Violations	<u>1</u>	# of Retail Practice Violations	<u>2</u>
# of Repeat Violations	<u>0</u>	# of Repeat Violations	<u>0</u>
Score	<u>1</u>	Score	<u>2</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	

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"/>
<u>Y</u> N	2. Exclusion, restriction and reporting	<input type="checkbox"/>	<input type="checkbox"/>
<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"/>
<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"/>
<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 <u>N/A</u>	10. Records: shellstock tags, parasite destruction, required HACCP plan (3-202 & 3-203)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N <u>N/A</u>	11. Food segregated, separated and protected (3-302)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N <u>N/A</u>	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 <u>N/O</u> <u>N/A</u>	15. Proper cooking, time and temperature (3-401)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N <u>N/O</u> <u>N/A</u>	16. Reheating for hot holding (3-403)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N <u>N/O</u> <u>N/A</u>	17. Cooling (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N <u>N/O</u> <u>N/A</u>	18. Hot holding (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N <u>N/O</u> <u>N/A</u>	19. Cold Holding (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N <u>N/O</u> <u>N/A</u>	20. Date marking and disposition (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N <u>N/O</u> <u>N/A</u>	21. Time as a public health control (procedures/records) (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N <u>N/A</u>	22. Consumer advisory for raw or undercooked food (3-603)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N <u>N/O</u> <u>N/A</u>	23. Pasteurized foods used, avoidance of prohibited foods (3-601)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N <u>N/A</u>	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"/>
<u>Y</u> N <u>N/A</u>	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>Blk # 2 refri</u>	<u>39.8</u>	<u>mineraline soup</u>	<u>34.5</u>	<u>Blk # 1 refri</u>	<u>45.3</u>	<u>Smr Pim</u>	<u>46.4</u>

GOOD RETAIL PRACTICES (☒ = 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) Kimberly Johnson (Print) Title Adm Date 6/20/14
Inspector (Signature) (Print) Date 6/20/14 Follow-up: (Circle One) Yes No



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

Page 2 of 2
Date 6/20/14

Establishment Name Bishop Hughes CAA	Operator Kimberly Johnson
Address 280 W. Prairie Ave	CDA 83815
County Estab #	EHS/SUR.#
	License Permit #

OBSERVATIONS AND CORRECTIVE ACTIONS (Continuation Sheet)

19. Items in the refrigerator measured above 41°. Staff turned the refrigerator to a colder setting. Items were retemped 7LE next day and continued to measure above 41°. (Building #1 refrigerator)

Evidence of resolution due June 30th [KA 6/30/14]

Person in Charge <i>[Signature]</i>	Date 6/20/14	Inspector <i>[Signature]</i>	Date 6/20/14
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