



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

November 21, 2013

Stephanie Kilpatrick, Administrator
By The Lake - Honeysuckle
1027 E Honeysuckle
Hayden, ID 83835

License #: RC-1031

Dear Ms. Kilpatrick:

On September 11, 2013, a Complaint Investigation was conducted at By The Lake, Llc (by The Lake - Honeysuckle). As a result of that survey, deficient practices were found. The deficiencies were cited at the following level:

- Non-core issues, which are described on the Punch List, and for which you have submitted evidence of resolution.

Your submitted plan of correction and evidence of resolution are being accepted by this office. Please ensure the corrections you identified are implemented for all residents and situations, and implement a monitoring system to make certain the deficient practices do not recur.

Thank you for your work to correct these deficiencies. Should you have questions, please contact Donna Henscheid, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 364-1962.

Sincerely,

Donna Henscheid
Team Leader
Health Facility Surveyor

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



Facility By The Lake - Honeysuckle	License # RC-1031	Physical Address 1027 E Honeysuckle	Phone Number (208) 762-3828
Administrator Stephanie Kilpatrick	City Hayden	ZIP Code 83835	Survey Date September 11, 2013
Survey Team Leader Donna Henscheid	Survey Type Complaint Investigation and Follow-up	RESPONSE DUE: October 11, 2013	
Administrator Signature <i>Stephanie Kilpatrick</i>	Date Signed 9.11.13		

NON-CORE ISSUES

Item #	IDAPA Rule #	Description	Department Use Only	
			EOR Accepted	Initials
1	152.04	The facility did not implement their policy to notify families when residents were moved out of or within the facility.	10/31/13	DH
2	220.02	The facility's admission agreement did not reflect how the levels of care were determined. Further, each level contained a range of prices, but there was no explanation of how the range would be determined. **Previously cited on 10/19/12**	10/31/13	DH
3	220.03.d	Rates were not listed for the private rooms with private bathrooms.	10/21/13	DH
4	220.03.e	The admission agreement did not identify the assessment tool, the assessor and the frequency of the assessment used to determine rates.	10/31/13	DH
5	220.08	The admission agreement did not provide for the returning of the resident's belongings once the resident left the facility.	10/31/13	DH
6	220.10.c	The admission agreement did not reflect the prorated rates when a resident had an emergency discharge or death.	10/31/13	DH
7	220.17	The admission agreement did not disclose the conditions under which a resident transitions to Medicaid.	10/31/13	DH
8	225.01.a-g	The facility did not evaluate residents' behaviors.		
9	225.02.a-c	The facility did not develop interventions for residents' behaviors.		
10	305.02	The facility nurse did not ensure Resident #1 was weighed as ordered by the physician, Resident #3 had medications as ordered and Resident #4 had current medication orders. **Previously cited 10/19/12**	10/14/13	DH
11	310.01.d	Unlicensed staff documented they assisted a resident with injections. **Previously cited 10/19/12**	11/14/13	DH
12	350.02	The administrator did not document investigations were completed for complaints.	10/31/13	DH
13	505.01	The facility did not maintain an accounting record for Resident #2.	10/31/13	DH
14	625.01	The facility did not have documentation that 3 of 5 employees had received 16 hours of orientation.	10/14/13	DH
15	630.01	Five of five employee records did not contain documentation that dementia training was completed.	10/31/13	DH



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Administrator Stephanie Kilpatrick	City Hayden	ZIP Code 83835	Survey Date September 11, 2013
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Administrator Signature <i>Stephanie Kilpatrick</i>	Date Signed 9.11.13		

NON-CORE ISSUES

Item #	IDAPA Rule # 16.03.22.	Description	Department Use Only	
			EOR Accepted	Initials
16	630.02	Five of five employee records did not contain documentation that mental illness training was completed.	10/21/13	DH
17	630.04	Five of five employee records did not contain documentation that traumatic brain injury training was completed.	10/31/13	DH
18	705.02	Admission agreement were not signed by the administrator.	10/31/13	DH
19	711.02	The facility did not maintain documentation of complaints, the day they were received, the written investigation and outcome and the response to the individual that made the complaint.	10/31/13	DH
20	711.08	There were no care notes written by the person providing the care.	10/31/13	DH
21	711.11	There was no documentation for the reason medications were not given. **Previously cited 10/19/12**	10/31/13	DH
22	711.14	There was no documentation of the disposition of residents' belongings.	10/31/13	DH
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September 25, 2013

Stephanie Kilpatrick, Administrator
By The Lake - Honeysuckle
1027 E Honeysuckle
Hayden, ID 83835

Dear Ms. Kilpatrick:

An unannounced, on-site complaint investigation survey was conducted at By The Lake - Honeysuckle between September 9 and September 11, 2013. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00006133

Allegation #1: The facility moved residents to shared rooms without notifying families.

Allegation #1: Substantiated. The facility was issued a non-core deficiency at IDAPA 16.03.22.152.04 for not implementing the facility policy to notify families when residents were moved out of, or within the facility. The facility was required to submit evidence of resolution within 30 days.

Allegation #2: The administrator did not refund the difference of the cost of private rooms and semi-private rooms.

Findings #2: Insufficient evidence was available at the time of the investigation to substantiate this allegation.

Unsubstantiated.

Allegation #3: The administrator was not at the facility enough to provide adequate oversight.

Findings #3: Between 9/9/13 and 9/11/13, five residents, two family members, four staff members, and one outside agency employee were interviewed. None of them expressed concerns with the availability of the administrator. One caregiver stated the administrator was at the facility everyday, but did spend a great deal of time at the other facility where she was also the administrator. Another caregiver stated the administrator, even when not there, was "always available by phone."

Stephanie Kilpatrick
September 25, 2013
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On 9/10/13 at 9:45 AM, the administrator stated she was at the facility everyday, sometimes late at night, for at least a couple of hours and could always be reached by phone.

Unsubstantiated.

Allegation #4: The facility did not follow-up on complaints.

Findings #4: Substantiated. The facility was issued a non-core deficiency at IDAPA 16.03.22.350.02 for not documenting investigations were completed for all complaints. The facility was required to submit evidence of resolution within 30 days.

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, on **September 11, 2013**. The completed punch list form and accompanying evidence of resolution (e.g., receipts, pictures, policy updates, etc) are to be submitted to this office within thirty (30) days from the exit date.

If you have questions or concerns regarding our visit, please call us at (208) 364-1962. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,



Donna Henscheid, LSW
Health Facility Surveyor
Residential Assisted Living Facility Program

DH/TFP

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



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September 25, 2013

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By The Lake - Honeysuckle
1027 E Honeysuckle
Hayden, ID 83835

Dear Ms. Kilpatrick:

An unannounced, on-site complaint investigation survey was conducted at By The Lake - Honeysuckle between September 9 and September 11, 2013. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00006134

Allegation #1: Residents were discharged from the facility without permission from the residents or their families.

Findings #1: Insufficient evidence was available at the time of the investigation and in the records reviewed to substantiate this allegation.

Unable to substantiate. However, the facility was issued a non-core deficiency at IDAPA 16.03.22.152.04 for not implementing their policy to notify families when residents were moved out of, or within the facility.

Allegation #2: Residents were promised and paid for a private room with a private bathroom when there was not one available.

Findings #2: Insufficient evidence was available at the time of the investigation and in the records reviewed to substantiate this allegation.

Unsubstantiated.

Allegation #3: The facility did not appropriately handle residents' personal funds.

Findings #3: Substantiated. The facility was issued a non-core deficiency at IDAPA 16.03.22.505.01 for not maintaining accounting records for handling residents' personal funds. The facility was required to submit evidence of resolution within 30 days.

- Allegation #4: The facility did not conduct investigations when items were reported missing.
- Findings #4: Substantiated. The facility was issued a non-core deficiency at IDAPA 16.03.22.350.02 for the administrator not documenting that investigations were conducted. The facility was required to submit evidence of resolution within 30 days.
- Allegation #5: Medications were not given as ordered by the residents' physicians.
- Findings #5: Substantiated. The facility was issued a non-core deficiency at IDAPA 16.03.22.305.02 for the facility nurse not ensuring residents' medications were available as ordered. The facility was required to submit evidence of resolution within 30 days.
- Allegation #6: Admission agreements were not signed by all parties.
- Findings #6: Substantiated. The facility was issued a non-core deficiency at IDAPA 16.03.22.705.02 for not ensuring admission agreements were signed by the administrator. The facility was required to submit evidence of resolution within 30 days.
- Allegation #7: Staff were not documenting care notes.
- Findings #7: Substantiated. The facility was issued a non-core deficiency at IDAPA 16.03.22.711.08 for not documenting care notes. The facility was required to submit evidence of resolution within 30 days.
- Allegation #8: The administrator did not document written responses to complaints.
- Findings #8: Substantiated. The facility was issued a non-core deficiency at IDAPA 16.03.22.711.02 for the administrator not documenting complaints were received, investigated and a response given to the complainants. The facility was required to submit evidence of resolution within 30 days.
- Allegation #9: The facility allowed medications to accumulate longer than 30 days.
- Findings #9: Between 9/9/13 and 9/11/13, observations and interviews were conducted. Observations of the medication cart, medication room, garage storage area, and two office areas were conducted. There was no accumulation of unused medications observed in the facility. Further, four staff members stated the house manager, the nurse, or administrator and a witness disposed of all unused medications. The facility's destruction log was observed and contained appropriate documentation of medication destruction.
- Unsubstantiated. This does not mean the incident did not take place; it only means that the allegation could not be proven.
- Allegation #10: The administrator was not at the facility enough to provide sufficient oversight.
- Findings #10: Between 9/9/13 and 9/11/13, five residents, two family members, four staff members, and one outside agency employee were interviewed. None of them expressed concerns

with the availability of the administrator. One caregiver stated the administrator was at the facility everyday, but did spend a great deal of time at the other facility where she was also the administrator. Another caregiver stated the administrator, even when not there, was "always available by phone."

On 9/10/13 at 9:45 AM, the administrator stated she was at the facility everyday, sometimes late at night, for at least a couple of hours and could always be reached by phone.

Unsubstantiated.

Allegation #11: The facility did not follow physician's orders to obtain weights.

Findings #11: Between 9/9/13 and 9/11/13, six residents' records were reviewed. For approximately three weeks, weights were not taken because the facility scale was removed from the facility. After purchasing a new scale, the facility resumed documenting the resident weights in August through September.

On 9/10/13, the administrator stated the facility's scales were removed from the facility. She stated it took approximately three weeks to order and receive a new scale. She confirmed the facility was not able to weigh residents during that time, but the facility had corrected the problem as soon as possible.

Substantiated. However, not cited as the facility corrected the problem prior to the complaint investigation.

Allegation #12: Unlicensed caregivers were giving B12 injections.

Findings #12: Substantiated. The facility was issued a non-core deficiency at IDAPA 16.03.22.310.01.d for unlicensed staff documenting they had assisted a resident with a B12 injection. The facility was required to submit evidence of resolution within 30 days.

Allegation #13: The facility did not offer activities.

Findings #13: Between 9/9/13 and 9/11/13, observations and interviews were conducted. Six residents stated they were satisfied with the activities the facility provided. One resident stated she chose not to attend activities, but knew the facility offered bingo, exercise and music. Another resident stated she enjoyed the church service provided on Sundays. During the survey, residents were observed in the beauty shop getting their hair and nails done. On 9/10/13, a gentleman played guitar and conducted a sing-a-long for the residents; there were six residents observed in attendance. Also on this same day, two residents and two family members were observed playing a board game.

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

Allegation #14: The facility was not following the planned menu and served sandwiches every evening.

Stephanie Kilpatrick
September 25, 2013
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Findings #14: On 9/9/13, the September menu was observed. The menu was signed by a registered dietitian. The lunch meal was observed to be the bigger meal of the day and included menu items such as: baked chicken, pork chops, mashed potatoes and vegetables. Soup and sandwiches were often listed on the menu for the evening meal. Observations of the pantry, freezers and refrigerators were made and they contained food items necessary to meet the planned menu. Further, when substitutions were made to the menu, appropriate documentation of the substitutions were made and retained at the facility.

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

Allegation #15: Residents' narcotic medications were not appropriately tracked by the facility.

Findings #15: Insufficient evidence was available at the time of the investigation and in the records reviewed to substantiate this allegation.

Unsubstantiated.

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, on **September 11, 2013**. The completed punch list form and accompanying evidence of resolution (e.g., receipts, pictures, policy updates, etc) are to be submitted to this office within thirty (30) days from the exit date.

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,



Donna Henscheid, LSW
Health Facility Surveyor
Residential Assisted Living Facility Program

DH/ftp

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



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September 25, 2013

Stephanie Kilpatrick, Administrator
By The Lake - Honeysuckle
1027 E Honeysuckle
Hayden, ID 83835

Dear Ms. Kilpatrick:

An unannounced, on-site complaint investigation survey was conducted at By The Lake - Honeysuckle between September 9 and September 11, 2013. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00006154

Allegation #1: Residents were not assisted with a medication as ordered.

Findings #1: Insufficient evidence was available at the time of the investigation in the records reviewed to substantiate this allegation.

Unsubstantiated.

Allegation #2: Unlicensed staff administered an injectable medication.

Findings #2: Substantiated. The facility was issued a non-core deficiency at IDAPA 16.03.22.310.01.d for unlicensed staff documenting they had assisted a resident with a B12 injection. The facility was required to submit evidence of resolution within 30 days.

Allegation #3: The facility did not appropriately account for residents' spending money.

Findings #3: Substantiated. The facility was issued a non-core deficiency at IDAPA 16.03.22.505.01 for not maintaining accounting records for handling residents' personal funds. The facility was required to submit evidence of resolution within 30 days.

Stephanie Kilpatrick, Administrator
September 25, 2013
Page 2 of 2

Allegation #4: The facility did not have a functioning dishwasher and clothes washer.

Findings #4: On 9/10/13, the administrator stated there was a time one of the dishwashers and one of the clothes washers were not functioning. She stated that at no time was the facility without either a dishwasher or a clothes washer. The administrator stated she had the dishwasher and clothes washer repaired, but eventually had to replace the clothes washer.

On 9/10/13, the receipts, dated 12/8/12 and 2/7/13, for repairs were observed.

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

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, on **September 11, 2013**. The completed punch list form and accompanying evidence of resolution (e.g., receipts, pictures, policy updates, etc) are to be submitted to this office within thirty (30) days from the exit date.

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Sincerely,



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September 25, 2013

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By The Lake - Honeysuckle
1027 E Honeysuckle
Hayden, ID 83835

Dear Ms. Kilpatrick:

An unannounced, on-site complaint investigation survey was conducted at By The Lake - Honeysuckle between September 9 and September 11, 2013. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00006159

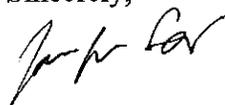
- Allegation #1: The facility moved residents to another facility without notifying the residents' family members.
- Allegation #1: Substantiated. The facility was issued a non-core deficiency at IDAPA 16.03.22.152.04 for not implementing the facility policy to notify families when residents were moved out of, or within the facility. The facility was required to submit evidence of resolution within 30 days.
- Allegation #2: The facility moved female residents to rooms that shared bathrooms with males.
- Findings #2: Substantiated. However, not cited as there is no rule regarding the opposite sex sharing a bathroom.
- Allegation #3: The facility did not appropriately handle residents' personal funds.
- Findings #3: Substantiated. The facility was issued a non-core deficiency at IDAPA 16.03.22.505.01 for not maintaining accounting records for handling residents' personal funds. The facility was required to submit evidence of resolution within 30 days.

Stephanie Kilpatrick
September 25, 2013
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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, on **September 11, 2013**. The completed punch list form and accompanying evidence of resolution (e.g., receipts, pictures, policy updates, etc) are to be submitted to this office within thirty (30) days from the exit date.

If you have questions or concerns regarding our visit, please call us at (208) 364-1962. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,



Donna Henscheid, LSW
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Residential Assisted Living Facility Program

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September 25, 2013

Stephanie Kilpatrick, Administrator
By The Lake - Honeysuckle
1027 E Honeysuckle
Hayden, ID 83835

Dear Ms. Kilpatrick:

An unannounced, on-site complaint investigation survey was conducted at By The Lake - Honeysuckle between September 9 and September 11, 2013. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00006194

- Allegation #1: Residents were not getting their medications as ordered.
- Findings #1: Substantiated. The facility was issued a non-core deficiency at IDAPA 16.03.22.305.02 for the facility nurse not ensuring residents' medications were available as ordered. The facility was required to submit evidence of resolution within 30 days.
- Allegation #2: Residents were denied visitor access.
- Findings #2: Substantiated. However, not cited. Due to the circumstances surrounding the visit, the facility had a right to limit the ex-employee access to the facility. The facility was provided technical assistance to develop a clear policy regarding under what conditions ex-employees would be allowed or not allowed back into the facility to see residents.
- Allegation #3: Staff were not appropriately trained.
- Findings #3: Substantiated. The facility was issued non-core deficiencies at IDAPA 16.03.22. 630.01, 630.02 and 630.04 for not providing the appropriate specialized training. The facility was required to submit evidence of resolution within 30 days.
- Allegation #4: The facility did not provide activities.
- Findings #4: Between 9/9/13 and 9/11/13, observations and interviews were conducted. Six residents stated they were satisfied with the activities the facility provided. One resident stated she chose not to attend activities, but knew the facility offered bingo, exercise and music. Another resident stated she enjoyed the church service provided on Sundays.

During the survey, residents were observed in the beauty shop getting their hair and nails done. On 9/10/13, a gentleman was observed playing guitar and conducting a sing-a-long for the residents; there were six residents in attendance. Also on this same day, two residents and two family members were observed playing a board game.

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

Allegation #5: Narcotics were not being tracked appropriately.

Findings #5: On 9/11/13 at 10:00 AM, the medication cart and narcotic tracking were observed. Three residents' narcotic tracking records were reviewed and the numbers in the "narcotic log" were congruent with the number of medications in the medication cart.

On 9/11/13 at 10:00 AM, the caregiver stated the caregivers counted narcotics at the start of each shift. The caregiver stated if the numbers were off, they reported it to the house manager or the administrator. The caregiver stated, since she had been working at the facility, there had been no problems with the narcotic count.

On 9/11/13 at 10:10 AM, the administrator stated the caregivers reported any discrepancies to either her or the house manager. She stated they would all work together to find where the error had occurred.

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

Allegation #6: Unlicensed staff were bubble-packing medications.

Findings #6: On 9/11/13, the medication cart was observed to contain bubble-packed medications which were appropriately labeled by the pharmacy.

Between 9/9/13 and 9/11/13, four caregivers, the current nurse and the administrator were interviewed. All four caregivers denied being asked to bubble-pack medications. All four of them said the administrator, who is a licensed practical nurse, and the facility nurse bubble-packed medications. The administrator stated she was not aware of any unlicensed staff bubble-packing medications. The administrator and nurse stated they were the ones responsible to ensure medications were bubble-packed.

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

Allegation #7: Unlicensed staff were giving injections.

Findings #7: Substantiated. The facility was issued a non-core deficiency at IDAPA 16.03.22.310.01.d for unlicensed staff documenting they had assisted a resident with a B12 injection. The facility was required to submit evidence of resolution within 30 days.

Allegation #8: There was no nurse available to assess the residents and provide direction to staff regarding residents' needs.

Stephanie Kilpatrick
September 25, 2013
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Findings #8: On 9/10/13, four caregiver records were reviewed and contained delegation from the current facility nurse.

On 9/10/13 at 2:30 PM, the facility nurse stated she had been working for the facility for three weeks and had conducted an in-service and completed delegation to caregivers for medication assistance.

On 9/10/13 at 3:00 PM, the administrator stated that the former nurse "quit" on 8/16/13 and the current nurse was hired on 8/14/13. A "Confidential Data Sheet" documented the current nurse verified her employment with the facility on 8/14/13.

Unsubstantiated.

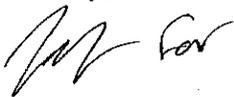
Allegation #9: There were no behavior management plans.

Findings #9: Substantiated. The facility was issued a non-core deficiency at IDAPA 16.03.22.225.01.a-g for not evaluating residents' behaviors. The facility was required to submit evidence of resolution within 30 days.

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, on **September 11, 2013**. The completed punch list form and accompanying evidence of resolution (e.g., receipts, pictures, policy updates, etc) are to be submitted to this office within thirty (30) days from the exit date.

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Sincerely,



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Residential Assisted Living Facility Program

DH/tfp

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