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

August 11, 2010

CERTIFIED MAIL #: 7008 0500 0002 2003 4379

Lynne Huyck, Administrator
Huckleberry Retirement Homes - IV
135 North Baldy Mountainn Road
Sandpoint, ID 83864

Dear Ms. Huyck:

Based on the state relicensure and follow-up survey conducted by our staff at Huckleberry Retirement Homes LLC - IV on **July 28, 2010,** we have determined that the facility failed to protect residents from inadequate care and protect residents from neglect.

These core issue deficiencies substantially limit the capacity of Huckleberry Retirement Homes LLC - IV to furnish services of an adequate level or quality to ensure that residents' health and safety are safe-guarded. The deficiencie are 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 **September 11, 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 **August 24, 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 process. If you disagree with the survey report findings, you may make a written request to the supervisor of the Residential Assisted Living 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 (**August 24, 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 **August 24, 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 hear 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 **August 27, 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 Hucklebeny Retirement Homes LLC - IV.

During the survey, the survey team identified that the administrator was over more than one facility. As of January 1, 2007, core issue deficiencies have been cited at IDAPA 16.22.03.215.03 when survey teams identify multiple facilities under one administrator for 30 days or more. However, due to the long history of the facility's administrator being over more than one facility, a core issue deficiency will not be issued for that requirement at this time. However, the facility must still comply with the following statute, which will be verified when a follow-up survey is conducted:

> ***"IDAHO RESIDENTIAL CARE OR ASSISTED LIVING ACT***
>
> *39-3321. QUALIFICATIONS AND REQUIREMENTS OF ADMINISTRATOR. Each residential care or assisted living facility must employ at least one (1) administrator licensed by the bureau of occupational licensing, which is responsible for licensing residential care facility administrators for the state of Idaho. Multiple facilities under one (1) administrator may be allowed by the department based on an approved plan of operation."*

Idaho Administrative Procedures Act (IDAPA) 16.03.22.215 of the rules for Residential Care or Assisted Living Facilities in Idaho, states:

> *"REQUIREMENTS FOR A FACILITY ADMINISTRATOR. Each facility must be organized and administered under one (1) licensed administrator assigned as the person responsible for the operation of the facility..."*

Facilities that meet the requirements stated below may be eligible to receive a variance to have one person serve as administrator over two or more facilities.

GUIDELINES FOR VARIANCE FOR ADMINISTRATOR OVER MORE THAN ONE FACILITY

1. The administrator holds a full residential care administrators license from the Idaho Bureau of Occupational Licensing.

2. The facilities are not located more than fifty (50) miles from the city in which the licensed administrator resides.

3. Neither facility has received a core issue deficiency within the past two years.

4. Each facility has corrected and sustained correction of non-core issue deficiencies cited on previous surveys.

5. The total number of facilities the administrator will act as administrator for does not exceed four.

6. The total number of beds, for which the variance is requested, does not exceed eighty (80).

7. The request for a variance must include a high level plan of operation (Idaho Code 39-3321), include at a minimum:
   a) an organizational chart;
   b) a description of the lines of authority; and
   c) a description of responsibility for supervision and notifications when the administrator is not in the building.

8. The administrator signs and returns the attached attestation.

However, due to the core deficiencies (IDAPA 16.03.22.520 and 16.03.22.525) cited on July 28, 2010, a variance cannot be granted for the current administrator to be over two facilities. Therefore, separate administrators must be obtained for Huckleberry Retirement Homes, LLC - III and Huckleberry Retirement Homes, LLC - IV.

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New plan of correction 9/1/10

PRINTED: 08/05/2010
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
	13R668		07/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY STATE, ZIP CODE
HUCKLEBERRY RETIREMENT HOMES LLC - I	1315 HEMLOCK COURT SANDPOINT, ID 83864

(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	R 000		
	The following deficiencies were cited during the re-licensure and follow-up conducted on 7/27/10 through 7/28/10 at your residential care/assisted living facility. The surveyors conducting the survey were: Rachel Corey, RN Team Coordinator Health Facility Surveyor Karen Anderson, RN Health Facility Surveyor Donna Henscheid, LSW Health Facility Surveyor Survey Definitions: mcg = microgram NSA = Negotiated Service Agreement RN = Registered Nurse sec = seconds UAI = Uniform Assessment Instrument yr = year			
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. This Rule is not met as evidenced by: Based on observation, record review and interview, it was determined the facility failed to provide supervision to 2 of 5 sampled residents (#1 and #4) by not providing up and awake staff. Further, the facility did not provide a safe living environment for 2 of 2 sampled residents	R 008		

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Bynne Huyck TITLE Administrator (X6) DATE 8-20-10

Accepted Michael 8 9/1/10

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R 008	Continued From page 1	R 008		
	(Resident #1 and #4) who were at risk for elopement. The findings include:		1. SUPERVISION	
	1. Supervision		CORRECTIVE ACTION	
	According to IDAPA 16.03.22600.01 "For Facilities licensed for fifteen (15) beds or less, there must be at least one (1), or more qualified and trained staff, immediately available, in the facility during resident sleeping hours. If any resident has been assessed as having night needs, or is incapable of calling for assistance staff must be up and awake."		RESIDENT #4 WAS TRANSFERED TO RCF WITH UP 24 HOUR STAFF	8-3-10
	On 7/27/10 at 3:25 PM, the administrator stated the night shift staff were not up and awake. She stated the intercom call system was turned on at night to a "monitor" position, so staff could hear if residents needed assistance. She further stated, "It is a small facility. We can hear everything that goes on."		RESIDENT #1 WAS TRANSFERED TO RCF WITH UP 24 HOUR STAFF	8-10-10
	A. Resident #1 was admitted to the facility on 1/9/08, with diagnoses including Alzheimer's dementia.		RESIDENTS WILL BE IDENTIFIED BY THEIR ASSESSMENTS (UAI). STATE CLIENTS WILL BE REASSESSED BY ADMINISTRATOR AS TO THEIR NIGHT NEEDS WHEN RMU RN'S ASSESS AS NONE NEEDED. STARTING 8-20-10	8-10-10
	An NSA, dated 5/21/10, documented under the "Supervision" section, the resident required "extensive supervision, constant verbal cues and a behavioral management program." Also, the resident required moderate assistance with toileting related to incontinence, cleaning and putting on protective garments and adjusting clothing		THROUGH REGULAR CHARTING BY STAFF TO INCLUDE WANDERING, COGNITIVE CHANGES. NOTIFICATION TO THE RN OF THESE CHANGES. STARTING 8-20-10	8-20-10
	A UAI, dated 4/22/10, documented under the "Supervision" section the resident required "extensive" supervision and the resident is "frequently disoriented to person, place, time or situation, even if in familiar surroundings, and		STAFF RECEIVING INSERVICE ON CHARTING 2X	8-31-10

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NAME OF PROVIDER OR SUPPLIER HUCKLEBERRY RETIREMENT HOMES LLC - II	STREET ADDRESS, CITY, STATE, ZIP CODE 1315 HEMLOCK COURT SANDPOINT, ID 83864		

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R 008	Continued From page 2 requires supervision and oversight for safety. Frequently, judgement is poor. Needs protection and supervision because client makes unsafe and inappropriate decisions." It also documented the resident required moderate assistance with toileting and physical assistance with parts of tasks such as wiping, cleaning, clothing adjustment. Care notes, undated, documented the resident wandered throughout the facility. Staff to "redirect if it is appropriate. She complies for the second and forgets what you said 5 - 10 secs later." Care notes, dated 6/27/10, documented the resident "still wanders within facility - Sits outside with other residents on nice days." On 7/27/10 at 2:00 PM, the administrator stated the staff were not up and awake at night. She stated they leave the intercoms "open" so the staff can hear in the rooms at night. On 7/28/10 at 10:30 AM, a caregiver stated Resident #1 was not aware there was an intercom in her room. Further, the caregiver stated see sometimes heard the resident up using the toilet and wandering around with another resident at night. Resident #1 required supervision and assistance with toileting during the night time hours and was not able to call for help using the intercom system, due to her decreased cognition. Up and awake staff were not provided to ensure Resident #1's safety and activities of daily living needs were met. B. Resident #4 was admitted on 1/21/07, with diagnoses of mixed dementia and left eye	R 008	ADMINISTRATOR TO REVIEW NOTES WEEKLY TO MONITOR AND RN TO REVIEW AND CHART HER ASSESSMENTS DURING HER VISITS. ACTIONS TO BE TAKEN SO THIS DOES NOT RECUR. FROM THIS DATE 8-20-10 FORWARD SHALL BE ONE OR THE OTHER 1. TRANSFER TO A FACILITY WITH UP NIGHT STAFF 2 OR IF FEASIBLE AT THAT TIME HIRE AND STAFF WITH 24 HR UP STAFF.	8-20-10

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R 008	Continued From page 3 blindness. Resident #4's NSA, dated 3/19/10, documented the resident needed assistance with tolleting and required stand-by assistance for transferring. It further documented the resident showed "frequent periods of confusion in walking and using a walker. Staff to supervise." Under the heading "Supervision," the NSA documented the resident required frequent verbal cues for confusion. Resident #4's Uniform Needs Assessment updated, on 6/20/10, documented the resident was "frequently disoriented, even in familiar surroundings - requires supervision and oversight for safety." Care notes, dated 6/20/10, documented the resident was unable to use walker correctly, and required assistance with dressing and tolleting. Care notes, dated 7/14/10, documented the resident's confusion was increasing and staff were assisting with all activities of daily living. On 7/28/10 at 7:45 AM, Resident #4 was asked how she contacted staff when she needed help and stated, "I don't know." On 7/28/10 at 8:00 AM, a caregiver stated Resident #4 required supervision due to her confusion, and required assistance with activities of daily living. On 7/28/10 at 10:30 AM, a caregiver stated she had heard Resident #4 up during the night with another resident. On 7/28/10 9:15 AM, Resident #4 was observed	R 008	ADMINISTRATOR TO REVIEW NOTES WEEKLY TO MONITOR + RN TO REVIEW + CHART HER ASSESSMENTS DURING HER VISITS. ACTIONS TO BE TAKEN SO THIS DOES NOT RECUR FROM THIS DATE FORWARD SHALL BE ONE OR THE OTHER 1. TRANSFER TO A FACILITY WITH UP NIGHT STAFF 2. OR IF FEASIBLE AT THAT TIME HIRE STAFF FOR UP NOC.	8-20-10

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NAME OF PROVIDER OR SUPPLIER HUCKLEBERRY RETIREMENT HOMES LLC - II	STREET ADDRESS, CITY, STATE, ZIP CODE 1315 HEMLOCK COURT SANDPOINT, ID 83864		

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R 008	Continued From page 4 unsteady on her feet and ambulating with her walker turned sideways. Resident #4 required assistance and supervision of activities of daily living. Due to her cognition and mobility needs, the resident was unable to call for assistance during the night. The facility did not provide up and awake staff to supervise the resident and ensure her toileting, mobility, and safety needs were met during the night. 2. Safe Living Environment According to IDAPA 16.03.22.150.14. "Secure Environment. If the facility accepts and retains residents who have cognitive impairment, the facility must provide an interior environment and exterior yard, which is secure and safe. On 7/27/10 and 7/28/10 the facility was observed. The main entrance was observed with an alarm system that was not in use. The front door opened to a circular driveway and the street. Exits to the rear of the facility were observed leading to a back yard which was surrounded by a chain-link fence that was approximately 4 1/2 feet tall. Several residents' rooms had sliding glass doors leading to outside patios and the backyard. A. Resident #1 was admitted to the facility on 1/9/08, with diagnoses including Alzheimer's dementia. A NSA, dated 5/21/10, documented "wandering: staff to provide supervision - redirect when appropriate and as needed. Comment: Has not wandered outside for quite sometime (a yr. or so).	R 008	NEW DOOR ALARMS HAVE BEEN PLACED ON FRONT AND REAR EXIT DOOR EXTRA ALARMS SHALL BE KEPT IN CASE OF MALFUNCTIONING GATE TO YARD FENCE IN BACK HAS A LOCK WITH KEY KEPT CLOSE BY AND ALL STAFF WILL HAVE A KEY TO LOCK.	8-22-10 8-30-10

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R 008	Continued From page 5	R 008		
	A UAI, dated 4/22/10, documented the resident is "frequently disoriented to person, place, time or situation, even if in familiar surroundings, and requires supervision and oversight for safety. Frequently, judgement is poor Needs protection and supervision because client makes unsafe and inappropriate decisions."		RESIDENTS TO BE ASSESSED FOR COGNITIVE AND ELOPEMENT.	8-31-10
	Care notes, undated, documented the resident wandered throughout the facility. Staff to "redirect if it is appropriate. She complies for the second and forgets what you said 5 - 10 secs later."		RESIDENTS WHO WANDER WITHIN FACILITY AND HAVE COGNITIVE ISSUES WILL BE ADMITTED TO ROOMS THAT FACE THE BACK FENCED AREA. THE ROOMS WITH SLIDERS WILL HAVE ALARMS PLACED ON SLIDERS TO SOUND IF OPENED.	
	On 7/28/10 Resident #1's room was observed to have an unsecured patio door which opened to an unsecured area in the front of the building.		ADMINISTRATOR TO REVIEW CARE NOTES WEEKLY. RN TO ASSESS ON VISITS	
	On 7/28/10 at 10:35 AM a family member stated the resident would not be safe outside unsupervised unless in a fenced yard.		NO RESIDENT WITH COGNITIVE ISSUES OR ELOPEMENT WILL BE PLACE IN THE ROOMS FACING THE STREET AS LONG AS THESE ROOMS HAVE SLIDERS	
	Resident #1 was at risk of elopement and was not provided a secure environment to ensure her safety.			
	B. Resident #4 was admitted on 1/21/07, with diagnoses of mixed dementia and left eye blindness.			
	Resident #4's NSA, dated 3/19/10, documented "Wandering: Staff to provide supervision-redirect when appropriate and monitor as needed "			
	Resident #4's Uniform Needs Assessment, updated on 6/20/10, documented the resident was "Frequently disoriented, even in familiar surroundings- requires supervision and oversight for safety." It further documented, "Wanders within the facility-may wander outside; health or			

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R 008	Continued From page 6 safety may be jeopardized..." Care notes, dated 3/14/10, documented the resident's confusion was increasing. Care notes, dated 4/20/10, documented the resident had been emptying her room and drawers to pack to go home to her kids. The notes documented, "happens frequently each week." On 7/28/10 at 8:00 AM, a caregiver stated Resident #4 frequently wanted to go home and needed to be redirected. Resident #4 was not provided a secure environment, necessary to provide a safe living environment due to her cognitive impairment and risk for elopement. The facility failed to provide the necessary supervision to Residents #1 and #4, as up and awake staff were not available to assist the residents to ensure their safety, mobility and toileting needs were met during night time hours. Furthermore, the facility did not provide a secure environment to Residents #1 and #4, who were at risk for elopement. These failures resulted in inadequate care.	R 008	REQUEST FOR INFO OR PLANS WILL BE SUBMITTED FIRE AND LIFE SAFETY TO EXCHANGE ROOMS FACING STREET THAT HAVE SLIDERS TO REPLACE WITH WINDOWS AND REMOVE SLIDERS. THESE REPLACEMENTS WILL MEET THE REQUIREMENTS OF THE FIRE AND LIFE SAFETY THE REPLACEMENT AFTER APPROVAL SHALL WILL BE DONE ONE UNIT AT A TIME - WILL NOT TAKE PLACE DURING COLDER WEATHER NO COGNITIVE OR POSSIBLE WANDER WILL OCCUPY THESE ROOMS WHILE THE SLIDERS REMAIN.	9-10-10 7-1-11 8-31-10
R 009	16.03.22.525 Protect Residents from Neglect. The administrator must assure that policies and procedures are implemented to assure that all residents are free from neglect. This Rule is not met as evidenced by: Based on observation, record review and interview, it was determined the facility failed to	R 009		

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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
	13R668		07/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUCKLEBERRY RETIREMENT HOMES LLC - I	1315 HEMLOCK COURT SANDPOINT, ID 83864

(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 009	Continued From page 7	R 009		
	protect 1 of 8 sampled residents (#8) from neglect. The findings include: Resident #8 was admitted to the facility on 3/3/09, with diagnoses that included degenerative arthritis in right knee. On 4/6/10, the resident was diagnosed with a fractured pelvis. On 7/28/10 at 10:15 AM, the resident's family member stated, "I was called on 3/16/10, by a caregiver to tell me that my mother had a fall while getting out of the recliner on 3/15/10." She further stated, "I stopped by the facility the same day and observed my mother having a lot of pain. Mom was not able to tell me me if the pain was related to her knee pain or if it was related to the fall. I requested the caregiver place a call to the facility nurse so she could consult with the doctor. The caregiver told me, the nurse was not available. My mother was not assessed by the nurse until after she was seen by the doctor and diagnosed with a fractured pelvis. Because she was not seen by the physician until 4/6/10, staff were not trained on how to best assist her with transfers. One caregiver insisted it was best for my mother to get up and walk." "Staff Notes" documented the following: *3/31/10, "[Resident's name] has not been herself the past couple of weeks. She will not hardly try to move around. She is anxious and weepy. Today is the worst I have seen - we are now having to lift & transfer her. She can't or won't use her walker. She wants to stay in bed, is in a lot of pain. Started pain pills today." *3/31/10, "Uncooperative making it difficult to transfer her."		POLICY REVIEW HAS BEEN DONE WITH STAFF FOR THE FOLLOWING 1) NOTIFICATION OF CHANGES TO RESIDENT HEALTH OR MENTAL STATUS 2) WHAT TO REPORT TO RN 3) NOTIFICATION TO RN FOR DIRECTION ON MEDICATION IF TO BE WITHHELD 4) ACCIDENT & INCIDENT REPORTS 5) REPORTABLE ACCIDENTS + INCIDENTS TO LICENSING 6) CARE NOTES DOCUMENTATION 7) ALL RECORDS / REPORTS TO BE KEEP FOR 3 YRS 8) FAXES TO PHYSICIANS SHALL BE KEPT AND DOCUMENTED IN CARE NOTES ALSO.	8-22-10

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R666	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/28/2010
NAME OF PROVIDER OR SUPPLIER: HUCKLEBERRY RETIREMENT HOMES LLC - II	STREET ADDRESS, CITY, STATE, ZIP CODE: 1315 HEMLOCK COURT SANDPOINT, ID 83864		

(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 009	Continued From page 8	R 009		
	*4/1/10, "About the same today."			
	*4/2/10, "I faxed the [physician's name] for a cushion for her wheelchair and to advise him that the pain pills don't appear to be knocking down the pain..."			
	*4/6//10, "[Resident's name] going for an x-ray..."			
	*4/7/10, "Seems easier to transfer her today though she is still having a lot of pain." A second entry noted the facility nurse faxed the physician regarding the resident.		(RESIDENT RECEIVING PT FEB APRIL 2010 ALSO BIG PART 2009) DOCUMENTATION TO LICENSING SHOWS STAFF AS WELL AS RESIDENT HAD BEEN GIVEN INSTRUCTION IN TRANSFERRING + MOBILITY. THIS SHALL BE ALSO DOCUMENTED IN CARE NOTES IN FUTURE	8-20-10
	*4/8/10, "Bearing weight better and moving her feet some to help her transfer. Still much pain and confused as she was yesterday. [Physician's name] in to see her - increased her patches."			
	*6/27/10, "[Resident's name] is still fearful at times about ambulating. Staff cues through transfers..."		IF NOT RECEIVING PT. SHALL HAVE RN DIRECT PROPER TECHNIQUES FOR TRANFERRING AND DIRECTION ON ANY SYMPTOMS / SIGNS STAFF SHOULD WATCH FOR.	8-20-10
	There were no documented incident or accident reports, nurse's notes, or care notes found in the resident's record that explained the increased pain and decline in mobility.			
	A physician's order, dated 4/8/10, documented fentanyl patches (2) at 25 mcg were to be used for pain relief. A handwritten note on the order documented, "Allow her to stay in bed more - but it's okay to get her up into her chair if tolerable and up for meals as tolerated."			
	A nursing assessment, dated 4/7/10, documented she had called the resident's doctor to increase the pain medication. She documented the resident was having terrible pain and had a fractured pelvis.			

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NAME OF PROVIDER OR SUPPLIER HUCKLEBERRY RETIREMENT HOMES LLC - II	STREET ADDRESS, CITY, STATE, ZIP CODE 1315 HEMLOCK COURT SANDPOINT, ID 83864		

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R 009	Continued From page 9	R 009		
	There was no documentation the nurse instructed caregivers what signs or symptoms staff should report to her, or how to provide proper assistance with transfers due to her increased pain and ADL needs.		STAFF INSTRUCTED POLICIES TO BE FOLLOWED. AT NO TIME IS STAFF TO FOLLOW FAMILIES INSTRUCTION DURING AN ACCIDENT OR INCIDENT. CONTACT RN - IF RESIDANT IS NOT IN NEED OF EMS	
	On 7/28/10 at 8:20 AM, a day shift caregiver stated she was not on duty when the resident fell. She stated she heard the resident was attempting to get up out of the recliner and was assisted by a caregiver to the arm of the recliner chair. She stated there was no incident report filled out, but the night caregiver who was on duty when the incident happened would know the details.		ACCIDENT REPORT TO BE COMPLETED ASAP EMS CALLED IF APPROPRIATE, RN TO BE NOTIFIED. ADMINISTRATOR TO BE NOTIFIED	8-20-10
	On 7/28/10 at 9:45 AM, a nightshift caregiver stated the resident had a fall sometime in mid March. "She was getting out of the recliner, she got her legs crossed and slid to the floor. I was in the kitchen and could see she was about to fall, but I was not able to get to her in time." She further stated the resident was not medically evaluated or treated at the time of the fall.		ADMINISTRATOR TO INVESTIGATE RN TO MAKE ANY RECOMMENDATIONS OR GIVE DIRECTIONS TO STAFF.	
	Resident #8 complained of increased pain after she had a fall on 3/15/10. She was not seen by the facility RN or physician until 4/6/10, twenty two days after her fall. During the twenty two days, the resident experienced significant pain and declined from being mostly independent to requiring almost total assistance with transfers and mobility. There was no documentation the physician was notified when the resident complained of increased pain. Additionally, there was no documentation that caregivers notified the RN of the resident's signs and symptoms of increased pain and decreased mobility, when the resident first exhibited a change of condition. As a result, the facility failed to seek timely medical		POLICIES FOR REPORTABLE ACCIDENTS ARE TO BE FOLLOWED. LOG TIME OF REPORT + FAX RECORD ACCIDENT IN CARE NOTES AND KEEP REPORT. RN TO FOLLOW UP ON ACCIDENT AND GIVE DIRECTION. STAFF TO DOCUMENT CARE NOTE FOLLOW UPS	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R668	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 07/28/2010
NAME OF PROVIDER OR SUPPLIER: HUCKLEBERRY RETIREMENT HOMES LLC - II	STREET ADDRESS, CITY, STATE, ZIP CODE: 1315 HEMLOCK COURT SANDPOINT, ID 83864		

(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 009	Continued From page 10 care for Resident #8. This failure resulted in neglect.	R 009		

IDAHO DEPARTMENT OF HEALTH & WELFARE

BUREAU OF FACILITY STANDARDS
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
Huckleberry Retirement Homes IV	1313 Hemlock Court	255-5999
Administrator	**City**	**ZIP Code**
Lynne Huyck	Sandpoint	83864
Survey Team Leader	**Survey Type**	**Survey Date**
Rachel Corey	reassure/Followup	7-28-10

NON-CORE ISSUES

ITEM #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	BFS USE
1.	152.05.b.iii	Three of three residents were not assessed for appropriate use of bedrails.	8-19-10	
2.	250.05	The walls in the shower room were worn and not cleanable.	8-17-10	
3	250.15	The call system was being used at night to monitor the residents and did not protect their privacy.	8-19-10	
4.	300.01	Four of four staff did not have RN delegation from the current RN.	8-17-10	
5	300.02	Resident #1 was not assessed when she fell and broke her arm. Resident #3 experienced a low blood sugar and the RN was not notified for direction. Resident #5 fell and was not assessed by the RN after exhibiting pain and an inability to transfer.	8-19-10	
6	305.06	Resident #3 was not assessed by the RN to safely self-inject insulin.	8-17-10	
7	310.01d	Caregivers made the assessment decision to hold insulin for residents without direction from the RN.	8-19-10	
8.	320.01	Resident #5's DSA was not updated to reflect care needed after her fall and fracturing her pelvis.	8-19-10	

Response Required Date	Signature of Facility Representative	Date Signed
8/27/10		

IDAHO DEPARTMENT OF HEALTH & WELFARE

BUREAU OF FACILITY STANDARDS
P.O. Box 83720
Boise, ID 83720-0036
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ASSISTED LIVING Non-Core Issues Punch List

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Huckleberry Retirement Homes IV	1513 Hemlock Court	255-5999
Administrator	**City**	**ZIP Code**
Lynne Huyck	Sandpoint	83864
Survey Team Leader	**Survey Type**	**Survey Date**
Rachel Corey	relicensure / Follow-up	7/28/10

NON-CORE ISSUES

ITEM #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	BFS USE
9	350.02	The administrator did not investigate incidents with residents ~~#1~~ #3 and #5	8-19-10	
10	350.07	Resident #1 & #3's incidents were not reported to licensing and certification	8-19-10	
11	600.06.b	One of four staff did not have current CPR/First aid certification.	8-17-10	
12	711.08.c	Case notes did not document incidents, accidents, and unusual events	8-19-10	
13	711.08.d	Calls to ~~at~~ the physician were not documented.	8-19-10	
14	730.02.a	An as-needed schedule was not maintained.	8-19-10	

Response Required Date	Signature of Facility Representative	Date Signed
8/23/10		

Date 7/28/10 Page 1 of 2

IDAHO DEPARTMENT OF HEALTH & WELFARE

Food Establishment Inspection Report

Food Protection Program, Office of Epidemiology
450 West State Street, Boise, Idaho 83702 208-334-5938

Establishment Name	Operator
Huckleberry IV	Lynne Huyck
Address: 1213 Hemlock Ct.	City: Sand Point Zip: 83864
County / Estab # / EHS/SUR #	Inspection time: / Travel time:
Inspection Type: / Risk Category: High	Follow-Up Report: Date:_____ OR On-Site Follow-Up: 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	1	# of Retail Practice Violations	0
# of Repeat Violations	0	# of Repeat Violations	
Score	1	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

	Demonstration of Knowledge (2-102)	COS	R
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	☐	☐
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)	☐	☐

	Potentially Hazardous Food Time/Temperature	COS	R
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 (3-401)	☐	☐
Y N N/O N/A	17. Cooling (3-403)	☐	☐
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)	☐	☐
	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 (3-202.12)	☐	☐
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
Sausage	185	Cool Whip	40°				
Cheese	39°						

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)	Title	Date
Lynne Huyck	LYNNE HUYCK		7/28/10

Inspector (Signature)	(Print)	Date	Follow-up: (Circle One)
Karen Anderson	Karen Anderson	7/28/10	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

Page 2 of 2
Date 7/28/10

Establishment Name	Operator
Huckleberry IV	Lynne Huyck
Address 1513 Hemlock CT	
County Estab # EHS/SUR # 20828	License Permit #

OBSERVATIONS AND CORRECTIVE ACTIONS (Continuation Sheet)

#12 The Caregiver / Kitchen Staff) Stated she did not always use a Sanitizer to clean food contact areas.

COS: Instructed to use an approved Sanitizer after each bread & bread Prep.

Person in Charge	Date	Inspector	Date
Lynne Huyck	7-28-10	Karen Hinkerson	7/28/10

CEP00-02-02