NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
Harbor Assisted Living	RC-1196	2308 East Harbour Grove Drive	208-461-8018
Administrator	City	Zip Code	Survey Date
Mary Burke	Nampa	83686	04/19/2023
Survey Team Leader	Survey Type		Response Due
McClenathan, Teresa	Health Care Licensure and Follow-Up		05/19/2023

Item #	Rule (16.03.22)	Description
1	.250.13. Secure Environment.	The facility had residents with cognitive impairments and a history of or who were at risk for elopement and did not provide a secured exterior environment. For example, the exterior gate leading out of the courtyard was not secured. The facility administrator stated she was not aware the gate was not secured.
2	.260.07. Toxic Chemicals.	Toxic chemicals were observed to be stored in an unlock area which was accessible to cognitively impaired residents on two separate occasions from 4/18/23 to 4/19/23. For example, a bleach mixture was observed in a cabinet in the shower room and multi purpose cleaner and degreaser, orange glow wood furniture cleaner and polish, spray nine heavy duty cleaner and degreaser, and resolve upholstery cleaner in a cupboard under the kitchen sink. The facility administrator confirmed the chemicals were not secured and were accessible to memory impaired residents.
3	.305.03. Change in Resident Health Status.	The facility nurse did not assess all residents when they experienced a change of condition. For example, Resident #1 was observed to have diarrhea on 2/16/23/, 2/17/23 and 4/2/23 and was not assessed by the facility nurse. Resident #1 also experienced a fall on 4/16/23 and there was not a nursing

		assessment completed which described the injuries from the fall. The facility nurse documented on an incident report the resident incurred a skin tear, however there is not description of the skin tear such as the location nor size of the injury. Resident #2 experienced a fall on 2/26/23 and went to the hospital with a 'gash' on their head and bruising and was not assessed by the facility nurse. Resident #2 also experienced falls on 3/1/23, 4/10/23 and 4/17/23 and was not assessed by the facility nurse. Resident #2 also had new hip pain in February 2023 which resulted in hip surgery and they were never evaluated by the facility nurse. The facility nurse was not available for interview and the administrator was unable to provide the surveyors with the assessments.
4	.319.03. Nursing Assessment.	Three of three sampled resident's (#1, #2 and #3) did not have a comprehensive nursing assessment completed prior to their admission. The facility nurse was unavailable for interview and facility administrator was unable to provide surveyors with the assessments.
5	.320.01. Use of NSA.	Residents' Negotiated Service Agreements (NSA) did not clearly reflect the residents' needs nor describe the services to be provided. For example: Resident #1's NSA did not include they required assistance to transfer, the assistance they required to eat, their use of a walker, and wheelchair nor how their hospice services were being coordinated, Resident #2's NSA did not describe details of assistance needed for bathing and grooming and Resident #3's NSA did not describe details of assistance for bathing, grooming, and dressing.
6	.320.03. Signature, Date, and Approval of Agreement.	Three resident records were reviewed and all three had NSAs which were not signed by the resident or their legal guardians. The facility administrator confirmed the NSAs were not signed.