PLAN OF CORRECTION

Harbor Assisted Living
2308 East Harbour Grove Drive
Nampa ID 83686

Provider ID: RC-1196

On 07/14/2025, a Health Care Complaint Investigation survey was conducted by Department staff at Harbor Assisted Living. As a result of the survey, core issue deficiencies were cited with the following plan of correction.

Rule Violation .510. REQUIREMENTS TO PROTECT RESIDENTS FROM ABUSE.

Describe what corrective actions will be accomplished for those residents/personnel/area found to have been affected by the deficient practice.

Harbor Assisted Living has set up mandatory employee training on Saturday August 2nd for behavioral training through Keystone Hospice. Also on August 2nd, there will be abuse, neglect and exploitation training. We have set up a meeting with Tory from the Bureau of Facility Standards on Tuesday July 29th at 0900. The administrator, Mary Burke, is working on setting up mandatory transfer and lift training to also be done on August 2nd through Keystone Hospice.

Describe how the provider will identify other residents/personnel/areas having the potential by the same deficient practice and what corrective action(s) will be taken.

There will be mandatory meetings monthly to discuss any concerns or issues the employees have. Also, there will be a monthly scheduled in-service relating to pertinent issues related to caring for the elderly population at the time of the monthly meeting. Staff will have input on what topics they would like more training on.

Describe how the corrective action will be monitored to ensure the deficient practice does not recur (QA program).

Administrator will follow up with staff weekly to ask if they have any issues or concerns about resident safety. We will have a third-party administrator come in to view staff interactions with residents and ask staff questions to make sure the staff know what to do if they suspect abuse or neglect. The third-party administrator date to the facility has yet to be determined. It will be after initial retraining has been completed (behavioral in-service (August 2nd), abuse, neglect and exploitation training (August 2nd), and lifting/transfer training (date has yet to be confirmed). A third-party administrator follow up will be completed by Monday September 15th. We want to make sure all the staff training is complete, and the staff is able to re-iterate what they learned a few weeks later, what steps to take for suspected abuse, how to report an incident, proper lifting/transfer techniques. If the third-party administrator recommends any further training, it will be scheduled at that time. We have contacted Angela Madsen, a licensed administrator in the State of Idaho, who has agreed to come in and be the third-party administrator. Angela will get back with us on dates she is available to come into the facility. Angela has stated it would most likely be at the end of August or the beginning of September.

Date when corrective action will be completed.

September 15, 2025

Program Comments

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	07/14/2025
Survey Team Leader	Survey Type		Response Due
Moss, Tom	Health Care Complaint Investigation		08/13/2025

Item #	Rule (16.03.22)	Description
1	39-3321.2.b. Qualifications and Requirements of Administrator.	The administrator did not ensure all facility policies were implemented when they failed to notify adult protective services of an allegation of abuse involving Resident #3 on 5/26/25. The administrator stated she did not report the incident to adult protective services because she did not believe the incident constituted potential abuse.
2	39-3321.2.e. Qualifications and Requirements of Administrator.	The administrator did not complete an investigation to determine if abuse occurred after a staff member told a resident, "You don't tell us to be quiet" after a resident made a comment that caregivers were being loud on 5/26/25. The staff person then observed the caregiver forcefully move Resident #3 to their room by slapping at their hands to unlock their wheelchair breaks then pushing the resident to their room which eventually resulted in the resident being on the floor with their wheelchair on top of them. The resident sustained a large skin tear on their right leg. The administrator failed to interview all possible witnesses or complete any other investigative tasks in order to determine if abuse occurred. The administrator stated the resident threw themselves on the floor causing the injury and she did not complete an investigation to determine if abuse occurred.

3	39-3321.3. Qualifications and Requirements of Administrator.	The administrator was not notified of all allegations of abuse at the facility. Multiple caregivers reported they witnessed potential abuse but did not report the incidents to the administrator. Caregivers reported they were not comfortable reporting the incidents.
4	39-3321.4. Qualifications and Requirements of Administrator.	The administrator did not protect residents from potential further abuse after they were aware Resident #1 was allegedly treated inappropriately by a staff member. See example in non-core punch 2231.2.e. The caregiver involved continued to work at the facility and had access to residents unsupervised.

CORE ISSUES

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Administrator	City	Zip Code	Survey Date
Mary Burke	Nampa	83686	07/14/2025
Survey Team Leader	Survey Type		Response Due
Moss, Tom	Health Care Complaint Investigation		07/24/2025

Item #	Rule (16.03.22)	Description
2	.510. REQUIREMENTS TO PROTECT RESIDENTS FROM ABUSE.	Based on record review and interview, it was determined the facility did not protect 2 of 2 sampled residents when the administrator failed to immediately notify APS, complete thorough investigations according to the facility's abuse policy, and protect residents after caregivers allegedly abused residents. This had the potential to affect 100% of the residents residing at the facility. The findings include: Section 39-3302.1 Idaho Code defines abuse as "a nonaccidental act of sexual, physical or mental mistreatment or injury of a resident through the action or inaction of another individual." Section 39.3321.2.b Idaho Code documents the administrator must "Ensure that adult protective services and law enforcement are notified when required pursuant to sections 39-5303 and 39-5310, Idaho Code." Section 39.33.02.15 Idaho Code documents a Core issue as "…abuse…"

		Section 39.3321.2.c Idaho Code documents the administrator must “Ensure that facility procedures for investigation of complaints, incidents, accidents, and allegations of abuse, neglect, or exploitation are implemented to ensure resident safety.” Section 39.3321.4 Idaho Code documents “When abuse, neglect, exploitation, incidents, or accidents occur, corrective action shall be immediately taken and monitored to ensure the problem does not recur.” IDAPA 16.03.22. 510 documents, “requirements to protect residents from abuse. The administrator must ensure that policies and procedures are developed and implemented to ensure that all residents are free from abuse.” The facility’s “Abuse, Neglect and Exploitation” policy dated May 2022, documented, “Any form of resident/patient abuse, mistreatment, or neglect will not be tolerated.” The policy documented the administrator was responsible for the following steps: “Any statements will be taken from parties involved, signed and dated…any accused will be sent home pending any investigation…administrator will not allow the accused to return to work until investigation is complete…administrator will complete interviews with resident, staff involved, and all other witnesses.” The policy defines abuse as "intentional or negligent infliction of physical pain, injury or mental injury.” The policy documents “anyone suspected of resident abuse, mistreatment, or neglect will be promptly relieved of duty until the Administrator or nurse completes an investigation.” Between 7/8/25 through 7/10/25 caregivers stated the following regarding possible abuse at the facility:

		Caregiver A stated they observed Caregiver C to be rough with residents when putting them into their wheelchairs by “grabbing their arms hard.” They stated Caregiver C became agitated when residents pushed their call lights and told the residents “Stop pushing that god***" button" and that they had “pushed it enough.” Caregiver A observed Caregiver C tell residents to “go to Walmart and get your own,” when they asked for coffee. They stated they tried to report their observations to the administrator, but the administrator stated, “I don’t want to hear it.” Caregiver A stated they sent the administrator a text message with details of their concerns but never received a response. Caregiver G stated they observed caregivers being rough with residents by “pulling them around” the facility. They stated caregivers forced residents to sit and they often heard employees “being rude” towards residents. The caregiver stated they had not reported their concerns to the administrator nor to APS. Caregiver B stated they observed an employee verbally tell a resident they could "stay in their room and die" after the resident refused their medications. The caregiver stated they were not comfortable reporting concerns to the administrator. According to their record, Resident #3 was a 91 year old, who was admitted to the facility on 10/18/24, with a diagnosis of dementia. Resident #3 resided at the facility at the time of the survey. Caregiver B stated they observed Resident #3 in the common area of the facility on 5/26/25. They stated the resident made a comment that caregivers were being loud. Caregiver B then

		observed Caregiver C approach Resident #3 and state, "you don't tell us to be quiet." Caregiver B then observed Caregiver C tell Resident #3 they were going to their room and slapped at Resident #3's hands to unlock their wheelchair brakes. Caregiver B stated Resident #3 was taken to their room by Caregiver C. After this, Resident #3 was observed with a large skin tear on their left leg. Caregiver B stated at no time did the administrator ask them about their observations on 5/26/25. Caregiver B stated they felt what they observed constituted abuse. As-worked records documented Staff member C worked at the facility during eleven shifts on 6/20/25, 6/22/25, 6/23/25, 6/24/25, 6/28/25, 6/29/25, 6/30/25, 7/1/25, 7/5/25, 7/6/25 and 7/7/25, where Resident #3 resided, and the alleged abused occurred. There was no documentation in Resident #3's record of an abuse investigation regarding Caregiver B's observations. On 7/7/25 at 9:30 AM, the administrator stated she had not received any recent allegations of abuse, and she had not completed any abuse investigations. The facility failed to appropriately respond when Resident #3 was allegedly abused by Caregiver C on 5/26/25. The allegations were not immediately reported to APS and an abuse investigation was not initiated according to Idaho Code and the facility's abuse policy. The administrator failed to ensure the facility's policies for abuse were followed, including reporting, protecting residents during the course of an investigation, and implementing appropriate corrective action to prevent recurrence, in response to allegations of abuse.

		According to their record, Resident #2 was a 75 year old, who was admitted to the facility on 12/4/23, with a diagnosis of dementia. Resident #2 resided at the facility at the time of the survey. Caregiver D stated they observed Caregiver E be physically and mentally abusive towards residents. They stated Caregiver E was "very rough" with Resident #2 and they would "man handle" them and forced them to sit. The resident said "you are hurting me" but Caregiver E continued to be forceful. Caregiver D stated there were times Resident #2 had red marks on them after being assisted by Caregiver E. Caregiver D stated they informed the administrator that Caregiver E was "rough with residents" but the administrator was "not addressing things." There was no documentation in Resident #2's record of an abuse investigation regarding Caregiver D's observations. On 7/7/25 at 9:30 AM, the administrator stated she had not received any allegations of abuse, and she had not completed any abuse investigations. The facility failed to appropriately respond when Resident #2 was allegedly abused by Caregiver E. The allegations were not immediately reported to APS and an abuse investigation was not initiated according to Idaho Code and the facility's abuse policy. The administrator failed to ensure the facility's policies for abuse were followed, including reporting, protecting residents during the course of an investigation, and implementing appropriate corrective action to prevent recurrence, in response to allegations of abuse. The facility failed to appropriately respond when Resident #3

		was allegedly abused by Caregiver C on 5/26/25 nor when Resident #2 was allegedly abused by Caregiver E. This had the potential to affect 100% of the residents residing at the facility. These failures resulted in abuse.