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December 17, 2010

Denise Hall, Administrator
Streamside Assisted Living
1355 South Edgewater Circle
Nampa, ID 83686

Dear Ms. Hall:

An unannounced, on-site complaint investigation survey was conducted at Streamside Assisted Living on December 2, 2010. During that time, observations, interviews, and record reviews were conducted with the following results:

Complaint # ID00004652

Allegation #1: The facility did not report suspected cases of Norovirus to the local health department.

Findings #1: On 12/2/10 at 1:15 PM, the administrator stated a week before she was hired to work at the facility, several residents had experienced bouts with diarrhea. When she began her employment, she investigated the situation. At this time, one resident was determined to have Clostridium difficile, so it was thought the other residents may have had the same infection. The nurse then called the health department, who instructed them to obtain stool samples from three residents. Those three residents tested positive for Norovirus.

At 1:30 PM, the facility nurse stated, "When people began showing signs of illness, I called the health department and followed their instructions. Three stool samples were taken, which came back positive for Norovirus."

A call log book was reviewed, which documented a call to the health department.

Unsubstantiated. Although the allegation may have occurred, it could not be determined during the complaint investigation.

Allegation #2: The facility did not respond appropriately when confirmed cases of Norovirus were identified.

Findings #2: On 12/2/10 at 1:15 PM, the administrator stated before the confirmed cases of Norovirus were identified, interventions were put in place to prevent the spread of any disease. One resident had tested positive for Clostridium difficile, so it was thought other residents may have had the same infection. She determined all the residents who had experienced symptoms of diarrhea and/or vomiting and highlighted their rooms on a facility map. She then marked off an area in front of their rooms with masking tape and placed an isolation cart beside their room. She counseled the residents on hand washing and remaining in their rooms. Staff were retrained on infection control techniques. Once Norovirus was discovered, instructions from the heath department were followed. These instructions included isolating residents who had symptoms, limiting visitors and disinfecting everything the residents could come in contact with. She further stated, employees were monitored for signs of Norovirus and were told to immediately report any symptoms to her. No one was allowed to work until symptoms had resolved for 72 hours. Additionally, outside services were informed of the outbreak and were instructed to wear separate scrubs when entering and exiting the facility.

At 1:30 PM, the facility nurse stated she and the administrator worked together to identify the ill residents, isolate them, disinfect the facility, train staff, and monitor the situation. Instructions from the health department were followed. At this time, she provided an inservice record on infection control techniques and a checklist that was followed, which had been provided from the health department.

At 2:15 PM, a caregiver stated, "When this came about, there was a meeting where we were taught how to enter a room, how to clean a room, how to exit a room and sanitize everything. They told us if we had any symptoms we were to let them know and we could not work. The walls, the chairs and everything was sanitized with a bleach solution. Snacks were not left out. A sign was posted on the front door asking visitors to limit visitation and to wash hands before and after entering the facility."

Care notes of three sampled records, documented instructions were provided to them on proper handwashing techniques, the importance of staying in their rooms and maintaining hydration. A memo sent out to all residents not infected, on 5/27/10, documented residents were informed of the Norovirus outbreak. They were instructed to stay in their rooms from 2:00 PM to 5:00 PM, so that everything could be sanitized. The memo stressed the importance of handwashing. A map of the facility documented all residents who exhibited symptoms of Norovirus. Sheets attached to the map documented the dates the symptoms began for each resident and what the symptoms were.

At 2:35 PM, an isolation cart was observed. It contained gloves, masks, gowns, separate garbage cans, trash bags, and bathing supplies.

Unsubstantiated. Although the allegation may have occurred, it could not be determined during the complaint investigation.

As no deficiencies were cited as a result of our investigation, no response is necessary to this report. Thank you to you and your staff for the courtesies extended to us on our visit.

Sincerely,

Rachel Corey, RN
Health Facility Surveyor
Residential Assisted Living Facility Program

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