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January 17, 2012

Jennifer Hagen, Administrator  
Park Place Assisted Living Community, Inc  
616 16th Avenue North  
Nampa, ID 83687

Dear Ms. Hagen:

An unannounced, on-site complaint investigation survey was conducted at Park Place Assisted Living Community on January 6, 2012. During that time, observations, interviews, and record reviews were conducted with the following results:

**Complaint # ID00005349**

**Allegation #1.** The facility did not respond appropriately when an infestation of bed bugs was identified.

**Findings #1:** On 1/6/11 at 9:00 AM, two caregivers were interviewed. They stated as soon as an infestation of bed bugs was identified, a pest control company was called. They followed the pest control company's instructions and were in-serviced on the steps they needed to take to help resolve the issue. The caregivers further stated, the problem was isolated to four rooms. The residents in those four rooms had been moved to new rooms until the pest control company finished with spraying and deemed the rooms safe for the residents to return.

On 1/6/11, between 9:00 AM and 10:00 AM, two of the four residents whose rooms had been identified as having bed bugs were interviewed (the remaining two residents were unavailable for interview). They stated they felt the facility acted in a timely manner when the bed bugs were identified. They were not happy with having to change rooms, but understood the rationale for having to move.

On 1/6/11 at 9:45 AM, the administrator stated as soon as bed bugs were identified in a resident's room, the resident was relocated to a different room

and a pest control company was called. All rooms were searched for signs of bed bugs; three other rooms were identified as having an infestation. The pest control company instructed them to leave the affected resident's belongings in their rooms, bag laundry and wash the laundry three times. She further stated, residents who had to relocate to different rooms were provided with the necessary furniture. The pest control determined which residents' belongings could be salvaged and which one needed to be disposed of. Some belongings were bagged and sent home with residents' families.

On 1/6/11 at 10:15 AM, the assistant administrator stated she had added bed bug training to the orientation program, so new employees would be trained on the "bed bug protocol."

On 1/6/11, the facility's documentation was reviewed. An in-service record, dated 9/9/11, documented staff were trained on instructions received from the pest control program. Progress notes in the four identified residents' records documented the steps staff took to eradicate the bed bug infestation. Receipts from the pest control company documented the treatments done in each room.

Unsubstantiated.

Allegation #2.

The facility did not allow an identified resident to bring her blanket back to the facility after she received services at an outside service provider.

Findings #2:

On 1/6/12 at 9:00 AM, two caregivers stated to their knowledge, the identified resident was allowed to bring her blanket back the facility after receiving services from an outside service provider. However, they were instructed to bag the blanket and wash it each time, as there was concern that bed bugs were being brought from the outside service provider.

On 1/6/12 at 9:30 AM, the identified resident was interviewed. She stated she was allowed to bring her blanket back and forth between the outside service provider and the facility, but her blanket was washed each time she brought it back to the facility. At this time, the identified resident's blanket was observed in her bedroom.

The identified resident's record was reviewed and there was no documentation stating staff were instructed to not allow the identified resident to bring her blanket back to the facility after receiving services from an outside service provider.

Unsubstantiated.

Allegation #3.

The facility disposed of an identified resident's personal furniture.

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Findings #3: Substantiated. However, the facility was not cited as they acted appropriately by following the instructions provided by the pest control company, which included disposing of items which the company deemed not salvageable. Further, the facility provided the identified resident with suitable furniture, which was observed on 1/6/12 at 9:30 AM.

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,

A handwritten signature in cursive script, appearing to read "Rachel Corey, RN".

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

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