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

April 11, 2011

Kathy Axtell, Administrator
Grace Assisted Living
4356 North Nines Ridge Lane
Boise, ID 83702

License #: RC-812

Dear Ms. Axtell:

On March 18, 2011, a state licensure survey and four complaint investigations were conducted at Grace Assisted Living. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level(s):

- Non-core issues, which are described on the Punch List, and for which you have submitted evidence of resolution.

This office is accepting your submitted evidence of resolution.

Should you have questions, please contact Maureen A. McCann, RN, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 334-6626.

Sincerely,

Maureen A. McCann, RN

Maureen A. McCann, RN
Team Leader
Health Facility Surveyor
Residential Assisted Living Facility Program

IDAHO DEPARTMENT OF HEALTH & WELFARE

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FAX: (208) 364-1888

March 21, 2011

Kathy Axtell, Administrator
Grace Assisted Living
4356 North Nines Ridge Lane
Boise, ID 83702

Dear Ms. Axtell:

On March 18, 2011, a licensure/follow-up survey and complaint surveys were conducted at Grace Assisted Living. The facility was found to be providing a safe environment and safe, effective care to residents.

The enclosed form, stating no core issue deficiencies were cited during the survey, is for your records only and need not be returned.

Please bear 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 evidence of resolution (e.g., receipts, pictures, policy updates, etc.) are to be submitted to this office by April 17, 2011.

Should you have any questions about our visit, please contact me at (208) 334-6626.

Sincerely,

Maureen A. McCann, RN
Team Coordinator
Health Facility Surveyor
Residential Care/Assisted Living Program

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
	13R812		03/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE ASSISTED LIVING	1610 SUNNYRIDGE ROAD NAMPA, ID 83686

(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 The residential care/assisted living facility was found to be in substantial compliance with the Rules for Residential Care or Assisted Living Facilities in Idaho. No core deficiencies were cited during the licensure/follow-up and complaint survey conducted on 03/15/11 through 03/18/11 at your facility. The surveyors conducting the survey were: Maureen A. McCann, RN Team Coordinator Health Facility Surveyor Rachel Corey, RN Health Facility Surveyor Karen Anderson, RN Health Facility Surveyor Polly Watt-Geier, MSW Health Facility Surveyor	R 000		

Bureau of Facility Standards

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Reset Form | Print Form

IDAHO DEPARTMENT OF HEALTH & WELFARE

MEDICAID LICENSING & CERTIFICATION - RALF
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
Grace Assisted Living	1610 Sunnyridge Rd	208-442-9595
Administrator	**City**	**Zip Code**
Kathy Axtel	Nampa	83686
Team Leader	**Survey Type**	**Survey Date**
Maureen McCann	Licensure, Follow-up and Complaint	03/18/11

NON-CORE ISSUES

Item #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	L&C USE
1	300.02	The facility did not implement Resident #2's physician's diet order.	4/11/11 MMC	
2	305.02	Resident #13 had 2 sets of medication orders which were conflicting.	COS MMC	
3	305.08	The facility did not ensure staff were educated regarding Resident #2's physician's diet order.	4/11/11 MMC	
4	310.01d	A) Staff were observed injecting Resident #14's insulin. B) Staff also stated they had dialed an insulin pen for a random resident.	4/11/11 MMC	
5	320.01	Four of five residents' NSAs did not clearly document the services provided by outside agencies.	4/11/11 MMC	
6	711.04	The facility did not document that Resident #13 was informed of the consequences after refusing to wear TED hose 12 of 16 days, nor that	4/11/11 MMC	
		the physician was notified.	—	
7	711.08.e	Care staff did not notify the facility nurse when Resident #5 had a change in condition, i.e. developed a large blister on the heel.	4/11/11 MMC	

Response Required Date	Signature of Facility Representative	Date Signed
4/17/2011	Kathy Axtel	3-18-11

Date 3/15/11 Page 1 of 1

IDAHO DEPARTMENT OF HEALTH & WELFARE

Food Establishment Inspection Report

Food Protection Program, Division of Health
450 W. State Street, Boise, Idaho 83720-0036
208-334-5938

Establishment Name: Grace AL	Operator: Kathy Attell
Address: 1610 Sunnyridge Rd Nampa 83686	
County: Canyon Estab #: EHS/SUR #: 20828	Inspection time: Travel time:
Inspection Type: Risk Category: High	Follow-Up Report: OR On-Site Follow-Up: Date: Date:

Items marked are violations of Idaho's Food Code, IDAPA 16.02.19, and require correction as noted.

# of Risk Factor Violations: 0	# of Retail Practice Violations: 0
# of Repeat Violations:	# of Repeat Violations:
Score: 0	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.

		COS	R
	Demonstration of Knowledge (2-102)		
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 (2-301)	☐	☐
Y N	6. Bare hand contact with ready-to-eat foods/exemption (3-301)	☐	☐
Y N	7. Handwashing facilities (5-203 & 6-301)	☐	☐
	Approved Source		
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)	☐	☐

		COS	R
	Potentially Hazardous Food Time/Temperature		
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 (3-403)	☐	☐
Y N N/O N/A	17. Cooling (3-501)	☐	☐
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 (3-207)	☐	☐
Y N	25. Toxic substances properly identified, stored, used (7-101 through 7-301))	☐	☐
	Conformance with Approved 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
Potato	180	Carrots	185	breakfast		Cottage Cheese	38
Steak	170	Chicken	170	Casserole	180		

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. Utensil & 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) Kathy Attell (Print) Attendant Title Date 3-18-11

Inspector (Signature) Karen Anderson (Print) KAREN Anderson Date 3/17/11

Follow-up: (Circle One) Yes No

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March 24, 2011

Kathy Axtell, Administrator
Grace Assisted Living
1610 Sunnyridge Rd
Nampa, ID 83688

Dear Ms. Axtell:

An unannounced, on-site complaint investigation survey was conducted at Grace Assisted Living from March 15, 2011 to March 18, 2011. During that time, observations, interviews, and record reviews were conducted with the following results:

Complaint # ID00004736

Allegation #1: Caregivers did not assist an identified resident to meals because a family member refused the assistance.

Findings #1: The identified resident was admitted on 9/14/09 and was discharged from the facility on 1/9/10. Therefore, the identified resident could not be interviewed or observed around meal times.

he identified resident's closed record documented the facility offered three meals a day and snacks. There was no documentation of significant weight loss for the four months the resident resided at the facility.

On 3/16/11 at 12:21 PM, the administrator stated the identified resident's spouse did try to limit accessibility to meals, especially breakfast because the identified resident had previously slept through breakfast when living at home. She stated the caregivers would wait for the spouse to come down to the dining room and then would go to the identified resident's room and assist the resident down to breakfast, so meals were not missed.

On 3/16/11 between 2:48 PM and 3:16 PM, three caregivers stated the identified resident's spouse had tried to limit access to meals in the dining room. They stated they would assist the identified resident down to meals after the spouse had gone down to the dining room to eat.

Unsubstantiated. This does not mean the incident did not take place; it only means that the allegation could not be proven.

Allegation #2: Two identified residents (A and B) did not receive showers from September 2009 through January 2011 due to refusing the care.

Findings #2: A) Resident A was admitted on 9/14/09 and was discharged from the facility on 1/9/10. Therefore, the resident could not be interviewed or observed during the complaint investigation.

Resident A's closed record documented the resident was independent with showering when admitted to the facility. The record also documented the caregivers began to cue the resident with showers on 10/20/09 and then began assisting with showers in mid-December. There was no documentation in the record indicating when the resident was showered or not showered prior to mid-December.

On 3/16/11 at 12:21 PM, the administrator stated Resident A's spouse did try to limit the resident's showers. She stated the resident was moved out of the facility due to the spouse's refusals of care.

On 3/16/11 at 3:08 PM, the facility nurse stated Resident A was initially independent with showering, but then the caregivers began to cue the identified resident to shower. In December, the resident's family notified the facility of concerns related to the resident not showering and the caregivers began to assist the resident with all showering needs.

On 3/16/11 between 2:48 PM and 3:16 PM, three caregivers stated they were not aware of Resident A not receiving showers from September to 2009 through January 2011.

B) Between 3/15/11 and 3/17/11, Resident B was observed to be clean and well-groomed.

Resident B's record documented the facility staff assist the resident with washing hard to reach areas on legs, back and feet. A nursing assessment, dated 1/10/11, documented the resident "doesn't do complete shower put on shower list." A nursing assessment, dated 4/11, documented staff were assisting the resident with hygiene and bathing needs.

On 3/16/11 at 3:08 PM, the facility nurse stated Resident B was mostly independent with cares, but needed cueing assistance with hygiene and bathing.

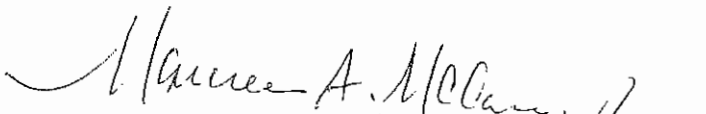
On 3/16/11 between 2:48 PM and 3:16 PM, three caregivers stated Resident B

needed cueing and assisting with hygiene, toileting and showering. They stated he would refuse on occasion, but would complete the tasks when reproached.

Unsubstantiated. Although the allegation may have occurred, it could not be proven during the complainant 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,



Maureen A. McCann, RN
Health Facility Surveyor
Residential Assisted Living Facility Program

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March 24, 2011

Kathy Axtell, Administrator
Grace Assisted Living
4356 North Nines Ridge Lane
Boise, ID 83702

Dear Ms. Axtell:

An unannounced, on-site complaint investigation survey was conducted at Grace Assisted Living from March 15, 2011 to March 18, 2011. During that time, observations, interviews, and record reviews were conducted with the following results:

Complaint # ID00004776

Allegation #1: The facility forced an identified resident to change pharmacies.

Findings #1: On 3/16/11, the identified resident's closed record was reviewed. It contained a pharmacy agreement signed by the identified resident, dated 8/31/10. The pharmacy agreement documented the resident was the financial responsible party. The identified resident's record documented she was alert and oriented.

On 3/16/11 at 11:49 AM, the administrator stated residents could choose whichever pharmacy desired. The identified resident was approached with an alternative pharmacy and decided to change. The identified resident was alert, oriented and capable to make decisions.

On 3/16/11 at 12:04 PM, the licensed practical nurse stated the identified resident was not required to utilize a specific pharmacy and was offered an alternative option, for which she agreed to. The identified resident was described as being alert and oriented.

On 3/15/11 through 3/16/11, twenty eight residents interviewed stated they were allowed to retain the pharmacy of their choice.

Unsubstantiated. Although the allegation may have occurred, it could not be proven during the complainant investigation.

Allegation #2: An identified residents adverse medication reactions were not reported to the resident's physician.

Findings #2: On 3/16/11, the identified resident's closed record was reviewed. Nursing assessments and care notes from July 2010 until the resident discharge date did not document any adverse medication reactions were noted. During this time period, two faxes were sent to the physician reporting drowsiness, and diarrhea to the physician.

On 3/16/11 at 12:04 PM, the licensed practical nurse stated she did not recall the resident experiencing any adverse reactions to medications, but if it were observed, they would notify the physican or 911 in an emergency.

On 3/16/11 between 3:07 PM and 3:30 PM, two caregivers were interviewed separately. They stated they did not recall the identified resident having any adverse medication reactions, but if they were to have observed any, they would notify the nurse or would call 911 in an emergency.

Between 3/15/11 through 3/17/11, ten sampled resident records were reviewed. Each record contained documentation of notification of the physician for changes of condition or medication concerns.

Unsubstantiated. Although the allegation may have occurred, it could not be proven during the complainant investigation.

Allegation #3: An identified resident received medications after the physician discontinued the medications.

Findings #3: On 3/16/11, the identified resident's record was reviewed. The resident's July, August, September and October 2010 medication assistance records (MARs) were reviewed. The MARs were congruent with physician orders. There was no documentation that medications were given after being discontinued by the physician.

On 3/16/11 and 12:06 PM, the licensed practical nurse stated she did not recall any medication errors occurring with the identified resident. If errors were found, the physician or 911 would be immediately notified.

On 3/15/11 through 3/17/11, ten sampled residents' records were reviewed. MARs were congruent with physician orders, and the medication labels.

Two medication passes were observed. Caregivers were observed assisting with medications appropriately, by comparing medication labels with the MARs. The caregivers stated the nurse reviewed new medication orders and updated the

MARs with the current medication orders. New orders were flagged in each chart to alert caregivers of the new changes.

Unsubstantiated. Although the allegation may have occurred, it could not be proven during the complainant investigation.

Allegation #4: An identified resident's physician was not notified when the resident refused medications.

Findings #4: On 3/16/11, the identified resident's closed records was reviewed. Between July 2010 until October 2010, the record contained two faxes to the physician reporting the resident's refusal of two different medications. The corresponding Medications Assistance Records (MARs), documented the resident's refusals of those two medications. No other medications were documented as refused.

On 3/16/11 at 12:04 PM, the licensed practical nurse stated residents had the right to refuse medications, but the physician would be notified of consistent refusals.

On 3/15/11 through 3/17/11, ten sampled residents records were reviewed. The records documented notification of the physician for medication refusals.

Unsubstantiated. Although the allegation may have occurred, it could not be proven during the complainant investigation.

Allegation #5: The administrator did not complete a written response to a complainant, regarding an identified resident.

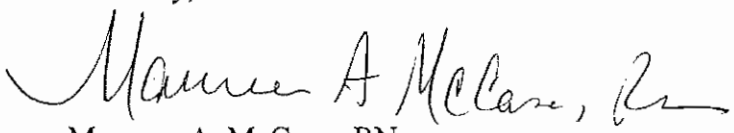
Findings #5: On 3/16/11, the identified resident's record was reviewed. Care notes documented a complaint was received on 9/30/10. The record, contained a response to the complaint, which was a 30 day discharge notice, dated September 30, 2010. The notice documented as the result of a conversation with the owner and family, it was determined the facility could not meet the identified resident's needs.

On 3/15/11 at 10:55 AM, the administrator stated a copy of a written response to any complainants would be contained in each residents' record if applicable.

Unsubstantiated. Although the allegation may have occurred, it could not be proven during the complainant 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,



Maureen A. McCann, RN
Health Facility Surveyor
Residential Assisted Living Facility Program

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March 24, 2011

Kathy Axtell, Administrator
Grace Assisted Living
4356 North Nines Ridge Lane
Boise, ID 83702

Dear Ms. Axtell:

An unannounced, on-site complaint investigation survey was conducted at Grace Assisted Living from March 15, 2011 to March 18, 2011. During that time, observations, interviews, and record reviews were conducted with the following results:

Complaint # ID00004858

Allegation #1: There was not enough staff on duty to meet the care needs of the residents.

Findings #1: Between 3/15/11 and 3/18/11, the majority of residents were observed to be independent, while a few residents were observed to need assistance of one caregiver. When residents needed assistance, staff were observed responding and assisting the residents in a timely manner. The residents were further observed to be clean, well groomed, appropriately dressed and odor free. Resident's rooms and the facility common areas were observed to be clean, tidy and free from odors.

Between 3/15/11 and 3/18/11, twenty-eight residents, six caregivers and two family members stated they felt the staffing was adequate and felt the staff could meet all of the residents' needs.

The February and March 2011 staff schedules were reviewed On 3/16/11. The schedule documented four caregivers were scheduled for the day and evening shifts. One caregiver and one medication aide were scheduled for the night shift. A dedicated housekeeper was scheduled Monday through Friday. The facility administrator and nurse were on call 24 hours a day, 7 days a week.

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

Allegation #2: Residents were not being assisted with showers as required.

Findings #2: Between 3/15/11 and 3/18/11, residents were observed to be clean, well groomed, appropriately dressed and odor free.

Between 3/15/11 and 3/18/11, twenty-eight residents, six caregivers and two family members stated residents received showers per their Negotiated Service Agreements (NSAs), usually twice weekly and as needed if necessary.

Between 3/16/11 and 3/18/11, shower schedule check sheets were reviewed. Caregivers initialed when residents received a shower. The documentation supported interviews that residents had been receiving showers per their NSAs.

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

Allegation #3: There were not enough staff available to assist residents that required a two person transfer assist.

Findings #3: On 3/15/11, during the facility tour, the majority of residents were observed to be independent, while a few residents were observed to require assistance of one caregiver for transfers and mobility.

Between 3/15/11 and 3/18/11, six caregivers, the facility administrator and facility nurse stated there was only one resident that had required a two-person assist for safety. The resident's health improved and no longer required two person assist. They further stated, there were at least 2 caregivers in the facility at all times.

On 3/16/11, the February and March 2011 staff schedules, were reviewed. The schedule documented four caregivers were scheduled for the day and evening shifts. Two caregivers scheduled for the night shift. The facility administrator and nurse were on call 24 hours a day, 7 days a week.

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

Allegation #4: Call lights were not being answered in a timely manner.

Findings #4: On 3/15/11, during a tour of the facility, pull cords were observed in the resident bedrooms and bathrooms throughout the facility.

Between 3/15/11 and 3/18/11, call lights were observed being answered in a timely manner. Caregivers were observed checking their pagers when a call light

sounded and/or calling the residents room on a phone to provide assistance.

Between 3/15/11 and 3/18/11, twenty-eight residents, six caregivers and two family members stated they felt the residents' call lights were answered in a timely manner. The six caregivers stated they carried pagers that were connected to the resident's call system. When a resident pulled their call light, the caregivers' pagers showed the room number where the call light was pulled. Staff could call the room from any phone to check with the resident to find out what assistance the resident needed or physically respond to the room number the call came from.

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

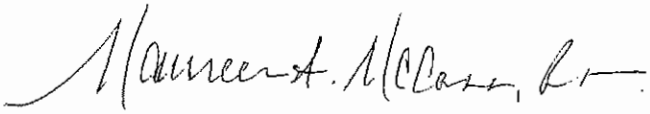
Allegation #5: An identified resident was moved from her room to another room without agreeing to the move.

Findings #5: On 3/16/11 at 10:30 AM, the identified resident stated, "I have moved all over this building since I've lived here, for various reasons. I didn't have a problem changing rooms and was involved in the decision." The resident further stated she was comfortable in her current room and was happy she had a private room to enjoy her own space.

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,



Maureen A. McCann, RN
Health Facility Surveyor
Residential Assisted Living Facility Program

IDAHO DEPARTMENT OF
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March 24, 2011

Kathy Axtell, Administrator
Grace Assisted Living
4356 North Nines Ridge Lane
Boise, ID 83702

Dear Ms. Axtell:

An unannounced, on-site complaint investigation survey was conducted at Grace Assisted Living from March 15, 2011 to March 18, 2011. During that time, observations, interviews, and record reviews were conducted with the following results:

Complaint # ID00004862

Allegation #1: An identified resident was not provided adequate hygiene, especially after toileting.

Findings #1: Between 3/15/11 and 3/18/11, residents, including the identified resident, were observed to be clean and free of odor. The identified resident's room was also observed to be clean and free of odor during the above dates of the survey.

On 3/15/11 at 2:26 PM, the identified resident stated the caregivers assisted her with everything, including toileting. The resident said she was assisted with peri-care and had no problems or difficulties with caregivers providing this task.

On 3/16/11 between 2:48 PM and 3:16 PM, four caregivers stated they provided peri-care to the identified resident. All of the caregivers described the steps to proper peri-care.

On 3/16/11 at 10:28 AM, the facility nurse stated caregivers provided peri-care only to residents who needed the assistance. She stated all of the caregivers had been appropriately trained to provide peri-care.

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

Allegation #2: The facility nurse did not assess an identified resident when the resident complained of stomach pain for two months and then was admitted to the hospital.

Findings #2: A "History and Physical" from a hospital documented the resident was admitted to the hospital, on 12/10/10, for "shortness of breath" and was subsequently diagnosed with "chronic obstructive pulmonary disease" and a "urinary tract infection." There was no documentation the resident had complained of stomach pain upon assessment at the hospital.

The facility notes, from October to December 2010, were reviewed. There was no documentation the resident complained of stomach pain. The daily log, on 12/10/10, documented the resident had shortness of breath and was taken to the hospital for an assessment.

On 3/15/11 at 2:26 PM, the identified resident stated that she "may have had a touch of pneumonia at some point, but other than that was healthy." She said she did not remember having stomach pain for an extended period of time.

On 3/16/11 at 10:28 AM, the facility nurse stated she did not recall the resident having stomach pain for an extended period of time. She stated the resident became ill on 12/10/10 and was sent to the hospital to be assessed.

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

Allegation #3: An identified resident's bathroom was not kept cleaned after the resident had diarrhea.

Findings #3: Between 3/15/11 and 3/18/11, the identified resident's bathroom was observed t to be clean and the toilet was free of feces.

On 3/15/11 at 2:26 PM, the identified resident stated she has had accidents, but the staff helped clean her up in a timely manner and she never had a dirty bathroom.

On 3/16/11 between 2:48 PM and 3:16 PM, four caregivers stated they had never seen the resident's bathroom dirty and they was always assisted her with cleaning after toileting.

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

Allegation #4: Call lights were not answered in a timely manner.

Findings #4: On 3/15/11, during a tour of the facility, pull cords were observed in the resident bedrooms and bathrooms throughout the facility.

Between 3/15/11 and 3/18/11, call lights were observed being answered in a timely manner. Caregivers were observed checking their pagers when a call light sounded and/or calling the residents room on a phone to provide assistance.

Between 3/15/11 and 3/18/11, twenty-eight residents, six caregivers and two family members stated they felt the residents' call lights were answered in a timely manner. The six caregivers stated they carried pagers that were connected to the resident's call system. When a resident pulled their call light, the caregivers' pagers showed the room number where the call light was pulled. Staff could call the room from any phone to check with the resident to find out what assistance the resident needed or physically respond to the room number the call came from.

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

Allegation #5: There was not enough staff on duty to meet the care needs of the residents.

Findings #5: Between 3/15/11 and 3/18/11, the majority of residents were observed to be independent and a few residents were observed to require a one person assist. When residents needed assistance, staff were observed responding and assisting the residents in a timely manner. The residents were further observed to be clean, well groomed, appropriately dressed and odor free. Resident rooms and the facility common areas were observed to be clean, tidy and free from odors.

Between 3/15/11 and 3/18/11, twenty-eight residents, six caregivers and two family members stated they felt the staffing was adequate and felt the staff could meet all of the residents' needs.

The February and March 2011 staff schedules were reviewed on 3/16/11. The schedule documented four caregivers were scheduled for the day and evening shifts. Two caregivers were scheduled for the night shift. A dedicated housekeeper was scheduled Monday through Friday. The facility administrator and nurse were on call 24 hours a day, 7 days a week.

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

Allegation #6: Facility did not make or take an identified resident to a follow-up physician appointment for coumadin checks.

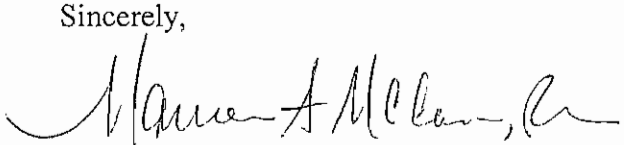
Findings #6: The identified resident's record contained lab results from November 2010 to March 2011. The results documented the resident's blood checks were consistently completed at scheduled times. There was no documentation of the resident missing a physician appointment related to coumadin checks.

On 3/16/11 at 10:28 AM, the facility nurse stated the lab came in every Monday and drew the resident's blood when they were scheduled. She would receive the results that same day and report them to the resident's physician who would adjust the coumadin doses as needed. Additionally, she stated she was not aware of a time the resident missed a physician's appointment, except on one occasion when the van was broken down. The physician's appointment had been rescheduled.

Unsubstantiated. This does not mean the incident did not take place; it only means that the allegation could not be proven.

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,



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