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April 18, 2012

Nathaniel Knowles, Administrator
Heritage Assisted Living Of Boise
1777 S Curtis Rd
Boise, ID 83705

Dear Mr. Knowles:

An unannounced, on-site complaint investigation survey was conducted at Heritage Assisted Living Of Boise - Heritage Assisted Living, Inc. on April 16, 2012. During that time, interviews and record reviews were conducted with the following results:

Complaint # ID00005514

Allegation #1: An identified resident was confined to her room without medical proof of a MRSA (methicillin-resistant staphylococcus aureus) infection.

Findings #1: On 4/16/12, the identified resident's record was reviewed. It contained wound clinic notes, dated 3/28/12, documenting that a culture conducted on 3/20/12 showed moderate growth of MRSA. A laboratory report, dated 3/25/12, documented that the culture was positive for MRSA on 3/23/12. A repeat culture was obtained on 4/11/12; the laboratory report of 4/14/12 documented the culture as again positive for MRSA. A doctor's note, dated 4/16/12, documented: "+MRSA Culture." The note further documented to begin antibiotics.

An "Observation" note from the facility Licensed Practical Nurse (LPN), dated 4/11/12, documented she had received treatment notes by the wound clinic that the identified resident's wound was cultured and found to be positive for MRSA on 3/23/12. The note further documented the LPN went over the resident's lab results with the identified resident. The identified resident had been informed another wound culture would be obtained since she had been on two antibiotics for ten days. If the second wound culture was positive, the facility would not be able to retain resident due to a higher level of care being required. The note

further documented, the identified resident was informed she was fine to leave the facility and catch the bus, since her wound was covered. The resident was reminded to use her call light for anything she required, and caregivers were instructed to use gowns and gloves when caring for the resident.

An "Observation" note from a caregiver, dated 4/11/12, documented the resident was informed she was in isolation precautions and meal trays and anything she needed would be brought to her.

An "Observation" note, dated 4/12/12, documented the LPN contacted the wound clinic to determine if it was necessary to keep the identified resident in isolation or if the dressing would be enough to protect (against) the spread of the MRSA to other residents. An "Observation" note, dated 4/13/12, documented the resident had been taken out of isolation precautions per physician order.

On 4/16/12, at 2:40 PM, the LPN and Registered Nurse (RN) stated when they got the report of positive MRSA, they put the resident on contact isolation precautions until results from the second culture came back, or until the physician ordered otherwise. The LPN stated she reviewed CDC (Centers for Disease Control and Prevention) recommendations for MRSA. The RN stated, "it is standard precautions to isolate someone with MRSA."

The CDC documented in a report titled "Precautions to Prevent the Spread of MRSA in Healthcare Settings," "In...long-term care and other residential settings, limit transport and movement of patients outside of the room to medically-necessary purposes."

It could not be determined if the facility initiated isolation precautions that were not medically indicated. Further, IDAPA rule 16.03.22.152.05.b.xi. documents, "No resident will be admitted or retained who requires ongoing skilled nursing or care not within the legally licensed authority of the facility. Such residents include: A resident who has MRSA in an active stage."

Unsubstantiated.

Allegation #2: An identified resident was given a 30 day discharge notice in retaliation after the resident voiced concerns about another resident.

Findings #2: On 4/16/12, the identified resident's record was reviewed. It contained a 30-day discharge notice, dated 4/10/12, documenting the discharge notice was given due to a non-healing wound. Attached to the admission agreement was a copy

of the Idaho Residential Care or Assisted Living Facilities rules, citing rule 16.03.22.152.05.b.x, which states, "No resident will be admitted or retained who requires ongoing skilled nursing or care not within the legally licensed authority of the facility. Such residents include: A resident with any type of pressure ulcer or open wound that is not improving bi-weekly."

An "Observation" note from the LPN, dated 4/9/12, documented the identified resident's wound had a greenish color with some drainage that she observed when the home health nurse was doing a dressing change. She discussed the wound with the home health nurse who stated, the wound was worsening.

Wound clinic notes from February 2012 until the present date were reviewed. The clinic notes from 3/6/12 to 3/20/12 documented that the wound increased significantly in size. The 3/28/12 note documented the wound had been infected with MRSA and other bacteria. The note further documented wound healing was compromised due to other medical issues.

It could not be determined that the facility issued a 30-day notice for a reason other than to comply with rule 16.03.22.152.05.b.x.

On 4/16/12, at 1:40 PM, the ombudsman was interviewed. She stated she was notified by the facility that the resident had voiced concerns about another resident. She did an investigation and could not determine the resident was a danger to the identified resident or any other residents. She stated she felt the facility handled the situation appropriately and had conducted a thorough investigation.

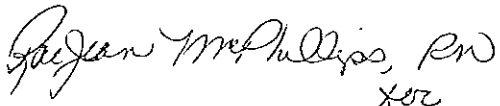
On 4/16/12, the identified resident's record contained a letter, dated 3/21/12, which documented the facility's response and investigation to a complaint received on 3/19/12. It documented the facility owner, RN and administrator were available to meet for further discussion as the facility wanted to serve the identified resident "for a long time."

It could not be determined that the facility issued a 30-day discharge notice in response to the complaint received, as the identified resident's wound was showing no progress towards healing and became infected with MRSA during the same time-frame.

Unsubstantiated.

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

RC/rm

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