



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

June 16, 2011

Tammy Witham, Administrator  
Grace Assisted Living Of Fairview Lakes  
1960 North Lakes Place  
Boise, ID 83642

License #: Rc-835

Dear Ms. Witham:

On April 20, 2011, a complaint investigation survey was conducted at Grace Assisted Living Of Fairview Lakes. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level(s):

- Core issues, which are described on the Statement of Deficiencies, and for which you have submitted a Plan of Correction.
- 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 plan of correction and evidence of resolution.

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

Sincerely,

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

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



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May 2, 2011

CERTIFIED MAIL #: 7009 0820 0000 2807 1767

Tammy Witham, Administrator  
Grace Assisted Living of Fairview Lakes  
1960 North Lakes Place,  
Meridian, ID 83642

Dear Ms. Witham:

Based on the complaint investigation survey conducted by the Idaho Department of Health and Welfare's staff at Grace Assisted Living of Fairview Lakes from **April 19 through April 20, 2011**, it has been determined that the facility failed to protect residents from abuse.

This core issue deficiency substantially limits the capacity of Grace Assisted Living of Fairview Lakes to provide services at an adequate level or quality to ensure that residents' health and safety are safe-guarded. The deficiency is described on the enclosed Statement of Deficiencies. As a result of the survey findings, the Department is issuing the facility a provisional license, effective April 22, 2011 through October 22, 2011. The following administrative rule for Residential Care or Assisted Living Facilities in Idaho (IDAPA 16.03.22) gives the Department the authority to issue a provisional license:

***935. ENFORCEMENT REMEDY OF PROVISIONAL LICENSE.***

*A provisional license may be issued when a facility is cited with one (1) or more core issue deficiencies, or when noncore issues have not been corrected or become repeat deficiencies. The provisional license will state the conditions the facility must follow to continue to operate. See Subsections 900.04, 900.05 and 910.02 of these rules.*

The conditions of the provisional license are as follows:

- 1. A Residential Care Administrator Consultant, with at least five years of experience working for a residential care assisted living facility in Idaho, will be obtained and paid for by the facility, and approved by the Department. This Administrator consultant must have an Idaho Residential Care Facility administrator license, and may not also be employed by Grace Assisted Living or any of its affiliates. The administrator consultant must also have demonstrated experience and success implementing and monitoring systems to protect residents from abuse. The administrator consultant must be allowed unlimited access to the**

staff, residents, the facility and its systems for the provision of care to residents. The name of the consultant with the person's qualifications will be submitted to the Department for approval no later than May 2, 2011.

2. The Department-approved consultant will submit a weekly written report to the Department commencing on May 6, 2011 and every Friday thereafter for the duration of the provisional license. The reports will address progress on correcting the deficiencies on the Statements of Deficiencies and Non-Core Issues Punch Lists.
3. The facility will maintain, on an ongoing basis, the deficient area in a state of compliance in accordance with the submitted Plan of Correction.
4. The provisional license to be prominently displayed in the facility. Upon receipt of this provisional license, please return the full license currently held by the facility.
5. When the consultant and the administrator agree the facility is in full compliance, they will notify the Department and a follow-up survey will be conducted.

The following administrative rule for Residential Care or Assisted Living Facilities in Idaho gives the Department the authority to impose a monetary penalty for this violation:

**IDAPA 16.03.22.925. ENFORCEMENT REMEDY OF CIVIL MONETARY PENALTIES.**

**01. Civil Monetary Penalties.** Civil monetary penalties are based upon one (1) or more deficiencies of noncompliance. Nothing will prevent the Department from imposing this remedy for deficiencies which existed prior to the survey or complaint investigation through which they are identified. Actual harm to a resident or residents does not need to be shown. A single act, omission or incident will not give rise to imposition of multiple penalties, even though such act, omission or incident may violate more than one (1) rule.

**02. Assessment Amount for Civil Monetary Penalty.** When civil monetary penalties are imposed, such penalties are assessed for each day the facility is or was out of compliance. The amounts below are multiplied by the total number of occupied licensed beds according to the records of the Department at the time non-compliance is established.

- a. Initial deficiency is eight dollars (\$8).

Based on the findings of the complaint investigation, it was determined the facility failed to protect residents from abuse. Therefore, the Department is imposing the following penalties:

For the dates of February 4, 2011 through April 20, 2011:

Penalty	Number of Deficiencies	Times number of Occupied Beds	Times Number of days of non-compliance	Amount of Penalty
\$8.00	1	30	75	\$18,000

Maximum penalty allowed in any ninety day period per IDAPA 16.03.22.925.02.c: \$3,200.00

Send payment of \$3,200.00 by check or money order, made payable to:

**Medicaid Licensing and Certification  
3232 Elder Street  
Boise, ID 83705**

Payment must be received in full within 30 calendar days from the date this notice is received. Interest accrues on all unpaid penalties at the legal rate of interest for judgments. Failure of a facility to pay the entire penalty, together with any interest, is cause for revocation of the license or the amount may be withheld from Medicaid payments to the facility.

Please be advised that you may contest this decision by filing a written request for administrative review pursuant to IDAPA 16.05.03.300. **no later than twenty-eight (28) days after this notice was mailed.** Any such request should be addressed to:

**Randy May  
Deputy Administrator  
Division of Medicaid-DHW  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0036**

If you fail to file a request for administrative review within the time allowed, this decision shall become final.

You have an opportunity to make corrections and thus avoid further enforcement action. Correction of this deficiency must be achieved by **June 5, 2011**. **We urge you to begin correction immediately.**

After you have studied the enclosed Statement of Deficiencies, please write a Plan of Correction by answering **each** of the following questions for **each** deficient practice:

- What corrective action(s) will be accomplished for those specific residents/personnel/areas found to have been affected by the deficient practice?
- How will you identify other residents/personnel/areas that may be affected by the same deficient practice and what corrective action(s) will be taken?
- What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?
- How will the corrective action(s) be monitored and how often will monitoring occur to ensure that the deficient practice will not recur (i.e., what quality assurance program will be put into place)?
- What date will the corrective action(s) be completed by?

Return the **signed** and **dated** Plan of Correction to us by **May 5, 2011**, and keep a copy for your records. Your license depends upon the corrections made and the evaluation of the Plan of Correction you develop.

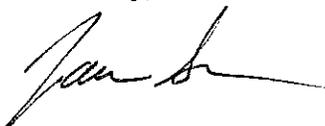
You have available the opportunity to question cited deficiencies through an informal dispute resolution process. If you disagree with the survey report findings, you may make a written request to the Supervisor of the Residential Care Program for a Level 1 IDR meeting. The request for the meeting must be made within ten (10) business days of receipt of the statement of deficiencies (**May 5, 2011**). The specific deficiencies for which the facility asks reconsideration must be included in the written request, as well as the reason for the request for reconsideration. The facility's request must include sufficient information for Licensing & Certification to determine the basis for the provider's appeal. If your request for informal dispute resolution is received after **May 5, 2011**, your request will not be granted. Your IDR request must be made in accordance with the Informal Dispute Resolution Process. The IDR request form and the process for submitting a complete request can be found at [www.assistedliving.dhw.idaho.gov](http://www.assistedliving.dhw.idaho.gov) under the heading of Forms and Information.

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 proof of resolution (e.g., receipts, pictures, policy updates, etc.) are to be submitted to this office by **May 20, 2011**.

If, at the follow-up survey, it is found that the facility is not in compliance with the rules and standards for residential care or assisted living facilities, the Department will have no alternative but to proceed with revocation of the license held by Grace Assisted Living Of Fairview Lakes - Grace At Fairview Lakes, Llc.

Should you have any questions, or if we may be of assistance, please call our office at (208) 334-6626.

Sincerely,



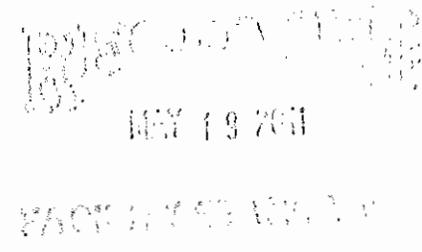
JAMIE SIMPSON, MBA, QMRP  
Program Supervisor  
Residential Assisted Living Facility Program

JS/js

Enclosure

c: Pam Mason, Program Manager, Regional Medicaid Services, Region IV - DHW  
Randy May, Deputy Administrator, Division of Medicaid  
Charina Newell, Deputy Attorney General, Department of Health and Welfare  
Natalie Peterson, Long Term Care Bureau Chief  
Lori Stiles, Supervisor, Program Integrity Unit

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13R835	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 04/20/2011
NAME OF PROVIDER OR SUPPLIER  GRACE ASSISTED LIVING OF FAIRVIEW LAKE		STREET ADDRESS, CITY, STATE, ZIP CODE 1960 NORTH LAKES PLACE MERIDIAN, ID 83642		
(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 following deficiency was cited during the complaint investigation conducted on 4/19/2011 through 4/21/2011, at your residential care/assisted living facility. The surveyors conducting the survey were:  Rachel Corey, RN Team Coordinator Health Facility Surveyor  Donna Henscheid, LSW Health Facility Surveyor  Gloria Keathley, LSW Health Facility Surveyor  Survey Definitions: g/f =girlfriend LPN = Licensed Practical Nurse RN = Registered Nurse	R 000	Item #1 Rule #16.03.22.510: The facility did not protect residents from abuse. This was the determination by facility standards from the survey completed on 4/20/11. We are implementing the following systems.  1. We have retained an Administrator Consultant as part of the corrective action. Our Administrator consultant has been in our facility from 5-9-11 thru 5-12-11 and is submitting her first report to Licensing and Survey on 5-13-11 as required. Our Administrator consult will submit weekly reports as agreed upon to Licensing and survey for the duration of time that we hold a provisional license. (Resolved 5-9-11)	
R 006	16.03.22.510 Protect Residents from Abuse.  The administrator must assure that policies and procedures are implemented to assure that all residents are free from abuse.  This Rule is not met as evidenced by: Based on record review and interview, it was determined the facility failed to protect 3 of 6 sampled residents (#1, #3 & #4), a random resident, and potentially 100% of the residents from abuse. The facility did not follow their abuse policy, as the administrator failed to investigate incidents of inappropriate sexual behaviors, notify Adult Protection, and implement interventions to assure residents were protected. The findings include:	R 006	2. Nurse and Administrator will review medical history and behaviors of potential resident to determine if they are appropriate for the facility prior to admission. (Resolved 4-22-11)  	

Bureau of Facility Standards

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

*Sammy W...*  
TITLE

Administrator (X6) DATE 5-19-11

Bureau of Facility Standards

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R 006	<p>Continued From page 1</p> <p>The Facility's "Abuse/Neglect Policy" documented..."If the Administrator has cause to believe that a vulnerable adult has been abused...she shall immediately report such information to Adult Protection Services...all allegations of abuse will be treated as serious and will be investigated, documented and reported." The policy documented staff members were to do the following if abuse was suspected to have occurred:            ***Ensure the safety of the resident. Separate the resident and the person allegedly abusing the resident.            *Immediately report the alleged abuse to your administrator.            *Initiate an incident report.            *Write a statement on an "Incident/Accident Form" of what was seen, heard or what is suspected.            *Give a copy of the statement to your administrator."</p> <p>The policy further documented the administrator would conduct an investigation, including interviewing all staff who might have witnessed or have knowledge of the event and review the provided documentation to determine if it was thorough and complete. The policy further documented the administrator was to "notify regulatory agencies as required."</p> <p>Resident #6 was admitted to the facility on 2/4/11 from a behavioral hospital, with a diagnosis of dementia. The admission and discharge register, documented Resident #6 was discharged back to the behavioral hospital on 3/17/11 for increased behaviors, then readmitted back to the facility on 3/24/11.</p>	R 006	<p>3. Behavior plans: First our staff will initiate a change of condition form when a resident displays an inappropriate behavior and call the Administrator immediately. Our facility nurse will then evaluate the behavior and determine if it is a transitory or permanent. The nurse will then implement behavior management plan if that behavior is found to be transitory and update that residents care plan. If the behavior is permanent we will update the care plan. All staff will be updated and instructed on the new behavior and how to monitor it. Once the behavior plan is initiated, the Administrator will read the behavior plan including the goal and sign the behavior plan. Staff will be instructed to call the Administrator immediately if this behavior is considered abuse.</p> <p>The nurse will talk to staff and monitor the behavior plans weekly. The Administrator will also monitor each behavior plan weekly, determine if the goal has been met, review information with the nurse and resolve or initiate another plan for this behavior. If for some reason the behavior cannot be resolved and it is sexual in nature we will discharge the resident to an appropriate setting. Behavior management plans have been updated and implemented (forms were developed off the state site) (Resolved 5-7-11)</p>	

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R 006	<p>Continued From page 2</p> <p>The behavioral hospital's records, dated 1/22/11, documented staff at the resident's prior facility reported, he had been sexually inappropriate with female residents.</p> <p>The behavioral hospital's records, dated 3/18/11, documented, "The patient sexually threatened his girlfriend on the phone if she didn't come in and pick him up he would go down the hall to another woman's room and have sex with her anyway. The patient is also trying to kiss on other patients. The patient continues to get mad at staff when they try to redirect him. The patient also becomes agitated with several patients, especially if the female patients say they are not his wife, he will become very agitated."</p> <p>1. Resident #4 was admitted to the facility on 5/13/10 with a diagnosis of dementia.</p> <p>On 4/19/11 at 1:30 PM, Resident #4 was observed to be confused and unable to answer questions appropriately.</p> <p>On 4/19/11, there were no incident reports or documentation regarding sexually inappropriate behaviors involving Resident #6 towards Resident #4.</p> <p>At 11:16 AM, Caregiver A stated Resident #6 had sexually inappropriate behaviors. He was observed "having intercourse" with Resident #4, by Caregiver B and Caregiver C. She stated she was aware Caregiver B and Caregiver C filled out incident reports, but did not think anything happened as a result of the incident reports. She further stated, she heard the assistant administrator state, "give me the reports and I will figure out what to shred."</p>	R 006	<p>4 Administrator has had an in-service with staff on 4-25-11 which outlined reporting procedures, who to notify (administrator only), when to notify the administrator (immediately if it is a reportable incident, neglect, abuse or exploitation), what form to fill out (incident report or change of condition) where to turn in the report (under administrators door at end of their shift).</p> <p>Upon hire, staff will be given initial in-service training books as required per state rules and regulations in addition to the administrator sitting down with each new employee and going through reporting procedures as stated above. Each employee will be trained on the Adult protection guide lines that were left from the in-service on 5-13-11. (Resolved 4-25-11 and ongoing)</p> <p>Our administrator consultant will be teaching an in-service to staff in an effort to educate them on what normal behaviors are and what is an actual behavior that requires intervention, how and where to document that behavior, who to notify and how to track and communicate those behaviors to the nurse and administrator. In-service will be on 5-30-11)</p>	
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R 006	<p>Continued From page 3</p> <p>At 11:28 AM, Caregiver B stated she observed Resident #6 having sexually inappropriate behaviors. She stated there was one incident, when Caregiver D walked in on Resident #6 and Resident #4 "having sex." Caregiver D brought her and Caregiver C into the room, because she "didn't know what to do." She stated the residents were separated; an incident report was written up and the assistant administrator was notified. She further stated, "My boss did nothing about it. We were told to keep an eye on him." She further stated, Resident #6 was eventually discharged to the hospital, then came back to the same unit and "he tried the same things with the other residents." She stated incident reports were written for all observed incidents.</p> <p>At 11:35 AM Caregiver C stated she witnessed an incident involving Resident #6 and Resident #4. Caregiver D initially caught Resident #6 and Resident #4 together in Resident #4's bed; she and Caregiver B were brought in, because Caregiver D did not know what to do. She further stated, she was not sure if intercourse had occurred, but both residents were observed in bed, with their adult briefs down. She confirmed incident reports were filled out for all sexually inappropriate incidents involving Resident #6. She stated she was suspicious the documents were being shredded, when nothing was done after the incidents. Therefore, she began copying the reports.</p> <p>At 11:49 AM, Caregiver D stated she had witnessed sexually inappropriate behaviors regarding Resident #6. She stated, sometime in March, when she went in to check on Resident #4, Resident #6 was in bed with her. Both were observed naked. She went to get Caregiver C, and Caregiver B to help her. The residents were</p>	R 006	<p>5. If staff witness abuse, they will immediately separate the alleged resident from all other residents and keep that resident in line of sight. They will then immediately call the Administrator. The Administrator will come into the facility immediately and follow Grace Assisted Living's abuse/neglect policy, notify the appropriate agencies, put a plan in place to keep the residents safe, talk to staff, investigate the allegation thoroughly and notify the families. I will investigate all allegations. (Resolved 4-22-11)</p> <p>6. We are restructuring the management in our Memory care unit. I am placing a new manager in this facility, effective 6/1/11. The new manger has worked for our facility for the last 4 years. She has over 30 years of experience working in both nursing homes and assisted living facilities. As part of her daily responsibilities, she will be required to report to myself, the Administrator with all issues.</p>	
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R 006	<p>Continued From page 4</p> <p>separated; an incident report was filled out and given to the assistant administrator the next day. She further stated, Resident #6 was discharged to the hospital a week or two after the incident and then brought back. "They put him on the other side of the building. There are still females over there. I don't know why they thought that would help."</p> <p>At 2:24 PM, the assistant administrator stated an incident with Resident #6 and Resident #4 was reported to her, as she remembered receiving a report of the incident. She stated she was told their pants were to their knees and they were "cuddling." She stated she had instructed staff to keep them separated and within a few days Resident #6 was sent to the hospital. She confirmed she did not report the incident to Adult Protection, as she did not feel it was abuse. She stated she did not know where the incident report was and could not confirm she had done an investigation of the incident. She stated she was unaware of any further incidents.</p> <p>At 2:52 AM, the administrator stated, "staff wrote a report about the two of them lovey dovey in [Resident #4's name]'s room. They were redirected out. ' She stated she talked with one of the employees about the incident and the employee did not mention intercourse. She further stated, "I did not feel he was aggressive towards her." She confirmed Adult Protection had not been notified and that all employees who witnessed the incident were not interviewed. She further stated, "Things were accumulating after the fact, so he was admitted to [name of hospital]." She stated she thought incident reports were written for all incidents and was unaware of where they were, or if investigations had taken place. She stated the assistant administrator was</p>	R 006	<p>7. As an ongoing effort to improve the education of our staff so they can provide quality care to our residents we will have the following annual in-services:</p> <p>A. Adult Protection on what determines abuse, neglect and exploitation including reporting procedures.</p> <p>B. We will have the Ombudsman give an in-service on resident rights. We will also have the Ombudsman come talk with any interested families and residents on resident rights.</p> <p>C. Dementia training to include behaviors, triggers, how to re-direct the residents safely and communication.</p> <p>10. We have hired a new nurse that has excellent credentials. Our nurse should be able to help us develop and implement this plan of correction and educate our staff on an ongoing basis.</p> <p>Total Completion 5-30-11</p>	

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R 006	<p>Continued From page 5</p> <p>in charge of conducting investigations taking place in the memory care unit.</p> <p>On 4/15/11 at 3:26 PM, two "Incident/Accident" reports were faxed to Licensing and Certification. The reports documented sexually inappropriate behaviors involving Resident #6 towards Resident #1 and Resident #3.</p> <p>2. Resident #1 was admitted to the facility on 12/6/10 with a diagnosis of dementia.</p> <p>The report faxed to Licensing and Certification, dated 4/5/11, documented "[Resident #6's name] was caught going into resident [Resident #1's name] room without permission and making sexual advances towards her. She was very upset and expressed her anger at the entrance." The report documented the administrator was notified and was signed by four caregivers. There was no documentation the administrator had investigated the incident.</p> <p>On 4/19/11, an on-site investigation was conducted at the facility. No records were found in Resident#1's record documenting the above incident. The "Incident/Accident" book did not contain the above report.</p> <p>On 4/19/11 at 10:20 AM, Resident #1 was observed to be confused and was not able to answer questions regarding the incident.</p> <p>On 4/19/11, at 11:04 AM, the facility's LPN stated Resident #6 had some sexually inappropriate behaviors, such as going into other females rooms and wanting to kiss them, but she did not think anything physical had occurred with Resident #1 or any other residents.</p>	R 006		

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NAME OF PROVIDER OR SUPPLIER  <b>GRACE ASSISTED LIVING OF FAIRVIEW LAKE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1960 NORTH LAKES PLACE MERIDIAN, ID 83642</b>		
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R 006	<p>Continued From page 6</p> <p>On 4/19/11 at 11:16 AM, Caregiver A verified the accuracy of the information documented and confirmed she had signed the incident report dated, 4/5/11, which had been faxed to Licensing and Certification, but could not be found at the facility.</p> <p>On 4/19/11 at 11:35 AM, Caregiver C verified the information documented on the incident report, dated 4/5/11, was accurate and confirmed she had signed the report.</p> <p>On 4/19/11 at 12:35 PM, Caregiver E stated she had observed Resident #6 touch Resident #1 inappropriately. She verified the information documented on the incident report, dated 4/5/11, was accurate and confirmed she had signed the report.</p> <p>On 4/19/11, the fourth caregiver, who signed as a witness, was not available for interview.</p> <p>3. Resident #3 was admitted to the facility on 1/27/10 with a diagnosis of dementia.</p> <p>An "Incident/Accident" report faxed to Licensing and Certification, dated 3/30/11, documented "[Resident #6's name] was caught touching [Resident #3's name] inappropriately and against her will. She said, no, don't multiple times. When asked about the incident, [Resident #3's name] stated, he touched my breasts and (pointed to genitals) and I said no, but he smiled and just kept rubbing me." The incident report documented the residents were separated. The report was signed by three caregivers. There was no documentation the administrator had investigated the incident.</p> <p>On 4/19/11, an on-site investigation was</p>	R 006		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13R835</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/20/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>GRACE ASSISTED LIVING OF FAIRVIEW LAKE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1960 NORTH LAKES PLACE MERIDIAN, ID 83642</b>		
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R 006	<p>Continued From page 7</p> <p>conducted at the facility. No documentation was found in Resident 3's record regarding the incident on 4/30/11. The "Incident/Accident" book did not contain the above report.</p> <p>On 4/19/11 at 10:30 AM, Resident #3 was observed to be confused and was not able to answer questions regarding the incident.</p> <p>On 4/19/11 at 11:35 AM, Caregiver C verified the information documented on the incident report, dated 4/5/11, was accurate and confirmed she had signed the report. She stated, "[Resident #6's name] was very hypersexual the moment we got him. He was constantly making advances towards women and kissing them." She further stated, he was caught putting his hand down the pants of Resident #3, after Resident #3 was heard screaming. An incident report was filled out and the assistant administrator was notified. She stated, when the assistant administrator was notified, she was told to keep the residents separated, because the assistant administrator "could not afford to lose another bed."</p> <p>On 4/19/11 at 12:35 PM, Caregiver E stated she observed Resident #6 touch Resident #3's breasts. She confirmed she signed the incident reports faxed to Licensing and Certification and verified the accuracy of information documented. She further stated, she did not know if the administrator had investigated the incidents and she was not told how to intervene when witnessing any sexually inappropriate behaviors.</p> <p>The third caregiver, who signed as a witness, was not available to be interviewed.</p> <p>On 4/20/11, at 9:15 AM, upon entering the facility for an exit conference, the administrator stated</p>	R 006			

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER  GRACE ASSISTED LIVING OF FAIRVIEW LAKE		STREET ADDRESS, CITY, STATE, ZIP CODE 1960 NORTH LAKES PLACE MERIDIAN, ID 83642		
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R 006	<p>Continued From page 8</p> <p>she had located some incident reports involving Resident #6. She stated some of the incident reports were in the RN's box, awaiting review and some were obtained from the behavioral hospital, because they had been faxed there upon Resident #6's admission. The "Incident/Accident" reports and "Change of Condition" forms documented the following:</p> <p>*On 3/14/11, "[Random resident's name] came and got me to help. [Resident #6's name] was standing over her telling her to come with him. I asked [Random Resident's name] if she needed help and she said "yes." I asked [Resident #6's name] to please come with me to his room. He said no and that he was taking her with him. I told him she didn't know him and told him her name. I tried to escort him and he got angry and acted as if he'd push me. I again explained that she didn't know him and would like him to leave her alone. I walked him down to his room..." The section titled "Nurse Review" documented, "Admin notified." The section titled "Administrator Investigation" was blank.</p> <p>*On 3/14/11, "...[Resident #6's name] threaten g/f if she didn't come and pick him up then he would go down the hall to the woman's room across from the wash room. [Resident #4's name's] room and do away...he said because there was nothing else to do here." The form documented caregivers were "keeping a heavy eye on him" and Resident #4's door had been locked. There was no documentation the administrator had reviewed the report.</p> <p>*On 3/14/11, "[Resident #6's name] is increasingly agitated. He is saying that several female residents are his wife. He gets angry with me and the women for telling him that they are</p>	R 006		

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R 006	<p>Continued From page 9</p> <p>not his wife. I have tried talking with him and redirecting him. I've been trying to re-direct women that I see him watching so that they are all easy for me to observe. This also made him angry (sic) with me." There was no documentation the administrator had reviewed the report.</p> <p>*On 4/12/11, "[Resident #6's name] was trying to kiss on [Resident #4's name] and so I moved him over to the other side and he desited (sic) he was not staying over there..." There was no documentation the incident report was reviewed by the administrator.</p> <p>Resident #6 was admitted to the facility, on 2/4/11, with a history of sexually inappropriate behaviors. He inappropriately touched Resident #1 and Resident #3 and was found in bed with Resident #4. Five caregivers confirmed they witnessed Resident #6's sexually inappropriate behaviors and had informed the administrator or the assistant administrator. However, no investigation took place by the administrator to determine if abuse had occurred. Additionally, Adult Protection was not notified to determine if abuse had occurred. Because no investigation took place regarding Resident #6's sexually inappropriate behaviors, interventions were not put in place to protect the residents and assure they felt safe in their environment. The facility failed to protect Residents #1, #3, #4 and a random resident from abuse, which also had the potential to affect 100% of female residents in the facility. This failure resulted in abuse.</p>	R 006		





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 22, 2011

Tammy Witham, Administrator  
Grace Assisted Living Of Fairview Lakes  
4356 North Nines Ridge Lane  
Boise, ID 83702

Dear Ms. Witham:

An unannounced, on-site complaint investigation survey was conducted at Grace Assisted Living Of Fairview Lakes from April 19, 2011, to April 20, 2011. During that time, observations, interviews, and record reviews were conducted with the following results:

Complaint # ID00005021

**Allegation #1:** The facility did not give a 30 day written notice to move identified residents to the memory care unit.

**Findings #1:** On 4/19/11, the identified residents' records were reviewed. An admission agreement documented the facility "...reserves the right to relocate a resident to a more appropriate room within the home as required for their health or safety, or because of the residents of the Friendship Suites is incompatible." This agreement was signed and dated by one of the identified residents.

"Resident Service Notes," dated 2/15/11, documented a meeting was held with family members, hospice staff and the administrator. It was agreed by all parties to move the identified residents to the memory care unit where there was "more staff to resident ratio."

Substantiated. However, the facility was not cited; the facility acted within their right, outlined in the admission agreement, to move residents to other rooms within the facility.

**Allegation #2:** An identified resident's Negotiated Service Agreement was not updated after a change of condition.

**Findings #2:** Substantiated. The facility was issued a non-core deficiency at IDAPA

Tammy Witham, Administrator  
April 22, 2011  
Page 2 of 2

16.03.22.320.08 for not updating the identified resident's NSA to include the additional care required following a change of condition.

If you have questions or concerns regarding our visit, please call us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,

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

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

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



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April 22, 2011

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Boise, ID 83702

Dear Ms. Witham:

An unannounced, on-site complaint investigation survey was conducted at Grace Assisted Living Of Fairview Lakes from April 19, 2011, to April 20, 2011. During that time, observations, interviews, and record reviews were conducted with the following results:

Complaint # ID00005018

Allegation #1: The facility did not protect residents from abuse.

Findings #: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.510 for not investigating allegations of sexual inappropriate behaviors and implementing interventions to protect residents. The facility was required to submit a plan of correction.

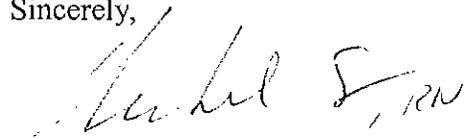
Allegation #2: Incident reports regarding residents' sexual inappropriate behaviors were destroyed.

Findings #2: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.330.03 for not ensuring records were protected from destruction. The facility was required to submit evidence of resolution within 30 days.

If you have questions or concerns regarding our visit, please call us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Tammy Witham, Administrator  
April 22, 2011  
Page 2 of 2

Sincerely,

A handwritten signature in black ink, appearing to read "Rachel Corey, RN". The signature is written in a cursive style with a large initial "R" and "C".

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

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