



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) 364-1686

August 5, 2011

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

License #: Rc-835

Dear Ms. Witham:

On July 13, 2011, a Complaint Investigation and follow-up 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):

- 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 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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July 14, 2011

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

Dear Ms. Witham:

On July 13, 2011, a follow-up visit to the complaint investigation survey of 4/20/11, was conducted at Grace Assisted Living Of Fairview Lakes. The core issue deficiency issued as a result of the 4/20/11, survey have been corrected.

- The conditions of your provisional license have been met. Your full license has been restored and a new certificate enclosed.
- You are no longer required to retain your consultant. No further consultant reports are required.

Please bear in mind that four non-core issue deficiencies were identified on the punch list and one was identified as a repeat punch. As explained during the exit conference, the completed punch list form and accompanying proof of resolution (e.g., receipts, photographs, policy updates, etc.) needs to be submitted to our office no later than August 12, 2011

If the facility fails to submit acceptable evidence of resolution within sixty (60) days from when the facility was found out of compliance, or on a subsequent survey visit, it is determined that any of these deficiencies still exist, the Department will have no alternative but to initiate the enforcement of civil monetary penalties, as described in IDAPA 16.03.22.910.02 and IDAPA 16.03.22.925.

Please ensure the facility is continually monitoring its compliance with state rules, as further repeat punches identified during future surveys could result in enforcement actions including:

- a. Issuance of a provisional license
- b. Limitations of admissions to the facility
- c. Hiring a consultant who submits periodic reports to the Licensing and Certification
- d. Civil monetary penalties

Our staff is available to answer questions and to assist you in identifying appropriate corrections to

avoid further enforcement actions. Should you require assistance or have any questions about our visit, please contact us at (208) 334-6626. Thank you for your continued participation in the Idaho residential care assisted living facility (RALF) program.

Sincerely,

A handwritten signature in black ink, appearing to read 'J. Simpson', written in a cursive style.

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

Enclosure



ASSISTED LIVING
Non-Core Issues
Punch List

Facility Name Grace Assisted Living of Fairview Lakes	Physical Address 1960 North Lakes of Fairview Lakes	Phone Number 884-8080
Administrator Tammy Witham	City Meridian	Zip Code 83642
Team Leader Rachel Corey	Survey Type Complaint and Follow-up	Survey Date 07/13/11

NON-CORE ISSUES

Item #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	L&C USE
1	305.08	The facility nurse did not provide specific parameters regarding abnormal blood glucose levels and the appropriate response.	8/5/11 RC	
2	320.01	Residents #7, and 9 did not receive the frequency of showers according to their NSAs.	8/5/11 RC	
3	320.08	Resident #6's NSA did not describe the frequency or required assistance with showers. Resident #7's NSA was not updated to include a mechanical soft diet. *REPEAT PUNCH*	8/5/11 RC	
4	711.08.e	Staff did not document notification of the nurse and their response each time Resident #1 experienced abnormal blood glucose levels.	8/5/11 RC	
Response Required Date 08/12/11	Signature of Facility Representative 		Date Signed 7-13-11	



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July 18, 2011

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

Dear Ms. Witham:

An unannounced, on-site complaint investigation survey was conducted at Grace Assisted Living Of Fairview Lakes - Grace At Fairview Lakes, Llc from July 12, 2011, to July 13, 2011. During that time, observations, interviews, and record reviews were conducted with the following results:

Complaint # ID 00005064

Allegation #1: The facility administrator did not conduct an investigation when an identified resident had inappropriate sexual behaviors.

Findings #1: A "Change of Condition" report, dated 5/7/11, documented the identified resident was "holding hands with another female resident and telling her he was her husband." The report further documented, adult protection was called and the administrator investigated the situation to determine if the behavior was inappropriate.

A "Behavior Management Plan," dated 5/7/11, documented the resident had a behavior of "kissing residents and staff hands." The plan included interventions to "keep resident in line of sight in common area, redirect if seen going for hands of females." The plan was signed and dated by the administrator and the facility nurse.

Between 7/12/11 through 7/13/11, five caregivers were interviewed. All stated they were instructed to report inappropriate sexual behaviors, incidents or concerns they had observed to the administrator. They all stated the administrator had followed up with all concerns they had expressed.

On 7/13/11 at 9:00 AM, the administrator stated she investigated reports of the observed interactions with the identified resident and other female residents.

She stated, Adult protection was notified about the resident's interactions with other residents and nothing was determined to be inappropriate.

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

Allegation #2: There were ants all over the back rooms of the memory care unit and the facility did not respond appropriately.

Findings #2: On 7/12/11 through 7/13/11, ants were not observed anywhere within the memory care unit. The administrator and house manager stated they were unaware of an ant infestation within the memory care unit. The house manager further stated, there were a few rooms on the assisted living side that had a problem with ants, but an exterminator was brought in, and there was no longer a problem. Three caregivers stated they were unaware of an ant problem. One caregiver stated she recalled a problem in the past, but the facility brought in an exterminator right away.

On 7/12/11, pest control receipts were reviewed and documented quarterly services. One receipt dated 6/6/11, documented a room was sprayed for "flying ants."

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

Allegation #3: Residents were not receiving showers.

Findings #3: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.320.01 for not providing assistance with showers at the frequency stated in the Negotiated Service Agreement. The facility was required to submit evidence of resolution within 30 days.

Allegation #4: An identified resident had blood glucose levels below 41 several times in April and staff did not respond appropriately.

Findings #4: On 7/12/11, the identified resident's record was reviewed. The April 2011, medication assistance record did not document any blood glucose levels below 50. However, "Change of Condition" forms documented three instances of abnormal blood glucose levels that occurred in April 2011 and May 2011. Each time, the resident was given orange juice, the nurse was notified and the

resident's blood glucose increased to a normal level. Each "Change of Condition" form documented the resident's physician was notified by the facility nurse.

Unsubstantiated. However, the facility was cited at 16.03.22.305.08 for the facility nurse not providing parameters and instructions to staff regarding abnormal blood glucose levels. The facility was also cited at 16.03.22.711.08.e for the staff not documenting each time they notified the facility nurse for abnormal blood glucose levels.

Allegation #5: An identified resident who was bed bound was not assisted to eat or drink.

Findings #5: On 7/12/11 and 7/13/11, residents' cares were observed. There were currently no bed bound residents within the facility and the identified resident no longer resided at the facility. All residents were observed being assisted to eat and drink.

On 7/13/11, the identified resident's record was reviewed. Hospice notes documented the resident was not eating well, but staff were observed offering the resident soft foods.

On 7/13/11 at 9:02 AM, the identified resident's hospice nurse stated she had observed staff offering and assisting the resident with food and fluids, but the resident did not eat well after she had experienced a significant decline. She further stated, she had no concerns regarding the resident's care.

On 7/13/11 at 8:50 AM, the administrator stated a caregiver would stay and feed the identified resident in her room.

On 7/13/11 at 9:18 AM, the cook stated she had observed caregivers going into the resident's room to assist with food and fluids frequently throughout the day, but many times the resident would not eat or drink.

On 7/13/11 at 9:45 AM, a caregiver stated the identified resident was "constantly" offered food and fluids. She further stated, the resident needed a lot of reassurance and care, so staff checked on her frequently.

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

Allegation #6: An identified resident experienced a skin tear and did not receive medical

treatment in a timely manner.

Findings #6.

On 7/13/11, the facility's incident reports were reviewed. One incident report, dated 4/18/11 at 9:30 AM, documented the identified resident hit her elbow on her wheelchair and developed a skin tear. The facility nurse dressed the wound and applied pressure. When the wound continued to bleed, the resident's physician was notified and requested the resident be seen. The incident report documented the administrator drove the resident to a nearby medical clinic.

On 7/13/11 at 8:45 AM, the administrator stated when the resident had a skin tear, staff applied pressure and the facility nurse and hospice nurse bandaged the wound. When the bleeding continued, the physician's office was contacted and she drove the resident to the medical clinic around 1:00 PM.

On 7/13/11 at 10:50 AM, a caregiver stated she did not think medical treatment was delayed when the identified resident experienced a skin tear, as the facility nurse and hospice nurse were overseeing her care before it was determined she need to be further evaluated.

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

Allegation 7:

Two identified residents' incontinent briefs were not being changed and were observed urine soaked by the morning shift caregivers.

Findings #7:

On 7/12/11 through 7/13/11, observations, interviews and record reviews were conducted. At the time of the survey, both identified residents no longer resided at the facility. Activity of daily living (ADL) sheets, contained in the residents' records, documented the residents were toileted every two hours, as well as checking to ensure their briefs were dry. Current residents were observed to be clean and well groomed. Caregivers were observed assisting residents with toileting needs. Four caregivers stated, they toileted residents every two hours. They further stated, they did rounds with the oncoming shift to check residents to ensure they were clean and that their briefs were dry.

On 7/12/11 at 8:56 AM, the RN consultant stated she had observed caregivers toileting residents appropriately. She further stated, staff were instructed to make rounds with the oncoming shift to ensure each resident was clean and dry.

On 7/12/11 at 11:34 AM, the ombudsman stated she did not have concerns with the facility not providing the necessary care to residents.

On 7/12/11 at 1:50 PM, the administrator stated caregivers reported to her that one of the identified residents was found with urine soaked briefs one morning. She stated, the night shift caregivers that were on duty were counseled for not providing the care. Additionally she stated an in-service was given regarding toileting residents; she also changed the staffing patterns and had experienced caregivers work various shifts to ensure all cares would be provided timely.

Substantiated. However, the facility was not cited as they corrected the problem prior to the survey.

Allegation #8: An identified resident fell and broke a hip, but did not receive medical treatment in a timely manner.

Findings #8: On 7/12/11, the identified resident's closed record was reviewed. An incident report, dated 3/28/11, documented the identified resident was experiencing pain in the right hip. The hospice and facility nurses assessed the resident and ordered a bed-side X-ray. The administrator documented an investigation was completed regarding the cause of the pain. There was no evidence of a fall or incident that occurred. The report documented the identified resident was with family prior to the complaint of pain and had not complained of pain to the family. There was no documentation the resident had complained of pain for an extended time period, prior to being professionally evaluated.

On 7/12/11 At 1:54 PM, the administrator stated it was not determined what caused the fracture. The resident had spent the weekend with family and had been moving without difficulty. The next day, the resident began complaining of pain. As soon as the resident began having pain, a bed-side X-ray was ordered to evaluate the resident.

Four caregivers interviewed were either not present at the time of the alleged incident or did not recall the incident, but stated the facility nurse addressed any concerns they expressed about residents in a timely manner. They further stated, the facility nurse was reachable by phone, if not present at the facility.

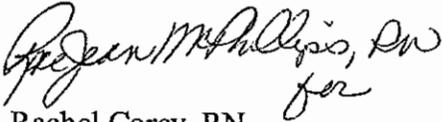
Incident reports reviewed, from May 2011 until the survey date, documented the facility responded appropriately to all incidents.

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

Tammy Witham, Administrator
July 18, 2011
Page 6 of 6

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 Corey, RN".

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

RC/rm

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



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Dear Ms. Witham:

An unannounced, on-site complaint investigation survey was conducted at Grace Assisted Living Of Fairview Lakes - Grace At Fairview Lakes, Llc from July 12, 2011, to July 13, 2011. During that time, observations, interviews, and record reviews were conducted with the following results:

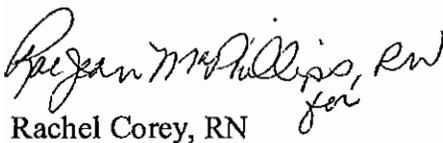
Complaint # ID00005084

Allegation #1: An outside service agency of an identified resident was discontinued without the resident's consent.

Findings #1: Unsubstantiated. The identified resident no longer resided at the facility and was unavailable for interview. A family member was contacted by phone on 7/13/11 at 12:02 PM. The family member stated the family and the identified resident decided he no longer needed home health services and wanted the service discontinued.

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

Tammy Witham, Administrator
July 18, 2011
Page 2 of 2

RC/rm

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



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July 18, 2011

Tammy Witham, Administrator
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1960 North Lakes Place
Meridian, ID 83642

Dear Ms. Witham:

An unannounced, on-site complaint investigation survey was conducted at Grace Assisted Living Of Fairview Lakes - Grace At Fairview Lakes, Llc from July 12, 2011, to July 13, 2011. During that time, observations, interviews, and record reviews were conducted with the following results:

Complaint # ID00005088

Allegation #1: An identified resident did not receive medical treatment after a fall.

Findings #1: The identified resident's record contained an incident report, dated 4/17/11 at 3:20 PM, that documented the resident had fallen. The record documented the caregivers were instructed, by the facility RN, to check and document the resident's condition at least every two hours. The caregivers documented, from 4:00 PM on 4/17/11 until 5:00 AM on 4/18/11, the resident's medical condition was stable. The resident was assessed by the facility nurse, on 4/18/11, and found to have no injuries.

Incident reports reviewed, from May 2011 until the survey date, documented the facility responded appropriately to all incidents.

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

Allegation #2: Residents were not assessed by the facility nurse when they experienced changes of condition.

Findings #2: Substantiated. However, the facility was not cited. When reviewing closed records, it was determined the facility nurse did not document an assessment of

all changes of conditions in the past. However, each resident experiencing a change of condition, did receive appropriate medical treatment. It was determined the facility remedied the problem; the facility implemented a communication log, which documented changes of condition and the nurse's response. Further, nursing notes and incident reports documented a nursing assessment for changes of condition for current residents.

Allegation #3: Incidents (falls) were not documented and investigated.

Findings #3: From 7/12/11 through 7/13/11, four caregivers stated they filled out incident reports for all falls or unusual occurrences and were unaware of a time when incidents were not documented. The house manager stated to her knowledge all falls or incidents had been documented.

On 7/12/11 at 2:45 PM, the administrator stated she had been told by a caregiver that not all falls were being documented. She had conducted an investigation and was unable to prove the allegation. She did an in-service to staff regarding documenting incidents and the facility installed cameras to monitor interactions between the caregivers and the residents.

An inservice record, dated 4/25/11, documented staff were instructed on the appropriate procedure for documenting incidents. The inservice record was signed by 36 employees.

Incidents and accident reports were reviewed from May 2011 until the present date. Each report documented a nursing assessment and an investigation by the administrator.

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

Allegation #4: Medical treatment was delayed for an identified resident who experienced a skin tear requiring stitches.

Findings #4: On 7/13/11, incident reports were reviewed. One incident report, dated 4/18/11 at 9:30 AM, documented the identified resident hit her elbow on her wheelchair and developed a skin tear. The facility nurse dressed the wound and applied pressure. When the wound continued to bleed, the resident's physician was notified and requested the resident be seen. The incident report documented the administrator drove the resident to a nearby medical clinic.

On 7/13/11 at 8:45 AM, the administrator stated when the resident had a skin tear, staff applied pressure and the facility nurse and hospice nurse bandaged the wound. When the bleeding continued, the physician's office was contacted and she drove the resident to the medical clinic around 1:00 PM.

On 7/13/11 at 10:50 AM, a caregiver stated she did not think medical treatment was delayed when the identified resident experienced a skin tear, as the facility nurse and hospice nurse were overseeing her care before it was determined she need to be further evaluated.

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

Allegation #5: The administrator did not investigate an allegation of inappropriate sexual behaviors by an identified resident.

Findings #5: A "Change of Condition" report, dated 5/7/11, documented the identified resident was "holding hands with another female resident and telling her he was her husband." The report further documented, adult protection was called and the administrator investigated the situation to determine if the behavior was inappropriate.

A "Behavior Management Plan," dated 5/7/11, documented the resident had a behavior of "kissing residents and staff hands." The plan included interventions to "keep resident in line of sight in common area, redirect if seen going for hands of females." The plan was signed and dated by the administrator and the facility nurse.

Between 7/12/11 through 7/13/11, five caregivers were interviewed . All stated they were instructed to report inappropriate sexual behaviors, incidents or concerns they had observed to the administrator. They all stated the administrator had followed up with all concerns they had expressed.

On 7/13/11 at 9:00 AM, the administrator stated she investigated reports of the observed interactions with the identified resident and other female residents. She stated, Adult Protection was notified about the resident's interactions with other residents and nothing was determined to be inappropriate.

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

Allegation #6: An identified resident was not assisted with toileting appropriately.

Findings #6: On 7/12/11 through 7/13/11, observations, interviews and record reviews were conducted. At the time of the survey, the identified resident no longer resided at the facility. Activity of daily living (ADL) sheets, contained in the resident's record, documented the identified resident was toileted every two hours. Four caregivers stated, they toileted residents every two hours. They further stated, they did rounds with the oncoming shift to check residents to ensure they were clean and dry. One caregiver who was employed during the time the resident lived at the facility, stated she did not recall ever finding the identified resident soiled or wet.

From 7/12/11 through 7/13/11, all residents were observed clean and well groomed. No odors were detected. Residents were observed being toileted appropriately. "ADL" sheets documented residents received assistance with toileting every two hours.

On 7/12/11 at 8:56 AM, the RN consultant stated she had observed caregivers toileting residents appropriately. She further stated, staff were instructed to make rounds with the oncoming shift to ensure each resident was clean and dry.

On 7/12/11 at 11:34 AM, the ombudsman stated she did not have concerns with the facility not providing the necessary care to residents.

On 7/13/11 at 9:02 AM, a hospice nurse stated she had never found any of the residents soiled or wet when visiting the facility.

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

Allegation #7: Residents were not assisted with hydration.

Findings #7: On 7/12/11 through 7/13/11, residents were observed being assisted to drink at meals, during snack time and during activities. Residents who were sitting in the dining room, were observed with glasses of water or other beverages in front of them. Four caregivers stated they were instructed to remind and assist residents to drink frequently throughout the day. One caregiver stated, "... has instructed us that they must have fluid in front of them all the time."

On 7/12/11 at 11:34 AM, the ombudsman stated during her visits she has observed beverages in front of the residents and has observed residents being assisted to drink fluid.

On 7/12/11 at 2:50 PM, the administrator stated she had in-serviced staff on providing assistance with hydration frequently throughout the day.

On 7/13/11 at 9:18 AM, the cook stated she observed caregivers providing assistance with hydration frequently throughout the day.

An inservice record dated 4/25/11, documented staff were instructed to "push fluids." The in-service record was signed by 36 employees.

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

Allegation #8: Residents were not assisted with showers.

Findings #8: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.320.01 for not providing assistance with showers at the frequency stated in the Negotiated Service Agreement. The facility was required to submit evidence of resolution within 30 days.

Allegation #9: The administrator did not address concerns regarding residents' cares.

Findings #9: On 7/12/11, the complaint log was reviewed. It documented an investigation of each complaint and a written response to the complainant. A form, dated 4/25/11, documented a concern from a caregiver was received at 11:00 AM. The form documented an in-service addressing the caregiver's concerns would be conducted at 2:00 PM, the same day. An in-service record, dated 4/25/11, signed by 36 employees documented the caregiver's concerns were addressed.

Between 7/12/11 through 7/13/11, five caregivers stated the administrator addressed any concerns they had and was readily available to them.

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

Allegation #10: A caregiver was forced to falsify incident reports involving inappropriate sexual behaviors.

Findings #10: On 7/12/11 through 7/13/11, four caregivers stated they have never been instructed to document things that were not true, but have been told to

Tammy Witham, Administrator
July 18, 2011
Page 6 of 6

document reports with more details.

On 7/12/11 at 2:00 PM, the administrator stated she has instructed caregivers to document further details to clarify information. She had instructed them not to document opinions, but specific observations. She remembered asking one caregiver to clarify what specifically was observed after the caregiver documented inappropriate sexual behaviors were observed with an identified resident.

An incident report documenting "inappropriate sexual behaviors" of an identified resident was reviewed. Attached to the report was clarification to the previous incident report. It was written by the caregiver as instructed. The attached report did not document different information from the the first incident report. The only difference was that the word "inappropriate" was not documented, and only observations were documented.

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

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,



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

RC/rm

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