



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – GOVERNOR
RICHARD M. ARMSTRONG – DIRECTOR

LESLIE M. CLEMENT – DEPUTY DIRECTOR
RANDY MAY – DEPUTY ADMINISTRATOR
LICENSING AND CERTIFICATION
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

September 8, 2011

CERTIFIED MAIL #: 7007 3020 0001 3745 7590

Sheila Oetting, Administrator
Bridge At Post Falls
515 North Garden Plaza Court
Post Falls, ID 83854

Dear Ms. Oetting:

Based on the licensure/follow-up survey and complaint investigation conducted by our staff at Post Falls Retirement LLC - DBA - The Bridge at Post Falls on **September 2, 2011**, we have determined that the facility admitted and retained a resident with a history of wandering and aggressive behaviors, for whom the facility did not have the capacity, capability and services to provide appropriate care. Additionally, the facility did not develop behavioral management plans for for a resident who displayed behaviors.

This core issue deficiency substantially limits the capacity of Post Falls Retirement LLC - DBA - The Bridge at Post Falls to furnish services of 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.

You have an opportunity to make corrections and thus avoid a potential enforcement action. Correction of this deficiency must be achieved by **October 17, 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?

Sheila Oetting, Administrator
September 8, 2011

Return the **signed** and **dated** Plan of Correction to us by **September 21, 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 I IDR meeting. The request for the meeting must be made within ten (10) business days of receipt of the statement of deficiencies (**September 21, 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 **September 21, 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 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 **October 2, 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 initiate an enforcement action against the license held by Post Falls Retirement LLC - DBA - The Bridge at Post Falls.

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
Medicaid Licensing & Certification

JS/mmc

Enclosure



IDAHO DEPARTMENT OF
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PHONE 208-334-6626
FAX 206-364-1868

October 3, 2011

Sheila Oetting, Administrator
Bridge at Post Falls
515 North Garden Plaza Court
Post Falls, ID 83854

License #: RC-976

Dear Ms. Oetting:

On September 2, 2011, a Licensure\follow-up Survey and Complaint Investigation was conducted at Post Falls Retirement LLC - DBA - The Bridge at Post Falls. 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 Maureen A. McCann, RN, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 334-6626.

Sincerely,

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

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R976	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/02/2011
NAME OF PROVIDER OR SUPPLIER BRIDGE AT POST FALLS		STREET ADDRESS, CITY, STATE, ZIP CODE -515 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854		
(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 licensure/follow-up survey and complaint investigation conducted on 08/25/11 through 9/2/11 at your residential care/assisted living facility. The surveyors conducting the survey were: Maureen McCann, RN Team Leader Health Facility Surveyor Donna Henscheid, LSW Health Facility Surveyor Gloria Keathley, LSW Health Facility Surveyor BM = Bowel Movement Eve = Evening MD = Medical Doctor Med = Medication Min = Minute NW = Northwest PJ = Pajama PRN = As Needed RN = Registered nurse Res = Resident RX = Prescription SW = Southwest	R 000	Please note that Resident #1 moved from The Bridge on September 9, 2011. This was a decision made by the family of Resident #1. 16.03.22.520 Protect Residents from Inadequate Care Administrator and RN have been talking to and reeducating staff regarding appropriate documentation and notification of concerning behaviors such as wandering and aggression. A mandatory all staff meeting has also been scheduled for Friday, September 23, 2011 in which these concerns will be reiterated. The forms titled "Behavior Management Plan" and "Behavior Management Tracking" are also being introduced to staff at these times and have been implemented for existing behaviors. 16.03.22.152.05.d - "A resident will not be admitted or retained who has physical, emotional, or social needs that are not compatible with the other residents in the facility." An addendum has been added to our initial assessment that includes behaviors that could be of concern. Please see attached. This will assist in preventing future issues of this kind upon admittance. Staff has been and will continue to be reeducated on appropriate documentation by RN making sure to note continued	9-16-11
R 008	16.03.22.520 Protect Residents from Inadequate Care. The administrator must assure that policies and procedures are implemented to assure that all residents are free from inadequate care.	R 008		

Bureau of Facility Standards

Sheila Oetting

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

TITLE

Assisted Living Manager

(X6) DATE

9-21-11

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R 008	<p>Continued From page 1</p> <p>Based on observation, record review and interview, the facility admitted and retained 1 of 1 sampled residents (#1) with a history of wandering and aggressive behaviors, for whom the facility did not have the capability, capacity and services to provide appropriate care. Additionally, the facility did not develop behavioral management plans to address behaviors of 1 of 3 sampled residents (#1), who demonstrated behaviors. The facility utilized behavioral modifying medications as a first resort in an attempt to control the resident's behaviors. The finding include:</p> <p>IDAPA 16.03/22.152.05.d - "A resident will not be admitted or retained who has physical, emotional, or social needs that are not compatible with the other residents in the facility."</p> <p>IDAPA 16.03.22.310.04.a - "Psychotropic or behavior modifying medication intervention must not be the first resort to address behaviors. The facility must attempt non-drug interventions to assist and redirect the resident's behavior."</p> <p>On 8/24/11 at 3:10 PM, the facility was observed to be a large, three story building which contained both assisted living and independent apartments. A separate entrance led to the assisted living section which consisted of twenty-five apartments on the first story and thirty five apartments on the second and third stories. Each story consisted of multiple hallways with several unsecured exits. When an exit door was opened, a talking alarm would notify staff which door was being used. There were three caregivers scheduled for the entire facility.</p> <p>Resident #1 was admitted to the facility on 1/29/11, with diagnoses including Alzheimer's</p>	R 008	<p>any change in condition, behavior and/or cognition. RN has been implementing and will continue to implement the new Behavior Management Plan and Behavior Management Tracking Worksheet. These sheets will be used until the RN determines the behavior no longer exists.</p> <p>16.03.22.310.04.a - "Psychotropic or behavior modifying medication intervention must not be the first resort to address behaviors. The facility must attempt non-drug interventions to assist and redirect the resident's behavior." Behavior Management Plans and Behavior Management Tracking Worksheets have been implemented. Please see attached. These forms will outline for staff the status and objective of the behavior (s) as well as list both proactive and re-active interventions. The interventions will include options to assist and redirect the resident's behavior prior to using medication(s). An example of what had been implemented for Resident #1 is attached.</p> <p>Caregivers assist only the apartments designated for assisted living which are 24 units on the 1st floor and 34 units on both the 2nd and 3rd floors. At this time we have four (4) caregivers scheduled from 6 a.m. to 6 p.m. and three (3) caregivers on staff from 6 p.m. to 6 a.m. On the date mentioned, August 24, 2011, there were four (4) caregivers on duty. Please see the attached Employee Time Card.</p>	

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R 008	Continued From page 2 Disease and anxiety. A "Uniform Assessment Instrument" form, dated 12/9/10, described wandering as the "moving about aimlessly; wondering [sic] without purpose or regards to safety." It documented the Resident #1 "wonders [sic] within the residents [sic] or facility and may wonder [sic] outside but does not jeopardize health or safety." An admission agreement, dated 12/22/10, documented the facility would "not accept or retain Resident with a history of wandering." A fax to the resident's physician, dated 5/15/11, documented, "I'm contacting you at the request of resident's family. There have been on-going behavioral and exit seeking issues with [Resident #1's name]. When tring [sic] to get into other resident's room, resident gets mad and upset with others and is very hard to redirect. [Resident #1's name] has been very compliant with RX regimend [sic]. Has been receiving PRN xanax [sic] daily and still continues to exit seek and be resistant to redirection." A fax from the physician, dated 7/8/11, documented the resident has Alzheimer's disease and "...exiting behaviors/entering other resident's rooms. This is normal for Alzheimer's - advice is to redirect patient, use Xanax pm." "Resident Log Notes" documented the following: *2/15/11 at 6:00 PM - "Exit seeking. Was goin [sic] out north west stairwell. Asked her to please stay inside. We were able to get her back inside. We let her know it's not safe outside, it's dark and she has black clothes on." The administrator was informed of the resident's behavior.	R 008		

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R 008	<p>Continued From page 3</p> <p>*2/20/11 at 3:30 PM - "Exit seeking again, unable to redirect, PRN was given for anxiety and appeared to not be effective."</p> <p>*2/22/11 at 2:00 PM - "Res exit seeking. Was going out the front door to go to her sisters. She was redirected to music."</p> <p>*3/23/11 at 7:00 PM to 9:00 PM - Res following staff around trying to open other Res doors, upsetting them. When staff told her those weren't her room she charged at staff very aggressively saying to leave her alone, that she was who she was. Res continued to follow staff and trying to open doors. Staff continued to redirect her, gave PRN for anxiety and redirect to her room numerous times."</p> <p>*3/24/11 at 11:30 AM - "Notified MD regarding up behaviors and possible med change as PRN's have little effect."</p> <p>*4/4/11 at 9:25 AM - "Res went outside the cafe door. Res had PRN." There was no documentation regarding what interventions were tried prior to giving Resident #1 the PRN medication.</p> <p>*4/4/11 at 9:30 AM - "Res went outside of the SW door and walked to the back of the building. Res came back in at NW door because she couldn't walk the other way."</p> <p>*4/4/11 at 10:00 AM - "Res PRN not effective."</p> <p>*4/4/11 at 6:00 PM to 10:00 PM - "Resident walked up and down hallways, trying her key in random locks. After being asked to refrain from using her key except in her own room door - she insisted [room number] was her room. she</p>	R 008		

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R 008	<p>Continued From page 4</p> <p>repeatedly attempted to get into that room. The resident in [room number] opened the door several times and told her to go away. She did - She went across the hall to [another room number]. After a while, [unidentified name] came out and informed her he would call the police if she kept it up. While trying to redirect her, staff was cursed at and threatened to be aggressive."</p> <p>*4/6/11 at 9:00 AM - "After Res ate breakfast, she started eating her napkins. She let me remove her plate and napkins and just wanted to sit and drink her coffee."</p> <p>*4/10/11 - "This is a late entry. Sorry! Resident went outside 3 times today, 2 times through the south corridor and 1 through the southwest. All three times she was saying she 'needed to leave and that she had enough.' Care aide had to bring resident in. This happened on Sunday the 2nd of April."</p> <p>*4/10/11 at 2:00 PM - "Resident came back from lunch with her sister and was exit seeking and finally got out through southwest exit. Care aides brought her back in and she kept saying that her 'sister was sick and needed to go to the hospital.' Resident very anxious and can't get her interested in anything so she keeps wondering [sic] around."</p> <p>*4/10/11 at 2:30 PM - "Yesterday April 9th [random resident's name] informed care aide that [Resident #1's name] came into her room and sat down at about 9:15 PM on the 8th. [random resident's name] was able to get her out and as she was closing the door [Resident #1's name] was fighting to get back in. Once outside the apartment, [Resident's name] stood outside the door a couple of minutes and then left." The note</p>	R 008		

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R 008	<p>Continued From page 5</p> <p>documented the administrator was made aware of the resident's behaviors.</p> <p>*4/10/11 at 2:30 PM - "Resident trying to get into other rooms. A verbal altercation accrued [sic] with resident in [room number]."</p> <p>*4/10/11 at 4:30 PM - "Staff heard loud voices shouting at each other. [Resident's room numbers] were verbally engaged in a heated conversation." The note documented Resident #1 had gone into another resident's room and tore off the door decorations. Staff broke up the confrontation and took Resident #1 to the dining room. The other resident was "shaking and pale" and the caregivers sat with her until she was calm.</p> <p>*4/18/11 at 8:00 AM - "Res was found walking outside in the parking lot. Brought res back in before I left work."</p> <p>*4/25/11 at 5:30 PM - " Res exit seeking, went out NW and SW doors. Res redirected."</p> <p>*5/11/11 at 10:00 PM - "Resident has been trying to open other Res rooms all eve. Staff keeps redirecting her. Res in [room number] are very upset. Res very anxious. PRN given." There was no documentation regarding what interventions were tried prior to giving Resident #1 the PRN medication.</p> <p>*5/12/11 at 10:00 PM - "Resident has been refusing all care, walking all over the building with poop all over her pants, went outside, then to the third floor. 11:00 PM we then were able to get resident into the shower."</p> <p>*5/14/11 at 7:00 PM - "Resident has been walking</p>	R 008		

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R 008	Continued From page 6 around trying to open doors, thought [room number] was her apartment [sic], tried to redirect her to her apartment [sic]. Resident refused, while [room number] got upset and said they wanted to call the cops. Resident finally came to aid station and took a PRN. Sat down for a while but refused care for cleaning her up, smells behind her as she walks." There was no documentation regarding what interventions were tried, other than redirection, prior to giving Resident #1 the PRN medication. *5/17/11 at 7:45 PM - "Resident aggitated at beginning of shift. Insisted [room number] is her room. After a lot of coaxing and many attempts, she took a PRN at 7:30 PM. She became very combative with a staff and receptionist who were trying to keep her from pestering around [room number]." There was no documentation regarding what interventions were tried prior to giving Resident #1 the PRN medication. *5/28/11 at 1:30 PM - "Resident very angry demanding to go to her house. Exited southwest corridor and tried to get into staff vehicles. Called the sister. Unable to come and help. Got resident back inside and trying to keep her busy..." *5/30/11 at 2:00 PM - "Res wandered through the southwest corridor and was trying to get into staff vehicles. Res agreed to come inside..." *6/8/11 at 10:00 PM - "Res was very anxious about everything and was found outside twice within the past hour by receptionist...Will continue to monitor. Gave xanax and will be effective soon." There was no documentation regarding what interventions were tried prior to giving Resident #1 the PRN medication.	R 008		

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R 008	Continued From page 7 *6/19/11 at 6:15 AM - "Res went out this morning telling staff that she has to go home. Staff was able to get res back in building. Res wondering [sic] all over this am wanting out. Gave PRN." There was no documentation regarding what interventions were tried prior to giving Resident #1 the PRN medication. *7/3/11 at 1:00 PM to 3:00 PM - "Res has been exit seeking and going outside. Res says she is going home." *7/8/11 at 1:15 AM - "...When we went to put her to bed she lashed out angrily [sic], so we tried to give res her xanax but she refused to take the pill, or give it back. We spent 15 min trying to coax her to take the pill or give it back. Res got more and more mad. We finally had to pry the pill out of her hand. Will try again in a few hours." *7/12/11 at 2:00 AM - "Resident became verbally confrontational with another resident. Gave resident PRN for anxiety and redirected." There was no documentation regarding what interventions were tried prior to giving Resident #1 the PRN medication. *7/14/11 (day shift and night) - "Resident tried to leave through the north stairwell and tried to go into the kitchen several times today. Getting very aggressive and mean toward care staff and receptionist, and kitchen staff..." *7/15/11 at 9:00 PM - "Resident was sitting in the hallway with [unidentified person's name] and took her shirt off and then put her PJ top on." *7/17/11 at 9:00 AM - "Res has been very aggressive to staff. Tried to get her to take her meds and res refused. Yelling at staff and telling	R 008		

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R 008	Continued From page 8 us to get out and stay out." *7/17/11 at 10:00 AM - "Other staff got res to take meds. Res refused to take a shower or even change clothes. Res smells like BM and hair looks bad. PRN given at this time." There was no documentation regarding what interventions were tried prior to giving Resident #1 the PRN medication. *7/17/11 at 12:15 PM - "Res has been exit seeking. Has been outside about 2 times. Res walked out to the bus and tried to get in it. Res was refusing to go with staff to do anything. Staff got her to come back inside for a few min. but she went back out. PRN given at 12:30 PM." There was no documentation regarding what interventions were tried prior to giving Resident #1 the PRN medication. *7/17/11 at 1:00 PM - "Staff got res to sit outside and do actives [sic]. Res has still been very aggressive to staff and yelling at us. Also still refusing to shower." *7/17/11 at 4:00 PM - "Res seems to be doing a little better with 2nd PRN." There was no documentation regarding what interventions were tried prior to giving Resident #1 the first or second PRN medication. *7/17/11 at 11:00 PM - "Resident very combative and contrary. She was trying to enter other residents apartments on all (3) floors. She has refused assistance to her apartment countless times. Staff is still unable to get her to her room." *7/18/11 at 11:30 PM - "Resident is trying to enter other residents' rooms. She has been alternating between [room numbers] since about 8 PM.	R 008		

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R 008	<p>Continued From page 9</p> <p>Luckily nobody seems to hear her banging. The more she is encouraged to do something else - the more she shows determination."</p> <p>*7/25/11, at 9:45 PM - "Res refused to put pajamas on or got to bed. Staff offer assistance and she replied saying, 'she will do whatever she wants, when she feels'..."</p> <p>There were no further "Resident Log Notes" after 7/25/11 found in Resident #1's record. Additionally, there was no behavior management plan to guide staff on what non-pharmacological interventions to use to address the resident's behaviors.</p> <p>On 8/25/11 at 3:20 PM, a random resident stated there was a female resident who "has dementia" and speaks with "non-intelligible words." The random resident stated Resident #1 was "outside [resident's name] apartment the other day and wouldn't let [resident's name] in."</p> <p>On 8/25/11 at 3:30 PM, a random resident stated, "there was one lady that did not belong at the facility. She is very confused but was unsure what her name was."</p> <p>On 8/25/11 at 3:40 PM, two random residents stated they were concerned about the people with dementia and felt "they didn't belong there." They further stated, "There were two women, one of them had left and the other was still there."</p> <p>On 8/26/11 at 8:10 AM, the RN stated the plan for the resident was to work with the MD and the resident's sister to address the exit seeking and aggressive behaviors. The RN also stated the resident used to sit with the receptionist one on one, but felt it was not "appropriate to have the</p>	R 008		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R976	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/02/2011
NAME OF PROVIDER OR SUPPLIER BRIDGE AT POST FALLS		STREET ADDRESS, CITY, STATE, ZIP CODE 515 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854		
(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 008	<p>Continued From page 10</p> <p>resident sit there like that all day." Further, the RN stated the resident had never left campus and when staff hear a door alarm "they are conditioned to look, she's the first person we look for."</p> <p>On 8/26/11 at 9:05 AM, two caregivers stated Resident #1 had wandered outside but "mainly stays in the building." They stated the resident wandered the hallways, up to the second and third floors. One of the caregivers stated the other residents were encouraged to keep their doors locked "so others did not get in."</p> <p>Although the facility's admission agreement clearly documented they would not "accept or retain" residents with a history of wandering, Resident #1 was admitted. Within days of admission, Resident #1 began exhibiting exit seeking and agressive behaviors. For eight months the facility continued to retain the resident who was not compatible with other residents. Further, the facility did not have a plan in place to address Resident #1's behaviors. As a result, staff utilized behavioral modifying PRN medications in an attempt to control those behaviors. This resulted in inadequate care.</p>	R 008		



Facility Name BRIDGE AT POST FALLS	Physical Address 515 N. GARDEN PLAZA COURT	Phone Number 208-773-3701
Administrator Sheila Oetting	City POST FALLS	ZIP Code 83854
Survey Team Leader Maureen McCann, RN	Survey Type licensure/follow-up survey and complaint investigation	Survey Date Sept. 2, 2011

NON-CORE ISSUES PAGE 1 OF 2

ITEM #	RULE #	DESCRIPTION	DATE RESOLVED	L&C USE
1	215	The facility operated without a licensed administrator between 8/4/11 and 8/30/11.	COS	<i>mic</i>
2	225	The facility did not document/initiate/implement a behavioral management plan (BMP) for Residents' 1, 4, 5 or 7's behaviors.	9-12-11	10/3/11 <i>mic</i>
3	300.01	A) The required 90 day nursing assessments were not current for ten of ten sampled residents. B) Not all caregivers had current nurse delegation documented.	9-28-11 9-20-11	10/3/11 <i>mic</i>
4	305.06	The facility nurse must assess all residents participating in self-administration of medication. Multiple resident rooms were noted to have supplements and medications.	9-16-11	10/3/11 <i>mic</i>
5	310.04.e	A) The facility did not have a 6 month physician's review for Resident #1 & 5's psychotropic medications. B) The facility did not provide behavioral updates to the resident's physician for psychotropic medication reviews for Residents' #1 & 5.	9-14-11 9-15-11	10/3/11 <i>mic</i>
6	320.01	Negotiated Service Agreements (NSAs) did not clearly identify Resident #1, 2, 3, 4, 5 & 9's current care needs to include the level of support in activity of daily living (ADLs) needs, frequency and scope of services as well as frequency and scope of outside agency services.	9-10-11	10/3/11 <i>mic</i>
7	320.03	NSAs were not signed by all necessary parties for ten of ten sampled resident records.	9-21-11	10/3/11 <i>mic</i>
8	350.02	All incidents/accidents and complaints must be investigated by the facility administrator within 30 days.	9-6-11	10/3/11 <i>mic</i>
9	625.01	Orientation records must include the number of hours of orientation and date of training.	9-8-11	10/3/11 <i>mic</i>
10	630.01	Nine of ten staff did not have current dementia training completed.	9-23-11	10/3/11 <i>mic</i>
11	630.02	Ten of ten staff did not have mental illness training completed.	9-23-11	10/3/11 <i>mic</i>
Response Required Date Oct. 2, 2011	Signature of Facility Representative <i>Sheila Oetting</i>		Date Signed 9-2-11	



Facility Name BRIDGE AT POST FALLS	Physical Address 515 N. GARDEN PLAZA COURT	Phone Number 208-773-3701
Administrator Sheila Oetting	City POST FALLS	ZIP Code 83854
Survey Team Leader Maureen McCann, RN	Survey Type licensure/follow-up survey and complaint investigation	Survey Date Sept. 2, 2011

NON-CORE ISSUES PAGE 2 OF 2

ITEM #	RULE #	DESCRIPTION	DATE RESOLVED	L&C USE
12	640	Nine of ten staff did not have current annual continuing education training (CEU) completed.	9-20-11	10/3/11 me
13	711.01.a	The facility did not track behaviors for Residents' #1, 4, 5 & 7.	9-28-11	10/3/11 me
14	711.08.c	Resident #3's record did not contain care notes documenting an unusual occurrence (nausea).	9-23-11	10/3/11 me
15	711.08.f	Outside service provider notes must be maintained in the Resident's record.	9-16-11	10/3/11 me
Response Required Date Oct. 2, 2011	Signature of Facility Representative <i>Sheila Oetting</i>		Date Signed 9-2-11	



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 <u>Cricket's of Post Falls</u>		Operator <u>Brian Todd</u>	
Address <u>315 N. Garden Plaza Ct</u>		<u>Post Falls ID 83854</u>	
County <u>Kootenai</u>	Estab #	EHS/SUR.#	Inspection time: <u>0810</u>
Inspection Type:	Risk Category: <u>High</u>	Follow-Up Report: OR	On-Site Follow-Up:
Items marked are violations of Idaho's Food Code, IDAPA 16.02.19, and require correction as noted.		Date:	Date:

# of Risk Factor Violations	<u>0</u>	# of Retail Practice Violations	<u>0</u>
# of Repeat Violations	<u>0</u>	# of Repeat Violations	<u>0</u>
Score	<u>0</u>	Score	<u>0</u>
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.

Demonstration of Knowledge (2-102)		COS	R
<u>Y</u> N	1. Certification by Accredited Program; or Approved Course; or correct responses; or compliance with Code	<input type="checkbox"/>	<input type="checkbox"/>
Employee Health (2-201)			
<u>Y</u> N	2. Exclusion, restriction and reporting	<input type="checkbox"/>	<input type="checkbox"/>
Good Hygienic Practices			
<u>Y</u> N	3. Eating, tasting, drinking, or tobacco use (2-401)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N	4. Discharge from eyes, nose and mouth (2-401)	<input type="checkbox"/>	<input type="checkbox"/>
Control of Hands as a Vehicle of Contamination			
<u>Y</u> N	5. Clean hands, properly washed (2-301)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N	6. Bare hand contact with ready-to-eat foods/exemption (3-301)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N	7. Handwashing facilities (5-203 & 6-301)	<input type="checkbox"/>	<input type="checkbox"/>
Approved Source			
<u>Y</u> N	8. Food obtained from approved source (3-101 & 3-201)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N	9. Receiving temperature / condition (3-202)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N <u>N/A</u>	10. Records: shellstock tags, parasite destruction, required HACCP plan (3-202 & 3-203)	<input type="checkbox"/>	<input type="checkbox"/>
Protection from Contamination			
<u>Y</u> N <u>N/A</u>	11. Food segregated, separated and protected (3-302)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N <u>N/A</u>	12. Food contact surfaces clean and sanitized (4-5, 4-6, 4-7)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N	13. Returned / reservice of food (3-306 & 3-801)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N	14. Discarding / reconditioning unsafe food (3-701)	<input type="checkbox"/>	<input type="checkbox"/>

Potentially Hazardous Food Time/Temperature		COS	R
<u>Y</u> N <u>N/O</u> <u>N/A</u>	15. Proper cooking, time and temperature (3-401)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N <u>N/O</u> <u>N/A</u>	16. Reheating for hot holding (3-403)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N <u>N/O</u> <u>N/A</u>	17. Cooling (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N <u>N/O</u> <u>N/A</u>	18. Hot holding (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N <u>N/O</u> <u>N/A</u>	19. Cold Holding (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N <u>N/O</u> <u>N/A</u>	20. Date marking and disposition (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N <u>N/O</u> <u>N/A</u>	21. Time as a public health control (procedures/records) (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
Consumer Advisory			
<u>Y</u> N <u>N/A</u>	22. Consumer advisory for raw or undercooked food (3-603)	<input type="checkbox"/>	<input type="checkbox"/>
Highly Susceptible Populations			
<u>Y</u> N <u>N/O</u> <u>N/A</u>	23. Pasteurized foods used, avoidance of prohibited foods (3-801)	<input type="checkbox"/>	<input type="checkbox"/>
Chemical			
<u>Y</u> N <u>N/A</u>	24. Additives / approved, unapproved (3-207)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N	25. Toxic substances properly identified, stored, used (7-101 through 7-301)	<input type="checkbox"/>	<input type="checkbox"/>
Conformance with Approved Procedures			
<u>Y</u> N <u>N/A</u>	26. Compliance with variance and HACCP plan (8-201)	<input type="checkbox"/>	<input type="checkbox"/>

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
<u>Scrambled eggs</u>	<u>164</u>	<u>Aggregated in ref</u>	<u>384</u>				
<u>Cheddar</u>	<u>139</u>	<u>collage cheese</u>	<u>393</u>				

GOOD RETAIL PRACTICES (X = not in compliance)

	COS	R		COS	R		COS	R
<input type="checkbox"/> 27. Use of ice and pasteurized eggs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 34. Food contamination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 42. Food utensils/in-use	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 28. Water source and quantity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 35. Equipment for temp. control	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 43. Thermometers/Test strips	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 29. Insects/rodents/animals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 36. Personal cleanliness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 44. Warewashing facility	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 30. Food and non-food contact surfaces, constructed, cleanable, use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 37. Food labeled/condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 45. Wiping cloths	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 31. Plumbing installed; cross-connection, back flow prevention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 38. Plant food cooking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 46. Utensil & single-service storage	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 32. Sewage and waste water disposal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 39. Thawing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 47. Physical facilities	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 33. Sinks contaminated from cleaning maintenance tools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 40. Toilet facilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 48. Specialized processing methods	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/> 41. Garbage and refuse disposal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 49. Other	<input type="checkbox"/>	<input type="checkbox"/>

OBSERVATIONS AND CORRECTIVE ACTIONS (CONTINUED ON NEXT PAGE)

Person in Charge (Signature) <u>[Signature]</u>	(Print) <u>Brian Todd</u>	Title <u>GM</u>	Date <u>8/26/11</u>
Inspector (Signature) <u>[Signature]</u>	(Print) <u>Maureen A. Miller</u>	Date <u>Aug 26, 2011</u>	Follow-up: (Circle One) <u>Yes</u> <u>No</u>



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – GOVERNOR
RICHARD M. ARMSTRONG – DIRECTOR

LESLIE M. CLEMENT – DEPUTY DIRECTOR
RANDY MAY – DEPUTY ADMINISTRATOR
LICENSING AND CERTIFICATION
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

September 8, 2011

Sheila Oetting, Administrator
Bridge At Post Falls
515 North Garden Plaza Court
Post Falls, ID 83854

Dear Ms. Oetting:

An unannounced, on-site complaint investigation survey was conducted at Post Falls Retirement LLC - DBA The Bridge at Post Falls from August 25, 2011, to September 2, 2011. During that time, observations, interviews, and record reviews were conducted with the following results:

Complaint # ID00005184

Allegation #1: The facility did not have a current licensed administrator.

Findings #1: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.215 for not having a licensed administrator between 8/4/11 and 8/29/11.

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,

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



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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LICENSING AND CERTIFICATION
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

October 3, 2011

Sheila Oetting, Administrator
Bridge at Post Falls
515 North Garden Plaza Court
Post Falls, ID 83854

Dear Ms. Oetting:

An unannounced, on-site complaint investigation survey was conducted at Post Falls Retirement LLC - DBA - The Bridge at Post Falls from August 25, 2011, to September 2, 2011. During that time, observations, interviews, and record reviews were conducted with the following results:

Complaint # ID00005065

Allegation #1: The facility did not have registered nurse coverage for several days in May 2011.

Findings #1: On 8/26/11 at 10:25 AM, two caregivers stated they did not recall a time when the facility nurse was not available.

On 8/26/11 at 10:40 AM, the facility nurse stated, he was out of the facility and not available for several days in the spring, however another nurse had covered for him.

On 8/29/11 at 2:30 PM, an office staff member was not aware of a time when a nurse was not available.

On 8/29/2011 between 3:47 PM and 4:30 PM, the former facility administrator, stated she had received conflicting information regarding nurse coverage when the facility nurse was not available. While the facility nurse was not available in May 2011, the administrator stated she thought another registered nurse was on-call. However, recently, caregivers told her they had been instructed to call

the business manager or either of the two marketing staff for any emergencies.

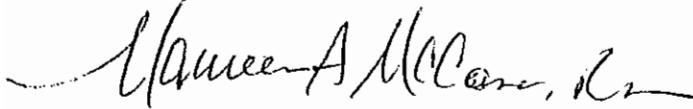
On 8/31/11 at 3:15 PM, a medication aide stated she recalled a time in the spring when she had been instructed to call the business manager or either of the two marketing staff for emergencies because the facility nurse was not available.

On 9/1/11 at 1:05 PM, the "on-call" registered nurse stated he had taken call for 1 or 2 days when the facility nurse was at training or on vacation. He further stated, although he could not remember the exact dates, he did remember a time in January 2011 and possibly another time in the spring.

Unsubstantiated. Though the allegation may have occurred, it could not be determined during the complaint investigation due to conflicting information.

As no deficiencies were cited as a result of our investigation, no response is necessary to this report. Thank you to you and your staff for the courtesies extended to us on our visit.

Sincerely,

A handwritten signature in black ink that reads "Maureen A. McCann, RN". The signature is written in a cursive style with a long horizontal flourish extending to the left.

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