IDAHO DEPARTMENT OF HEALTH & WELFARE

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

TAMARA PRISOCK – ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
JAMIE SIMPSON – PROGRAM SUPERVISOR
RESIDENTIAL ASSISTED LIVING FACILITY PROGRAM
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: 208-334-6626
FAX: 208-364-1888

November 28, 2012

Vickie McCuistion, Administrator
Annabelle House, Assisted Living Concepts, Inc
917 East Ustick Road
Caldwell, ID 83605

License #: RC-576

Dear Ms. McCuistion:

On October 30, 2012, a licensure/follow-up survey, complaint investigation and follow-up to your compliance agreement was conducted at Annabelle House, Assisted Living Concepts, Inc. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level:

- 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 Polly Watt-Geier, MSW, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 334-6626.

Sincerely,

Polly Watt-Geier, MSW

Polly Watt-Geier, MSW
Team Leader
Health Facility Surveyor
Residential Assisted Living Facility Program

PWG

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

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FAX: 208-364-1888

November 6, 2012

Vickie McCuistion, Administrator
Annabelle House, Assisted Living Concepts, Inc
917 East Ustick Road
Caldwell, ID 83605

Dear Ms. McCuistion:

Congratulations to both you and your staff on your recent Complaint Investig.,state Licensure which was conducted at Annabelle House, Assisted Living Concepts, Inc on 10/30/2012. No core deficiencies were found and you had three or fewer non-core deficiencies cited during your survey, which qualifies you for a ***Silver Excellence in Care Award.***

This award demonstrates that you have worked exceptionally hard to meet the requirements set forth in the Rules for Residential Care or Assisted Living Facilities. Thank you for providing excellent care and ensuring the residents you serve live in a clean, safe and home-like community.

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, on **11/29/12**. The completed punch list form and accompanying evidence of resolution (e.g., receipts, pictures, policy updates, etc) are to be submitted to this office within thirty (30) days from the exit date.

Again, congratulations to you and your staff for a job well done.

Sincerely,

Polly Watt-Dein, MSW

The Residential Assisted Living Facility Survey Team

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R576	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 10/30/2012
NAME OF PROVIDER OR SUPPLIER ANNABELLE HOUSE, ASSISTED LIVING CONC	STREET ADDRESS, CITY, STATE, ZIP CODE 917 EAST USTICK ROAD CALDWELL, ID 83605		

(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 A follow-up survey to ensure compliance with a "Settlement Agreement" established between Assisted Living Concepts and Idaho Department of Health & Welfare, as well as a licensure/follow-up and complaint investigation, was conducted at your residential care/assisted living facility on 10/25/2012. At that time, no core deficiencies were cited and the facility was found to be in substantial compliance with the Rules for Residential Care or Assisted Living Facilities in Idaho. The surveyors conducting the survey were: Polly Watt-Geier, MSW Team Leader Health Facility Surveyor Gloria Keathley, LSW Health Facility Surveyor Rae Jean McPhillips, RN, BSN Health Facility Surveyor	R 000		

IDAHO DEPARTMENT OF
HEALTH & WELFARE

MEDICAID L & C – RALF PROGRAM
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-6626 fax: (208) 364-1888

ASSISTED LIVING Non-Core Issues Punch List

Facility Name	Physical Address	Phone Number
Annabelle House	917 E Ustick Rd	455-2324
Administrator	**City**	**ZIP Code**
Vickie McCuistion	Caldwell	83605
Survey Team Leader	**Survey Type**	**Survey Date**
Polly Watt-Geier	Licensure/follow-up and Complaint	10/30/12

NON-CORE ISSUES

ITEM #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	L&C USE
1	300.01	90 day nursing assessments were not completed for Resident #1 and #2	COS 10/30/12	
2	640	3 of 5 staff did not have continuing education with in the last year.	11/28/12 PWG	

Response Required Date	Signature of Facility Representative	Date Signed
11/29/12	Vickie McCuistion	10/30/12

Date 10/30/12 Page 1 of 1

IDAHO DEPARTMENT OF HEALTH & WELFARE

Food Establishment Inspection Report

Residential Assisted Living Facility Program, Medicaid L & C
3232 W. Elder Street, Boise, Idaho 83705
208-334-6626

	Critical Violations	Noncritical Violations
# of Risk Factor Violations	0	# of Retail Practice Violations ____
# of Repeat Violations	____	# of Repeat Violations ____
Score	0	Score ____
	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

Establishment Name: Annabelle House	Operator: Vicki McCuistion
Address: 917 E. Ustick Rd	Caldwell 83605
County: Canyon; Estab #: ; EHS/SUR.#:	Inspection time: ; Travel time:
Inspection Type: ; Risk Category: High	Follow-Up Report: OR On-Site Follow-Up: Date: ____ Date: ____

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

RISK FACTORS AND INTERVENTIONS (Idaho Food Code applicable sections in parentheses)

The letter to the left of each item indicates that item's status at the inspection.

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

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

Y = yes, in compliance; N = no, not in compliance; N/O = not observed; N/A = not applicable; COS = Corrected on-site; R = Repeat violation; ☒ = COS or R

Item/location	Temp	Item/location	Temp	Item/location	Temp	Item/location	Temp
Turkey / Fridge	39°	Meat loaf / Oven	177				
Mayo / Fridge	39°	Carrots / Stove	200				

GOOD RETAIL PRACTICES (☒ = not in compliance)

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

OBSERVATIONS AND CORRECTIVE ACTIONS (CONTINUED ON NEXT PAGE)

Person in Charge (Signature): Vicki McCuistion (Print): Vicki McCuistion Title: RD Date: 10/30/12

Inspector (Signature): [illegible] (Print): [illegible] Date: 10/30/12 Follow-up: (Circle One) Yes No

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November 6, 2012

Vickie McCuistion, Administrator
Annabelle House, Assisted Living Concepts, Inc
917 East Ustick Road
Caldwell, ID 83605

Dear Ms. McCuistion:

An unannounced, on-site complaint investigation was conducted at Annabelle House, Assisted Living Concepts, Inc between October 29, 2012 and October 30, 2012. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00005363

Allegation #1: The admission agreements were not signed by the facility administrator.

Findings #1: Substantiated. The facility's past admissions agreements did not allow the administrator to sign the admission agreements.

On 7/23/12, Assisted Living Concepts entered into a compliance agreement with the Department and agreed to correct the above concern.

Between 10/29 and 10/30/12, a survey to determine compliance was conducted. Three of three current residents' updated admission agreements were reviewed and were observed to be signed by the current facility administrator.

Allegation #2: The admission agreements did not allow for a 30 day written notice to terminate the agreement.

Findings #2: Substantiated. The facility's past admissions agreements did not allow residents to give a 30 day notice to terminate their agreement, if they had signed a term ending agreement.

On 7/23/12, Assisted Living Concepts entered into a compliance agreement with the Department and agreed to correct the above concern.

Between 10/29 and 10/30/12, a survey to determine compliance was conducted. Three of three current residents' updated admission agreements were reviewed and were observed to allow the residents to give a 30 day written notice to terminate the agreement.

Allegation #3: The admission agreements were not in plain language that could be understood by residents.

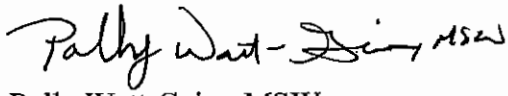
Findings #3: Substantiated. The facility's past admissions agreements were not written in a plain language that residents could understand.

On 7/23/12, Assisted Living Concepts entered into a compliance agreement with the Department and agreed to correct the above concern.

Between 10/29 and 10/30/12, a survey to determine compliance was conducted. Three of three current residents' updated admission agreements were reviewed and were observed to be in a plain language that could be understood by residents.

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,



Polly Watt-Geier, MSW
Health Facility Surveyor
Residential Assisted Living Facility Program

PWG

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

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November 6, 2012

Vickie McCuistion, Administrator
Annabelle House, Assisted Living Concepts, Inc
917 East Ustick Road
Caldwell, ID 83605

Dear Ms. McCuistion:

An unannounced, on-site complaint investigation was conducted at Annabelle House, Assisted Living Concepts, Inc between October 29, 2012 and October 30, 2012. During that time, observations, interviews, and record reviews were conducted with the following results:

Complaint # ID00005429

Allegation #1: Resident records were not protected from former employees.

Findings #1: Between 10/29 and 10/30/12, the facility records, both current and former residents records, were observed to be held in a secure manner. The current resident records were contained in the nurses office/medication room and the former resident records were observed to be contained in a maintenance room, both rooms were locked and could only be accessed by the staff on duty who had keys.

Between 10/29/12 and 10/30/12, five employees were interviewed. They all stated the current and closed residents records were always under lock and key and only staff on duty with keys, could unlock the doors.

On 10/30/12 at 9:50 AM, the administrator stated only staff on duty had keys to unlock the doors to access current and former resident records. Additionally, she stated she was not aware of a time the records were not safeguarded and secure.

On 10/30/12 at 10:33 AM, the facility nurse stated all current and former residents' records were stored under lock and key. She stated only staff on duty,

who had keys could access the room. She was not aware of a time that residents' current or closed records had not been secured.

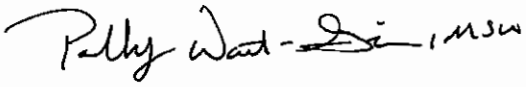
On 10/30/12 at 10:05 AM, a family member of one of the residents stated the former marketer, who did not work at the facility at that time, called her to notify her of the facility no longer accepting Medicaid as a payment source and told her the facility was going to give a 30 day notice to the resident. She said that she was not aware of this issue at the time and was not sure how the former marketer had gotten her contact information to call her.

On 10/30/12 at 10:57 AM, the former marketer stated he had heard that the company was going to give all Medicaid residents a 30 day notice to move from the facility. He stated he remembered two of the residents fondly and wanted to help them, so he looked up their contact information online either through the white pages or other resources. He denied getting the information from the facility and/or having kept the contact information when he left the facility.

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

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

Sincerely,



Polly Watt-Geier, MSW
Health Facility Surveyor
Residential Assisted Living Facility Program

PWG

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

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November 6, 2012

Vickie McCuistion, Administrator
Annabelle House, Assisted Living Concepts, Inc
917 East Ustick Road
Caldwell, ID 83605

Dear Ms. McCuistion:

An unannounced, on-site complaint investigation was conducted at Annabelle House, Assisted Living Concepts, Inc between October 29, 2012 and October 30, 2012. During that time, observations, interviews, and record reviews were conducted with the following results:

Complaint # ID00005468

Allegation #1: The facility had an identified resident sign a term ending agreement, that did not allow the resident to terminate the agreement with a 30 day notice.

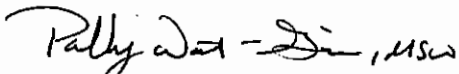
Findings #1: During the survey, between 10/29 and 10/30/12, the identified resident's record was reviewed. The resident's record contained a signed admission agreement that included a Term Ending Agreement (TEA); which stated the resident would be required to pay for 12 months, even if the resident gave a 30 day notice and moved out of the facility.

On 10/29/12 at 11:58 AM, a family member of the identified residents stated they had signed a TEA; however, the billing had been resolved and she did not have to pay for the timeframe when the identified resident had moved out of the facility.

Substantiated. However, the facility was not cited as Assisted Living Concepts (ALC) entered into a compliance agreement with the Department on 7/23/12 and had corrected the deficient practices prior to the complaint investigation conducted between 10/29 and 10/30/12.

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,



Polly Watt-Geier, MSW
Health Facility Surveyor
Residential Assisted Living Facility Program

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

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November 6, 2012

Vickie McCuistion, Administrator
Annabelle House, Assisted Living Concepts, Inc
917 East Ustick Road
Caldwell, ID 83605

Dear Ms. McCuistion:

An unannounced, on-site complaint investigation was conducted at Annabelle House, Assisted Living Concepts, Inc between October 29, 2012 and October 30, 2012. During that time, observations, interviews, and record reviews were conducted with the following results:

Complaint # ID00005470

Allegation #1: The facility operated more than 30 days without a licensed administrator.

Findings #1: On 10/29/12, the facility provided documentation that the former administrator had left on 1/4/12 and the current administrator began on 2/1/12.

Between 10/29/12 and 10/30/12, five employees were interviewed. They all stated the current administrator began working at the facility in early February. They stated she was not always on-site in February, but visited the facility intermittently and then was there full-time in March. They stated she was available by phone during that time and the administrator designee was also available at all times.

On 10/29/12 at 11:25 AM, the current administrator stated her license was placed on the building on 2/1/12. She stated she had visited the facility on 1/29/12 to meet all of the residents and staff. She stated she was planning on being at the facility full-time once her license was on the building; however, corporate had directed her to manage the closing of another building out of state at the same time she was supposed to be at this facility. She stated she traveled back and forth between the facilities in February and then began full-time at the facility on 3/9/12. She stated during that time the former facility nurse was her

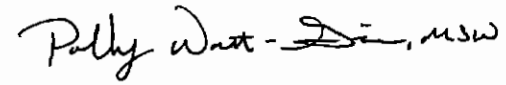
administrator designee and they were in constant contact about the ongoing issues at the facility.

10/31/12 at 9:28 AM, the former facility nurse/administrator designee stated the current administrator had become the administrator of the facility on 2/1/12. She stated she came intermittently to the facility throughout the month of February as she transitioned back to Idaho from another state. She stated she was the acting designee at that time and was in constant contact with the administrator during the time until the administrator was full-time at the facility in March 2012.

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

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

Sincerely,



Polly Watt-Geier, MSW
Health Facility Surveyor
Residential Assisted Living Facility Program

PWG

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

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November 6, 2012

Vickie McCuistion, Administrator
Annabelle House, Assisted Living Concepts, Inc
917 East Ustick Road
Caldwell, ID 83605

Dear Ms. McCuistion:

An unannounced, on-site complaint investigation was conducted at Annabelle House, Assisted Living Concepts, Inc between October 29, 2012 and October 30, 2012. During that time, observations, interviews, and record reviews were conducted with the following results:

Complaint # ID00005512

Allegation #1: The facility had an identified resident sign a term ending agreement, that did not allow the resident to terminate the agreement with a 30 day notice.

Findings #1: During the survey, between 10/29 and 10/30/12, the identified resident's closed record was reviewed. The resident's record contained a signed admission agreement that included a Term Ending Agreement (TEA); which stated the resident would be required to pay for 12 months even if the resident gave the proper, 30 day notice and moved out of the facility.

On 10/29/12 at 12:20 PM, a family member of the identified resident's stated they had signed a TEA, prior to transitioning to Medicaid. During this time, the facility gave notice to the resident that they no longer accepted Medicaid as a payment source and gave her a 30 day notice to move out of the facility. She stated the billing had been resolved and she did not have to pay for the timeframe when the identified resident had moved out of the facility.

Substantiated. However, the facility was not cited as Assisted Living Concepts (ALC) entered into a compliance agreement with the Department on 7/23/12 and had corrected the deficient practices prior to the complaint investigation conducted between 10/29 and 10/30/12.

Allegation #2: After an identified resident moved out of the facility, the facility attempted to charge the resident for a higher rate than was specified in the admission agreement.

Findings #2: During the survey, between 10/29 and 10/30/12, the identified resident's closed record was reviewed. The resident's record contained a signed admission agreement that included a Term Ending Agreement (TEA); which stated the resident would reside at the facility for a term of 12 months in order to receive a discounted rate. The record also contained documentation the resident was in the process of transitioning to Medicaid and had received a 30 day move-out notice from the facility, as they no longer accepted Medicaid payment.

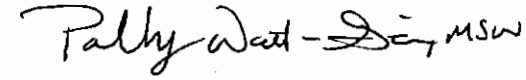
A review of the facility's complaint documentation on 10/29/12, documented the facility had received a complaint on 5/31/12, regarding the billing of the resident. The complaint documented the administrator had worked with corporate office and they had dropped the extra charges.

On 10/29/12 at 12:20 PM, a family member of the identified residents stated they had signed a TEA, prior to transitioning to Medicaid. During this time, the facility gave notice to the resident that they no longer accepted Medicaid as a payment source and gave her a 30 day notice to move out of the facility. The family member stated the facility had attempted to charge a higher rate for January, February and March. She said she had complained to the facility and the administrator had worked to resolve the billing issue. She confirmed the billing issue had been resolved and she did not have to pay for higher rate.

Substantiated. However, the facility was not cited as Assisted Living Concepts (ALC) entered into a compliance agreement with the Department on 7/23/12 and had corrected the deficient practices prior to the complaint investigation conducted between 10/29 and 10/30/12.

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,



Polly Watt-Geier, MSW
Health Facility Surveyor
Residential Assisted Living Facility Program

PWG

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

IDAHO DEPARTMENT OF HEALTH & WELFARE

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

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RESIDENTIAL ASSISTED LIVING FACILITY PROGRAM
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November 6, 2012

Vickie McCuistion, Administrator
Annabelle House, Assisted Living Concepts, Inc
917 East Ustick Road
Caldwell, ID 83605

Dear Ms. McCuistion:

An unannounced, on-site complaint investigation survey was conducted at Annabelle House, Assisted Living Concepts, Inc from October 29, 2012, to October 30, 2012. During that time, observations, interviews, and record reviews were conducted with the following results:

Complaint # ID00005550

Allegation #1: The closed records of former residents were not safeguarded.

Findings #1: Between 10/29 and 10/30/12, the closed records were observed being stored in a locked maintenance room by the administrative offices.

Between 10/29/12 and 10/30/12, five employees were interviewed. They all stated the closed records were always under lock and key and only staff on duty with keys, could unlock the doors. They stated all outside providers (such as fire inspectors) could only go into the room with the staff who had keys and they were never left alone in the room with the records.

On 10/30/12 at 9:50 AM, the administrator stated only staff on duty had keys to unlock the doors to access the former resident records. She stated the records were not accessible to outside agencies (such as fire inspectors) without supervision of staff. Additionally, she stated she was not aware of a time the records were not safeguarded and secure.

On 10/30/12 at 10:33 AM, the facility nurse stated all former residents' records were stored under lock and key in the maintenance room. She stated only staff on duty, who had keys could access the room. She was not aware of a time that residents' closed records had not been secured.

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

Allegation #2: Two identified residents admission agreements did not allow residents to terminate the agreements with a 30 day notice.

Findings #2: During the survey, between 10/29 and 10/30/12, the identified residents' records were reviewed. Both of the residents records contained signed admission agreements that included a Term Ending Agreement (TEA); which stated the residents would be required to pay for for a term of 12 months, even if they gave a 30 day notice and moved out of the facility.

On 10/29/12 at 11:58 AM, a family member of one of the identified resident's stated they had signed a TEA; however, the billing had been resolved and she did not have to pay for the timeframe when the identified resident had moved out of the facility.

On 10/30/12 at 9:52 AM, an identified resident stated a TEA had been signed, but the billing issues around that had been resolved.

Substantiated. However, the facility was not cited as Assisted Living Concepts (ALC) entered into a compliance agreement with the Department on 7/23/12 and had corrected the deficient practices prior to the complaint investigation conducted between 10/29 and 10/30/12.

Allegation #3: A resident's basic service rate was increased in December 2012, without a 30 day notice.

Findings #3: During the investigation, between 10/29 and 10/30/12, the identified resident's record was reviewed. The former billing information was reviewed and it documented the resident's fees had been increased without a 30 day notice.

The identified resident's family member was called, but could not be reached during the investivation.

On 10/30/12, a review of the identified resident's billing information documented the resident had received credits back to her account for the amount of the increase.

Substantiated. However, the facility was not cited as ALC entered into a compliance agreement with the Department on 7/23/12 and had corrected the deficient practices prior to the complaint investigation conducted between 10/29 and 10/30/12.

Allegation #4: An employee of the facility did not follow proper infection control when they did not cover a wound after cutting themselves.

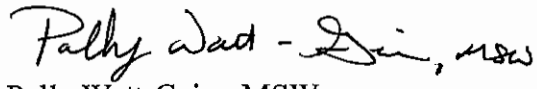
Findings #4: Between 10/29/12 and 10/30/12, five employees were interviewed. They all stated they had never witnessed an employee with an uncovered wound. They all stated they had been well trained in infection control and would cover any wound with a Band-Aid or dressing. They stated that if they saw an employee with an uncovered wound they would direct them to cover the wound up.

On 10/30/12 at 9:50 AM, the administrator stated that she had not seen, nor was she told about a time when an employee did not cover a wound after cutting themselves. She stated that all employees were trained in infection control and knew to cover wounds.

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

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

Sincerely,



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