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HEALTH & WELFARE

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November 2, 2012

Laura Lee Mathias, Administrator
Edgewood Spring Creek Eagle LLC
P.O. Box 13336
Grand Forks, ND 58208

Dear Ms. Mathias:

An unannounced, on-site complaint investigation survey was conducted at Edgewood Spring Creek Eagle LLC from October 30, 2012, to October 30, 2012. During that time, observations, interviews, and record reviews were conducted with the following results:

Complaint # ID00005662

Allegation #1: The facility did not complete an adequate assessment to determine if the identified resident was an elopement risk.

Findings #1: The following assessments were completed prior to, or on the day the identified resident was admitted to the facility:

* A "Resident Services Worksheet" was completed 15 days prior to the identified resident's admission.

* "A New Potential Resident" assessment was completed 3 days prior to the resident's admission.

* A nursing assessment, "Interim Plan of Care" and "Elopement Risk Evaluation" was completed on the day the resident was admitted to the facility.

All of the above assessments identified the resident as a low elopement risk without a history of wandering.

Unsubstantiated.

Allegation #2: An identified resident was inappropriately given an immediate discharge notice.

Findings #2: A progress note dated three days after the identified resident was admitted to the facility, documented the facility could not assure the resident's safety as the resident was at high risk for elopement and the facility was not a secure environment.

A progress note, dated the day the resident was admitted to the facility, documented the resident "Became increasingly anxious when family left." Further, the facility contacted a family member and requested they stay with the resident to assist her in adjusting to her new environment. The note also documented, the family member stated the resident did not have a history of wandering. The facility further placed a WanderGuard on the resident's wrist.

A progress note, dated the day after the resident was admitted to the facility, documented the resident continued to become anxious when her family left and "seeks them when they leave." Further, the resident repeatedly took the WanderGuard off of her wrist and continued to exit seek, therefore a 1:1 companion was initiated.

A progress note, dated three days after the resident was admitted to the facility, documented the resident still continued to remove her WanderGuard, to exit seek when her family left and to require a 1:1 companion for safety. At that time, the identified resident was assessed to require a secure environment, the family was notified and began to seek appropriate placement.

On 10/30/12 at 10:15 AM, the administrator stated prior to admission the identified resident lived with a family member and did not have a history of elopement. However, after the resident arrived at the facility and family left, the resident would exit seek looking for her family. The administrator also stated, despite efforts to keep the resident safe, such as having family stay at the facility to assist the resident adjust to her new environment and having the resident wear a WanderGuard, the resident continued to exit seek. Therefore, the facility had to discharge the resident because they could not keep her safe.

Unsubstantiated.

Allegation #3: The facility did not address a complaints from an identified resident's family.

Findings #3: The identified resident was discharged from the facility eight (8) days after she was admitted, because the facility was not a secure environment and the resident continued to exit seek despite safeguards put into place by the facility. Facility documentation and interviews with the administrator and the nurse, supported that the facility had coordinated with the resident's family regarding all efforts to safeguard the resident. Further, facility documentation and interviews with the administrator and the nurse, supported that the facility had assisted the resident with her transfer to another facility.

Unsubstantiated.

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

Sincerely,



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

mmc/mmc

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