



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: 208-364-1962
FAX: 208-364-1888

March 13, 2014

Dale Amick, Administrator
Springridge Assisted Living Facility
2310 Rice Avenue
Caldwell, Idaho 83605

License #: RC-993

Mr. Amick:

On February 5, 2014, a state licensure survey was conducted at Springridge Assisted Living Facility. 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.

Your submitted evidence of resolution are being accepted by this office. Please ensure the corrections you identified are implemented for all residents and situations, and implement a monitoring system to make certain the deficient practices do not recur.

Thank you for your work to correct these deficiencies. Should you have questions, please contact Rachel Corey, RN, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 364-1962.

Sincerely,


RACHEL COREY, RN *for*
Team Leader
Health Facility Surveyor

RC/sc

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



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February 6, 2014

Dale Amick, Administrator
Springridge Assisted Living Facility
2310 Rice Avenue
Caldwell, Idaho 83605

Dear Mr. Amick:

A state licensure survey was conducted at Springridge Assisted Living Facility between February 4, 2014 and February 5, 2014. The facility was found to be in substantial compliance with the rules for Residential Care or Assisted Living Facilities in Idaho. No core issue deficiencies were identified. The enclosed survey document is for your records and does not need to be returned to the Department.

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 **February 5, 2014**. 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.

Our staff is available to answer questions and to assist you in identifying appropriate corrections. Should you require assistance or have any questions about our visit, please contact us at (208) 364-1962. Thank you for your continued participation in the Idaho Residential Care Assisted Living Facility program.

Sincerely,

RACHEL COREY, RN
Health Facility Surveyor
Residential Assisted Living Facility Program

RC/sc

Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R993	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/05/2014
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NAME OF PROVIDER OR SUPPLIER SPRINGRIDGE ASSISTED LIVING FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 2310 RICE AVENUE CALDWELL, ID 83605
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(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	<p>Initial Comments</p> <p>The residential care/assisted living facility was found to be in substantial compliance with the Rules for Residential Care or Assisted Living Facilities in Idaho. No core deficiencies were cited during the licensure and follow-up survey conducted on 2/4/2014 through 2/5/2014 at your facility. The surveyors conducting the survey were:</p> <p>Rachel Corey, RN, BSN Team Coordinator Health Facility Surveyor</p> <p>Rae Jean McPhillips, RN, BSN Health Facility Surveyor</p>	R 000		

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

