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March 17, 2014

Adi Mihalache, Administrator
Spaulding House
1709 Spaulding Street
Boise, Idaho 83705

Mr. Mihalache:

An unannounced, on-site complaint investigation was conducted at Spaulding House between March 11, 2014 and March 12, 2014. During that time, observations, interviews, and record reviews were conducted with the following results:

Complaint # ID00006273

Allegation #1: The facility did not protect residents from sexual abuse by other residents.

Findings: Between 3/11/14 and 3/12/14, the house manager and the identified resident's psychosocial rehabilitation worker (PSR) were interviewed regarding two residents who were roommates. The house manager and the identified resident's PSR worker stated the two residents did not trust each other. They further stated, each resident accused the other of making sexually provocative statements. The house manager and the identified resident's PSR worker stated they met with both residents on 7/8/13. They offered the identified resident several options to sleep in another room temporarily or sleep on the couch. However, the identified resident refused. They further stated, although each resident accused the other of making sexually provocative statements towards one another, neither had accused the other resident of sexual abuse.

A progress note, dated 7/8/13, documented the house manager, both residents, and both residents' PSR workers met to discuss the conflict between the two residents, but the identified resident was not in agreement with the solutions they had to offer.

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

Allegation #2: The facility did not give residents a 30 day discharge notice.

Findings: According to IDAPA 16.03.22.221.01, the facility must give a resident a 30 day discharge notice except under certain conditions such as, "c. Emergency conditions that requires the resident to be transferred to protect the resident...from harm."

On 3/11/14, between 2:00 PM and 4:00 PM, the house manager and the identified resident's psychosocial rehabilitation worker stated the resident had begun to decompensate and agreed to go to an emergency room.

A progress note, dated 7/10/13, documented the identified resident was admitted to a hospital on 7/10/13.

Unsubstantiated. It could not be determined the facility violated IDAPA 16.03.22.221.01.

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,

Patty Ward-Di, MSW for
MAUREEN MCCANN, RN
Health Facility Surveyor
Residential Assisted Living Facility Program

MM/sc

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