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May 19, 2017

Monica Brutsman, Administrator
The Terraces of Boise
5301 E. Warm Springs Avenue
Boise, ID 83716

Provider #: 135141

Dear Ms. Brutsman:

On **April 27, 2017**, an unannounced on-site complaint survey was conducted at The Terraces of Boise. The complaint was investigated during an on-site complaint investigation survey conducted from April 26, 2017 to April 27, 2017.

Several staff members were observed for interactions with residents.

The clinical record of the identified resident and three other residents' records were reviewed for Resident Rights and Quality of Care concerns. The facility's Grievance file, as well as Allegation of Abuse reports, Resident Council Minutes, and the facility's Incident and Accident reports from February 2017 to April 2017 were reviewed. Employee records and the facility's Admission Agreement were reviewed.

Several residents, nurses, Certified Nurse Aides (CNAs), and therapy staff were interviewed regarding various resident rights, abuse and quality of care concerns. The Social Worker, Director of Rehabilitation, Director of Nursing and the Assistant Director of Nursing were interviewed regarding various issues.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007512

ALLEGATION #1:

The Reporting Party said an identified resident was not given a choice of physician.

FINDINGS:

The identified resident was no longer residing in the facility at the time the complaint was investigated.

The identified resident's and three other residents' signed admission agreement forms did not document a concern regarding choice of physician. The facility's Resident Rights and Admission Agreement forms were reviewed and no concerns were identified. Resident Council minutes and the Grievance file from February 2017 to April 2017 did not document a concern regarding resident rights or choice of physician.

Two residents said there were no concerns regarding their choice of physician. The Social Worker said when residents and their interested parties were admitted, the right to choose a physician is reviewed and they sign the admission paperwork containing that information.

Based on record review and resident and staff interview, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The facility did not inform an interested party of an identified resident's out of facility appointments, changes to the resident's medication, changes in the resident's condition, and care conferences.

FINDINGS #2:

The clinical record of the identified resident and three other residents' records were reviewed for interested party notification and no concerns were identified. The facility's Grievance file and Resident Council minutes from February 2017 to April 2017 did not document concerns regarding notifications.

Two residents said their interested parties were always informed on any changes, appointments, and care conference meetings. The Social Worker, Director of Nursing and the Assistant Director

Monica Brutsman, Administrator
May 19, 2017
Page 3 of 5

of Nursing said there was extensive communication between staff and interested parties regarding medication, treatment, out of facility appointments, changes of condition, and care conferences.

Based on record review, resident and staff interviews, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

An identified staff member was physically abusive towards an identified resident.

FINDINGS #3:

During the survey several staff members were observed for interactions with residents and no concerns were identified.

The clinical record of the identified resident and three other residents' records were reviewed for abuse and no concerns were identified. The facility did not have any Allegation of Abuse reports and the facility's Incident and Accident reports from February 2017 to April 2017 did not document concerns of abuse. The facility's employee files did not document a staff member matching the name or description for the identified staff member.

Several residents said they were treated well and had no concerns of any staff member being rough or abusive towards them. Several nurses, CNAs, and therapy staff said they have not witnessed abuse and if they did, they would immediately stop the abuse and report it to the facility's abuse coordinator. The Director of Nursing and Director of Rehabilitation said all staff were screened for abuse through the appropriate state agency and they made sure staff were appropriate with residents.

Based on observation, record review, resident and staff interview, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

An identified resident received care by an outside provider, which was not necessary.

FINDINGS #4:

The clinical record of the identified resident and three other residents' records were reviewed for quality of care and no concerns were identified.

One resident said he/she received appropriate care by the facility and also by an out of facility provider, which was recommended by his/her physician. The Director of Nursing said care concerns were discussed with nurses and physicians and were treated according to each resident's clinical condition.

Based on record review, resident and staff interview, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

An identified staff member tried to delay the transfer of an identified resident to another facility.

FINDINGS #5:

The clinical record of the identified resident and one other resident's record were reviewed for resident rights and discharge planning and no concerns were identified. The facility's Grievance file did not document a concern regarding discharge planning.

One resident said he/she was about to be discharged and had no concerns with discharge planning. The Social Worker said discharge planning started as soon as residents were admitted and staff did not try to stop residents from leaving, but will encourage residents and families to make sure residents are strong enough from a clinical point of view to be ready for discharge.

Based on record review, resident and staff interview, it was determined the allegation could not be substantiated.

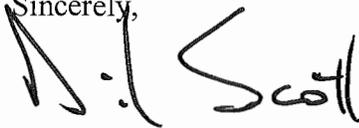
Monica Brutsman, Administrator
May 19, 2017
Page 5 of 5

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

A handwritten signature in black ink that reads "D. Scott". The signature is written in a cursive style with a large, stylized "D" and "S".

David Scott, R.N., Supervisor
Long Term Care

DS/lj