

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/11/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/11/2018
NAME OF PROVIDER OR SUPPLIER ORCHARDS OF CASCADIA, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH HORTON STREET NAMPA, ID 83651		
(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) COMPLETION DATE	
F 000	<p>INITIAL COMMENTS</p> <p>A complaint survey was conducted at the facility from October 9, 2018 through October 11, 2018. The facility was found in substantial compliance with 42 CFR 483.</p> <p>The surveyors conducting the survey were:</p> <p>Jenny Walker, RN Team Leader Presie Billington, RN Karen Gray, RD</p>	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

11/08/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
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January 10, 2019

Gary "Paul" Arnell, Administrator
The Orchards of Cascadia
404 North Horton Street
Nampa, ID 83651-6541

Provider #: 135019

Dear Mr. Arnell:

On **October 9, 2018** through **October 11, 2018**, an unannounced on-site complaint survey was conducted at The Orchards of Cascadia. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007678

Allegation #1:

The facility had offensive odors.

Findings #1:

During the investigation 8 residents were observed and their records were reviewed for Quality of Care and Quality of Life, residents and staff were interviewed, and observations were conducted for environment in resident rooms and offensive odors.

Staff were observed providing personal care to incontinent care residents. There was a transient odor during personal cares. The facility had air fresheners in the hallways that were on an automatic spray. After personal cares were provided the staff placed the dirty attends and wipes in a plastic bag then removed the plastic bag out of the room and placed it in the garbage bin in the soiled utility room. No concerns were identified.

Gary "Paul" Arnell, Administrator
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Resident and resident family members were interviewed regarding offensive odors and no concerns were identified.

The allegation was not substantiated due to lack of evidence the facility had offensive odors.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Allegation #2:

The facility's rooms had broken heaters in them.

Findings #2:

Residents were interviewed and no concerns were identified regarding the temperature in their room. One resident stated there was a thermostat in the room to adjust the temperature. Residents stated they did not have a concern with exposed pipes and did not experience a clanking noise to the exposed pipes in the room.

The Administrator stated the heater comes from the broiler and the exposed pipes were part of the heating system and each room has their own heater in the room with a thermostat to adjust the temperature. The Administrator stated sometimes there was a clanking noise through the exposed pipes to assure the broiler was working. No concerns were identified.

The Maintenance logs were reviewed and the broiler was turned on the first week of October. No concerns were identified.

The allegation could not be substantiated due to lack of evidence the heaters in resident rooms of the facility were broken.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Allegation #3:

The facility did not offer a room change to a resident.

Gary "Paul" Arnell, Administrator
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Findings #3:

The facility's grievance files were reviewed and no concerns were identified for residents requesting a room change.

Eight resident clinical records were reviewed for concerns with room changes. One resident's clinical record documented the facility offered a room change for a resident and the resident declined the room change. One resident's clinical record did not include documentation the resident requested a room change.

Four residents were interviewed and no concerns were identified for concerns of their room and requesting a room change. The residents stated they liked their room and if they did have a concern the facility would have offered a room change.

The allegation was substantiated. However, no deficiencies were cited related to the facility offering room changes to residents.

CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

One of the allegations was substantiated, but not cited. Therefore, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,



Belinda Day, RN, Supervisor
Long Term Care Program

BD/lj



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January 7, 2019

Gary "Paul" Arnell, Administrator
The Orchards of Cascadia
404 North Horton Street
Nampa, ID 83651-6541

Provider #: 135019

Dear Mr. Arnell:

On **October 9, 2018** through **October 11, 2018**, an unannounced on-site complaint survey was conducted at The Orchards of Cascadia. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007858

Allegation #1:

Residents did not receive pain or anti-nausea medication and it was not received in a timely manner.

Findings #1: During the investigation 9 residents were observed and their records were reviewed for Quality of Care and medication management. Six closed records were reviewed, administrative documents were reviewed, and residents and staff were also interviewed.

One resident 's record documented she was on chemotherapy. Her medication record documented she was administered morphine, gabapentin, and Norco as needed for pain. The resident also had Zofran as needed for nausea and vomiting. She was seen by a nurse on duty to administer her medications or to attend to her needs every day.

The Director of Nursing stated the facility allowed a 1 hour time frame before and after the documented time in the medication administration record for the resident 's medications to be administered. The resident 's medications for pain and nausea were given as scheduled according to the documentation in her medication record.

Residents who were interviewed said their pain was managed and they had no concerns.

The Grievance Logs from December 2017 through September 2018 had no concerns documented regarding medications being administered late.

Based on the investigative findings the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Allegation #2:

A resident was taken to the hospital by a family member instead of the facility calling an ambulance.

Findings #2:

During the investigation 9 residents were observed and their records were reviewed for Quality of Care and medication management. Six closed records were reviewed, administrative documents were reviewed, and residents and staff were also interviewed.

One resident was taken to the Emergency Room for nausea and vomiting by a family representative. The Emergency Room report documented the Resident was prescribed meclizine and Compazine in the past which did not alleviate her symptoms. The resident was administered intravenous fluid, metoclopramide (an anti-nausea medication), and promethazine (an anti-nausea medication) in the Emergency Room.

On 10/11/18 at 10:55 AM, the Director of Nursing said the nurse on duty the day the resident was taken to the Emergency Room by a family representative was a new nurse, and the nurse thought it was alright for a family representative to take the resident to the Emergency Room. The Director of Nursing said the facility had a transport service and provided transport to a resident when needed. The Director of Nursing said the nurse was educated regarding sending a resident to the hospital when necessary.

The allegation was substantiated, however no deficiencies were cited in relation to the allegation.

CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

Allegation #3:

Resident linens were not changed for over 3 weeks.

Findings #3:

Certified Nursing Assistants (CNAs) were interviewed and stated sheets and pillow cases were changed after each shower for the residents. They stated towels and washcloths were changed daily and when needed.

Several residents were interviewed and they did not have concerns regarding linen changes. The residents said their trash cans were being emptied during the day time by the housekeeper or by the CNAs.

Grievance logs from December 2017 through September 2018 were reviewed and there were no complaints linens were not changed.

Observations were conducted during the investigation of resident beds and bathrooms for linen cleanliness and there were no identified concerns.

Based on the investigative findings it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Allegation #4:

The floors of the resident rooms were not swept or mopped, and trashcans were not emptied for over 3 weeks.

Findings #4:

During the complaint investigation, resident's rooms were observed for cleanliness. Residents' rooms were observed to be clean and their trashcans were emptied.

The Grievance Log from December 2017 through September 2018 were reviewed and no complaints of residents ' room not being cleaned.

Several residents were interviewed and said their rooms were being cleaned every day. Based on investigative findings, it was determined the allegations could not be substantiated.

Gary "Paul" Arnell, Administrator
January 7, 2019
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CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Allegation #5:

A resident was left in the same compression wraps for 3 weeks.

Findings #5:

Several CNAs were interviewed and said residents' compression garments were being wash and hang to dry during the night to be use again the following day. The CNAs said they would ask the nurse to provide a new compression garment when it was really soiled or worn out.

Two residents were observed wearing a compression garments and there was no concern.

Based on investigative findings, the allegations could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,



Laura Thompson, RN, Supervisor
Long Term Care Program

LT/lj



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June 19, 2019

Gary "Paul" Arnell, Administrator
The Orchards of Cascadia
404 North Horton Street,
Nampa, ID 83651-6541

Provider #: 135019

Dear Mr. Arnell:

On **October 11, 2018**, an unannounced on-site complaint survey was conducted at The Orchards Of Cascadia. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007923

ALLEGATION #1:

Call light was purposely placed out of reach.

FINDINGS #1:

An unannounced complaint survey was conducted from 10/9/18 to 10/11/18. During the investigation, 9 residents were observed and their records were reviewed for Quality of Care. The facility's Grievance files, Incident and Accident Reports, and Resident Council minutes from December 2017 through September 2018 were reviewed for call light being placed out of reach and none were found. Residents and one family representative was interviewed and none expressed concern regarding call light being placed out of reach.

Throughout the complaint survey, residents who were in their room were observed to have their call lights within their reach.

CONCLUSIONS:

Based on investigative findings, it was determined the allegation could not be substantiated.

ALLEGATION #2:

Resident's arms were forced behind her head when her Foley catheter was re-inserted.

FINDINGS #2:

The record of the Resident who was no longer in the facility was reviewed. Two nurses were interviewed regarding urinary catheter insertion and there were no concern noted. Two residents records with urinary catheter were reviewed. One resident with urinary catheter was interviewed and said he was not asked to put his arm behind his head when his urinary catheter was changed. One family representative of an un-interviewable resident with urinary catheter was interviewed over the phone and had no concern with the quality of care their resident received in the facility.

The Resident was admitted to the facility on 8/13/18 at 6:23 PM. The resident's record documented she had a urinary catheter while she was at the hospital and it was removed prior to her discharged to the facility. The Resident's Nursing Progress Notes dated 8/13/18 at 7:30 PM, documented the Resident had no urine output since her urinary catheter was removed from the hospital that morning. A scanned image of the Resident's bladder documented 500 cc of urine. A physician ordered to catheterize the Resident every four hours using a straight catheter but the resident and her family representative refused, and requested for the urinary catheter to be reinserted. On 8/14/18 at 3:51 AM, a new physician order was received to reinsert the Foley catheter to the resident. Nursing notes documented the resident tolerated the urinary catheter reinsertion well.

CONCLUSIONS:

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

ALLEGATION #3:

Staff got into resident's face and told her to behave.

FINDINGS #3:

The Resident's record documented she was asked by a CNA (Certified Nursing Assistant) on 8/24/18 if she would like to go to the dining room for lunch. Resident said "No." The CNA

Gary "Paul" Arnell, Administrator
June 19, 2019
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explained to the Resident that she did not eat her lunch and would like her to have lunch so she would not be hungry but the Resident chose to stay in bed. A Physical Therapy (PT) note dated 8/24/18, documented the resident was exhausted and agreed to do her PT in her room instead of going to the PT gym.

The Resident's clinical record documented a family representative brought the Resident to the Emergency Room after her appointment on 8/28/18 due to pain on her arm, and did not come back to the facility due to verbal and physical abuse, that a staff got into the Resident's face.

The Hospital report dated 8/28/18, documented the Resident had an x-ray of her right shoulder which showed a normal result for her age. An x-ray of the Resident's wrist documented a normal alignment.

Eight residents were asked individually if any of the staff asked them to get out of bed against their will, residents said staff will wake them up for meal but if they want to stay longer in bed they can do so. None said they were forced to get out of bed for meals or for any activities. Residents said the staff were polite and accommodate their needs.

CONCLUSIONS:

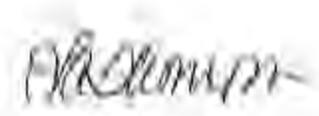
Based on review of record and residents' interviews, the allegation was unsubstantiated due to lack of evidence the Resident was mistreated, and no deficiency was identified.

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. If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,



LAURA THOMPSON, RN, Supervisor
Long Term Care Program

Gary "Paul" Arnell, Administrator
June 19, 2019
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June 26, 2019

Gary "Paul" Arnell, Administrator
The Orchards of Cascadia
404 North Horton Street,
Nampa, ID 83651-6541

Provider #: 135019

Dear Mr. Arnell:

On **October 11, 2018**, an unannounced on-site complaint survey was conducted at The Orchards of Cascadia. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007942

ALLEGATION #1:

A resident was verbally abused and mistreated by a staff member.

FINDINGS #1:

An unannounced complaint survey was conducted from 10/9/18 to 10/11/18. During the investigation nine residents were observed and their records were reviewed for Quality of Care. Five closed resident records were also reviewed. The facility's Incident and Accident reports from January 2018 to September 2018 were reviewed, and facility grievances from December 2017 to September 2018 were reviewed. Residents and staff were also interviewed. One family representative was interviewed over the phone. Staff interactions with the residents were observed during the survey.

Review of one resident's record documented the resident's family member had a concern with a staff member at the facility.

The Director of Nursing (DON) was interviewed and said she was informed by the Unit Manager (UM) a Licensed Practical Nurse (LPN) and a family member of a resident had an argument over the phone. The DON said the LPN was placed on suspension as soon as administration was made aware of the incident and an investigation was started immediately. The investigation documented several residents in the 300 Hall were interviewed and were asked if they felt safe in the facility, were they being treated with respect, were their needs being met, and whether their rights were being protected. The residents interviewed reported they felt safe, respected, their rights were protected and their needs were being met. A staff was also interviewed and said she did not see the LPN acting inappropriately with the resident on the day of the incident. The investigation also documented the LPN admitted the door to the resident's room slammed when she left and she apologized to the family member and said it was an accident. The DON said their investigation concluded the resident was not verbally abused or mistreated but it was a personality conflict between the LPN and the family member. The DON said the LPN was counseled and asked to attend a Customer Service training prior to going back to work, and the LPN was assigned to a different hall in the facility.

The Licensed Social Worker (LSW) said she spoke to the family member of the resident and explained the result of their investigation. The LSW said they assured the family member the LPN would not be assigned to the resident and would be working in a different hall. The LSW said she did not interview the resident at the request of the family member, because the family member did not want the resident to be "stressed out again." The LSW said she was in the resident's room with the family member when she asked the resident if she had any other concern, the resident stated there was no other concern. The LSW said she assured the resident the LPN would be assigned to a different hall. The LSW said she did not feel the resident was frightened or being inhibited from talking at that time.

CONCLUSIONS:

Based on the investigative findings, the allegation could not be substantiated.

ALLEGATION #2:

Call lights were not answered in a timely manner. A resident did not receive personal grooming.

FINDINGS #2:

The facility's grievances from December 2017 to September 2018 were reviewed and no complaints of long call light times were found. Call light response times were observed to be answered in a timely manner during the survey. Residents were observed to be appropriately groomed.

Gary "Paul" Arnell, Administrator
June 26, 2019
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CONCLUSIONS:

Based on observation and review of records it could not be established that call lights were not answered in a timely manner and residents were not groomed appropriately. Therefore, the allegation was unsubstantiated and no deficient practice was identified.

ALLEGATION #3:

The information for who and where concerns in the facility can be reported was not posted.

FINDINGS #3:

Information about the Idaho Department of Health and Welfare and the ombudsman were observed posted on the wall at four different locations in the facility. The postings were on the walls located on the way to the 400 Hall, before entering the Rose Garden dining room on the left side, on the way to the 300 Hall, and before entering the bath/tub room.

Several residents were interviewed and said they knew the information about their local ombudsman was posted on the wall and it was discussed during their Resident Council meetings.

CONCLUSIONS:

Based on the investigative findings, it was determined the allegation could not be substantiated.

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. If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,



LAURA THOMPSON, Supervisor
Long Term Care Program

Gary "Paul" Arnell, Administrator
June 26, 2019
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August 2, 2019

Gary "Paul" Arnell, Administrator
The Orchards of Cascadia
404 North Horton Street
Nampa, ID 83651-6541

Provider #: 135019

Dear Mr. Arnell:

On **October 9, 2018** through **October 11, 2018**, an unannounced on-site complaint survey was conducted at The Orchards of Cascadia. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007885

ALLEGATION #1:

Residents were not receiving personal care.

FINDINGS #1:

During the survey six residents records were reviewed, observations were conducted, facility grievance reports were reviewed, and staff and residents were interviewed.

Observations were conducted during the survey for personal care and services to residents. CNAs were observed providing personal care to residents and changing residents incontinent briefs efficiently. Six residents were observed for personal hygiene and no concerns were identified.

The facility's grievance reports from June 2018 to October 2018 were reviewed for residents' personal care not being provided. There was no grievances regarding personal care or services not being met.

Four of the six residents were interviewed regarding receiving personal care and services in a timely manner.

Gary "Paul" Arnell, Administrator
August 2, 2019
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Four of the six residents stated they had no concerns with their personal care and the staff completed and were efficient providing their personal cares and services. One of the six residents was unable to verbalize concerns and was observed receiving personal cares without concerns.

One of the six residents, admitted June 2018, required extensive assistance with one or two staff members for personal cares and services. The resident's record documented the resident was incontinent and was dependent on staff to provide personal cares and services per the care plan.

The Director of Nursing stated residents who were dependent for all personal cares and services received the care and services per the resident's personal care plan.

Based on the investigative findings, the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

Resident call lights were not accessible.

FINDINGS #2:

During the survey call lights were observed accessible to residents and appropriately placed close to residents. Four out of six residents stated their call light was in reach and activated the call light to assure the call light was functioning and was answered in a timely manner. One of the six residents had a touch pad call light located on the resident's chest and was observed activating the call light and staff answered in a timely manner.

One of the six resident's record was reviewed. The resident's record documented the call light was to be in reach for the resident at all times and staff were to check on the resident frequently. The resident's record did not document concerns with the call light not being accessible.

CNAs stated when residents were dependent on staff for assistance, they would check on the residents frequently and anticipate their needs. The Director of Nursing stated when residents were dependent on staff for personal cares and services the staff would check on the residents more frequently to assure the call light was accessible and their needs were being met.

Based on the investigative findings, the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Gary "Paul" Arnell, Administrator
August 2, 2019
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ALLEGATION #3:

The facility had family members provide suctioning care and services for residents.

FINDINGS #3:

Two of three residents were observed with a suction machine in the resident's room. One of the three residents were observed receiving suctioning care and services by the licensed staff for excessive secretions.

Three of the three residents records were reviewed for suctioning care needs and services. Three of the three residents' record documented suctioning care and services were provided to the residents for excessive secretions by the licensed staff.

The Director of Nursing stated residents who required suctioning services were provided by licensed staff and not by the family. The Director of Nursing stated the licensed staff were trained on how to suction a resident and did not expect families to provide the services for suctioning their loved one.

The allegation was unsubstantiated due to lack of evidence regarding the facility was having the residents' family members provide suctioning services to their loved one.

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.

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,

Belinda Day, RN, Supervisor
Long Term Care Program

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