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October 11, 2007

Ron Hedelius, Administrator
Pine Brook Assisted Living of Idaho Falls
1140 Science Center Dr
Idaho Falls, ID 83402

Dear Mr. Hedelius:

On September 20, 2007, a complaint investigation survey was conducted at Pine Brook Assisted Living of Idaho Falls. The survey was conducted by Rachel Corey, RN, Polly Watt-Geier, MSW and Karen McDannel, RN. This report outlines the findings of our investigation.

Complaint # ID00003080

Allegation # 1: Medications were not kept in a secure or locked cabinet.

Findings: On September 19, 2007 between 3:37 p.m. and 3:58 p.m., the residents' medications were observed being kept in locked cabinets in the kitchen. Additionally, the biological medications were stored in a small refrigerator located in the locked pantry. On September 20, 2007 at 11:00 a.m., the controlled medications were observed in a locked cabinet in the administrators' office. On September 20, 2007 at 11:01 a.m., the administrator stated the controlled medications were kept in a locked cabinet in the office. She also stated one caregiver on each shift had a key and counted the amount of controlled medications located in the cabinet after each shift.

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

Allegation # 2: Discontinued medications were not being disposed of properly.

Findings: Review of four random residents' records on September 20, 2007, revealed the facility appropriately disposed of discontinued and/or unused medication properly. On September 20, 2007 at 9:53 a.m., the administrator stated the facility would release medications to the hospice or home health nurse for disposal or the facility would destroy unused medications. She also stated the facility had kept unused medications approximately 2 years ago, but the procedure had been changed and all

medications were destroyed properly.

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

Allegation # 3: The facility nurse was not notified when problems arose with a resident.

Findings: On September 20, 2007 at 10:32 a.m., the administrator stated the caregivers would contact the facility nurse in situations that included: when a resident would refuse medications, when a resident had blood sugar levels drop or any infection control issues. She also stated there was a nurse communication log for the hospice, home health and facility nurse to communicate about residents' conditions and actions taken when there was a change in condition. On September 20, 2007 at 10:34 a.m., two caregivers were interviewed and stated they would call the facility nurse when a resident had an issue or change in condition.

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

Allegation # 4: Two identified residents were not assisted with ambulation.

Findings: Review of 1 open and 1 closed identified residents' records on September 20, 2007, revealed both residents needed assistance with ambulation by caregivers. On September 20, 2007 between 9:30 a.m and 11:00 a.m., residents were observed being assisted with transfers and ambulation in a safe and appropriate manner. On September 20, 2007 between 10:04 a.m. and 10:30 a.m., caregivers were interviewed and stated both residents needed and were provided a one person assistance with ambulation. On September 20, 2007 at 10:10 a.m., one of the identified resident's stated she was appropriately assisted with amublation/transfers by the caregivers. On September 20, 2007 at 10:21 a.m., a hospice nurse stated that facility had appropriately assisted the identified resident with her ambulation.

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

Allegation # 5: Not all residents have a call system in their room.

Findings: On September 19, 2007 between 3:37 p.m. and 3:58 p.m., all resident rooms were observed to contain a call system. On September 19, 2007 at 3:46 p.m., the administrator confirmed the residents all have call systems in their rooms. Additionally, she stated the caregivers continuously checked on the residents to assist them with their care needs.

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

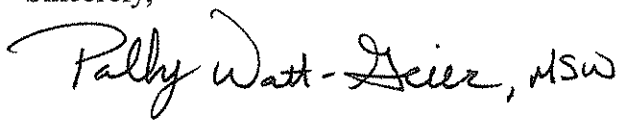
Allegation # 6: An identified resident who was incontinent, was not changed during night.

Findings: Review of the identified resident's record on September 20, 2007, revealed the resident needed assistance with toileting and colostomy care. The facility's daily log documented the resident was checked and toileted on the night shift at 11:00 p.m., 1:00 a.m., 3:00 a.m., and 5:00 a.m. On September 20, 2007 at 10:10 a.m., the identified resident stated the facility caregivers assisted her with toileting and checked the colostomy twice a day or changed it when it was requested. On September 19, 2007 at 3:58 p.m., the administrator stated residents who needed assistance with toileting at night, were checked on by the night staff every two hours or in some cases every hour depending on their toileting needs.

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

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,



POLLY WATT-GEIER, MSW
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PWG/sc

c: Jamie Simpson, MBA, QMRP, Supervisor, Residential Community Care Program
Polly Watt-Geier, MSW, Health Facility Surveyor