IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

LESLIE M. CLEMENT - Administrator
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888

January 22, 2008

Bryan Elliott, Administrator
Willow Park Assisted Living
2600 N Milwaukee Ave
Boise, ID 83704

Dear Mr. Elliott:

On January 16, 2008, a complaint investigation survey was conducted at Willow Park Assisted Living. The survey was conducted by Rachel Corey, RN and Debra Sholley, LSW. This report outlines the findings of our investigation.

Complaint # ID00002664

Allegation #1: An identified resident was not provided adequate care and services by the facility. The facility's lack of providing adequate care caused the resident to have extensive leg contractures and a stage IV pressure ulcer.

Findings #1: Based on interview and record review, it could not be determined the facility did not provide adequate care and services resulting in the identified resident's extensive leg contractures and a stage IV pressure ulcer.

The identified resident was admitted to the facility on January 30, 2006 with diagnosis that included severe arthritis, hypothyroidism and dementia.

A history and physical dated February 8, 2007, documented the resident had a history of severe arthritis of both hips that resulted in significant bilateral lower extremity contractures.

On January 16, 2008 at 11:30 a.m., the licensed nurse stated, "The resident came to us wheel chair bound, she was on 2 hour checks. She could turn herself and she would always end back up on her left side because that was the side that was less painful for her to lay on. She developed a wound on the left side which I became aware of on January 19, 2007. I called the physician's office but it was a Friday and he was not in. The physician's office called back on Monday and wrote an order for a home health assessment which was initiated on January 24, 2007. I estimated the wound to be approximately a stage II. After the initiation of the home health assessment she was referred to the wound clinic."

The progress notes documented the facility nurse conducted an assessment and notified the identified resident's physician on January 19, 2007.

The initial home health assessment dated January 24, 2007, documented, "unable to stage wound secondary to eschar."

Further progress notes dated January 29, 2007, documented the licensed nurse received notification the resident had an appointment with the wound clinic on February 8, 2007.

A progress note dated February 8, 2007, documented the wound clinic assessment determined that after debridement the wound was a stage IV. The progress note further documented the licensed nurse notified the resident's son to inform him the resident would have to be transferred to a skilled nursing facility.

On February 9, 2007, the progress note documented a Registered Nurse from a skilled nursing facility arrived to assess the identified resident for admission.

The progress note dated February 14, 2007, documented the identified resident was transferred to a skilled nursing facility.

Conclusion #1: 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,

DEBBIE SHOLLEY, LSW
Team Leader
Health Facility Surveyor
Residential Community Care Program

DS/sc

c: Jamie Simpson, MBA, QMRP, Supervisor, Residential Community Care Program
Debra Sholley, LSW, Health Facility Surveyor