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) 334-5747
FAX: (208) 364-1811

October 10, 2007

Kathi Brink, Administrator
Ashley Manor Care Centers Inc - Orchard
PO Box 1176
Meridian, ID 83642

License #: RC-646

Dear Ms. Brink:

On September 11, 2007, a complaint investigation survey was conducted at Ashley Manor Care Centers Inc - Orchard. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level(s):

- Core issues, which are described on the Statement of Deficiencies, and for which you have submitted aPlan of Correction.

This office is accepting your submitted plan of correction.

Should you have questions, please contact Rachel Corey, RN, Health Facility Surveyor, Residential Community Care Program, at (208) 334-6626.

Sincerely,

RACHEL COREY, RN
Team Leader
Health Facility Surveyor
Residential Community Care Program

RC/sc

c: Jamie Simpson, MBA, QMRP Supervisor, Residential Community Care Program

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September 21, 2007 **CERTIFIED MAIL #: 7003 0500 0003 1967 0698**

Kathi Brink, Administrator
Ashley Manor Care Centers Inc - Orchard
PO Box 1176
Meridian, ID 83642

Dear Ms. Brink:

Based on the complaint investigation survey conducted by our staff at Ashley Manor Care Centers Inc - Orchard on **September 11, 2007,** we have determined that the facility failed to assure all residents were provided adequate care, supervision and proper monitoring and assistance with medication; the facility failed to schedule sufficient trained staff to meet the terms of the NSA. Further, an NSA was not developed to guide staff to meet the toileting, mobility and safety needs of Resident #1. Additionally, the nutritional needs of resident #1 were not met because the NSA was not implemented. In addition, residents were not assisted with medications in a safe manner. These failures resulted in inadequate care.

This core issue deficiency substantially limits the capacity of Ashley Manor Care Centers Inc - Orchard to furnish services of an adequate level or quality to ensure that residents' health and safety are safe-guarded. The deficiency is described on the enclosed Statement of Deficiencies.

Due to the seriousness of this deficiency, the following enforcement actions are imposed:

1. **A provisional license is issued which is to be prominently displayed in the facility. Upon receipt of this provisional license return the full license, currently held by the facility.**
2. **The facility will submit weekly staffing reports to:**

   Rachel Corey, Residential Care Program, 3232 Elder Street, Boise, ID 83705

You have an opportunity to make corrections and thus avoid additional enforcement action. Correction of this deficiency must be achieved by **November 5, 2007.** **We urge you to begin correction immediately.**

After you have studied the enclosed Statement of Deficiencies, please write a Plan of Correction by answering **each** of the following questions for **each** deficient practice:

- What corrective action(s) will be accomplished for those specific residents/personnel/areas found to have been affected by the deficient practice?

- How will you identify other residents/personnel/areas that may be affected by the same deficient practice and what corrective action(s) will be taken?
- What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?
- How will the corrective action(s) be monitored and how often will monitoring occur to ensure that the deficient practice will not recur (i.e., what quality assurance program will be put into place)?
- What date will the corrective action(s) be completed by?

Return the **signed** and **dated** Plan of Correction to us by **October 4, 2007,** and keep a copy for your records. Your license depends upon the corrections made and the evaluation of the Plan of Correction you develop.

In accordance with Informational Letter #2002-16 INFORMAL DISPUTE RESOLUTION (IDR) PROCESS, you have available the opportunity to question cited deficiencies through an informal dispute resolution process. If you disagree with the survey report findings, you may make a written request to the Chief of the Bureau of Facility Standards for a Level 1 IDR meeting. The request for the meeting must be made within ten (10) business days of receipt of the statement of deficiencies (**October 4, 2007**). The specific deficiencies for which the facility asks reconsideration must be included in the written request, as well as the reason for the request for reconsideration. The facility's request must include sufficient information for the Bureau of Facility Standards to determine the basis for the provider's appeal. If your request for informal dispute resolution is received after **October 4, 2007,** your request will not be granted.

If, at the follow-up survey, it is found that the facility is not in compliance with the rules and standards for residential care or assisted living facilities, the Department will have no alternative but to initiate an enforcement action against the license held by Ashley Manor Care Centers Inc - Orchard.

Should you have any questions, or if we may be of assistance, please call our office at (208) 334-6626.

Sincerely,

JAMIE SIMPSON, MBA, QMRP
Supervisor
Residential Community Care Program

JS/sc

Enclosure

c: Ann Davis, Interim Program Manager, Regional Medicaid Services, Region IV - DHW

PRINTED: 09/21/2007
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R646	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 09/11/2007
NAME OF PROVIDER OR SUPPLIER ASHLEY MANOR CARE CENTERS INC - ORCH	STREET ADDRESS, CITY, STATE, ZIP CODE 2150 S ORCHARD BOISE, ID 83705		

(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) COMPLETE DATE
R 000	Initial Comments The following core deficiencies were cited during the complaint investigation survey conducted at your residential care/assisted living facility on 9/11/07. The surveyors conducting your survey were: Rachel Corey, RN Health Facility Surveyor Team Leader Karen McDannel, RN Health Facility Surveyor Survey Definitions: MAR = Medication Administration Record NSA = Negotiated Service Agreement RN = registered nurse	R 000		
R 008	16.03.22.520 Protect Residents from Inadequate Care. The administrator must assure that policies and procedures are implemented to assure that all residents are free from inadequate care. This Rule is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to assure all residents were provided adequate care, supervision and proper monitoring and assistance with medication; the facility failed to schedule sufficient, trained staff to meet the terms of the NSA. Further, an NSA was not developed to guide staff to meet the toileting, mobility and safety needs of Resident #1. Additionally, the nutritional needs of resident #1 were not met because the NSA was not	R 008	See next page	

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 10/4/07

PAGE 2/3 * RCVD AT 10/9/2007 8:10:31 AM [Mountain Daylight Time] * SVR:DHWRIGHTFAX/0 * DNIS:1888 * CSID:2083888909 * DURATION (mm-ss):01-50

PRINTED: 09/21/2007
FORM APPROVED

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R 008	Continued From page 1 implemented. In addition, residents were not assisted with medications in a safe manner. These failures resulted in inadequate care. I. Supervision a. Sufficient Personnel (IDAPA 16.03.22.600.06a): Review of the resident roster, prepared by the facility's house manager on 9/10/07, revealed a total of 8 residents. The roster indicated all residents had a diagnosis of Alzheimer's or dementia. Review of the "As Work Schedule" for the month of September 2007, revealed that one caregiver was scheduled for each shift. During the tour on 9/10/07 at 12:30 p.m., observations were made of 8 residents with one caregiver on duty. Room #7 was observed to have a Hoyer lift and a wheelchair present. The resident was asleep in her room. During the initial meeting with Caregiver A, he stated, "This is my first day on the job. I started at 6 a.m., I had training for a couple of hours this morning and have been working alone the rest of the day. I have had no further training. I don't know where any of the things you need are, but I will call someone who does." On 9/10/07 at 2:15 p.m., a hospice caregiver was observed wheeling Resident #2 to the shower room. It was observed that the house manager assisted the hospice caregiver to transfer the resident to the bath chair. The resident was soiled with wet bowel movement that was leaking through her clothing and onto her wheelchair. At this time Caregiver A stated, "She is a two person	R 008	R 008 16.03.22.520 Protect residents from Inadequate Care **Corrective actions that will be accomplished for those specific residents/personnel/areas affected by the deficient practice.** A new manager/designee has been hired **I. Supervision** a. Sufficient Personnel Resident #2 has been discharged to a higher level of care. 9/18/07 Resident #1 has been admitted to Hospice and is also receiving care from the hospice nurse and aides. 9/19/07 Staffing will be adjusted to accommodate the needs of the residents when it is necessary or if there is a change in condition which warrants it. b. Staff Orientation **Corrective actions that will be accomplished for those specific residents/personnel/areas affected by the deficient practice.** All caregivers have received 16 hours of orientation and it has been documented and is in their files. New hires have not worked alone during their orientation period. Resident #2 is no longer residing in the facility and the hoyer lift has been removed.	

PAGE 3/3 * RCVD AT 10/9/2007 8:10:31 AM [Mountain Daylight Time] * SVR:DHWRIGHTFAX/0 * DNIS:1888 * CSID:2083888909 * DURATION (mm-ss):01-50

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R 008	Continued From page 2 assist." On 9/10/07 at 2:20 p.m., When Caregiver A was asked how Resident #2 received appropriate pericare with only one staff on duty, he replied, "She is on a two hour toileting schedule. I have just been turning her side to side to change her. She has a Hoyer lift, but I don't feel comfortable using it alone." On 9/11/07 at 7:45 a.m., it was observed Caregiver A was preparing breakfast. A random resident was observed pulling herself up from a chair with her walker and pulling down her pants and attends. The resident continued to stand and pull pants down without notice from the caregiver. The regional director and the administrator observed the situation, then both assisted the resident to her room. On 9/11/07 at 8:10 a.m., the regional director and the administrator were observed prompting another random resident to eat as the resident kept falling asleep at the table with her head resting on the table top. On 9/10/07 through 9/11/07 during observations of residents, it was observed that a random resident had long facial hair. Another random resident was observed with dry cracked lips, her hair was uncombed and her clothing was wrinkled and worn. On 9/11/07 at 8:00 a.m., Caregiver A was inquired on the difficulty of one caregiver getting residents dressed and groomed in the morning while preparing breakfast; he stated, "When I come on at 6 am., most residents are asleep and I start preparing breakfast then."	R 008	**How we will identify other resident/personnel/areas that may be affected by the same deficient practice and what corrective action will be taken.** We have reviewed the records and spoken with staff in regard to their orientation to make sure that they received appropriate training. **What measure or systemic changes will you make to ensure that the deficient practice does not recur?** Employee records will be reviewed and new employees will receive orientation prior to being in the facility alone with the residents. **How the corrective actions will be monitored, how often, to make sure it does not recur.** During monthly audits and at the time of employment. **Date of Correction:** **September 27, 2007 and on-going**	

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R 008	Continued From page 3 On 9/11/07 at 8:15 a.m., when the regional director was asked how one caregiver would be able to get residents dressed and groomed in the morning and prepare breakfast she stated, "The night shift typically stays over to help residents get dressed and up for the day, so that when the caregiver comes on at 6 a.m., the residents are ready for breakfast. We only have three residents who need a lot of attention." The facility failed to schedule sufficient staff to meet the needs of 100% of the residents. It was observed that Resident #2 required a two-person assist and Hoyer transfers and only one staff was scheduled per shift. Further, random residents were observed to have an extensive need for assistance with ADLs. b. Staff Orientation Review of the employee schedule for September 2007, revealed that two new caregivers were scheduled to work. Caregiver A was scheduled to work on the day shift 9/10/07 through 9/13/07 alone. Further, Caregiver B was scheduled to work the night shift as orientation on 9/10/07 and 9/11/07. The house manager was scheduled to work the night shift to orient Caregiver B. However, on 9/11/07 at 9 a.m., the house manager was observed working the day shift. On 9/11/07 at 9 a.m., the house manager was questioned about working the night shift and orienting Caregiver B. He stated, "I did not work the night shift but the evening shift instead, as the evening shift employee did not show up for work." He confirmed that Caregiver B had worked alone without orientation. On 9/11/07 at 9:15 a.m., the administrator and	R 008		

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R 008	Continued From page 4 regional director confirmed that caregiver A had worked without 16 hours of orientation. They also confirmed that Caregiver B had not received 16 hours of orientation and had worked alone on the nightshift. Review of Hoyer lift training attendance form dated 11/29/06 documented that Caregiver A nor Caregiver B had attended the training. On 9/10/07 at 1:00 p.m. the administrator confirmed that the new employees had not been trained in the use of the Hoyer lift nor had the nurse delegated the task to them. On 9/11/07 at 10:45 a.m. the facility nurse confirmed that the new employees had not been trained nor delegated the usage of the Hoyer lift. During this time, the administrator was informed of the immediate danger issues related to having insufficient untrained staff to provide supervision to the residents and thus meet the safety and basic needs of all the residents in the facility. The administrator developed a plan to correct the immediate danger situation; this included a schedule of two trained caregivers for each shift for the next 45 days. II. NSAs a. Developing NSAs Review of Resident #1's record documented the resident was admitted on 7/10/05, with diagnoses of Alzheimer's dementia, depression and anxiety. The resident's NSA updated on 7/10/07, documented the resident required minimal assistance with mobility and toileting. It further described, "Resident can get around on her own.	R 008	**II. NSA's** **Corrective actions that will be accomplished for those specific residents/personnel/areas affected by the deficient practice.** a. Developing NSA's Resident #1's NSA has been updated to reflect the resident's actual needs. 9/25/07. And we will continue to update the NSA as necessary.	

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R 008	Continued From page 5 Resident can use bathroom without assistance but may need to be checked." On 9/10/07 at 12: 50 p.m., Resident #1 was observed laying in bed wearing dirty, stained clothing. Her hair was uncombed and her nails were dirty; a walker was at her bedside. No water was available at her bedside. On 9/10/07 at 2:30 p.m., Resident #1 was observed ambulating with an unsteady gait outside her room without her walker. Her pants were soiled with bowel movement and leaking down her pants. Dried rings of bowel movement were observed on the seat of her pants. The resident was not offered assistance to the bathroom or provided with pericare. The resident ambulated to and sat on a cloth chair outside her room. On 9/10/07 at 2:45 p.m., Caregiver A confirmed that resident #1 should use a walker for safety and would frequently forget to use it. On 9/10/07 at 3:10 p.m., Resident #1 was observed sitting in the same chair outside her room for 40 minutes without interaction from staff. She had not been offered assistance with toileting, pericare or a change of clothes. Review of the facility's incident and accident report on 9/10/07, documented the resident had fallen on 3/19/07, 4/14/07 and 8/13/07. The incident report on 8/13/07 documented that resident had hit her forehead. The investigation report was blank. The report did not include evidence of the facility nurse assessment, nor were caregivers instructed on interventions to prevent occurrence or to watch for signs and symptoms indicating a change in condition.	R 008		

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R 008	Continued From page 6 The facility failed to develop an NSA to guide staff in providing toileting assistance to meet Resident #1's current needs. Further, the NSA did not include resident #1's use of a walker nor interventions to prevent future falls. b. Implementing NSA's: Review of Resident #1's record documented the resident was admitted on 7/10/05, with diagnoses of Alzheimer's dementia, depression and anxiety. The resident's NSA dated 7/10/05 documented, "Eating: Minimal, resident needs no assistance only meal reminders...will not experience an unplanned weight loss...will be provided food and beverages of choice from planned menu and as ordered by physician.....weigh resident every week and caregiver to report to physician and R.N. any weight loss or changes in eating." The nursing assessment dated 7/18/07 documented, "Resident has been refusing meals; please get MD order for meal supplements or follow c.o. policy for hi-cal food/drink supplements. Please inform MD of refusals." A "Nurse Notification" dated 7/7/07 documented, "Resident has been refusing meals. Down 2 pounds. Dr. Notified. Please contact son for advice/suggestions." Further review of the record documented that three weekly weights had been done. No further documentation of weekly weights was found. Additionally, no evidence that the physician was notified about the resident's continued refusal of meals was found, as directed in the NSA.	R 008	b. Implementing NSA's Resident #1 has been put on hospice and is being re-evaluated to determine the need for a higher level of care. Resident #1 is being weighed weekly and is being offered Hi-CAL supplements. The physician is aware of her weight loss and has addressed this issue on the visit of 9/18/09 . We will notify hospice of meal refusals and weight loss as necessary. Caregivers have been instructed on interventions related to hospice, falls and meals. Resident #1 NSA has been updated. **How we will identify other resident/personnel/areas that may be affected by the same deficient practice and what corrective action will be taken.** All of the resident's NSA's have been reviewed for accuracy and updated as necessary. Caregivers are aware of changes to the NSA's and the care that is required by the residents.	

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R 008	Continued From page 7 On 9/10/07 at 3:10 p.m., during an interview with the house manager, he confirmed that weights were not documented and could not provide any further documentation regarding weight. The "Meal monitor" was reviewed from September 1st through September 10th 2007; the resident refused 9 out of 10 breakfasts, 1 out of 10 lunches and 9 out of 10 meal supplements. Dinner documentation was not provided. On 9/11/07 at 9 a.m., Caregiver A stated that Resident #1 was offered water in the morning and then offered breakfast later that morning, which she refused. He stated that the day before, "the resident refused breakfast and lunch, but had a few crackers at 11:45 p.m." He was unaware if the resident had eaten dinner as he had not worked that shift. On 9/10/07 through 9/11/07, Resident #1 was observed lying in bed with no staff observed entering the resident's room and offering food or fluids. Further, the resident was not observed to attend any meals during the breakfast and lunch meals, nor where meal trays brought into the resident's room. The facility failed to implement Resident #1's NSA regarding resident's nutritional needs related to resident's refusal to eat and weekly weights. III. Assistance and Monitoring of Medications On 9/11/07 at 8:30 a.m., the house manager was observed leaving a narcotic for random Resident #1 in a med cup while the resident was sitting at the dining room table with two other random residents. The resident was not observed taking medication by the house manager, as he walked	R 008	**What measure or systemic changes will you make to ensure that the deficient practice does not recur?** Resident NSA's will be reviewed quarterly and with any change of condition to reflect any changes in the care. The Administrator and or designee will notify the staff of changes to the NSA using the Staff Log and verbally. **How the corrective actions will be monitored, how often, to make sure it does not recur.** The Regional Director, RN and Administrator/designee to determine the accuracy of the cares that are outlined will review NSA's on a monthly basis. **Date of Correction:** **September 27, 2007 and on-going** **<u>III. Assistance and Monitoring of Medications</u>**	

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R 008	Continued From page 8 off after setting the medication cup beside the resident. Further, the house manager left the narcotic blister pack sitting on top of medication cart unattended. On 9/11/07 at 8:40 a.m., the house manager was observed leaving a stack of blister packed medications on the medication cart as he walked to the dining room table to assist random Resident #2 with medications. He walked away without observing her take the medications. On 9/11/07 at 8:45 a.m. the house manager left a psychiatric and pain medication unattended on the medication cart as he walked to the dining room table to assist random Resident #3 with her medications. He did not sanitize his hands between assisting residents. On 9/11/07 at 8:50 a.m., the house manager was observed popping medications from the blister packs into a medication cup for Resident #1. During this time, the phone rang and he left the area into an office to answer the phone. The house manager came back and continued to pop more medications from the blister packs into the cup. The phone rang again and the house manager left the area again to answer the phone, leaving the medications unattended on top of the medication cart. (The medications included: Aspirin, Multivitamin, Paxil, Calcium, and albuterol and Atrovent inhalers). On 9/11/07 at 9:00 a.m., the house manager was observed entering Resident #1's room to assist with medications. The resident had not eaten breakfast; the house manager handed her the medications. Next, the house manager administered 2 puffs of Atrovent without allowing the appropriate time in between puffs. He then	R 008	**Corrective actions that will be accomplished for those specific residents/personnel/areas affected by the deficient practice.** Resident #1 does not have an order for narcotics. In fact, there are narcotics in the facility but they are double locked and none of the residents receive them on a routine basis. None were given at the medication pass in question. However, we have in-serviced all staff that is medication certified on the appropriate procedures for the medication pass to include: 1. Leaving blister packs out and unattended. 2. Sanitizing hands between every pass 3. Not leaving meds unattended to answer the telephone. 4. To follow protocol on inhalers. 5. Not to administer medications, they must assist only. 6. To follow physicians orders for medication times as written. 7. To watch residents take their medications and not just leave them with the resident. Training completed 9/17/07	

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NAME OF PROVIDER OR SUPPLIER ASHLEY MANOR CARE CENTERS INC - ORCH	STREET ADDRESS, CITY, STATE, ZIP CODE 2150 S ORCHARD BOISE, ID 83705		

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R 008	Continued From page 9 administered albuterol 2 puffs, without allowing the appropriate time in between puffs. At this time, the house manager confirmed that the resident was unable to dispense the inhalers, so he had been dispensing them for her. The house manager also confirmed that he was an unlicensed medication aid and did not realize he was administrating medications without a license. On 9/11/07 at 9:05 a.m., the house manager was observed measuring antipsychotic sprinkles into a medication cup for Resident #2. He then added yogurt to medication cup. He walked to dining room table and using a spoon, spooned the medication into the resident's mouth. During the medication pass observation, it was noted that Eucerin creme was not applied to Resident #2 as scheduled on the MAR, which was to be given at 8:00 am and 8:00 p.m. When the house manager was asked about when the resident would be receiving the Eucerin creme he stated, "We have been giving that to her before we get her up for lunch, before dinner and before bed." On 9/11/07 at 9:06 a.m., the house manager was observed leaving multiple blister packs of medications on the medication cart after leaving the dining room to go to a resident's room. Four residents were left in dining room unattended with medications left out. Five minutes later, the house manager returned to the dining room where the medication cart was located. The facility's administrator failed to assure all residents received adequate care and supervision by ensuring that sufficient, trained staff was available to meet the needs of the residents specified in their NSAs. An NSA was	R 008	**How we will identify other resident/personnel/areas that may be affected by the same deficient practice and what corrective action will be taken.** All staff was in-serviced, that have completed the Medication class, by the RN to refresh them on the matter of assisting with medications. **What measure or systemic changes will you make to ensure that the deficient practice does not recur.** All staff that are medication certified and delegated by the RN will pass medications under scrutiny periodically to make sure that they will not become nervous upon being observed by the surveyors and that they are following the appropriate protocol. **How the corrective actions will be monitored, how often, to make sure it does not recur.** Both the RN and the Regional Director will do observation of the medication pass and protocol on a monthly basis. **Completion Date:** **October 10, 2007 and on-going**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R646	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 09/11/2007
NAME OF PROVIDER OR SUPPLIER ASHLEY MANOR CARE CENTERS INC - ORCH	STREET ADDRESS, CITY, STATE, ZIP CODE 2150 S ORCHARD BOISE, ID 83705		

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R 008	Continued From page 10 not developed to guide staff to meet the toileting, mobility and safety needs of Resident #1. Nor was the NSA implemented to address Resident #1's nutritional needs. Further, the facility did not assist residents with medication in a safe manner, as medications were not given as ordered and left out where cognitively impaired residents could access them. Further, unlicensed staff were administering medication without a nursing license. These failures had the potential to put all residents in danger and resulted in inadequate care.	R 008		

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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September 24, 2007

Kathi Brink, Administrator
Ashley Manor Care Centers Inc - Orchard
PO Box 1176
Meridian, ID 83642

Dear Ms. Brink:

On September 11, 2007, a complaint investigation survey was conducted at Ashley Manor Care Centers Inc - Orchard. The survey was conducted by Rachel Corey, RN and Karen McDannel, RN. This report outlines the findings of our investigation.

Complaint # ID00003008

Allegation #1: An identified resident was not groomed appropriately.

Findings: Based on observation, interview and record review it was determined the facility failed to provide appropriate grooming to an identified resident.

Observations between September 10, 2007 and September 11, 2007 were made of the identified resident in which the resident was found to be wearing stained, worn clothing. The identified resident's nails were dirty and her hair was uncombed. The resident was not observed to have been offered assistance with toileting or grooming despite bowel movement stains observed on the seat of her pants.

Conclusion: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.520 for inadequate care. The facility was required to submit a plan of correction.

Allegation #2: An identified resident had a weight loss of eight pounds over an unknown timeframe.

Findings: Based on observation, record review and interview it could not be determined the identified resident had a significant weight loss.

The nursing assessment dated July 18, 2007 documented the resident had experienced a two pound weight loss which was determined not to be significant. This weight loss was reported to the physician and recommendations were made by the facility R.N. for use of high calorie supplements. The progress notes dated August 1, 2007 documented the identified resident had gained three pounds in one month.

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

Allegation #3: An identified resident was not assisted with prescibed medications in February as ordered by the physician.

Findings: Based on observation, record review and interview, it could not be determined that the facility failed to assist an identified resident with prescribed medication in February.

The Medication Administration Record from February 2007 until September 2007 documented all prescribed medications were given as ordered to the identified resident. Observation on September 11, 2007 at 9 a.m., staff were observed assisting the identified resident with all current, prescribed medications.

Conclusion: Unsubstantiated for this identified concern. However, other deficient medication pratices were indentified. The facility was issued a deficiency at IDAPA 16.03.22.520 for inadequate care related to assistance and monitoring of medications. The facility was required to submit a plan of correction.

Allegation #4: The facility caregivers had not received training/orientation related to assisting residents with their medications.

Findings: Based on record review and interview it could not be determined that caregivers did not receive required training to assist residents with their medications.

On September 10, 2007 personnel files were reviewed for 3 out of 3 employees. All three employees had received a medication assistance training class approved by the Board of Nursing.

On September 11, 2007 at 11 a.m. the facility nurse stated she would be teaching an in-service to refresh employees on medication assistance.

Conclusion: Unsubstantiated. Although medication orientation was completed, deficient medication practices were observed. The facility was issued a deficiency at IDAPA 16.03.22.520 for inadequate care related to assistance and monitoring of medications. The facility was required to submit a plan of correction.

If you have questions or concerns regarding our visit, please call us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,

RACHEL COREY, RN
Team Leader
Health Facility Surveyor
Residential Community Care Program

RC/sc

c: Jamie Simpson, MBA, QMRP, Supervisor, Residential Community Care Program
Rachel Corey, RN, Health Facility Surveyor