IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – GOVERNOR
RICHARD M. ARMSTRONG – DIRECTOR

TAMARA PRISOCK – ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
JAMIE SIMPSON – PROGRAM SUPERVISOR
RESIDENTIAL ASSISTED LIVING FACILITY PROGRAM
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: 208-364-1962
FAX: 208-364-1888

February 03, 2016

Chris Moore, Administrator
Hancock House - CTM Enterprises
7100 South Valley Heights Drive
Boise, Idaho 83709

Provider ID: RC-750

Chris Moore:

On December 17, 2015, a complaint investigation survey was conducted at Hancock House - CTM Enterprises. 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 a Plan of Correction.

Non-core issues, which are described on the Punch List, and for which you have submitted evidence of resolution.

Your submitted plan of correction and evidence of resolution are being accepted by this office. Please ensure the corrections you identified are implemented for all residents and situations and implement a monitoring system to make certain the deficient practices do not recur.

Thank you for your work to correct these deficiencies. Should you have questions, please contact Matt Hauser, QMRP, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 364-1962.

Sincerely,

Matt Hauser, QMRP
Team Leader
Health Facility Surveyor

MH/sc

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December 29, 2015

Chris Moore, Administrator
Hancock House - CTM Enterprises
7100 South Valley Heights Drive
Boise, Idaho 83709

Provider ID: RC-750

Mr. Moore:

Based on the complaint investigation survey conducted by Department staff at Hancock House - CTM Enterprises between December 15, 2015 and December 17, 2015, it has been determined that the facility failed to protect a resident's right to be treated with dignity and respect.

This core issue deficiency substantially limits the capacity of Hancock House - CTM Enterprises to furnish services of an adequate level or quality to ensure that the residents' health and safety are protected. The deficiency is described on the enclosed Statement of Deficiencies.

You have an opportunity to make corrections and thus avoid a potential enforcement action. Correction of this deficiency must be achieved by **January 31, 2016.** **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)?
- By what date will the corrective action(s) be completed?

Return the **signed** and **dated** Plan of Correction to us by **January 10, 2016,** and keep a copy for your records. Your license depends upon the corrections made and the evaluation of the Plan of Correction you develop.

Pursuant to IDAPA 16.03.22.003.02, you have available the opportunity to question the core issue deficiency through an informal dispute resolution process. If you disagree with the survey report findings, you may make a written request to the Supervisor of the Residential Assisted Living Facility Program for an IDR meeting. The request for the meeting must be in writing and must be made within ten (10) business days of receipt of the Statement of Deficiencies. The facility's request must include sufficient information for Licensing and Certification to determine the basis for the provider's appeal, including reference to the specific deficiency to be reconsidered and the basis for the reconsideration request. If your request for informal dispute resolution is received more than ten (10) days after you receive the Statement of Deficiencies, your request will not be granted. Your IDR request must be made in accordance with the Informal Dispute Resolution Process. The IDR request form and the process for submitting a complete request can be found at *www.assistedliving.dhw.idaho.gov* under the heading of Forms and Information.

Please bear in mind that non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference, on December 17, 2015 The completed punch list form and accompanying evidence of resolution (e.g., receipts, pictures, policy updates, etc) are to be submitted to this office by **January 16, 2016**.

Our staff is available to answer questions and to assist you in identifying appropriate corrections to avoid further enforcement actions. Should you have any questions, or if we may be of assistance, please contact us at (208) 364-1962 and ask for the Residential Assisted Living Facility program. Thank you for your continued participation in the Idaho Residential Care Assisted Living Facility program.

Sincerely,

JAMIE SIMPSON, MBA, QMRP
Program Supervisor
Residential Assisted Living Facility Program

JS

CORE ISSUES

Facility	License #	Physical Address	Phone Number
Hancock House - CTM Enterprises	RC-750	7100 South Valley Heights Drive	208-344-9044
Administrator	City	Zip Code	Survey Date
Chris Moore	Boise	83709	12/17/2015
Survey Team Leader	Survey Type		Response Due
Hauser, Matt	Complaint Investigation		
Administrator Signature	Date Signed		

Item #	Rule	Description
1	16.03.22.000 Initial Comments	The following deficiency was cited during the complaint investigation conducted between December 15, 2015 and December 17, 2015 at your residential care/assisted living facility. The surveyors conducting the survey were: Matt Hauser, QIDP Team Leader Health Facility Surveyor Rae Jean McPhillips, RN, BSN Health Facility Surveyor
2	16.03.22.520-10 Resident Rights	Based on record review and interview it was determined the facility failed to protect 1 of 4 sampled residents' (Resident #1) right to be treated with dignity and respect. The findings include: IDAPA 16.03.22.010 defines Inadequate Care as: "When a facility...engages in violations of resident rights...." IDAPA 16.03.22.550.03.b. states "Each resident has the right to

		be treated with dignity and respect." Resident #1's closed record documented he was a 44 year-old male admitted to the facility on 3/6/2013 and discharged to a local hospital on 10/29/14. His record documented his diagnoses included borderline personality disorder, insomnia, PTSD, schizoaffective disorder, depression and panic disorder with agoraphobia. Staff notes, dated 8/29/14 through 10/22/14, were reviewed. The notes documented Resident #1 became incontinent of bowel several times a day starting in September 2014. The notes documented staff had to assist Resident #1 after his incontinent episodes with showers, washing his bedding and clothing, deep cleaning his room and common areas, sometimes multiple times in a day. On 12/15/15 from 9:30 AM through 10:30 AM, seven residents were interviewed. Of the 7 residents interviewed, two residents (Resident #3 and #4) stated they resided at the facility when Resident #1 lived there. They stated, they remembered Resident #1 and the former house manager during that time period. The other 5 residents stated they did not live at the facility when Resident #1 resided there. On 12/15/15 at 9:38 AM, Resident #3 stated the former house manager "yelled a lot" and did not like helping Resident #1. Additionally, he stated the former house manager was "mean" to Resident #1. On 12/15/15 at 10:20 AM, Resident #4 stated the former house manger yelled at residents. He stated the former house manager was "mean to [Resident #1's name] and nagged him." Resident #4 stated, he thought the former house manager

		"couldn't handle it any more and was frustrated with the situation [Resident #1's frequent episodes of diarrhea]." On 12/15/15 at 1:32 PM, Resident #1 was interviewed at his current residence. He stated the former house manager yelled at him and was "abrasive, made snide remarks and was a bitch to him and other residents." He stated the former house manager checked on him in the bathroom after episodes of diarrhea, because she "didn't trust me to wash and dry." Additionally, Resident #1 stated the former house manager badgered and nagged him until he cut his hair to get her "off his back." Resident #1 further stated, he did not report the former house manager to the facility administrator, but "knew [Resident #2's name] reported it to the facility administrator." Resident #2 was deceased at the time of the complaint investigation and could not be interviewed. On 12/16/15 at 11:45 AM, the current house manager stated, she began as house manager in August 2015. She stated the former house manager was transferred to a sister facility at the end of August 2015. She stated, she provided quality assurance for approximately 2 years prior to becoming the house manager, during that time residents complained the former house manager was very short with the residents and did not have a lot of patience. She stated sometime around September 2015, a few of the residents complained to her again about the former house manager treating them "crappy." She stated, she reported the complaints to the administrator in September 2015 and was told he would speak to the former house manager about it. On 12/16/15 at 11:58 AM, the administrator confirmed he received complaints from residents about the former house

		manager. He stated Resident #2 called him several times regarding the former house manager's treatment of residents. He stated these complaints were "about a year or a year and 1/2 ago." He stated, he did not document the complaints or investigations, but had "unsubstantiated the complaints and felt the residents were not in danger." The administrator also confirmed the current house manager reported residents' complaints about the former house manager, but since the former house manager was no longer at this facility, he felt "the problem was solved." The administrator stated the former house manager was given verbal counseling and training regarding being calmer during conflicts with residents. On 12/16/15, the facility submitted documentation on a calendar that the administrator provided the former house manager with 2 hours of conflict management training on June 4, 2014 and 1/2 hour of conflict management on October 15, 2015. There was no evidence the administrator provided training to the former house manager after complaints of treating Resident #1 and other residents in a "mean" and disrespectful manner. On 12/17/15 at 9:11 AM, the former house manager stated she had yelled at Resident #1. She stated, Resident #1 "got mad if he had to sit on the toilet and wait until he had a bowel movement." She stated he would get up to go smoke and have diarrhea "all over the place." She stated she yelled at Resident #1 saying, "I told you to sit there, and you didn't." She denied that she yelled at other residents. She stated, "I'm a perfectionist. I first thought my job was to change people. I would get frustrated." She further stated, when residents first complained, the administrator trained her "to be more kind and have a calm voice...to help them."

		The facility did not protect Resident #1's, and other residents', rights when they allowed the former house manager to continue working without implementing interventions to ensure the residents' right to be treated with dignity and respect. This resulted in inadequate care.

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ASSISTED LIVING
Non-Core Issues Punch List

Facility	License #	Physical Address		Phone Number
HANCOCK HOUSE - CTM ENTERPRISES	RC-750	1322 HANCOCK DRIVE		(208) 344-9044
Administrator	**City**		**ZIP Code**	**Survey Date**
Chris Moore	BOISE		83706	December 17, 2015
Survey Team Leader	**Survey Type**			**RESPONSE DUE:**
Matt Hauser, QMRP/QIDP	Complaint Investigation			January 16, 2016
Administrator Signature	**Date Signed**			

NON-CORE ISSUES

Item #	IDAPA Rule # 16.03.22.	Description	Department Use Only: EOR Accepted	Department Use Only: Initials
1	305.02	The facility did not document investigations for all complaints and allegations of a caregiver yelling at residents.		
2	350.03	There was no evidence the facility protected residents after allegations were made regarding a caregiver yelling at residents.		
3	350.04	Complainants' were not given a written response within 30 days of their complaints.		
4	350.05	The facility did not notify adult protection after allegations of a caregiver yelling at residents.		
5	350.08	The administrator did not identify or monitor patterns of incidents or complaints.		
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December 29, 2015

Chris Moore, Administrator
Hancock House - CTM Enterprises
7100 South Valley Heights Drive
Boise, Idaho 83709

Mr. Moore:

An unannounced, on-site complaint investigation was conducted at Hancock House - CTM Enterprises between December 15, 2015 and December 17, 2015. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # 5530

Allegation #1: Residents were not treated with respect and dignity when a staff yelled and screamed at them.

Findings: Substantiated. The facility was issued a core deficiency at IDAPA 16.03.22.520.10 for staff not treating residents with respect and dignity. The facility was required to submit a plan of correction within 10 days.

Allegation #2: Residents' pain medications were not given as ordered by their physicians.

Findings: Unsubstantiated.

Allegation #3: The administrator did not respond to complainants in writing within 30 days.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.350.04 and has to submit evidence of resolution within 30 days.

Allegation #4: Residents' privacy was not protected when residents were unable to lock the facility's bathroom doors.

Findings: Unsubstantiated. Though the allegation may have occurred, it could not be determined during the complaint investigation.

If you have questions or concerns regarding our visit, please call us at (208) 364-1962. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,

Matt Hauser, QMRP
Health Facility Surveyor
Residential Assisted Living Facility Program

MH/sc