



IDAHO DEPARTMENT OF  

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HEALTH & WELFARE

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

LESLIE M. CLEMENT—DEPUTY DIRECTOR  
RANDY MAY —DEPUTY ADMINISTRATOR  
LICENSING AND CERTIFICATION  
P.O. Box 83720  
Boise, Idaho 83720-0036  
PHONE 208-334-6626  
FAX 208-364-1888

November 4, 2011

Trista Wolfe, Administrator  
Quaker Ridge  
2087 South Tollgate Way  
Boise, ID 83709

License #: Rc-563

Dear Ms. Wolfe:

On August 31, 2011, a Complaint Investigation survey was conducted at Quaker Ridge. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level(s):

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

This office is accepting your submitted evidence of resolution.

Should you have questions, please contact Matt Hauser, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 334-6626.

Sincerely,

Matt Hauser  
Team Leader  
Health Facility Surveyor  
Residential Assisted Living Facility Program

MH/mh

c: Jamie Simpson, MBA, QMRP Supervisor, Residential Assisted Living Facility Program



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September 6, 2011

FILE COPY

Trista Wolfe, Administrator  
Quaker Ridge  
2087 South Tollgate Way  
Boise, ID 83709

Dear Ms. Wolfe:

An unannounced, on-site complaint investigation survey was conducted at Quaker Ridge on August 31, 2011. During that time, observations, interviews, and record reviews were conducted with the following results:

Complaint # ID00005171

- Allegation #1: An identified resident was not given a 30 day written discharge notice.
- Findings #1: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.221.01.a for not giving an identified resident a written 30 day discharge notice. The facility was required to submit evidence of resolution within 30 days.
- Allegation #2: An identified resident's rights were violated when the facility owner discussed her medical condition in front of his friend.
- Findings #2: Substantiated. However, the facility was not cited as they acted appropriately by identifying the problem and correcting it. The staff member who had spoken to a hospital employee about the resident's condition in front of another individual was reprimanded and all staff were re-trained on the facility's confidentiality policy prior to the survey investigation. The staff member also provided a written apology to the resident prior to the survey investigation. All 8 current residents interviewed, had no complaints regarding the facility maintaining their confidentiality or respecting their right to privacy.
- Allegation #3: An identified resident's rights were violated when the administrator intimidated the resident.

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Findings #3: On 8/31/11 from 8:00 AM, until 12:00 PM, all eight current residents were interviewed. All stated they did not feel threatened or intimidated by staff. None had complaints regarding being mistreated by staff. During this time, staff were observed to treat residents in a courteous manner.

On 8/31/11 at 10:30 AM, the ombudsman stated he had not observed staff mistreat residents when visiting the facility and had not received any complaints regarding the mistreatment of residents.

Care notes reviewed for three sampled resident records, did not contain documentation regarding a violation of any residents' rights.

Unsubstantiated. This does not mean the incident did not take place; it only means that the allegation could not be proven.

Allegation #4: An identified resident was not properly assisted with medication, when their medication was not given before meals.

Findings #4: On 8/31/11, the identified resident no longer resided at the facility. The resident's closed record was reviewed. The resident's medication assistance records documented the identified resident was assisted with the medication prior to the scheduled meal times.

On 8/31/11 at 11:45 AM, the house manager stated that to her knowledge, the medication was always given prior to meals.

On 8/31/11 at 8:10 AM, the house manager was observed assisting with medications appropriately. Eight residents interviewed, stated they had no complaints regarding the medication assistance process.

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

Allegation #5: The administrator did not investigate an identified residents complaint, nor provide the resident a written report of the findings.

Findings #5: On 8/31/11, the identified resident's closed record contained documentation regarding complaints received, the administrator's investigation and response to the identified resident.

Unsubstantiated.

Trista Wolfe, Administrator  
September 6, 2011  
Page 3 of 3

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,



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

FILE COPY

mh/rc

c: Jamie Simpson, MBA, QMRP, Supervisor, Residential Assisted Living Facility Program



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September 6, 2011

Trista Wolfe, Administrator  
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2087 South Tollgate Way  
Boise, ID 83709

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Dear Ms. Wolfe:

An unannounced, on-site complaint investigation survey was conducted at Quaker Ridge on 8/31/11. During that time, observations, interviews, and record reviews were conducted with the following results:

**Complaint # ID00005176**

**Allegation #1:** An identified resident did not receive a medication as ordered and the resident had to be admitted to the hospital due to a seizure.

**Findings #1:** On 8/31/11, the identified resident's record was reviewed. It contained care notes documenting the resident was admitted to the hospital on 7/27/11, after experiencing a seizure. The seizure was determined to be a result of the resident's Klonopin medication being decreased too abruptly. The resident's record contained physician's orders documenting that on 6/22/11, the resident's Klonopin was ordered to be given as needed (prn) for anxiety, rather than scheduled. June and July 2011 medication assistance records documented the resident received the medication as ordered by the physician. A fax to the physician on 6/30/11, documented the facility clarified the medication change with the physician, to ensure it was intended to be ordered as prn. Another fax to the physician on 7/20/11, documented the facility was requesting the medication be ordered as scheduled, rather than prn.

Unsubstantiated.

As no deficiencies were cited as a result of our investigation, no response is necessary to this report.

Trista Wolfe, Administrator  
September 6, 2011  
Page 2 of 2

Thank you to you and your staff for the courtesies extended to us on our visit.

Sincerely,



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

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mh/rc

c: Jamie Simpson, MBA, QMRP, Supervisor, Residential Assisted Living Facility Program



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Trista Wolfe, Administrator  
Quaker Ridge  
2087 South Tollgate Way  
Boise, ID 83709

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Dear Ms. Wolfe:

An unannounced, on-site complaint investigation survey was conducted at Quaker Ridge from on August 31, 2011. During that time, observations, interviews, and record reviews were conducted with the following results:

**Complaint # ID00005177**

Allegation #1: Staff did not ensure medications were kept locked.

Findings #1: Substantiated. However, the facility was not cited as they responded appropriately, by identifying the problem and correcting it, prior to the complaint investigation. The staff member who was found to have left medications unlocked was terminated and current staff were in-serviced on the facility's medication policy. On 8/31/11, from 8:30 AM until 12:00 PM, medications were observed to be locked appropriately or under the direct supervision of the house manager. The house manager described the facility's policy on double locking medications. Additionally, 8 residents interviewed stated they had not observed medications to be unlocked.

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.

Trista Wolfe, Administrator  
September 6, 2011  
Page 2 of 2

Sincerely,

A handwritten signature in blue ink, appearing to read 'M Hauser', with a long horizontal line extending to the right.

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

FILE COPY

mh/rc

c: Jamie Simpson, MBA, QMRP, Supervisor, Residential Assisted Living Facility Program



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Dear Ms. Wolfe:

An unannounced, on-site complaint investigation survey was conducted at Quaker Ridge on August 31, 2011. During that time, observations, interviews, and record reviews were conducted with the following results:

**Complaint # ID00005185**

**Allegation #1:** A caregiver did not treat residents with dignity and respect.

**Findings #1:** On 8/31/11 from 8:00 AM through 12:00 PM, all eight current residents were interviewed. All stated caregivers treated them with dignity and respect. None had complaints regarding being mistreated by staff. During this time, staff were observed to treat residents in a courteous manner.

On 8/31/11 at 10:30 AM, the ombudsman stated he had not observed staff mistreat residents when visiting the facility and had not received any complaints regarding the mistreatment of residents.

Care notes reviewed for three sampled resident records, did not contain documentation regarding a violation of any residents' rights.

Unsubstantiated. This does not mean the incident did not take place; it only means that the allegation could not be proven.

**Allegation #2:** The facility did not protect residents' rights to confidentiality.

**Findings #2:** Substantiated. However, the facility was not cited as they acted appropriately by

identifying the problem and correcting it. A staff member was determined to have breached an identified resident's confidentiality and was reprimanded; all staff were retrained on the facility's confidentiality policy prior to the survey investigation. The staff member also provided a written apology to the identified resident prior to the survey investigation. All 8 current residents interviewed, had no complaints regarding the facility maintaining their confidentiality or respecting their right to privacy.

Allegation #3: Snacks were not offered.

Findings #3: On 8/31/11, between 8 AM and 12:00 PM, all 8 current residents residing at the facility, stated snacks were offered to them throughout the day.

At 10:15 AM, a mid-morning snack of the residents' choice was observed being offered to each resident at the facility. At this time, the house manager stated snacks were offered three times a day.

A sign on the refrigerator documented various items available for snacks. Apples were observed in a fruit bowl located in the dining area and sufficient snack items were observed in the pantry.

Unsubstantiated. This does not mean the incident did not take place; it only means that the allegation could not be proven.

Allegation #4: An identified resident did not receive a physician ordered diet.

Findings #4: On 8/31/11, the identified resident no longer resided at the facility. The resident's closed record was reviewed. The resident's physician's order documented the identified resident was on a regular diet.

On 8/31/11 from 8:00 AM, until 12:00 PM, all 8 current residents were interviewed. All stated caregivers offered them meal substitutions if they requested something other than what was on the planned menu. None had complaints regarding their food preference being honored by the facility.

On 8/31/11 at 10:30 AM, the ombudsman stated he had no concerns regarding residents' diet preferences not being honored and had not received any complaints regarding residents diets.

Care notes reviewed for three sampled resident records, including the identified residents, did not contain documentation regarding a violation of any residents' rights or complaints regarding diets.

Unsubstantiated. This does not mean the incident did not take place; it only means that the allegation could not be proven.

Trista Wolfe, Administrator

September 6, 2011

Page 3 of 3

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,



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

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mh/rc

c: Jamie Simpson, MBA, QMRP, Supervisor, Residential Assisted Living Facility Program

