



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: 208-334-6626
FAX: 208-364-1888

September 27, 2013

Jessica Taylor, Administrator
Ashley Manor - Midland - Ashley Manor LLC
67 South Midland Boulevard
Nampa, ID 83651

License #: RC-536

Dear Ms. Taylor:

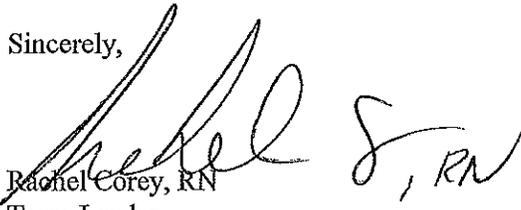
On August 22, 2013, a complaint investigation survey was conducted at Ashley Manor - Midland, Ashley Manor LLC. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level(s):

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

Your submitted 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 Rachel Corey, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 364-1962.

Sincerely,


Rachel Corey, RN
Team Leader
Health Facility Surveyor

RC/TFP

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



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August 27, 2013

Jessica Taylor, Administrator
Ashley Manor - Midland - Ashley Manor LLC
67 South Midland Boulevard
Nampa, ID 83651

Dear Ms. Taylor:

An unannounced, on-site complaint investigation survey was conducted at Ashley Manor - Midland, Ashley Manor LLC between August 20, 2013 and August 22, 2013. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00005948

Allegation #1: Caregivers were not provided with adequate orientation.

Findings #1: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.625.01 for not providing 16 hours of orientation for two sampled employees. Additionally, the facility was issued a deficiency at IDAPA 16.03.22.625.03.f for not ensuring all caregivers were adequately trained regarding each residents' care needs. The facility was required to submit evidence of resolution within 30 days.

Allegation #2: Residents were not assessed by the facility nurse after experiencing a change of condition.

Findings #2: Insufficient evidence was available in records reviewed to substantiate this allegation at the time of the investigation.

Unsubstantiated.

Allegation #3: Sufficient staff was not scheduled to meet the needs of the residents.

Findings #3: On 8/20/13 from 9:30 AM to 3:30 PM, the facility was observed during an unannounced survey. During this time, two caregivers were observed in each building and the administrator was present at the facility. Residents were observed to be

well-groomed and receiving assistance with toileting, showering, and grooming. On 8/21/13, the facility was observed from 8:00 AM until 11:00 AM, and residents were observed being supervised appropriately and were receiving assistance with meals, grooming tasks and medications. During the survey, 5 interviewable residents stated they received the necessary assistance from staff. Three family members were interviewed, and stated they felt staffing was sufficient to meet their loved one's care needs.

Between 8/20/13 and 8/21/13, five staff members from various shifts, were interviewed individually and in a private location. Each stated they were able to meet the needs of the residents with the amount of staff scheduled. Three staff members stated, cares would get delayed if a staff member "called in," but the tasks would get completed.

On 8/21/13 at 10:15 AM, the administrator stated she staggered staffing patterns to ensure extra coverage during busy times, such as meals and bathing times. She further stated, she was available to assist caregivers with providing assistance to residents during the week, and an administrator's assistant was available to provide extra assistance on the weekends.

Four records were reviewed for care issues. Activities of Daily Living ("ADL") sheets from March 2013 through August 2013 documented showers and assistance with cares being provided for each resident.

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

Allegation #4: Residents were not receiving assistance with ADL's (Activities of Daily Living).

Findings #4: Between 8/20/13 and 8/21/13, all residents were observed and appeared well-groomed. On 8/20/13, between 9:30 AM and 3:30 PM, three residents were observed to receive assistance with showers. Several residents were observed being assisted with grooming needs and taken to the restroom to receive assistance with toileting. Residents were observed being assisted when necessary with meals, snacks and mobility. Further observations were conducted on 8/21/13 from 8:00 AM until 11:00 AM, and residents were observed being provided the necessary care.

During the survey, five interviewable residents and three family members stated they were satisfied with the care provided by the facility. Additionally, five caregivers and the administrator stated staff were able to meet residents' care needs, which included toileting and repositioning residents every two hours.

Five sampled residents' records were reviewed. "ADL" sheets from March 2013 through August 2013, documented the residents received assistance with ADL tasks.

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

Allegation #5: Residents were chemically restrained prior to showers.

Findings #5: Insufficient evidence was available in records reviewed to substantiate this allegation at the time of the investigation.

Unsubstantiated. However, the facility was issued a related deficiency at 310.04.e for not providing behavioral updates to residents' physicians when behavior modifying medications were utilized.

Allegation #6: An identified employee did not treat residents with dignity and respect.

Findings #6: On 8/20/13 through 8/21/13, residents were observed being treated respectfully by all staff. Five interviewable residents described staff as kind and caring. Three family members stated they observed staff interact with residents in an appropriate manner.

During the survey, five caregivers and the administrator were interviewed individually and in private. They stated they had not witnessed staff mistreat residents or hear residents complain about it.

The facility's complaint log documented a complaint was filed regarding one employee had a "poor attitude." The complaint log documented the employee was counseled on appropriate behavior. There was no other complaints documented regarding staffs' behavior or interactions with residents.

The identified employee's file and four other employee's files were reviewed. Employee evaluations did not document any of the staff members were observed to mistreat residents.

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

Allegation #7: Residents were left in bed and not provided breakfast.

Findings #7: On 8/20/13, five caregivers and the administrator stated there were two to three residents who liked to sleep in. Those residents would be offered breakfast, but if they desired to sleep in, they would be provided breakfast at a later time. On 8/20/13 and 8/21/13, all residents were observed to be offered and served breakfast as they woke up. On 8/21/13 at 8:05 AM, one resident was observed to refuse breakfast; she was offered breakfast again at 9:10 AM, for which she accepted and was provided French toast.

On 8/20/13 at 3:30 PM, a resident's daughter stated her loved one liked to sleep in, but staff would offer her breakfast at a later time. The daughter stated she frequently came during meal times and her mother always ate very well.

"ADL" sheets were reviewed from March 2013 until August 2013, for two sampled residents, who liked to sleep in. The records documented that on most days the residents ate 75-100% of their breakfast meals.

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

Allegation #8: The facility did not have sufficient supplies, such as paper towels.

Findings #8: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.335.03 for not ensuring the facility had sufficient paper towels to promote proper handwashing. The facility was required to submit evidence of resolution within 30 days. However, it could not be verified at the time of the survey that sufficient toilet paper, gloves, or cleaning supplies were not available.

Allegation #9: The hot water heater in building two was not functional.

Findings #9: On 8/20/13 and 8/21/13, the hot water was tested and observed to be at an appropriate temperature. During the survey, 5 caregivers and the administrator stated they were unaware of a time when the hot water was not functional. They further stated, the maintenance man was very responsive to any maintenance issues they had.

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

Allegation #10: The facility did not have an activity program.

Findings #10: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.210 for not providing an activity program to engage residents. The facility was required to submit evidence of resolution.

Allegation #11: Food was not palatable.

Findings #11: Between 8/20/13 through 8/21/13, three meals and three snacks were observed. The meals appeared appetizing, and the residents were observed eating their meals without complaints. Five interviewable residents stated they were satisfied with the meals. During the survey, three family members were interviewed and stated the meals they had observed were appealing and their loved ones had not complained about the food.

The facility's complaint log was reviewed. It did not document any complaints were filed regarding food.

Unsubstantiated.

Allegation #12: Residents were not observed taking their medications.

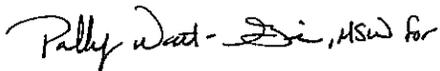
Findings #12: On 8/21/13, from 8:00 AM until 9:10 AM, medication pass was observed. The medication aid was observed to watch all residents take their medications. At 9:10 AM, a resident's medications were crushed and placed in pudding. At this time, the medication aid cued the resident to eat the pudding and stayed with the resident until the pudding was finished.

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

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 **August 22, 2013**. The completed punch list form and accompanying evidence of resolution (e.g., receipts, pictures, policy updates, etc) are to be submitted to this office within thirty (30) days from the exit date.

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,



Rachel Corey, RN
Health Facility Surveyor
Residential Assisted Living Facility Program

RC/tfp

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



ASSISTED LIVING
Non-Core Issues
Punch List

Facility Name Ashley Manor - Midland	Physical Address 67 South Midland Boulevard	Phone Number 208-461-1452
Administrator Jessica Taylor	City Nampa	Zip Code 83651
Team Leader Rachel Corey	Survey Type Complaint	Survey Date 08/21/13

NON-CORE ISSUES

Item #	RULE #	DESCRIPTION	DATE RESOLVED	L&C USE
1	210	All residents interviewed stated the facility did not offer activities which engaged them. Activities were not observed while on survey. Residents were observed sitting in common areas with no activities offered.	9/27/13 RC	
2	310.04.e	Psychotropic medication reviews did not include behavioral updates to the physician.	9/3/13 RC	
3	335.03	Sufficient paper towels were not available to promote proper hand-washing. As a result, staff were using shared cloth towels to dry their hands.	9/27/13 RC	
4	225.01	The facility did not evaluate environmental, medical and other causes contributing to behaviors, so that individualized interventions could be developed for Resident #1 and #2.	9/27/13 RC	
5	625.01	Two of five staff did not have documented evidence of 16 hours of orientation.	9/3/13 RC	
6	625.03. f	Caregivers who transferred from a sister facility were not provided adequate training on each resident's care needs.	9/3/13 RC	

Response Required Date 09/20/13	Signature of Facility Representative 	Date Signed 8/21/13
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