



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

December 15, 2014

Kimberly Keegan, Administrator
Ashley Manor - Cloverdale
3749 North Cloverdale Road
Boise, Idaho 83713

Provider ID: RC-555

Ms. Keegan:

On November 13, 2014, a complaint investigation survey was conducted at Ashley Manor - Cloverdale, Ashley Manor LLC. 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 Maureen McCann, RN, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 364-1962.

Sincerely,

MAUREEN MCCANN, RN
Team Leader
Health Facility Surveyor

MM/sc

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



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November 24, 2014

CERTIFIED MAIL #: 7007 3020 0001 4050 8654

Kimberly Keegan
Ashley Manor - Cloverdale, Ashley Manor LLC
3749 North Cloverdale Road
Boise, ID 83713

Provider ID: RC-555

Ms. Keegan:

Based on the Complaint Investigation survey conducted by Department staff at Ashley Manor - Cloverdale, Ashley Manor LLC between November 6, 2014 and November 13, 2014, it has been determined that the facility failed to protect residents from abuse and protect residents from inadequate care.

This core issue deficiency substantially limits the capacity of Ashley Manor - Cloverdale, Ashley Manor LLC to furnish services of an adequate level or quality to ensure that 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 December 28, 2014. 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 December 7, 2014, 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. Your evidence of resolution (e.g., receipts, pictures, policy updates, etc.) for each of the non-core issue deficiencies is to be submitted to this office by December 13, 2014.

Also, be aware that any variance allowing the administrator to serve over other facilities is revoked as of the date of the exit conference. The facility must now employ a single, licensed administrator who is not serving as administrator over any other facilities. Failure to do so within thirty (30) days of the date of the exit conference will result in a core issue deficiency.

If, at the follow-up survey, the core deficiency still exists or a new core deficiency is identified, or if any of the repeat non-core punches are identified as still out of compliance, the Department will have no alternative but to initiate an enforcement action against the license held by Ashley Manor - Cloverdale, Ashley Manor LLC.

Enforcement actions may include:

- imposition of civil monetary penalties;
- issuance of a provisional license;
- limitation on admission to the facility;
- requirement that the facility hire a consultant who submits periodic reports to Licensing and Certification.

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.

Kimberly Keegan
November 24, 2014
Page 3 of 3

Sincerely,

A handwritten signature in black ink, appearing to read "Jamie Simpson", with a long horizontal flourish extending to the right.

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

JS/mmc

Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R555	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/13/2014
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NAME OF PROVIDER OR SUPPLIER ASHLEY MANOR - CLOVERDALE, ASHLEY M.	STREET ADDRESS, CITY, STATE, ZIP CODE 3749 NORTH CLOVERDALE ROAD BOISE, ID 83713
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(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 care deficiencies were cited during the complaint investigation survey conducted between November 6, 2014 and November 13, 2014 at your residential care/assisted living facility. The surveyors conducting the survey were: Maureen McCann, RN Team Coordinator Health Facility Surveyor Rae Jean McPhillips, BSN, RN Health Facility Surveyor Donna Henscheid, LSW Health Facility Surveyor	R 000		
R 006	16.03.22.510 Protect Residents from Abuse. The administrator must assure that policies and procedures are implemented to assure that all residents are free from abuse. This Rule is not met as evidenced by: Based on interview and record review, it was determined the facility failed to protect 6 of 7 sampled residents (#1, #2, #3, #5, #6 and #7) from physical and verbal abuse. The findings include: The facility reported to Licensing and Certification that Reba Curtis worked as the administrator of Ashley Manor - Cloverdale from 12/5/12 through 5/13/14 and was moved to Ashley Manor - Storybook Way #1 on 5/14/14. According to interviews, the following incidents	R 006	Ashley Manor is devoted to the health, safety and well being of our residents. We would never knowingly put our residents in harms way. Unfortunately we investigated a complaint unrelated to what was discovered during your complaint investigation and the other charges, abuse, were never brought to light by the staff that we spoke with. You will see that we have changed the way our reporting is done and expect that the employees will not feel threatened in the future if they are in a situation that they feel needs to be reported and involves a superior.	

Buyer of Facility Standards
LA (STORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE) TITLE (X6) DATE

Kimberly Keegan Administrator

12.9.14

Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R555	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/13/2014
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R 006	<p>Continued From page 1</p> <p>took place between November 2013 through May 2014. Reba Curtis was the facility administrator and the alleged abuser during the time period when these incidents happened.</p> <p>1. According to her record, Resident #1 was a 78 year-old female admitted to the facility on 11/18/13 with a diagnosis of dementia. At the time of the survey, the resident no longer resided in the facility and was not available for interview.</p> <p>On 11/7/14 at 1:05 PM, Caregiver B stated Reba told Resident #1, who had once worked as a nurse, "You're not a nurse anymore, you're a fat bitch, you're nothing!"</p> <p>On 11/10/14 at 11:15 AM, Caregiver C stated Reba would swear at Resident #1. She stated Resident #1 would swear at Reba and Reba would "one up her" by swearing back at her, such as calling her "a bitch."</p> <p>On 11/10/14 at 1:30 PM, Caregiver D stated, she heard Reba say to Resident #1, "You're not a nurse now." Further, she stated she witnessed Reba grab Resident #1 and "yanked hard around her wrists" when assisting the resident out of a chair. The caregiver stated she later could see "fingerprint bruises" on Resident #1's wrists.</p> <p>On 11/10/14 at 2:55 PM, Caregiver E stated Reba would "get in" Resident #1's face. Reba "flipped her off and called her the B word" and threatened to move her out of the facility. Caregiver E stated Reba said "f*** you" which was directed at Resident #1. Further, the caregiver stated a complaint was made against Reba to the hospice director of nursing.</p> <p>2. According to her record, Resident #2 was a 61</p>	R 006	<p><u>R006 – 16.03.22.510 Protect Residents from Abuse</u></p> <p><u>What corrective actions will be accomplished for those specific residents/personnel/areas found to have been affected by the deficient practice?</u></p> <p>Residents #1 and #3 do not reside in the facility any longer. In regard to residents #2, 4,5,6, the Administrator has been removed from the facility and does not work for Ashley Manor any longer. We have a new Administrator that took over this facility when Reba was removed and is very compassionate and caring and has the trust and respect of the staff in the facility.</p>	
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Residential Care/Assisted Living

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R 006	<p>Continued From page 2</p> <p>year-old female admitted to the facility on 5/23/13 with a diagnosis of advanced dementia. Resident #2 was not interviewable due to her advanced dementia.</p> <p>Resident #2 was observed to wander aimlessly about the facility with her face towards the ground. She was observed to be unable to formulate words into comprehensible sentences.</p> <p>On 11/7/14 at 1:05 PM, Caregiver B stated Reba "grabbed" Resident #2 by her arms and "shoved" her down into a chair. She stated the incident was forceful enough to cause bruises on Resident #2's arms. Caregiver B stated that when she told Reba about the bruises the next day, Reba stated, "Oh, she's OK." Further, Caregiver B stated Reba would brag about kissing Resident #2's husband in front of the resident. She also stated Reba told Resident #2, "I'm f***ing your husband" and would sit on his lap in front of the resident.</p> <p>On 11/10/14 at 11:15 AM, Caregiver C stated Reba grabbed Resident #2's arm and "pushed her down into a chair." The caregiver stated this made her feel uncomfortable because "it was so forceful."</p> <p>On 11/10/14 at 2:55 PM, Caregiver E stated Reba "pushed" Resident #2 into a chair. She stated Resident #2 was yelling out and Reba pushed her down.</p> <p>3. According to her record, Resident #3 was an 80 year-old female admitted to the facility on 10/31/13 with a history of schizophrenia. Resident #3 was discharged from the facility on 6/5/14 and was not available for an interview.</p>	R 006	<p><u>How will we identify other residents/personnel/areas that may be affected by the same deficient practice and what corrective action will be taken?</u></p> <p><i>We have talked to the other residents and/or their families who were residing in the Facility during the period of time in question and they have assured us that they were not aware of problems with Reba and that they have no issues at the present time.</i></p> <p><i>We also sent a crew to the facility that Reba had been working at and viewed the tapes in the common areas and spoke with the staff and residents and families to rule out the possibility of abuse at that facility. They found no evidence of anything amiss at the new facility. Even though we did not find anything amiss at the other facility we did terminate Reba because of the substantiation of Abuse at Cloverdale.</i></p>	
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Residential Care/Assisted Living

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R 006	<p>Continued From page 3</p> <p>On 11/6/14 at 10:40 AM, Caregiver A stated she had not heard Reba swear at residents, but stated she was verbally "abrasive" towards residents. She stated Reba would "lose her patience" with Resident #3 and was inappropriate when she spoke to her.</p> <p>On 11/6/14 at 1:45 PM, Reba Curtis was interviewed at Ashley Manor, Storybook Way #1, where she was serving as the administrator. Reba stated she told Resident #3 that she would "hold the door open" for her if she wanted to move out. She stated, she felt she had "crossed the line" with her comments and tone of voice.</p> <p>On 11/7/14 at 1:05 PM, Caregiver B stated Reba was "especially" harsh towards Resident #3. Caregiver B stated Resident #3 frequently complained that she did not feel well, and Reba would reply, "Oh you don't feel good?" Then Reba would "flip her off behind her back." She stated Reba would tell Resident #3 she was not sick, but just "making it up." Additionally, she stated she would make the resident walk to the dining area, even if she felt ill.</p> <p>On 11/7/14 at 4:20 PM, an outside agency employee stated, Resident #3 reported to her that Reba was "unkind." The employee stated she had not seen or heard Reba abuse Resident #3, but she had witnessed Reba be "impatient" and "short" with other residents.</p> <p>On 11/10/14 at 11:15 AM, Caregiver C stated Reba and Resident #3 "did not get along." Resident #3 told Caregiver C "she was afraid" of Reba. She stated Reba threatened to kick Resident #3 out of the facility.</p> <p>On 11/10/14 at 1:30 PM, Caregiver D stated she</p>	R 006	<p><u>What measures will be put into place or what Systemic changes will be made to ensure that the deficient practice does not recur?</u></p> <p>We had all the staff in on November 25, 2014 and spoke extensively about the Abuse policy and the necessity to report anything at all that they felt uncomfortable with even if it was their supervisor, We have set up an "Employee Hotline for Abuse and Neglect Reporting" using a ring-central number that they can call and report anything that they are uncomfortable with. Please see the enclosed flyer that is currently in the Ashley Manor – Cloverdale house and is being distributed throughout Idaho.</p>	
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Residential Care/Assisted Living

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R 006	<p>Continued From page 4</p> <p>heard Reba say to Resident #3, "You can get up and walk, you know you can. If you want to eat, get into the dining room." Additionally, she stated Reba threatened to kick Resident #3 out of the facility, if the she did not do as she was told.</p> <p>On 11/10/14 at 2:55 PM, Caregiver E stated Reba was "verbally aggressive" with Resident #3. Caregiver E stated Reba would tell Resident #3 she was going to move her out of the facility.</p> <p>4. According to her record, Resident #5 was a 76 year-old female admitted to the facility on 5/20/13 with a diagnosis of dementia.</p> <p>On 11/6/14 at 1:45 PM, Reba confirmed she had "grabbed" Resident #5 by her arms, pushed her into a chair and "told her to sit," because Resident #5 was hitting and slapping her.</p> <p>On 11/10/14 at 11:15 AM, Caregiver C stated Reba grabbed Resident #5 "by the arms and put her into the chair." The caregiver said Reba could have "left bruises on the resident because she had to take her a long distance to the chair." The caregiver stated she felt the way Reba pushed the resident into the chair was "abusive."</p> <p>5. According to her record, Resident #6 was a 80 year-old female admitted to the facility on 8/24/13 with a diagnosis of Lewy-body dementia.</p> <p>On 11/10/14 at 1:30 PM, Caregiver D stated Resident #6 was "afraid to sleep in her room" for some reason. Caregiver D stated she witnessed Reba "roughly" take Resident #6 to her room because the resident did not want to go.</p> <p>6. According to her record, Resident #7 was a 90 year-old female admitted to the facility on 4/16/12</p>	R 006	<p><u>How will corrective actions be monitored and how often will monitoring occur to ensure that the deficient practice will not recur?</u></p> <p><i>The hotline number will email the VP of Operations any time a message is left. The VP of Operations will notify the Director of Operations immediately. Any allegations will be investigated within 24 hours by the Director of Operations or the designee assigned by the VP of Operations.</i></p> <p><u>By what date will corrective action be completed?</u></p> <p>The inservice with current staff was completed on November ^{25th}24th. See copy of sign in sheet and agenda. Marked Exhibit "A". The "Ring Central" (208-310-7999)number will be up and running and Flyers put up by 12-7-14.</p> <p>See copy of flyer attached. (Exhibit "B")</p>	
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Residential Care/Assisted Living

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R 006	<p>Continued From page 5</p> <p>with a diagnosis of dementia.</p> <p>On 11/7/14 at 1:05 PM, Caregiver B stated, Resident #7 called Reba "a bitch," to which Reba replied, "You're a bitch, you're a bitch!"</p> <p>Between 11/6/14 and 11/13/14, staff, family members, and outside agency staff made the following comments regarding Reba's abuse towards residents:</p> <p>*Caregiver A stated, she had witnessed Reba speak to residents in a "rude" and "abrasive" tone of voice, particularly when she was in a bad mood. She stated Reba Curtis was especially abusive towards Resident #1 and #3. The caregiver stated Reba Curtis's interactions with residents was frequently inappropriate.</p> <p>*A resident's family member stated he had seen the former administrator "push" a resident down into a chair. He additionally, stated he heard the former administrator speak harshly towards residents in a way he felt was abusive.</p> <p>*The former director of nursing of a hospice agency, stated she heard from the facility's staff, that Reba was physically and verbally abusive, but had not witnessed it herself. She stated staff told her Reba would call the residents "bitches" and "mother-f****er." She also stated staff told her Reba "pushed" residents if they were walking too slow. Finally, she stated staff told her, Reba told one resident if she told anyone about the way she was treated she would "kick her out" of the facility.</p> <p>*Caregiver C confirmed the "pushing into the chair" was done angrily and in an abusive way. Caregiver C further stated, Reba "would always</p>	R 006		
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R 008	Continued From page 6 threaten staff with their jobs." *Caregiver D stated, she had repeatedly witnessed Reba Curtis use a loud, abrupt tone of voice with residents and "She spoke to them like they were children." She further stated she had observed Reba treat residents "roughly". Caregiver D further stated, these interactions between Reba and the residents made her feel uncomfortable. She stated, "Of course it was abusive, I wouldn't want someone to do that to me." The facility failed to protect Resident #1, #2, #3, #5, #6 and #7 from physical and verbal abuse.	R 008		
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: IDAPA 16.03.22.011.08, defines Inadequate Care as: "When a facility...engages in violations of residents rights..." IDAPA 16.03.22.550.12 documents: "Each resident must have the right to control his receipt of health related services..." IDAPA 16.03.22.550.12.c documents, each resident must have the "right to confidentiality and privacy concerning his mental or dental condition and treatment..." IDAPA 16.03.22.430.04 documents, "The facility	R 008	R008: 16.03.22.520 Protect Residents from Inadequate Care What corrective action will be accomplished for those specific resident/personnel/areas found to have been affected by the deficient practice? <i>The resident in question, resident #3, no longer resides in the Ashley Manor-Cloverdale facility.</i>	

Residential Care/Assisted Living

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R 008

Continued From page 7

must have at least one (1) telephone that is accessible to all residents, and provide local calls at no additional cost. The telephone must be placed in such a manner as to provide the resident privacy while using the phone."

Based on interview it was determined the facility did not protect 1 of 7 sampled residents' (#3) right to control their health related services when they denied Resident #3 the use of a phone to call her physician. The findings include:

Resident #3's record documented she was an 80 year-old female admitted to the facility on 10/30/13 with a history of schizophrenia. The resident was discharged from the facility on 6/5/14 and was unavailable for interview.

On 11/7/14 at 1:05 PM, Caregiver B stated Resident #3 called her physician without Reba's knowledge, which made Reba angry. The caregiver stated Reba told Resident #3 she could not use the facility phone to call her physician. Additionally, the caregiver stated Reba frequently threaten to "kick" Resident #3 out of the facility if she did not "behave."

On 11/10/14 at 11:14 AM, Caregiver C stated Resident #3 was not allowed to contact her physician. She stated Resident #3's physician's was "OK" with the frequent calls, but Reba did not want the resident to call without her knowledge.

On 11/10/14 at 1:20 PM, Caregiver D stated Reba told Resident #3, she could not use the phone to call her physician.

On 11/7/14 at 4:20 PM, an outside agency employee stated it was reported to her, by the resident and 2 staff members, that Reba would

R 008

How will we identify other residents/personnel/areas that May be affected by the same deficient practice and what Corrective actions will be taken?

All residents who would like to use the phone (there are currently two) have been informed that the phone is available for use by them if they will let us know. They currently are reminded if they make a statement of wanting to call someone that they can use the phone.

Some of our residents have their own cell phones that they have brought from home.

What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?

Telephone Access: The staff will be oriented and trained in the provision of access of the resident to a private area for telephone use.

It will be explained that the facility phone use is

a business line and every effort will be made to provide use to the Residents as they request.

All staff will sign off on the policy and it will be posted in the facility and inservices will be conducted monthly for the first two months and Quarterly after that for two quarters. (See copy of signed sheet, Exhibit "A")

Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R555	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/13/2014
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NAME OF PROVIDER OR SUPPLIER ASHLEY MANDR - CLOVERDALE, ASHLEY M.	STREET ADDRESS, CITY, STATE, ZIP CODE 3749 NORTH CLOVERDALE ROAD BOISE, ID 83713
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(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
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R 008	Continued From page 8 not allow Resident #3 to call her physician. The facility failed to protect Resident #3's right to have access to her physician when they restricted her phone usage. This resulted in inadequate care.	R 008		
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How will the corrective action be monitored and how often will monitoring occur to ensure that the deficient practice will not recur?
The Administrator will periodically remind all of the residents that they can use the telephone and She will remind the staff that the resident can have access to the phone to make phone calls.

By what date will the corrective action be completed?
Initial review of the policy will be completed by December 7, 2014 and signed off by the employees and residents who use the phone.



Facility ASHLEY MANOR - CLOVERDALE	License # RC-555	Physical Address 3749 NORTH CLOVERDALE ROAD	Phone Number (208) 377-4929
Administrator Kimberly Keegan	City BOISE	ZIP Code 83713	Survey Date November 13, 2014
Survey Team Leader Maureen McCann	Survey Type Complaint Investigation	RESPONSE DUE: December 13, 2014	
Administrator Signature <i>Kimberly Keegan</i>	Date Signed 12.4.14		

NON-CORE ISSUES

Item #	IDAPA Rule #	Description	Department Use Only	
			EOR Accepted	Initials
1	153.01	The facility's staff did not follow their policy regarding reporting allegations of abuse.		
2	159.02.a	The facility did not follow their policy regarding electronic records to ensure integrity of the records was maintained.		
3	305.03	The facility's registered nurse did not complete an assessment when residents experienced a change in their physical or mental condition.		
4	450	The facility's staff used the kitchen sink to wash their hands after toileting residents.		
5	711.08	Progress notes were not documented by the staff who provided the care.		
6	711.08.c	The facility staff did not document all unusual incidents they stated they had witnessed to include mistreatment of residents.		
7	735.04	The facility did not identify or investigate discrepancies in control substance documentation.		
8		Solutions to NON-CORE ISSUES		
9	153.01	Inservice meeting was held on 11.25.14 for staff to review the procedure on reporting allegations of abuse		
10		See attached training attendance document abuse policy		
11		and procedure, marked 153.01 #1, 2, 3, 4, 5, 6, 7, 8		
12				
13	159.02A	Inservice meeting held 11.25.14 for staff. Policy & Procedure attached. Marked 159.02A #1		
14				
15	305.03	The facility RN in question is no longer with Ashley Manor. The current RN is very experienced with the Rules and regulations		
16				
17				
18	450.	Inservice held on 11.25.14 for staff. Policy and Procedure currently state no handwashing in the kitchen.		
19		Staff have reviewed the information. A hand sanitizer dispenser has been ordered and will (cont)		
20				
21				



Facility ASHLEY MANOR - CLOVERDALE	License # RC-555	Physical Address 3749 NORTH CLOVERDALE ROAD	Phone Number (208) 377-4929
Administrator Kimberly Keegan	City BOISE	ZIP Code 83713	Survey Date Nov
Survey Team Leader Maureen McCann	Survey Type Complaint Investigation		RES Dec
Administrator Signature <i>Kimberly Keegan</i>	Date Signed 12.9.14		

for info
OK

NON-CORE ISSUES

Item #	IDAPA Rule #	Description		
1	153.01	The facility's staff did not follow their policy regarding reporting allegations of abuse.		
2	159.02.a	The facility did not follow their policy regarding electronic records to ensure integrity of the records was maintained.		
3	305.03	The facility's registered nurse did not complete an assessment when residents experienced a change in their physical or mental condition.	12/9/14	UAC
4	450	The facility's staff used the kitchen sink to wash their hands after toileting residents.	12/9/14	UAC
5	711.08	Progress notes were not documented by the staff who provided the care.	12/9/14	UAC
6	711.08.c	The facility staff did not document all unusual incidents they stated they had witnessed to include mistreatment of residents.	12/9/14	UAC
7	735.04	The facility did not identify or investigate discrepancies in control substance documentation.	12/9/14	UAC
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IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK – ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
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RESIDENTIAL ASSISTED LIVING FACILITY PROGRAM
P.O. Box 83720
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December 1, 2014

Kimberly Keegan, Administrator
Ashley Manor - Cloverdale, Ashley Manor LLC
3749 North Cloverdale Road
Boise, Idaho 83713

Provider ID: RC-555

Ms. Keegan:

An unannounced, on-site complaint investigation was conducted at Ashley Manor - Cloverdale, Ashley Manor LLC between November 6, 2014 and November 13, 2014. During that time, observations, interviews, and record reviews were conducted with the following results:

Complaint # ID00006407

Allegation #1: The facility did not implement physicians' orders regarding weights and medications.

Findings: Substantiated. However, the facility was not cited as a plan was developed to correct the problem. After the plan was put into place, physician orders were implemented immediately.

Allegation #2: The facility RN did not document an assessment was completed when residents had changes of condition.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.305.03 for the facility nurse not documenting assessments were completed when residents had changes in their mental and physical status. The facility was required to submit evidence of resolution within 30 days.

Allegation #3: The facility did not provide residents assistance with their activities of daily living (ADL) needs, specifically toileting.

Findings: Substantiated. However, the facility was not cited as they had identified the deficiency, put a correction plan and had implemented the plan.

Allegation #4: The facility staff did not document the care and services they provided to residents.

Kimberly Keegan, Administrator
December 1, 2014
Page 2 of 2

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.711.08 for the caregivers not documenting the cares they provided to residents. The facility was required to submit evidence of resolution within 30 days.

Allegation #5: The facility did not follow their policy regarding electronic records to ensure integrity of the records was maintained.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.159.02 for not having a policy regarding the handling of electronic records. The facility was required to submit evidence of resolution within 30 days.

Allegation #6: The facility did not have appropriate staffing in place to meet the transferring needs of the residents requiring two-person assistance.

Findings: Unable to substantiate due to conflicting information. However, the facility was provided technical assistance to ensure staff were scheduled appropriately to provide two-person assistance, when required.

Allegation #7: Facility call lights were not in working condition.

Findings: Substantiated. However, the facility was not cited as the facility had identified the deficiency, repaired the call light system and the call lights were observed to be fully functional during the complaint investigation. The facility complaint log was reviewed and there were no complaints regarding the call light system since May 2014.

Allegation #8: The staff did not implement appropriate infection control measures.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.450 for not following the standards of the Idaho Food Code when they used the food preparation area to wash their hands after providing resident care and handling soiled items. The facility was required to submit evidence of resolution within 30 days.

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,



MAUREEN MCCANN, RN
Health Facility Surveyor
Residential Assisted Living Facility Program

MM/sc



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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December 1, 2014

Kimberly Keegan, Administrator
Ashley Manor - Cloverdale, Ashley Manor LLC
3749 North Cloverdale Road
Boise, Idaho 83713

Provider ID: RC-555

Ms. Keegan:

An unannounced, on-site complaint investigation survey was conducted at Ashley Manor - Cloverdale, Ashley Manor LLC between November 6, 2014 and November 13, 2014. During that time, observations, interviews, and record reviews were conducted with the following results:

Complaint # ID00006467

Allegation #1: The administrator restricted residents' right to call their physician.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.520 for restricting residents' right to call their physician. The facility was required to submit a plan of correction within 10 days.

Allegation #2: The facility administrator did not protect residents from abuse.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.510 for not protecting residents from abuse. The facility was required to submit a plan of correction within 10 days.

Allegation #3: The facility did not implement physician's orders regarding a urine analysis (UA).

Findings: Unsubstantiated. Although, the allegation for this resident was not substantiated, it was determined at the time of the complaint allegation, the facility had a system problem with physicians' orders being implemented. However, at the time of the complaint investigation, the facility had identified the system problems and corrected them.

Kimberly Keegan, Administrator
December 1, 2014
Page 2 of 2

Allegation #4: The facility did not appropriately assist and monitor medications.

Findings: Unsubstantiated. Although, the allegation for this resident was not substantiated, it was determined at the time of the complaint allegation, the facility had a system problem with assistance and monitoring of medications. However, at the time of the complaint investigation, the facility had identified the system problems and had corrected them.

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,



MAUREEN MCCANN, RN
Health Facility Surveyor
Residential Assisted Living Facility Program

MM/sc

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



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December 1, 2014

Kimberly Keegan, Administrator
Ashley Manor - Cloverdale, Ashley Manor LLC
3749 North Cloverdale Road
Boise, Idaho 83713

Provider ID: RC-555

Ms. Keegan:

An unannounced, on-site complaint investigation survey was conducted at Ashley Manor - Cloverdale, Ashley Manor LLC between November 6, 2014 and November 13, 2014. During that time, observations, interviews, and record reviews were conducted with the following results:

Complaint # ID00006469

Allegation #1: The facility did not maintain a food supply to meet the daily menu.

Findings: During the complaint investigation, from 11/6/14 through 11/13/14, observations of the pantry, refrigerators, and freezers were conducted. The facility was observed to have substantial food items to meet the dietician approved menu and the 7 day food supply. However, interviews with current and former staff members and administration confirmed the former administrator did not ensure there was an adequate amount of food items available to meet the menu or the 7 day food supply at times during the spring of 2014. Some staff members stated they had to purchase food and other items from their personal accounts to provide for the residents. The staff members stated since May 2014, when the new administrator started at the facility, the problem was corrected. The facility complaint log was reviewed and there were no complaints regarding the lack of food since May 2014.

Substantiated. However, the facility was not cited as they had identified there had been a lack of food at times during the spring of 2014 and corrected the issue in May 2014, when the new administrator took over.

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,

MAUREEN MCCANN, RN
Health Facility Surveyor
Residential Assisted Living Facility Program

MM/sc



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December 1, 2014

Kimberly Keegan, Administrator
Ashley Manor - Cloverdale, Ashley Manor LLC
3749 North Cloverdale Road
Boise, Idaho 83713

Provider ID: RC-555

Ms. Keegan:

An unannounced, on-site complaint investigation survey was conducted at Ashley Manor - Cloverdale, Ashley Manor LLC between November 6, 2014 and November 13, 2014. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00006488

Allegation #1: The former administrator was mentally, physically and verbally abusive towards residents.

Findings: Substantiated. The facility was issued a core deficiency at IDAPA 16.03.22.510 for not protecting residents from abuse. The facility was required to submit a plan of correction within 10 days.

Allegation #2: The facility staff did not follow their policy regarding reporting abuse.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.153.01 for not staff reporting physical and verbal abuse according to the facility's abuse policy. The facility was required to submit evidence of resolution within 30 days.

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,

MAUREEN MCCANN, RN
Health Facility Surveyor
Residential Assisted Living Facility Program

MM/sc

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