



IDAHO DEPARTMENT OF
HEALTH & WELFARE

G.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

April 6, 2015

Patsy Strom, Administrator
Ashley Manor - Hawthorne
4826 Hawthorne Road
Chubbuck, Idaho 83202

Provider ID: RC-753

Ms. Strom:

On February 26, 2015, a state licensure survey/follow-up/revisit survey was conducted at Ashley Manor - Hawthorne. 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 Donna Henscheid, LSW, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 364-1962.

Sincerely,

DONNA HENSCHIED, LSW
Team Leader
Health Facility Surveyor

DH/sc

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



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P.O. Box 83720
Boise, Idaho 83720-0009
EMAIL: ralf@dhw.idaho.gov
PHONE: 208-364-1962
FAX: 208-364-1888

March 4, 2015

CERTIFIED MAIL #: 7007 3020 0001 4050 8807

DawnRae Hoffman, Administrator
Ashley Manor - Hawthorne
4826 Hawthorne Road
Chubbuck, Idaho 83202

Ms. Hoffman:

On February 26, 2015, a state licensure/follow-up/revisit survey conducted by Department staff at Ashley Manor - Hawthorne, Ashley Manor, LLC. The facility was cited with a repeat core issue deficiency for failing to protect residents from inadequate care.

This core issue deficiency substantially limits the capacity of Ashley Manor - Hawthorne, Ashley Manor, LLC to provide for residents' basic health and safety needs. The deficiency is described on the enclosed Statement of Deficiencies.

PROVISIONAL LICENSE:

As a result of the survey findings, a provisional license is being issued on March 5, 2015 and will remain in effect for 180 days or until a follow-up survey can be conducted to determine the facility's full compliance with the administrative rules for Residential Care or Assisted Living Facilities in Idaho. **Return the license currently held by the facility immediately.** The following administrative rule for Residential Care or Assisted Living Facilities in Idaho (IDAPA 16.03.22) gives the Department the authority to issue a provisional license:

935. ENFORCEMENT REMEDY OF PROVISIONAL LICENSE.

A provisional license may be issued when a facility is cited with one (1) or more core issue deficiencies, or when non-core issues have not been corrected or become repeat deficiencies. The provisional license will state the conditions the facility must follow to continue to operate. See Subsections 900.04, 900.05 and 910.02 of these rules.

Conditions of Provisional License 1-2:

PLAN OF CORRECTION:

1. 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?

An acceptable, **signed** and **dated** Plan of Correction must be submitted to the Division of Licensing and Certification within **ten (10) calendar days of your receipt of the Statement of Deficiencies**. You are encouraged to immediately develop and submit this plan so any adjustments or corrections to the plan can be completed prior to the deadline.

EVIDENCE OF RESOLUTION:

2. Non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference. The following administrative rule for Residential Care or Assisted Living Facilities in Idaho (IDAPA 16.03.22) describes the requirements for submitting evidence that the non-core issue deficiencies have been resolved:

910. Non-core Issues Deficiency.

01. Evidence of Resolution. Acceptable evidence of resolution as described in Subsection 130.09 of these rules, must be submitted by the facility to the Licensing and Survey Agency. If acceptable evidence of resolution is not submitted within sixty (60) days from when the facility was found to be out of compliance, the Department may impose enforcement actions as described in Subsection 910.02.a through 910.02.c of these rules.

The fourteen (14) non-core issue deficiencies must be corrected and evidence (including but not limited to receipts, pictures, completed forms, records of training) must be submitted to this office by **March 27, 2015**.

ADMINISTRATIVE REVIEW

You may contest the provisional license by filing a written request for administrative review pursuant to IDAPA 16.05.03.300, which states: **the request must be signed by the licensed administrator of the facility, identify the challenged decision, and state specifically the grounds for your contention that this decision is erroneous.** The request must be received **no later than twenty-eight (28) days after this notice was mailed.** Any such request should be addressed to:

Tamara Prisock, Administrator
Division of Licensing and Certification - DHW
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036

Upon receipt of a written request that meets the requirements specified in IDAPA 16.05.03.300, an administrative review conference will be scheduled and conducted. The purpose of the conference is to clarify and attempt to resolve the issues. A written review decision will be sent to you within thirty (30) days of the date of the conclusion of the administrative review conference.

If the facility fails to file a request for administrative review within the above specified time period, this decision shall become final.

INFORMAL DISPUTE RESOLUTION

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.

FOLLOW-UP SURVEY

An on-site, follow-up survey will be scheduled after the administrator submits a letter stating that all deficiencies have been corrected and systems are in place to assure the deficient practices remain corrected. If at the follow-up survey, the core issue deficiency still exists, a new core issue deficiency is identified, non-core deficiencies have not been corrected, or the facility has failed to abide by the conditions of the provisional license, the Department will take further enforcement action against the license held by Ashley Manor - Hawthorne, Ashley Manor, LLC. Those enforcement actions will include one or more of the following:

- Revocation of the Facility License
- Summary Suspension of the Facility License
- Imposition of Temporary Management
- Limit or Ban on Admissions
- Civil Monetary Penalties

Division of Licensing and Certification staff is available to assist you in determining appropriate corrections and avoiding further enforcement actions. Please contact our office at (208) 364-1962 if we may be of assistance, or if you have any questions.

Sincerely,



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

JS/sc

Enclosure

cc: Medicaid Notification Group

Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R753	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/26/2015
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NAME OF PROVIDER OR SUPPLIER ASHLEY MANOR - HAWTHORNE, ASHLEY MA	STREET ADDRESS, CITY, STATE, ZIP CODE 4826 HAWTHORNE ROAD CHUBBUCK, ID 83202
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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 repeat core deficiency was cited during the Follow-up and Licensure survey conducted on 2/24/15 through 2/26/15 at your residential care/assisted living facility. The surveyors conducting the survey were: Donna Henscheid, LSW Team Coordinator Health Facility Surveyor Maureen McCann, RN Health Facility Surveyor Abbreviations: 1:1 = one to one NSA = negotiated service agreement	{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: On 9/26/14, the facility received a deficiency for inadequate care during a complaint investigation survey. Between 2/24/15 and 2/26/15, inadequate care was again identified during a follow-up survey. Based on observation, interview and record reviewed, it was determined, the facility failed to provide adequate supervision to 1 of 4 sampled residents (Resident #1). These findings include: SUPERVISION:	{R 008}	A new Administrator in place as of 3-10-15 (A) The Resident's Roster Was updated and is accurate A NSA list was created which contains all the Residents's names this list will be utilized by staff for all fire drills/evacuations This list is located on the cork board in the Office	3/13/15

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Patsy Stum</i>	TITLE <i>Adm.</i>	(X6) DATE <i>3/13/15</i>
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Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R753	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/26/2015
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{R 008}	<p>Continued From page 1</p> <p>IDAPA 16.03.22.012.25, defines supervision as, "A critical watching and directing activity which provides protection, guidance, knowledge of the resident's general whereabouts, and assistance with activities of daily living. The administrator is responsible for providing the appropriate supervision based on each resident's Negotiated Service Agreement or other legal requirements."</p> <p>According to his record, Resident #1 was an 89 year-old male who was admitted to the facility on 2/5/14 with a diagnosis of progressive dementia. The record indicated the resident was diagnosed as legally blind and very hard of hearing.</p> <p>On 2/24/15, a resident roster documented there were 11 residents residing in the facility. Nine residents had a diagnosis of dementia. The administrator stated all residents had some type of memory impairment.</p> <p>Between 2/24/15 and 2/26/15, Resident #1 was observed frequently ambulating independently throughout the facility with a slow, shuffling gait.</p> <p>A) EMERGENCY EVACUATION:</p> <p>Resident #1's NSA, updated on 2/5/15, documented staff were to "Take" the resident's "hand and lead to" a safe place during an emergency.</p> <p>On 2/25/15 at 11:22 AM, the facility fire alarm sounded and one of the facility staff stated a pot had "burnt" on the stove. The administrator and two caregivers began evacuating the 11 residents out of the building. Resident #1 was not observed to be assisted and "lead to safety." When the administrator instructed the residents and staff to</p>	{R 008}	<p>An emergency roster was created that contains the information on page 13 of the NSA for assistance needed to evacuate and identifies those Residents at risk of re-entering the building. This list is located under the NSA list</p> <p>(an unplanned fire drill was completed on 3-10 utilizing the NSA list and the evacuation list and the drill was completed successfully – Resident #1 was successfully evacuated and prevented from re-entering facility)</p> <p>3-13-15 the Staff inserviced on Utilizing these documents (attachment)</p> <p>The Administrator will ensure that all monthly planned fire drills and unplanned fire drills and evacuations will utilize these documents</p>	<p>3/13/15</p> <p>3/13/15</p>

Residential Care/Assisted Living

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{R 008}	<p>Continued From page 2</p> <p>return to the building, a surveyor asked if all of the residents had been accounted for? Twice, the administrator stated, all of the residents had been evacuated, except a female resident, who was still in the building with "her nurse." As the evacuated staff and residents returned to the building, Resident #1 was observed exiting the building, unattended. Neither the administrator nor the two caregivers noticed Resident #1 had not evacuated the building.</p> <p>The administrator and two caregivers on duty did not provide Resident #1 any supervision or hands on assistance during a fire alarm and subsequent facility evacuation, which resulted in the resident not being evacuated at all. The facility did not have an effective plan to assure all residents were evacuated in the event of an emergency. This created the potential for a resident to be left in a burning building.</p> <p>B) 1:1 WHEN AMBULATING:</p> <p>From October 2014 through February 2015, Resident #1's record documented he experienced at least 20 incidents which consisted of either a fall, a fall with an injury or an observation by staff of an injury of unknown origin. Some of the injuries Resident #1 had sustained were various lacerations and skin tears, a bloody nose, bruises to his face and sutures to his head.</p> <p>Resident #1's NSA was updated on 2/5/15 and contained a handwritten note which documented the resident was to have a 1:1 with a staff member when he "was ambulating."</p> <p>A "Temporary Plan of Care," dated 2/7/15, documented Resident #1 was to have "Staff 1:1 ratio" when the resident was "up and about."</p>	{R 008}	<p>(B)</p> <p>Resident # 1 – has not fallen since survey exit</p> <p>Resident #1 – NSA was reviewed and updated to reflect his present status</p> <p>A skin assessment was completed on Resident #1 with no new skin issues</p> <p>All I&A's /skins have been reviewed since 2-26 and investigations have been completed</p> <p>Blank skin sheets will be placed on a clip board in the tub room for staff to fill out with each bath. The completed skin sheet will be placed in a 3-ring binder designated for completed skin sheets for the Administrator to investigate and RN to follow-up.</p>	<p>3/13/15</p> <p>3/13/15</p>

Residential Care/Assisted Living

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{R 008}	<p>Continued From page 3</p> <p>An "Incident Report," dated 2/8/15, documented Resident #1 had an "unwitnessed" fall and sustained "Bleeding over left eye, skin tears on left top wrist...Skinned forehead where sutures were."</p> <p>A "Skin Report," dated 2/14/15, documented "Red liquid coming from back of right hand." There was no further documentation in Resident #1's record regarding this injury.</p> <p>A "Significant Change/Modification Request Form," dated 2/20/15, from the facility to The Bureau of Long Term Care requested an "Increase in unmet needs." The form documented the reason for the request was Resident #1 now required "One to one while ambulating due to an increase in falls and unsteady gait."</p> <p>The facility staff schedule for January and February 2015 was reviewed. Only one staff was scheduled for 14 hours during each day. A single staff member worked between 2:00 PM and 4:00 PM and between 8:00 PM and 10:00 AM the next morning.</p> <p>Between 2/24/15 and 2/26/15, Resident #1 was observed frequently ambulating throughout the facility with a slow, shuffling gait. Staff were not observed to provide 1:1 supervision while the resident was ambulating. Occasionally, a staff member was observed walking with and/or interacting with the resident. At times, there were no staff in sight of Resident #1.</p> <p>Between 2/24/15 and 2/26/15, three caregivers stated they "heard" Resident #1 was on a 1:1 related to the number of falls he had sustained. All three stated the 1:1 was not implemented.</p>	{R 008}	<p>3-13-15 Staff inserviced on the skin sheets and their completion (attachment)</p> <p>Staff inservice on 3-13-15 the NSA's reviewed/signed by staff (attached)</p> <p>The Administrator will notify staff of the need to review and sign the updated NSA's</p> <p>The Administrator will audit the charts to ensure staff have reviewed and signed the updated NSAs – per the NSA schedule or as indicated</p> <p>The Administrator will review the staffing schedule and initial the schedule to ensure staffing is in place for adequate Resident care</p>	<p>3/13/15</p> <p>3/13/15</p>

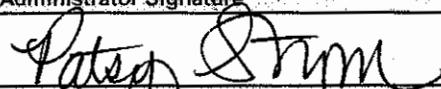
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{R 008}	<p>Continued From page 4</p> <p>Further, they stated there were times during each shift when there was only one caregiver in the building. One caregiver stated, "When I first heard this, I thought we would have more staff on, but that didn't happen. We do our best to keep an eye on him."</p> <p>On 2/25/15 at 9:30 AM, the administrator stated the corporate nurse decided the resident should have 1:1 supervision when ambulating. Further, she stated the corporate office determined how many staff the facility scheduled.</p> <p>The facility did not provide 1:1 supervision when Resident #1 was ambulating. Further, the facility did not increase staffing to ensure Resident #1 had this level of supervision as documented in the resident's NSA. After the facility determined he should receive 1:1 supervision, Resident #1 sustained an "unwitnessed" fall with an injury and another injury of an unknown origin.</p> <p>The facility did not provide adequate supervision when they failed to assist Resident #1 to evacuate in an emergency. Further, the facility failed to provide Resident #1 one to one assistance with ambulation as documented in his NSA. These failures resulted in inadequate care.</p> <p>THIS IS A REPEAT CORE DEFICIENCY</p>	{R 008}	<p>The Administrator - not the nurse nor the Corporate office determine the Resident's level of care needs.</p> <p>The Operations director will audit monthly to ensure compliance</p>	3/13/15



Facility ASHLEY MANOR - HAWTHORNE	License # RC-753	Physical Address 4826 HAWTHORNE ROAD	Phone Number (208) 637-1200
Administrator DawnRae Hoffman	City CHUBBUCK	ZIP Code 83202	Survey Date February 26, 2015
Survey Team Leader Donna Henscheid	Survey Type Licensure and Follow-up	RESPONSE DUE: March 28, 2015	
Administrator Signature 	Date Signed 3/25/15		

NON-CORE ISSUES

Item #	IDAPA Rule # 16.03.22.	Description	Department Use Only	
			EOR Accepted	Initials
1	009.01	The facility did not have documented evidence of criminal history and backgrounds checks for 3 of 4 employees.	4/6/15	DH
2	009.06.c	The facility did not have documented evidence of state police checks for 1 of 2 employees.	4/6/15	DH
3	250.11	Two residents' rooms had daytime temperatures that were less than 70 degrees.	3/31/15	DH
4	305.03	The facility RN did not document when residents had changes of condition. For example: Resident 2's wound status and stage of the pressure ulcers and Resident #3's seizure activity.	3/31/15	DH
5	305.04	Staff completed nurse notification forms regarding resident changes of condition. However, the RN did not document what recommendations were made.		
6	310.02	Expired medications were not disposed of within 30 days.	2/26/15 COS	DH
7	310.03	Controlled substances were not appropriately accounted for.	3/3/15	DH
8	320.01	The facility did not provide the services documented in Resident #1's Negotiated Service Agreement. For example: For two consecutive days Resident #1 was observed unshaven, wearing soiled clothing, and had an offensive body odor. The NSA did not identify that an outside agency was assisting with bathing.	3/3/15	DH
9	335.03	Staff were observed wearing gloves from task to task and from room to room without changing them. For example: One caregiver carried garbage out of a resident's room and then approached another resident with the same gloves to "help him shave."	3/31/15	DH
10	600.06a	The administrator did not schedule sufficient staff during all hours to ensure the residents' needs were met.	3/31/15	DH
11	625.01	Three of five employees did not have documented evidence of orientation training.	4/6/15	DH
12	630.01	Three of five employees did not have documented evidence of dementia training.	4/6/15	DH
13	630.02	Three of five employees did not have documented evidence of mental illness training.	4/6/15	DH
14	630.04	Three of five employees did not have documented evidence of traumatic brain injury training.	4/6/15	DH
15	735.01	Documentation of the temperatures of the refrigerator containing medications, indicated the temperatures were not maintained within 38 to 45 degrees.	4/6/15	DH

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IDAHO DEPARTMENT OF HEALTH & WELFARE Food Establishment Inspection Report

Residential Assisted Living Facility Program, Medicaid L & C
3232 W. Elder Street, Boise, Idaho 83705
208-334-6626

Critical Violations

Noncritical Violations

Establishment Name <u>Abby Mary Hawthorn</u>		Operator <u>Theresa Hoffmann</u>	
Address <u>1826 Hawthorne</u>			
County <u>Tarrant</u>	Estab #	BHS/SUR#	Inspection time: <u>4:00</u>
Inspection Type:		Risk Category: <u>high</u>	Travel time:
Follow-Up Report: OR		On-Site Follow-Up:	Date:
Items marked are violations of Idaho's Food Code, IDAPA 16.02.19, and require correction as noted.			

# of Risk Factor Violations <u>2</u>	# of Retail Practice Violations <u>0</u>
# of Repeat Violations <u>0</u>	# of Repeat Violations <u>0</u>
Score <u>2</u>	Score <u>0</u>
A score greater than 3 Med or 5 High-risk = mandatory on-site reinspection	A score greater than 6 Med or 8 High-risk = mandatory on-site reinspection

RISK FACTORS AND INTERVENTIONS (Idaho Food Code applicable sections in parentheses)

The letter to the left of each item indicates that item's status at the inspection.

	Demonstration of Knowledge (2-102)	COS	R
<u>Y</u> N	1. Certification by Accredited Program; or Approved Course; or correct responses; or compliance with Code	<input type="checkbox"/>	<input type="checkbox"/>
Employee Health (2-201)			
<u>Y</u> N	2. Exclusion, restriction and reporting	<input type="checkbox"/>	<input type="checkbox"/>
Good Hygienic Practices			
<u>Y</u> N	3. Eating, tasting, drinking, or tobacco use (2-401)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N	4. Discharge from eyes, nose and mouth (2-401)	<input type="checkbox"/>	<input type="checkbox"/>
Control of Hands as a Vehicle of Contamination			
<u>Y</u> N	5. Clean hands, properly washed (2-301)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N	6. Bare hand contact with ready-to-eat foods/exemption (3-301)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N	7. Handwashing facilities (5-203 & 6-301)	<input type="checkbox"/>	<input type="checkbox"/>
Approved Source			
<u>Y</u> N	8. Food obtained from approved source (3-101 & 3-201)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N	9. Receiving temperature / condition (3-202)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N <u>N/A</u>	10. Records: shellstock tags, parasite destruction, required HACCP plan (3-202 & 3-203)	<input type="checkbox"/>	<input type="checkbox"/>
Protection from Contamination			
<u>Y</u> N <u>N/A</u>	11. Food segregated, separated and protected (3-302)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N <u>N/A</u>	12. Food contact surfaces clean and sanitized (4-5, 4-6, 4-7)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N	13. Returned / reservice of food (3-306 & 3-801)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N	14. Discarding / reconditioning unsafe food (3-701)	<input type="checkbox"/>	<input type="checkbox"/>

	Potentially Hazardous Food Time/Temperature	COS	R
<u>Y</u> N <u>N/O</u> <u>N/A</u>	15. Proper cooking, time and temperature (3-401)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N <u>N/O</u> <u>N/A</u>	16. Reheating for hot holding (3-403)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N <u>N/O</u> <u>N/A</u>	17. Cooling (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N <u>N/O</u> <u>N/A</u>	18. Hot holding (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N <u>N/O</u> <u>N/A</u>	19. Cold Holding (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N <u>N/O</u> <u>N/A</u>	20. Date marking and disposition (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N <u>N/O</u> <u>N/A</u>	21. Time as a public health control (procedures/records) (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
Consumer Advisory			
<u>Y</u> N <u>N/A</u>	22. Consumer advisory for raw or undercooked food (3-603)	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Highly Susceptible Populations			
<u>Y</u> N <u>N/O</u> <u>N/A</u>	23. Pasteurized foods used, avoidance of prohibited foods (3-601)	<input type="checkbox"/>	<input type="checkbox"/>
Chemical			
<u>Y</u> N <u>N/A</u>	24. Additives / approved, unapproved (3-207)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N	25. Toxic substances properly identified, stored, used (7-101 through 7-301)	<input type="checkbox"/>	<input type="checkbox"/>
Conformance with Approved Procedures			
<u>Y</u> N <u>N/A</u>	26. Compliance with variance and HACCP plan (8-201)	<input type="checkbox"/>	<input type="checkbox"/>

Y = yes, in compliance N = no, not in compliance
 N/O = not observed N/A = not applicable
 COS = Corrected on-site R = Repeat violation
 = COS or R

Temp	Item/Location	Temp	Item/Location	Temp	Item/Location	Temp	Item/Location
	<u>lobster 392</u>		<u>meat 183</u>		<u>soup 108</u>		
	<u>meat 399</u>		<u>ham 117++</u>				

GOOD RETAIL PRACTICES (☒ = not in compliance)

	COS	R		COS	R		COS	R
<input type="checkbox"/>			27. Use of ice and pasteurized eggs	<input type="checkbox"/>			<input type="checkbox"/>	
<input type="checkbox"/>			28. Water source and quantity	<input type="checkbox"/>			<input type="checkbox"/>	
<input type="checkbox"/>			29. Insects/rodents/animals	<input type="checkbox"/>			<input type="checkbox"/>	
<input type="checkbox"/>			30. Food and non-food contact surfaces: constructed, cleanable, use	<input type="checkbox"/>			<input type="checkbox"/>	
<input type="checkbox"/>			31. Plumbing installed; cross-connection; back flow prevention	<input type="checkbox"/>			<input type="checkbox"/>	
<input type="checkbox"/>			32. Sewage and waste water disposal	<input type="checkbox"/>			<input type="checkbox"/>	
<input type="checkbox"/>			33. Sinks contaminated from cleaning maintenance tools	<input type="checkbox"/>			<input type="checkbox"/>	
<input type="checkbox"/>			34. Food contamination	<input type="checkbox"/>			<input type="checkbox"/>	
<input type="checkbox"/>			35. Equipment for temp. control	<input type="checkbox"/>			<input type="checkbox"/>	
<input type="checkbox"/>			36. Personal cleanliness	<input type="checkbox"/>			<input type="checkbox"/>	
<input type="checkbox"/>			37. Food labeled/condition	<input type="checkbox"/>			<input type="checkbox"/>	
<input type="checkbox"/>			38. Plant food cooking	<input type="checkbox"/>			<input type="checkbox"/>	
<input type="checkbox"/>			39. Thawing	<input type="checkbox"/>			<input type="checkbox"/>	
<input type="checkbox"/>			40. Toilet facilities	<input type="checkbox"/>			<input type="checkbox"/>	
<input type="checkbox"/>			41. Garbage and refuse disposal	<input type="checkbox"/>			<input type="checkbox"/>	
<input type="checkbox"/>			42. Food utensils/in-use	<input type="checkbox"/>			<input type="checkbox"/>	
<input type="checkbox"/>			43. Thermometers/Test drips	<input type="checkbox"/>			<input type="checkbox"/>	
<input type="checkbox"/>			44. Warewashing facility	<input type="checkbox"/>			<input type="checkbox"/>	
<input type="checkbox"/>			45. Wiping cloths	<input type="checkbox"/>			<input type="checkbox"/>	
<input type="checkbox"/>			46. Utensil & single-service storage	<input type="checkbox"/>			<input type="checkbox"/>	
<input type="checkbox"/>			47. Physical facilities	<input type="checkbox"/>			<input type="checkbox"/>	
<input type="checkbox"/>			48. Specialized processing methods	<input type="checkbox"/>			<input type="checkbox"/>	
<input type="checkbox"/>			49. Other	<input type="checkbox"/>			<input type="checkbox"/>	

OBSERVATIONS AND CORRECTIVE ACTIONS (CONTINUED ON NEXT PAGE)

Person in Charge (Signature) <u>[Signature]</u>	(Print) <u>admin</u>	Title	Date <u>2/26/15</u>
Inspector (Signature) <u>[Signature]</u>	(Print) <u>[Signature]</u>	Date <u>2/26/15</u>	Follow-up: (Circle One) Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>



Residential Assisted Living Facility Program, Medicaid L & C
3232 W. Elder Street, Boise, Idaho 83705
208-334-6626

Page 2 of 2
Date 3/26/15

Establishment Name Ashley Manor Hawthorne	Operator Dawn Lee Hoffner
Address 780 Hawthorne	Phubuck 83202
County Estab #	EHS/SUR.#
	License Permit #

OBSERVATIONS AND CORRECTIVE ACTIONS (Continuation Sheet)

12. The food contact surface sanitizer (chlorine solution) was too strong two days in a row. The chlorine paper turned black.

Must be corrected by 3/8/15 Corrected 3/4/15

19. Soup in a large pot was observed slightly covered in a refrigerator. The night shift caregiver stated she put it in the refrigerator at 4am. At 9:30 am, the soup jumped at 60.8 degrees. The house manager described the soup.

Must be corrected by 3/8/15. Corrected 3/4/15

22. The facility did not have a consumer advisory posted and served made-to-order eggs.

CBS: Administrator posted the sign in the dining room.

Corrected 3/4/15

12 + 19 will have of
recalibration as done by 3/8/15,
within 10 days

Person in Charge Dawn Lee Hoffner	Date 2/26/15	Inspector Nikola A. McKenna	Date 3/26/15
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