



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 25, 2013

Pam Lenerville, Administrator
Ashley Manor Care Centers Inc - Highmont
11099 Highmont Drive
Boise, ID 83713

License #: RC-598

Dear Ms. Lenerville:

On August 21, 2013, a complaint investigation survey was conducted at Ashley Manor Care Centers Inc - Highmont. 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 is 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 Polly Watt-Geier, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 364-1962.

Sincerely,

Polly Watt-Geier, MSW
Team Leader
Health Facility Surveyor

PWG/TFP

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



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PHONE: 208-364-1962
FAX: 208-364-1888

September 6, 2013

Pam Lenerville, Administrator
Ashley Manor Care Centers Inc. - Highmont
11099 Highmont Drive
Boise, ID 83713

Dear Ms. Lenerville:

An unannounced, on-site complaint investigation survey was conducted at Ashley Manor Care Centers Inc. - Highmont between August 20, 2013 and August 21, 2013. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00006016

Allegation #1: The facility did not protect residents from being hit by staff members.

Findings #1: Insufficient evidence was available at the time of the investigation in the records reviewed and from interviews conducted to substantiate this allegation.

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 implement behavior management plans to manage residents' behaviors.

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

Unsubstantiated.

Allegation #3: The facility did not protect residents rights to be free from involuntary seclusion.

Findings #3: Insufficient evidence was available at the time of the investigation in the records reviewed and from interviews conducted to substantiate this allegation.

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

Allegation #4: The facility used behavioral modifying medications as a first resort.

Findings #4: Insufficient evidence was available at the time of the investigation in the records reviewed and from interviews conducted to substantiate this allegation.

Unsubstantiated.

Allegation #5: A resident was not given an appropriate notice of discharge.

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

Unsubstantiated. According to IDAPA 16.03.22.152.05.e, a facility cannot keep "a resident that is violent or a danger to himself or others." Additionally, IDAPA 16.03.22.210.01, documents a facility can terminate a resident's admission agreement when emergency conditions exist, which "requires the resident to be transferred to protect the resident or other residents in the facility from harm."

Allegation #6: The facility did not update residents' NSAs (Negotiated Service Agreements) after changes of condition.

Findings #6: Insufficient evidence was available at the time of the investigation in the records reviewed and from interviews conducted to substantiate this allegation.

Unsubstantiated.

Allegation #7: A resident did not receive a refund or partial reimbursement after moving out of the facility.

Findings #7: Insufficient evidence was available at the time of the investigation in the records reviewed and from interviews conducted to substantiate this allegation.

Unsubstantiated.

Allegation #8: Residents' medication were not implemented as ordered.

Findings #8: Substantiated. However, the facility was not cited as the facility was unable to implement the change in the resident's medication orders due to the resident's discharge.

Allegation #9: The facility allowed family members to administer over-the-counter medications.

Pam Lenerville
September 6, 2013
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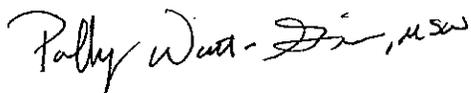
Findings #9: Insufficient evidence was available at the time of the investigation in the records reviewed and from interviews conducted to substantiate this allegation.

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

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 21, 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,



Polly Watt-Geier, MSW
Health Facility Surveyor
Residential Assisted Living Facility Program

PWG/TFP

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



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11099 Highmont Drive
Boise, ID 83713

Dear Ms. Lenerville:

An unannounced, on-site complaint investigation survey was conducted at Ashley Manor Care Centers Inc. - Highmont between August 20 and August 21, 2013. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00005905

Allegation #1: The facility did not employ sufficient staff to supervise and meet the needs of the residents.

Findings #1: Between 8/20 and 8/21/13, eight residents were observed residing at the facility. All of the eight residents were observed to be well-kempt and without odor. Two caregivers and the administrator were observed appropriately assisting residents with their care needs.

Between 8/20 and 8/21/13, three staff members and the administrator were interviewed. The staff members stated, they were able to meet the needs of the residents. The administrator stated there had been a time when a few staff members left at the same time and they did not have supplemental staff; however, she stated they were still able to meet the needs of the residents at that time. The administrator also stated, there had been one former caregiver, who did not properly care for residents and she was let go.

Between 8/20 and 8/21/13, a family member and an outside service provider were interviewed. They stated residents were always clean and well-kempt when they were at the facility. Additionally, they stated they did not have concerns about residents' needs not being met.

Pam Lenerville, Administrator

September 6, 2013

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

Allegation #2: Residents did not receive assistance with toileting and were left in soiled attends and linens.

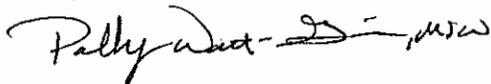
Findings #2: Insufficient evidence was available in the records reviewed at the time of the investigation to substantiate this allegation.

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

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 21, 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.

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Sincerely,



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Health Facility Surveyor
Residential Assisted Living Facility Program

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Dear Ms. Lenerville:

An unannounced, on-site complaint investigation survey was conducted at Ashley Manor Care Centers Inc. - Highmont between August 20 and August 21, 2013. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00005873

Allegation #1: Sufficient staff were not scheduled to meet the needs of the residents.

Findings #1: Between 8/20 and 8/21/13, eight residents were observed residing at the facility. All of the eight residents were observed to be well-kempt and without odor. Two caregivers and the administrator were observed appropriately assisting residents with their care needs.

Between 8/20 and 8/21/13, three staff members and the administrator were interviewed. The staff members stated, they were able to meet the needs of the residents. The administrator also stated there had been a time when a few staff members left at the same time and they did not have supplemental staff; however, she stated they were still able to meet the needs of the residents at that time. The administrator also stated, there had been one former caregiver, who did not properly care for residents and she was let go.

Between 8/20 and 8/21/13, a family member and an outside service provider were interviewed. They stated residents were always clean and well-kempt when they were at the facility. Additionally, they stated they did not have concerns about residents' needs not being met.

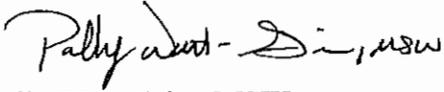
Pam Lenerville
September 6, 2013
Page 2 of 2

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

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 21, 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.

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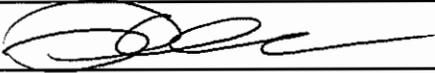


Polly Watt-Geier, MSW
Health Facility Surveyor
Residential Assisted Living Facility Program

PWG/TFP

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



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|--|--|--|--------------------------------|
| Facility ASHLEY MANOR CARE CENTERS INC - HIGHMONT | License # RC-598 | Physical Address 11099 HIGHMONT DRIVE | Phone Number (208) 377-4107 |
| Administrator Pam Lenerville | City BOISE | ZIP Code 83713 | Survey Date August 21, 2013 |
| Survey Team Leader Polly Watt-Geier | Survey Type Complaint Investigation | RESPONSE DUE: September 20, 2013 | |
| Administrator Signature  | Date Signed 8/21/13 | | |

NON-CORE ISSUES

| Item # | IDAPA Rule # | Description | Department Use Only | |
|--------|--------------|---|---------------------|----------|
| | | | EOR Accepted | Initials |
| 1 | 300.01 | There was no documentation the facility RN had assessed residents every ninety days or when they had a change in condition. | 9/20/15 | Pwlg |
| 2 | 305.05 | There was no evidence the facility RN ensured the administrator followed-up on a recommendation made by the facility LPN. | 9/20/15 | Pwlg |
| 3 | 711.01.a | Facility staff did not document the date and time of all specific behaviors that were identified on residents' behavior management plans. | 9/20/15 | Pwlg |
| 4 | 711.08.e | There was no documentation that staff notified the facility's RN when residents had changes in their condition. | 9/20/15 | Pwlg |
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