



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

November 6, 2013

Rhonda Repp, Administrator
Virginia Rose Resident Inn
2525 North Maple Grove Road
Boise, ID 83704

License #: RC-599

Dear Ms. Repp:

On September 18, 2013, a complaint investigation survey was conducted at Virginia Rose Resident Inn. As a result of that survey, deficient practices were found. The deficiencies were cited at the following levels:

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

Sincerely,

Maureen McCann, RN
Team Leader
Health Facility Surveyor

MM/TFP

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





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September 23, 2013

CERTIFIED MAIL #: 7007 3020 0001 4050 8159

Rhonda Repp, Administrator
Virginia Rose Resident Inn
2525 North Maple Grove Road
Boise, ID 83704

Dear Ms. Repp:

Based on the Complaint Investigation survey conducted by Department staff at Virginia Rose Resident Inn on **September 18, 2013**, we have determined that the facility violated residents' right to be treated with dignity and respect. The facility was cited for this same core deficiency on September 18, 2010.

Virginia Rose Resident Inn has demonstrated repeated violations of residents' right to be treated in a dignified manner. The deficiency is described on the enclosed Statement of Deficiencies. As a result of the survey findings, the Department is issuing the facility a provisional license, effective September 25, 2013, through March 25, 2013. The following administrative rule for Residential Care or Assisted Living Facilities in Idaho (IDAPA 16.03.22) give 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 noncore 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.

The conditions of the provisional license are as follows:

- 1. The facility shall have no instances of violating residents' rights, including using punishment, taking residents' belongings, or treating residents in a demeaning or disrespectful manner.**
- 2. A provisional license is issued which is to be prominently displayed in the facility. Upon receipt of this provisional license, return the full license currently held by the facility.**
- 3. The facility shall notify our office when staff training and policy changes have been accomplished to ensure all resident rights are respected and protected. A list of resident rights can be found in the rules for Residential Care or Assisted Living Facilities in Idaho (IDAPA 16.03.22) section 550.01 through 550.23.**

Rhonda Repp
September 23, 2013
Page 2 of 3

Please be advised that you may contest this decision by filing a written request for administrative review pursuant to IDAPA 16.05.03.300. **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
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009**

If you fail to file a request for administrative review within the time allowed, this decision shall become final.

You have an opportunity to make corrections and thus avoid further enforcement action. Correction of this deficiency must be achieved by **November 2, 2013**. **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 **October 6, 2013**, and keep a copy for your records. Your license depends upon the corrections made and the evaluation of the Plan of Correction you develop.

You have available the opportunity to question cited deficiencies 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 Care Program for a Level 1 IDR meeting. The request for the meeting must be made within ten (10) business days of receipt of the Statement of Deficiencies (**October 6, 2013**). The specific deficiencies for which the facility asks reconsideration must be included in the written request, as well as the reason for the request for reconsideration. The facility's request must include sufficient information for Licensing and Certification to determine the basis for the provider's appeal. If your request for informal dispute resolution is received after **October 6, 2013**, 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.

Rhonda Repp
September 23, 2013
Page 3 of 3

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. The completed punch list form and accompanying proof of resolution (e.g., receipts, pictures, policy updates, etc.) are to be submitted to this office by **October 18, 2013**.

A follow-up survey shall be conducted to verify the facility's compliance with protecting resident rights. If, at the follow-up survey, further violations of resident rights are identified, the Department will have no alternative but to initiate further enforcement actions against the license held by Virginia Rose Resident Inn.

Should you have any questions, or if we may be of assistance, please call our office at (208) 364-1962.

Sincerely,



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

MM/JS

cc: Medicaid Notification Group
Steve Millward, Licensing & Certification

RECEIVED
 PRINTED: 10/18/2013
 FORM APPROVED
 OCT 28 2013
 By RALF
 C
 09/18/2013

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R599	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/18/2013
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NAME OF PROVIDER OR SUPPLIER
VIRGINIA ROSE RESIDENT INN

STREET ADDRESS, CITY, STATE, ZIP CODE
**2525 NORTH MAPLE GROVE ROAD
 BOISE, ID 83704**

(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 deficiency was cited during a complaint investigation survey conducted on 9/18/2013 at your residential care/assisted living facility. The surveyors conducting the survey were: Maureen McCann, RN Team Leader Health Facility Surveyor Gloria Keathley, LSW Health Facility Surveyor Abbreviations: NSA - negotiated service agreement (care plan) UAI - uniform assessment instrument	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: Based on record review and interview, it was determined the facility failed to protect the rights of 1 of 1 sampled Residents (#1). The findings include: According to IDAPA 16.03.22.001.02, the purpose of a residential care or assisted living facility in Idaho is to provide choice, dignity and independence to residents while maintaining a	R 008		

Clonda App
 10/18/13

Bureau of Facility Standards
 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R599	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/18/2013	
NAME OF PROVIDER OR SUPPLIER VIRGINIA ROSE RESIDENT INN		STREET ADDRESS, CITY, STATE, ZIP CODE 2525 NORTH MAPLE GROVE ROAD BOISE, ID 83704		
(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 008	<p>Continued From page 1</p> <p>safe, humane, and home-like living arrangement for individuals needing assistance with daily activities and personal care.</p> <p>IDAPA 16.03.22.550.03.b. Each resident has the right "to be treated with dignity and respect."</p> <p>Resident #1 was a 25 year old male, admitted to the facility on 1/13/12, with diagnoses which included bipolar disorder, schizophrenia, attention deficit disorder and obsessive compulsive disorder.</p> <p>I. PERSONAL PROPERTY/DETERMINE OWN DRESS STYLE</p> <p>A) IDAPA 16.03.22.550.04.b. Each resident has the right "to determine his own dress or hair style."</p> <p>B) IDAPA 16.03.22.550.04.c. Each resident has the right to "retain and use his own personal property in his own living area so as to maintain individuality and personal dignity."</p> <p>A "Interim Plan of Care," dated 1/13/12, documented the resident needed to be cued to wear the appropriate clothing. There was nothing in the interim care plan about the resident not being allowed to wear women's clothing.</p> <p>An NSA, dated 1/32/12 and signed by the resident, documented the resident needed to be cued by staff to change clothes. There was nothing documented regarding the resident wearing women's clothing. The following sentence was handwritten under the comments section of the NSA: "[Resident #1's name] agreed to wear men's clothing while living at the facility at all times."</p>	R 008		

Bureau of Facility Standards

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 STREET ADDRESS, CITY, STATE, ZIP CODE: 2525 NORTH MAPLE GROVE ROAD, BOISE, ID 83704

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R 008	<p>Continued From page 2</p> <p>A UAI did not contain documentation regarding the resident's preferences to wear women's clothing.</p> <p>A facility "Residents' Rights" form, signed by the resident and dated 1/13/12, documented under personal possessions, "Each resident shall have the right to wear his own clothing, determine his own dress and hair style and retain and use his own personal property....to maintain individuality and personal dignity."</p> <p>A facility "House Rules" form, signed and dated by the resident on 1/13/12, was reviewed. The following sentence was handwritten under the "comment" section: "I understand and agree to wear men's clothes at all times." This handwritten sentence was in direct violation of the facility's "Residents' Rights."</p> <p>A "Counseling Notice" form, signed and dated by the resident on 4/10/13, documented the resident was "informed from the first day," to dress as a male. It further documented, that clothing had been "confiscated by staff." The counseling note additionally documented the resident would have "weekly room and belonging checks, for no less than 2 months." There was no documentation the resident had agreed to have his belongings confiscated.</p> <p>A "Physician's Letter," received after the resident was discharged from the facility dated 6/3/13, documented the resident was diagnosed with Gender Identity Disorder and that in the physician's belief, the resident would benefit greatly from being allowed to wear women's clothing and makeup and should be addressed as a "female named...."</p>	R 008		

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R 008	Continued From page 3 On 2/1/13 at 4:40 PM, Resident #1 stated, he was "forced" to agree to not wear women's clothing while at the facility. Additionally, he stated staff took his women's underwear and "cut it up" without his permission. On 9/18/13 at 8:50 AM, the house manager stated he had confiscated the resident's women's clothing, "some were destroyed..." On 9/18/13 at 1:05 PM, the administrator stated, when the resident was admitted to the facility, there was a stipulation that the resident would not wear women's clothing. She further stated when staff found women's clothing in with the resident's belongings, they took the clothing away from him. The administrator stated, there was no behavior plan regarding this, but it was documented in the resident's care plan. On 9/18/13, between 8:15 AM and 10:15 AM, five residents stated, at times Resident #1 wore women's clothing. On 9/18/13 between 8:30 AM and 3:00 PM, two caregivers stated, they were aware Resident #1 wore women's clothing at times. They also stated they each recalled at least one time when the clothing was taken away from the resident. The facility violated Resident #1's right to determine his own style of dress and to retain and use his own personal property (clothing) in his own living area so as to maintain individuality and personal dignity. 2. PUNISHMENT a) "WRITING LINES"	R 008	The House rules policy has been amended to discuss the issue of each resident wearing his/her clothes as they choose. A copy has been attached. Staff + residents have been informed of this change 9/25/13 The administrator + staff will monitor all residents daily to ensure the residents rights are not violated. If an issue arises from any resident or staff violating a resident's rights the administrator will be notified immediately and a resolution will be documented within 48 hours by the administrator and all parties involved.	

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R 008	Continued From page 4 A "Counseling Notice" form, dated 9/19/12, documented the resident slammed the front door and yelled profanities when he was told he could not stay at a friend's house overnight. The form further documented, "[Resident #1's name] will lose his privileges to go out on the patio with others without supervision and will write 800 lines per day for 1 week, 'I will respect others'." The facility's house rules or the resident's NSA did not document anything regarding rule infractions requiring a resident to "write lines." There was no behavior program in the resident's record regarding "writing lines." Further, there was no documentation in the resident's record that he had agreed to "writing lines" as a consequence after he broke a house rule. On 2/1/13, at 4:40 PM, Resident #1 stated, he was punished and "forced" to sit at the table and "write 700 lines" when he got "into trouble." On 9/18/13 at 8:50 AM, the house manager stated the resident was on probation and the judge told the resident if he did not follow the rules at the facility, he would have to return to jail. He stated, therefore, if the resident broke a house rule, instead of reporting the infraction to the resident's probation officer, the resident could "write lines." The house manager explained that "writing lines" meant the resident would sit at the dining table and write "I will not (whatever the infraction was)," multiple times, depending the situation. The house manager stated some of the infractions were, "refusing to clean his room, punching walls, arguing with staff, frequent use of profanity," and breaking curfew. On 9/18/13 between 9:25 AM and 2:00 PM, the	R 008	<i>The House rules policy has been amended regarding the respect of others + resolution of behaviors. A copy has been attached. The staff + residents have been informed of these changes. 9/25/13 The staff + administrator will monitor all residents daily to ensure these policies are being followed. If an issue arises from any resident or staff violating a resident's rights all administrator will be notified immediately and a resolution will be documented within 48 hours by the administrator and all parties involved.</i>	

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R 008	<p>Continued From page 5</p> <p>administrator stated, the resident was court ordered to the facility. She stated, this meant the resident had to follow the house rules or be in violation of the court. She stated if he did not follow the house rules, he would have to go to back jail and she tried to keep that from happening. She stated when the resident broke a house rule, they talked about it and the resident came up with the idea to "write lines." The administrator stated, there was no behavior plan or care plan regarding "writing lines".</p> <p>On 9/18/13 between 8:15 AM and 10:15 AM, five residents stated they observed the resident "writing lines," because he had broken one of the house rules. One resident said, "he had to write that he would not, whatever he had done wrong, 100 to 500 times, it just depended."</p> <p>On 9/18/13 between 8:30 AM and 3:00 PM, two caregivers stated the resident had to "write lines" after breaking a house rule.</p> <p>The facility failed to protect Resident #1's right to be treated with dignity and respect when the resident was punished for breaking house rules.</p> <p>b) SMOKING RESTRICTIONS</p> <p>An "Interim Plan of Care," dated 1/13/12, documented nothing about smoking restrictions.</p> <p>A facility "House Rules" form, signed and dated by the resident on 1/13/12, documented, "I understand I need to keep my money and property for my personal use only, and I will not ask other residents [for] their money or personal property." There was no documentation that residents smoking privileges would be restricted if the policy was not followed.</p>	R 008		

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 STREET ADDRESS, CITY, STATE, ZIP CODE: **2525 NORTH MAPLE GROVE ROAD
 BOISE, ID 83704**

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R 008	<p>Continued From page 6</p> <p>A "Smoking Policy," signed and dated by the resident on 1/13/12, documented if the policy was not followed, "the family will be asked to remove the resident from this facility." There was no documentation that residents could not borrow tobacco from each other or that smoking privileges would be restricted if the policy was not followed.</p> <p>A "Counseling Notice" form, dated 4/19/12, documented the resident shared his pipe and tobacco with others. It further documented the action the facility took. "You will not share your personal property with others.... [Resident's name] will not be allowed out on the smoking patio with any other residents."</p> <p>There was no documentation in the resident's care plan nor was there a behavioral management plan regarding smoking restrictions. There was no documentation in the resident's record that he had agreed to smoking restrictions if he was caught breaking a house rules.</p> <p>On 2/1/13, at 4:40 PM, Resident #1 stated the facility restricted his smoking privilege.</p> <p>On 9/18/13 at 8:50 AM, the house manager stated when the resident began to frequently ask other residents for tobacco and smoke in places not designated as smoking areas, the facility restricted the resident's smoking privileges. The resident was not allowed to smoke with other residents unless staff were present, although he could go out and smoke by himself.</p> <p>On 9/18/13, between 9:25 AM and 2:00 PM, the administrator stated the resident was court ordered to the facility. She stated this meant the</p>	R 008		

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R 008	<p>Continued From page 7</p> <p>resident had to follow the house rules or be in violation of the court. The administrator stated when Resident #1 asked other residents for tobacco or shared his tobacco, he was coercing other residents to also break the house rules. She stated therefore, Resident #1 was not allowed to smoke with other residents, unless staff were present. The administrator stated there was no behavior plan or care plan regarding this restriction.</p> <p>On 9/18/13, between 8:15 AM and 10:15 AM, five residents stated they had observed staff imposing smoking restrictions on Resident #1.</p> <p>On 9/18/13, between 8:30 AM and 3:00 PM, two caregivers stated Resident #1 was not allowed to smoke with other residents unless supervised by staff.</p> <p>The facility failed to protect Resident #1's rights when he was not allowed to determine his own dress style, when his personal clothing was taken away and when arbitrary punishment of "writing lines" and smoking restrictions were imposed without his agreement. These failures resulted in inadequate care.</p> <p>THIS IS REPEAT CORE DEFICIENCY PREVIOUSLY CITED ON 9/16/10</p>	R 008	<p>The smoking policy has been amended to reflect changes that a resident may smoke when ever they want to. A copy has been attached. Staff + residents have been informed of these changes. 9/18/13</p> <p>Staff + the administrator will monitor all residents daily to ensure this policy is followed. All residents rights are important to the staff at Virginia Rose. If an issue arises from any resident or staff regarding residents rights the administrator will be notified immediately and a resolution will be documented within 48 hours by the administrator and all parties involved. The administrator will have 1-on-1 discussions with all residents each quarter to ensure that all residents feel their rights have not been violated.</p>	10/18/13



Facility VIRGINIA ROSE RESIDENT INN	License # RC-599	Physical Address 2525 NORTH MAPLE GROVE ROAD	Phone Number (208) 375-2564
Administrator Rhonda Repp	City BOISE	ZIP Code 83704	Survey Date September 18, 2013
Survey Team Leader Maureen McCann	Survey Type Complaint Investigation		RESPONSE DUE: October 18, 2013
Administrator Signature	Date Signed		

NON-CORE ISSUES

Item #	IDAPA Rule # 16.03.22.	Description	Department Use Only	
			EOR Accepted	Initials
1	152.05.b.iii	A random resident's bed had bed rails.	10/18/13 <i>mm</i>	
2	305.03	The facility nurse did not document assessments after residents had a change of condition, such as, returning from the hospital or when an independently ambulatory resident was unable to stand unassisted.	10/18/13 <i>mm</i>	
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IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – GOVERNOR
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RESIDENTIAL ASSISTED LIVING FACILITY PROGRAM
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September 23, 2013

Rhonda Repp, Administrator
Virginia Rose Resident Inn
2525 North Maple Grove Road
Boise, ID 83704

Dear Ms. Repp:

An unannounced, on-site complaint investigation survey was conducted at Virginia Rose Resident Inn on September 18, 2013. At that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00005893

Allegation #1: The facility took away residents' personal belongings.

Findings #1: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.520 for taking away a resident's clothing. The facility was required to submit a plan of correction within 10 days.

Allegation #2: Residents were forced to sit at a table and write 700 times that they would not break a facility rule.

Findings #2: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.520 for punishing a resident when he broke a facility rule. The facility was required to submit a plan of correction within ten days.

Allegation #3: Residents' smoking privileges were restricted.

Findings #3: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.520 for restricting a resident smoking privileges. The facility was required to submit a plan of correction within ten days.

Allegation #4: The facility did not protect residents from verbal abuse.