PLAN OF CORRECTION

Ashley Manor Care Centers Inc - Orchard
2150 South Orchard
Boise ID 83705

Provider ID: RC-646

On 11/15/2024, a Health Care Licensure and Follow-Up survey was conducted by Department staff at Ashley Manor Care Centers Inc - Orchard. As a result of the survey, core issue deficiencies were cited with the following plan of correction.

Rule Violation .215.03. Lapse of Administrator.

Describe what corrective actions will be accomplished for those residents/personnel/area found to have been affected by the deficient practice.

Corrective action is that the Regional Director of Operations submitted to have her license added to Ashley Manor Orchard on 11/15/24 and it was approved. The license will stay on Ashley Manor Orchard until the Administrator in Training is able to obtain her license.

Describe how the provider will identify other residents/personnel/areas having the potential by the same deficient practice and what corrective action(s) will be taken.

After this survey we realized that as soon as an Administrator is no longer employed with the company that I will check FLARES to make sure the license is removed and to make sure we have a license to add to the community.

Describe how the corrective action will be monitored to ensure the deficient practice does not recur (QA program).

The Regional Director of Operations will verify there is a license on each house in the region.

Date when corrective action will be completed.

November 15, 2024

Program Comments

NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
Ashley Manor Care Centers Inc - Orchard	RC-646	2150 South Orchard	208-388-8909
Administrator	City	Zip Code	Survey Date
Angie Sanders	Boise	83705	11/15/2024
Survey Team Leader	Survey Type		Response Due
McClenathan, Teresa	Health Care Licensure and Follow-Up		12/15/2024

Item #	Rule (16.03.22)	Description
1	.215. REQUIREMENTS FOR A FACILITY ADMINISTRATOR.	The facility did not have a licensed administrator overseeing the day-to-day operations at the facility. According to a communication in the Facility Licensing and Regulatory Enforcement System portal, the previous administrator's last day was 10/11/24. Several staff stated the former administrator's last day was 10/11/24 and there was no licensed administrator at the time of survey. This lapse in administrator was greater than 30 days.
2	.215.08. Procedures for Investigations.	The facility administrator did not complete investigations for incidents or accidents. For example, Resident #2 eloped from the facility on 4/10/24. Resident #2 took medications off the table that were not theirs and consumed these medications then was taken to the hospital on 8/12/24. Resident #2 tried to break into the medication cart to get thier cigarettes on 8/09/24, 8/10/24 and 8/31/24. Resident #1 became physically aggressive with staff on 7/27/24 and 9/1/24. The Regional Director of Operations and the house manager stated the previous administrator had not completed the investigations.
3	.215.08.e. Corrective Action.	The facility did not ensure effective corrective action was put into place to prevent incidents' recurrence for Resident #1,

		who was cognitively impaired. For example, when Resident #1 had 11 falls between 5/1/24 and 9/7/24. Corrective actions were repeatedly to remind resident to use call light, to wait for or ask staff for assistance and/or continue to monitor. These interventions were not effective the facility failed to implement additional interventions to prevent further incidents.
4	.216.02. Written Agreement.	The facility did not enter into a new admission agreement when Resident #1 was admitted from a sister facility on 7/8/21. The regional director of operations confirmed a new admission agreement was not completed.
5	.250.09. Resident Sleeping Rooms.	The facility did not maintain water temperatures between 105 degrees F and 120 degrees F. For example, on 11/12/24 the water temperature was 125.2 degrees F in room 4 and 127.9 degrees F in room 9. On 11/14/24 the water temperature was measured to be 123.4 degrees F in room 9.
6	.330.06. Additional Resident Records.	The facility did not consistently evaluate residents' behaviors, nor create behavior management plans with interventions used for each behavior. For example: Resident #1 exhibited behaviors of intentionally having bowel movements in their briefs, eating stool from hands, verbal outbursts and aggression toward staff and other residents and eating cigarette butts. No behavior plan was implemented. Resident #2 exhibited elopement, physical aggression, property destruction with attempting to break into the medication cart to get their cigarettes, refusals of cares and medications, and consuming others medications with no behavior plan for these behaviors implemented. The Regional Director of Operations and the house manager stated the behavioral plans had not been completed by the former administrator.
7	.450. REQUIREMENTS FOR FOOD AND NUTRITIONAL CARE SERVICES.	The facility did not have a Certified Food Protection Manager at the time of survey. The administrator stated a staff member was in the process of completing the course.

CORE ISSUES

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Angie Sanders	Boise	83705	11/15/2024
Survey Team Leader	Survey Type		Response Due
McClenathan, Teresa	Health Care Licensure and Follow-Up		11/25/2024

Item #	Rule (16.03.22)	Description
2	.215.03. Lapse of Administrator.	Based on record review and interview, it was determined the facility failed to retain a licensed administrator for the day-to-day operations of the facility for a period greater than 30 days. The findings include: IDAPA 16.03.22.010.20.e defines a core issue as the following: "A situation in which the facility has operated for more than thirty (30) days without a licensed administrator overseeing the day-to-day operations of the facility." IDAPA 16.03.22.100.04 documents, "Each facility must have an administrator." IDAPA 16.03.22.215 documents, “Under Section 39-3321, Idaho Code, each facility must have one (1) licensed administrator assigned as the person responsible for the day-to-day operation of the facility.” IDAPA 16.03.22.215.03 documents, “If the facility operates for

		more than thirty (30) days without a licensed administrator, it will result in a core issue deficiency." According to the Facility Licensing and Certification database (FLARES), a communication was sent by Amber Mills in FLARES that her last day was 10/11/24 and to take her name of the building as the administrator and remove her access to FLARES for the facility. FLARES documented Amber Mills RCA-2607 was the administrator from 3/18/22 to 10/11/24. Between 11/12/24 and 11/13/24, four employees confirmed that Amber Mills was no longer the facility administrator as of 10/11/24. *On 11/13/24 at 1:47 PM, Amber Mills the previous Administrator, stated she no longer worked for the facility. She stated her last day was 10/11/24. *On 11/13/24 at 3:00 PM, Janice Ahmadi-Bell the unlicensed Acting Administrator/House Manager, stated Amber Mills no longer worked for the facility when she started on 10/16/24. *On 11/12/24 the facility's as-worked schedule was reviewed and documented Amber Mills's last day of employment was 10/11/24. The facility operated without a licensed administrator from 10/12/24 to 11/14/24. For 34 days there was no licensed administrator to oversee the day-to-day operations of the facility. This resulted in a core deficiency.