

HEALTH & WELFARE

C.L. "BUTCH" OTTER -- Governor RICHARD M. ARMSTRONG - Director LESLIE M. CLEMENT - Administrator DIVISION OF MEDICAID Post Office Box 83720 Boise, Idaho 83720-0036 PHONE: (208) 334-6526 FAX: (208) 364-1888

March 23, 2010

CERTIFIED MAIL #: 7005 1160 0000 1506 8394

Tina Martin, Administrator Ashley Manor - Crescent, Ashley Manor LLC 421 Crescent Drive Caldwell, ID 83605

Dear Ms. Martin:

Based on the State licensure survey conducted by our staff at Ashley Manor - Crescent, Ashley Manor LLC on March 16, 2010, we have determined that the facility failed to protect residents from inadequate care (failure to implement Negotiated Service Agreements).

This core issue deficiency substantially limits the capacity of Ashley Manor - Crescent, Ashley Manor LLC to furnish services of an adequate level or quality to ensure that residents' health and safety are safe-guarded. 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 April 30, 2010. 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)?
- What date will the corrective action(s) be completed by?

Return the **signed** and **dated** Plan of Correction to us by **April 4, 2010**, and keep a copy for your records. Your license depends upon the corrections made and the evaluation of the Plan of Correction you develop.

Tina Martin, Administrator March 23, 2010 Page 2 of 2

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 (April 4, 2010). 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 & Certification to determine the basis for the provider's appeal. If your request for informal dispute resolution is received after April 4, 2010, your request will not be granted. Your IDR request must me 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. 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 April 15, 2010.

If, at the follow-up survey, it is found that the facility is not in compliance with the rules and standards for residential care or assisted living facilities, the Department will have no alternative but to initiate an enforcement action against the license held by Ashley Mauor - Crescent, Ashley Manor LLC.

Should you have any questions, or if we may be of assistance, please call our office at (208) 334-6626.

Sincerely,

JAMIE SIMPSON, MBA, QMRP

Supervisor

Residential Assisted Living Facility Program

Medicaid Licensing & Certification

JS/sm

Enclosures

	TEMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R714				(X2) MULT A. BUILDII B. WING		СОМРЦ	(X3) DATE SURVEY COMPLETED 03/16/2010			
NAME OF F	PROVIDER OR SUPPLIER		STREE	T ADI	DRESS, CITY,	STATE, ZIP CODE		0/2010			
ASHLEY	MANOR - CRESCE	NT, ASHLEY MANC	421 C	RES	CENT DRI	VE					
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCI CY MUST BE PRECEDED BY LSC IDENTIFYING INFORM	Y FULL		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X6) COMPLET DATE			
R 000	Initial Comments				R 000						
	standard survey or care/assisted living conducting the sur	•	dentiat		φ O	Res. #1 Clarified Diet on with the PMD. Resident #2 diet and mechanical soft fo with administrator and staff family on 3/29/10 done with and Hospice to discuss die	thickened liquid od in-service done Meeting with nurse, regional,	ł			
	Donna Henscheid Team Coordinator Health Facility Sur	•	Ш >>	733	STANDARDS	understands we need to fol and family will consult with swallow evaluation or other	ne				
	Rae Jean McPhilli Health Facility Sur		U U	PR 0 5 2		they may want to look at. Stofollow the diet order. See attached order change staff and family meetings.					
	Abbreviations used	Ш	C	FACILITY	Each residents diet was reviewed by the administrator. Then every NSA was updated						
	NSA = Negotiated	Service Agreement	Œ	'n	ŭ.	to make sure the diet was correct. A meetings was done with staff on 3/29 to train staff on the diets. See attached NSA pages. 3) The administrator was disciplined for not following the diets ordered by the doctor, see and attached disiplinary action, and the administrator will review diets during monthly audits that are done by the administrator and reviewed by the Compliance team and the Regional. On 3/29/10 a new menu system was put into					
R 008	16.03.22.520 Prote Care.	ect Residents from In	adequa	te	R 008						
	procedures are im	must assure that poli plemented to assure from inadequate care	that all	i							
	Based on observation interview, it was desimplement the Neg	net as evidenced by: tion, record review, a etermined the facility gotiated Service Agre ents (#1 and #2) whos e findings include:	failed to ement f	or		place with Grove Menu systems. The dietician Diane Fager is more available to staff. On the menu it is printed on the bottom changes that are to be made to the meal to accommoda different diet orders, see attached examples. The Idaho Diet Manual was printed and put into the building on 3/30/10.					
	7/9/08 with diagno During the survey	s admitted to the facil ses that included den on 3/15/10, the facilit tifled that Resident #2	nentia. y's			4)The new menu system w 3/29/10 and is ongoing. The monthly and review monthly the regional. See attached and menu examples. 5)4/2/10	ne audits are done ly by compliance ar				

Bureau of Facility Standards (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 13R714 03/16/2010 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **421 CRESCENT DRIVE** ASHLEY MANOR - CRESCENT, ASHLEY MANO CALDWELL, ID 83605 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) 1D ΙD (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG **DEFICIENCY** R 008 R 008 Continued From page 1 Resident #2's NSA, signed and dated on 1/9/10, documented that, as of 12/22/09, the resident was to receive a mechanical soft diet with thickened liquids. Additionally, a note on the NSA. dated 3/10/10, documented foods were to be "soft" due to diet orders. A physician's order, dated 12/21/09, documented the resident was to receive a mechanical soft diet with thickened liquids. Additionally, the record contained a "Review of Medications & Therapeutic Diet" form, for "January 2010 -March 2010", that was reviewed and signed by the resident's physician on 3/1/10. The form documented the resident was to receive a mechanical soft diet with thickened liquids. The 2005 ninth edition "Idaho Diet Manual" reference manual defines, on pages 37 and 38, that a mechanical soft diet as a diet "designed to provide a texture modification of the regular diet for patients with chewing or swallowing difficulty." "Foods to Avoid" included "...ground meat formed in a solid patty such as a hamburger..." and "nuts or seeds." The manual also documented that "all meats should be served ground. It is recommended to ladle sauce or gravy over mechanically altered meats..." During a tour of the facility, on 3/15/10, a note taped to the inside of a kitchen cabinet door was observed. The note documented Resident #2 was to receive a mechanical soft diet. A weekly menu plan was observed posted on the wall. The menu documented the noon meal was to be hamburgers, french fries and lemon cake. On 3/15/10 at 10:15 AM, Resident #2 was observed sitting on a couch in the living room with a glass of unthickened water on a table next to

Bureau of Facility Standards STATE FORM

FORM APPROVED Bureau of Facility Standards STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 13R714 03/16/2010 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **421 CRESCENT DRIVE** ASHLEY MANOR - CRESCENT, ASHLEY MANO CALDWELL, ID 83605 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) R 008 Continued From page 2 R 008 her. On 3/15/09 at approximately 11:30 AM, a caregiver was observed to cook hamburgers and french fries for the residents. The caregiver served Resident #2's meal: a hamburger patty with sliced tomato and lettuce on a hamburger bun, french fries, and a small piece of chocolate cake. The resident's meal was delayed by approximately 20 minutes while the administrator assisted her with toileting. When the resident returned to the living room the administrator stated the hamburger was too cold to serve and she proceeded to cook the resident another hamburger. The administrator placed the freshly cooked hamburger on a plate to serve the resident. After the second attempt to serve the resident the inappropriate diet, the administrator was advised by the survey team that a hamburger was not allowed on a mechanical soft diet. The administrator stated she thought a hamburger was allowed if the "hamburger was thin." On 3/15/10 at 2:50 PM, a caregiver was observed to give Resident #2 popcorn as a snack. The resident had a "coughing" episode after she ate some of the popcorn. When the administrator was informed by the survey team that popcorn was not allowed on a mechanical soft diet she went to the resident and removed the popcorn. On 3/15/10 at 2:53 PM, the administrator stated the resident had a problem with choking one to two times a month. She stated the choking episodes became more frequent, in December

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2009, and they requested an order for a mechanical soft diet and thickened liquids from

the resident's physician.

03/16/2010

Bureau of Facility Standards (X3) DATE SURVEY COMPLETED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION

A. BUILDING B. WING

13R714

STREET ADDRESS, CITY, STATE, ZIP CODE

NAME OF PROVIDER OR SUPPLIER

421 CRESCENT DRIVE

	MANOR - CRESCENT, ASHLEY MANC	CALDWELL, ID 83605	·		
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
R 008	Continued From page 3	R 008			
	On 3/15/10 at 2:55 PM, a caregiver confiresident had choking episodes and adde month has been worse." He stated that hour up meats for the resident but thoug could eat a hamburger.	d "this ne would			
	On 3/15/10 at 3:43 PM, the administrator mechanical soft diet consisted of foods to be "mashed with a fork." She confirmed resident should not have been served portable and the caregiver should not be caregiver should not be caregiver would have known not serve popoorn to the resident.	hat could the epcorn. ould have had been			
	On 3/16/10 at 11:30 AM, the administrate located the facility's dietary manual. It documented, for a mechanical soft diet, thamburger patty should be ground and swith gravy. Additionally, it documented thand tomato should be "shredded." The administrator confirmed the resident's Not fully implement when they failed to put the resident a mechanical soft diet and the liquids.	the erved e lettuce SA was rovide			
	2. Resident #1 was admitted to the facilit diagnoses of hyperlipidemia, dementia a hypertension.				
	An NSA, dated 1/15/10, documented the was to receive a 3,500 calorie diet per da				
	A fax to the physician, dated 2/19/10, documented the administrator asked for calorie diet order change per the power of attorney's request. The physician signed approval for the order on 2/24/10.	of			

Bureau of Facility Standards

Bureau of Facility Standards STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 13R714 03/16/2010 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **421 CRESCENT DRIVE** ASHLEY MANOR - CRESCENT, ASHLEY MANO CALDWELL, ID 83605 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) R 008 Continued From page 4 R 008 The 2008 seventh edition "Nutrition & Diet Therapy" reference manual documented on page 20 table 7, the normal diet for an inactive male over the age of 50 as 2,000 calories. The facility's dietitian approved dietary manual was reviewed and did not contain instructions for a 3,500 calorie diet. During a tour of the facility on 3/15/10, a note was observed taped to the inside of a kitchen cabinet door. The note documented Resident #1 was on a 3,500 calorie diet. On 3/15/10, on two separate occasions, the resident was observed crying and the caregiver handed the resident carrots which he was observed eating. On 3/15/10 at 12:00 PM, the resident was observed eating a hamburger patty on a bun with lettuce and tomato, french fries and a small serving of chocolate cake. On 3/16/10 at 10:00 AM, when asked how the facility was meeting the resident's 3,500 calorie diet, the administrator replied, "We restrict his intake of sweets and give him carrots." The administrator confirmed the facility had not consulted other resources or a registered dietitian for guidance on how to ensure the resident received the increased caloric intake above the planned meals. Further, the administrator confirmed the resident was not being provided a 3,500 calorie diet as ordered by the physician and outlined in the resident's NSA. The facility failed to implement the therapeutic diets according to Residents' #1 and #2 NSAs. This failure placed Resident #2 at risk for choking

PRINTED: 03/18/2010 FORM APPROVED

Bureau of Facility Standards STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 13R714 03/16/2010 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **421 CRESCENT DRIVE** ASHLEY MANOR - CRESCENT, ASHLEY MANO CALDWELL, ID 83605 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY) R 008 Continued From page 5 R 008 or aspiration and Resident #1 at risk for an insufficient caloric Intake by not providing the physician ordered 3,500 calorie diet. The failure to implement the residents' NSAs resulted in inadequate care.

Bureau of Facility Standards



MEDICAID LICENSING & CERTIFICATION - RALF P.O. Box 83720 Boise, ID 83720-0036 (208) 334-6626 fax: (208) 364-1888

ASSISTED LIVING Non-Core Issues Punch List

Facility Name Ashley Manor, Crescent	Physical Address 421 Crescent	Phone Number 208-454-4160
Tīna Martin	City Caldwell	Zip Code 83605
Team Leader Donna Henscheid	Survey Type Relicensure	Survey Date 03/16/10

Item #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	L&C USE
1	310.04	The facility did not ensure Resident #2's psychotropic medications were reviewed every 6 months by the physician. Nor did	4/15/10	DH
		the facility provide behavioral updates to Resident #3's physician for psychotropic medication review.		
2	451.03	Resident #1 did not have a therapeutic diet in place to meet the physician's 3500 calorie order.	4/15/10	Sa#
3	455	The facility did not maintain a 7 day supply of nonperishable food items. Nor did the facility have the types of foods available to meet the	4/15/10	21/
		planned menu.		
4	711.04	The facility did not document Resident #2's refusals to follow the physician's order for a mechanical soft diet with thickened liquids.	4/15/10	D.M
·	_			
Response	Required Date	Signature of Facility Representative	Date Signed	
	5/10	Constitute of a dollar representative	3 - 16 -	10

Follow-up: (Circle One)

Yes

No

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HEALTH & WELFARE

Food Establishment Inspection Report

Food Protection Program, Office of Epidemiology 450 West State Street, Boise, Idaho 83702 208-334-5938

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				Tine	a Martin				Ш					,		
Address 421	Cresce.	7.		ity (ald.	welf 83605				# of Repea Violations		Ŀ	# of Repeat Violations	\$		
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Slanda	rd		D	ate:		Date:			114	or 5 High-risk = mandatory or 8 High-risk = man						
		Idaho's Fo	od Code, II	OAPA 1	6.02.19	9, and require correction as noted.			T L	on-site reinspection on-site reinspection						
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Y)N	7. Handwashing	Facilities (5.	203 & R_301\								, ,	Highly	Suscep	tible Populations	\vdash	
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/Ŷλν	8. Food obtained	- 1 -		-101 & 3	-201)						prohibited foods (3-801)					
Y)N	9. Receiving tem				,						Chemical					
	10. Records: she	llstock tags,	parasite dest	ruction,				Y N(N/A)			24. Additives / approved, unapproved (3-202.12) 25. Toxic substances properly identified, stored, used					
required macor plan (3-202 d 3-200)				_]		Y)N		(7-101 thro			eny identinea, storea, usea				
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Y)N N/A	12. Food contact (4-5, 4-6, 4-7)	Sunaces Cit	an and samu	zea												
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Ý)N	14. Discarding / r	econditionin	g unsafe food	i (3-701)							observed rrected on-	rita		A = not applicable Repeat violation		
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prevention U							food cooking					nsils & single-service storage				
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33, Sinks co	ntaminated from cl	eaning main	tenance tools						facilities	, C		<u> </u>	-	cialized processing mathods		<u> </u>
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.,			OBSE	RVATIO	NS AND	COR	RECT	VE A	CTIONS (CONTIN	UED	ON NEXT F	AGE)	11.7			

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Person in Charge	(Signature)	200	,	(Print)	110	4	161	-10	↑ Title		Date	3	-160	<u>-10</u>		

Donna Alexer Sig living Donne Henselvill Date



Date

3/16/10

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

Person in Charge

Establishment Name Operator Tina Martin
Address 421 (rescent
County Estab # EHS/SUR.# License Permit #
OBSERVATIONS AND CORRECTIVE ACTIONS (Continuation Sheet)
#17 Spanfielli saucest privared at approximately 3:00x
was not property cooled when checked at 9:50 MM
and temped at 53? The facility despased of the
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