



IDAHO DEPARTMENT OF  
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) 334-6626  
FAX: (208) 364-1888

February 14, 2011

Melinda Saville, Administrator  
Ashley Manor - Cedar, Ashley Manor Llc  
1525 East Cedar Street  
Pocatello, ID 83201

Dear Ms. Saville:

An unannounced, on-site complaint investigation survey was conducted at Ashley Manor - Cedar, Ashley Manor Llc from January 24, 2011, to January 25, 2011. During that time, observations, interviews, and record reviews were conducted with the following results:

**Complaint # ID00004839**

**Allegation #1:** An identified resident was retained when he had a history of violence and continued to be violent.

**Findings #1:** On 1/24/11 at 5:30 PM, an unannounced visit was conducted at the facility. It was determined the identified resident no longer resided at the facility. Two caregivers were observed providing care for the nine residents residing at the facility. The caregivers stated they thought there was adequate staff on duty to provide supervision. The identified resident's closed record was reviewed. A history and physical, dated 10/19/10, documented the resident was pleasant and cooperative. Progress notes also documented the resident as "pleasant and cooperative." There was no documentation the identified resident had a history of behaviors or violent outbursts.

On 1/25/11 at 10:40 AM, a caregiver stated when the identified resident was admitted, he was very easy going and calm. The caregiver further stated, the identified resident had never shown aggression towards other residents or staff.

On 1/25/11 at 11:30 AM, the house manager stated the identified resident did not have a history of violence while he resided at the facility. She stated there was an incident, on 11/12/10 at 5:10 PM, when another resident went into his room to use his bathroom. She said staff heard a "scream" from the resident's

room where staff found him standing over another resident who was lying on the floor. She stated the resident told her he saw a resident enter his room to use his bathroom. She said, he told her, he pulled the resident out of his bathroom by her arm and she fell on the floor. The administrator stated the resident was not involved in any other incidents at the facility. She stated they placed a motion detection alarm on the identified resident's door to alert caregivers when other residents entered his room. She said the resident was transferred to a local hospital, on 5/13/10, for a behavioral evaluation. Additionally, she stated she and the administrator talked with the resident when he returned to the facility about what to do if a similar incident happened again. She said he moved out of the facility shortly after the incident to another facility where residents were less confused.

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 delayed treatment of an identified resident who was thrown to the ground by another resident.

**Findings #2:** On 1/25/11 the identified resident's record and the facility's "Accident/Incident" reports were reviewed.

An accident/incident report, dated 11/12/10 at 5:10 PM, documented caregivers heard screaming, went into a resident's room and found the identified resident on the floor, lying on her back. The report documented caregivers asked the resident if she hurt anywhere, then assisted her off the floor. The report documented the facility nurse was notified of the incident at 5:25 PM. The report also documented a message was left at the resident's physician's office at 5:35 PM.

A nursing note, dated 11/12/10 at 9:00 PM, documented staff called and notified her the resident was found on the floor. She documented caregivers advised her the resident did not complain of pain. Additionally, the nurse documented she instructed caregivers to monitor the resident for "bruising and pain."

A fax sent to Licensing and Certification documented caregivers noted a bruise on the resident's right buttock area on 11/13/10.

A nursing note, dated 11/15/10 at 9:00 AM, documented the resident had a "softball size purple bruise on her right hip. There is no c/o (complaint of) pain upon palpitation. Resident has full ROM (range of motion), her gait is steady and can bear wt (weight) on leg." Further, the nurse documented the resident had not required any pain medications due to the incident.

A "Physician's Visit Record and Assessment" form, dated 11/15/10, documented the resident did not need a x-ray and that she had a bruise but "no sign of other injury."

On 1/25/11 at 11:30 AM, a caregiver stated the resident did not complain of pain after the incident. Further, she said the resident ambulated without difficulty.

On 1/25/11 at 11:45 AM, the facility nurse stated caregivers notified her of the incident between the two residents. She stated she instructed staff to monitor the resident and to call her if the resident exhibited pain or difficulty in ambulation.

On 1/25/11 at 11:50 AM, the house manager stated caregivers assisted the resident off the floor when she did not complain of pain. She said the resident was able to ambulate without difficulty and did not exhibit pain right after the incident.

On 1/25/11 at 11:52 AM, the administrator confirmed the resident was able to ambulate exhibiting pain or difficulty right after the incident. She stated if the resident had complained of pain or had difficulty walking, 911 would have been called.

Unsubstantiated.

**Allegation #3:** The facility did not have sufficient food to meet the planned menu.

**Findings #3:** An unannounced complaint investigation was conducted on 1/24/11 at 5:30 PM. The facility kitchen was toured and ample food was observed in the refrigerator and pantry.

On 1/24/11 at 5:40 PM, a caregiver stated there was always enough food to prepare the main meal. She stated they sometimes had to substitute things like apples for grapes.

On 1/24/11 at 6:03 PM, the facility house manager stated she bought groceries every Monday night. She further stated, if the facility ran out of milk or bread, she would go to the store and buy more.

On 1/25/11 at 12:45 PM, a family member stated she visited the facility almost every day around meal times. She stated on the days she visited the facility, she observed residents being served sufficient amounts of food. Additionally, she stated she had never heard a resident complain of not having enough to eat.

Melinda Saville, Administrator

February 14, 2011

Page 4 of 4

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

As no deficiencies were cited as a result of our investigation, no response is necessary to this report. Thank you to you and your staff for the courtesies extended to us on our visit.

Sincerely,

A handwritten signature in black ink that reads "Rae Jean McPhillips, RN". The signature is written in a cursive style.

Rae Jean McPhillips, RN, BSN  
Health Facility Surveyor  
Residential Assisted Living Facility Program

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



IDAHO DEPARTMENT OF  
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) 334-6626  
FAX: (208) 364-1888

February 14, 2011

Melinda Saville, Administrator  
Ashley Manor - Cedar, Ashley Manor Llc  
1525 East Cedar Street  
Pocatello, ID 83201

Dear Ms. Saville:

An unannounced, on-site complaint investigation survey was conducted at Ashley Manor - Cedar, Ashley Manor Llc from January 24, 2011, to January 25, 2011. During that time, observations, interviews, and record reviews were conducted with the following results:

**Complaint # ID00004860**

Allegation #1: The facility did not assist an identified resident with eating.

Findings # 1: On 1/25/11, the identified resident's closed record was reviewed. The identified resident resided at the facility from 12/1/10 through 12/12/10. The interim care plan, dated 12/1/10 and signed by a legal representative, documented the resident could feed herself but if she could not, staff would need to assist her. Progress notes, dated between 12/1/10 and 12/9/10, documented the resident was offered food by the caregivers and would either refuse to eat or would take a bite and then spit the food out stating she was not hungry. The progress notes additionally documented the identified resident was unhappy to be at the facility and wanted to go home. The caregivers' activities of daily living sheets documented the resident refused most meals, but would eat snacks or drink milk on her own. A temporary care plan, dated 12/8/10, documented staff would be in the room when the identified resident was eating and would assist the resident, as needed.

On 1/25/11 at 10:30 AM, a caregiver stated the resident was independent with eating. She stated the resident was not happy about being admitted to the facility. The identified resident would cry and ask why she had live at the facility. She additionally stated the resident would frequently refuse to eat her meals and spit food out.

On 1/25/11 at 1:22 PM, the house manager stated staff would take the resident's food into her room on a tray. If the resident became upset at being in the facility, the staff would leave and let her calm down. Staff were instructed to re-heat the identified resident's food, as needed, but the resident would refused to eat. She further stated, the resident was able to feed herself and staff would cue her to eat. She additionally stated, it was a struggle to get the identified resident to eat.

Unsubstantiated.

Allegation #2: The facility did not have sufficient staff to assist residents with showers and other personal cares.

Findings #2: On 1/24/11 at 5:30 PM, an unannounced complaint investigation was conducted at the facility. During the tour of the facility, residents were observed to be clean, groomed and odor free. Nine current and two closed residents' records were reviewed. Activities of Daily Living (ADL) care sheets were reviewed for each resident. Each care sheet documented residents' showers and what day the resident received their shower and or care. The facility's as-worked schedule was reviewed and the schedule documented caregiver hours were staggered to provide extra coverage at meal times and after meals for assistance with showers.

On 1/24/11 at 5:45 PM, a caregiver stated she was able to assist residents with personal care in a timely manner. She further stated, at times, it did become hectic but residents received needed cares.

On 1/25/11 at 8:35 AM, the administrator stated caregivers overlap at meal times and after meals to get showers and cares completed. She further stated caregivers had not voiced a concern of not having enough help. Additionally, she stated if she felt more staff was needed to provide care to the residents, she would ask corporate for more hours. She also stated she had not heard family members expressing concerns about not having sufficient staff to meet the residents' needs.

On 1/12/11 at 12:45 PM, a family member stated she visited the facility almost every day. She stated the facility had sufficient staff to meet her mother's care needs. Additionally, she stated the residents were always clean and appropriately dressed when she visited.

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

Allegation #3: The facility did not respond appropriately when an identified resident sustained an injury.

Findings #3: The identified resident no longer resided at the facility. The identified resident's record was reviewed and contained an incident report, dated 12/7/10. The report documented the facility nurse was called as soon as family pointed out discoloration on the resident's foot. A progress note, dated 12/8/10 by the facility nurse, documented staff had called her on 12/7/10 and stated the resident's right foot was swollen and bruised. The report and care notes documented the facility nurse came and assessed the resident's foot. It further documented the resident's daughter was present and had pointed out the injury to caregivers. The nurse documented the resident's physician was called about the injury. He recommended the resident be assessed at the emergency room. The emergency room paperwork, dated 12/7/10, documented the resident had a metatarsal fracture. The facility implemented a temporary care plan, dated 12/8/10, which documented caregivers were to assist the identified resident with ambulation.

On 1/25/11 at 11:35 AM, the house manager stated the injury was noted on 12/7/11. The resident's daughter pointed out the bruise and swelling. The house manager stated she called the facility nurse and the nurse arrived an hour later to look at the injury. The facility conducted an investigation of the injury but could determine what caused the injury.

On 1/25/11 at 11:45 AM, the facility nurse stated she was called by a caregiver about the injury to the identified resident's foot. She further stated she came to the facility to assess the resident and determined the resident needed to be seen by her physician or in the emergency room. The resident was diagnosed with a fracture of small bone in her foot and returned to the facility the same day.

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 was not maintained in clean and sanitary manner.

Findings #4: On 1/24/11 at 5:30 PM, an unannounced complaint investigation was conducted. The facility was toured and was observed to be clean and odor free.

On 1/24/11 at 5:45 PM, a caregiver stated residents' rooms were deep cleaned once a week or more often if necessary.

On 1/24/11 at 6:15 PM, a resident stated his room was cleaned weekly and if he had garbage that needed taken out the caregivers would take care of it.

Melinda Saville, Administrator

February 14, 2011

Page 4 of 4

On 1/25/11 at 12:45 PM, a family member stated she visited the facility almost daily. She stated the facility was always picked up, clean and odor free.

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

As no deficiencies were cited as a result of our investigation, no response is necessary to this report. Thank you to you and your staff for the courtesies extended to us on our visit.

Sincerely,



Rae Jean McPhillips, RN, BSN  
Health Facility Surveyor  
Residential Assisted Living Facility Program

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



IDAHO DEPARTMENT OF  
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) 334-6626  
FAX: (208) 364-1888

February 14, 2011

Melinda Saville, Administrator  
Ashley Manor - Cedar, Ashley Manor Llc  
1525 East Cedar Street  
Pocatello, ID 83201

Dear Ms. Saville:

An unannounced, on-site complaint investigation survey was conducted at Ashley Manor - Cedar, Ashley Manor Llc from January 24, 2011, to January 25, 2011. During that time, observations, interviews, and record reviews were conducted with the following results:

**Complaint # ID00004872**

Allegation #1: The facility did not assist residents with eating.

Findings #1: On 1/25/11, nine current and two closed resident records were reviewed. Activities of Daily Living (ADL) records documented residents received assistance with their meals. The staff as-worked schedule was reviewed and the schedule documented caregivers were staggered to provide extra coverage at meal times.

Nine current residents' records were reviewed for weight loss. Three residents' records recorded weight loss from 11/2/10 to 1/18/11. The records documented one resident lost two pounds and the other resident lost one pound from 11/10 to 1/11.

One resident's record documented she had a six pound weight loss since 11/2/10. Her record contained a fax to her physician, dated 1/1/11, that documented the facility was offering the resident "...high calorie snacks also putting extra butter on her potatoes & vegetables to prevent weight loss." An ADL task sheet for January, documented the resident usually ate 75 to 100% of her meals and snacks.

On 1/24/11 a note was observed posted in the facility's pantry. The note documented caregivers were to offer "super pudding" to all residents, but

especially to those residents who had documented weight loss.

Between 1/24/11 and 1/25/11, residents were observed eating lunch and dinner. The staff were observed assisting residents with eating. Two residents who were cognizant were interviewed. The two residents stated they got enough to eat. One resident further stated if he were hungry, the caregivers would bring him a snack.

On 1/25/11 at 8:35 AM, the house manager stated caregivers were staffed at mealtimes to overlap so there was enough caregivers on duty to make sure the residents received assistance, if needed.

On 1/25/11 at 10:55 AM, the facility nurse stated residents were weighed weekly. She said when a weight loss was noted the resident was started on a nutritional supplement.

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 respond appropriately when an identified resident sustained an injury.

**Findings #2:** The identified resident no longer resided at the facility. The identified resident's record was reviewed and contained an incident report, dated 12/7/10. The report documented the facility nurse was called as soon as family pointed out discoloration on the resident's foot. A progress note, dated 12/8/10 by the facility nurse, documented staff had called her on 12/7/10 and stated the resident's right foot was swollen and bruised. The report and care notes documented the facility nurse came and assessed the resident's foot. It further documented the resident's daughter was present and had pointed out the injury to caregivers. The nurse documented the resident's physician was called about the injury. He recommended the resident be assessed at the emergency room. The emergency room paperwork, dated 12/7/10, documented the resident had a metatarsal fracture. The facility implemented a temporary care plan, dated 12/8/10, which documented caregivers were to assist the identified resident with ambulation.

On 1/25/11 at 11:35 AM, the house manager stated the injury was noted on 12/7/11. The resident's daughter pointed out the bruise and swelling. The house manager stated she called the facility nurse and the nurse arrived an hour later to look at the injury. The facility conducted an investigation of the injury but could not determine what caused the injury.

On 1/25/11 at 11:45 AM, the facility nurse stated she was called by a caregiver

about the injury to the identified resident's foot. She further stated she came to the facility to assess the resident and determined the resident needed to be seen by her physician or in the emergency room.

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

**Allegation #3:** Caregivers did not provide supervision to protect residents, when an identified resident had violent outbursts.

**Findings #3:** On 1/24/11 at 5:30 PM, an unannounced visit was conducted at the facility. It was determined the identified resident no longer resided at the facility. Two caregivers were observed to be present to provide care for the nine residents who currently resided at the facility. The caregivers stated they thought there was adequate staff on duty to provide supervision. The identified resident's closed record was reviewed. A history and physical, dated 10/19/10, documented the resident was pleasant and cooperative. Progress notes also documented the resident as pleasant and cooperative. There was no documentation the identified resident had a history of behaviors or violent outbursts.

On 1/25/11 at 10:40 AM, a caregiver stated when the identified resident was admitted, he was very easy going and calm. The caregiver further stated the identified resident had never shown aggression towards other residents or staff.

On 1/25/11 at 11:30 AM, the house manager stated the identified resident did not have a history of violence while he resided at the facility. She stated there was an incident when another resident went into his room to use his bathroom. She said staff heard a "scream" from the resident's room where staff found him standing over another resident who was lying on the floor. She stated the resident told her he saw a resident enter his room to use his bathroom. She said he told her that he pulled the resident out of his bathroom by her arm and she fell on the floor. The administrator stated the resident was not involved in any other incidents at the facility. She stated they place a motion detection alarm on the identified residents door to alert caregivers when residents entered his room. She said he moved out of the facility shortly after the incident to another facility where residents are less confused.

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

Melinda Saville, Administrator

February 14, 2011

Page 4 of 4

As no deficiencies were cited as a result of our investigation, no response is necessary to this report. Thank you to you and your staff for the courtesies extended to us on our visit.

Sincerely,

A handwritten signature in black ink that reads "Rae Jean McPhillips, RN". The signature is written in a cursive style with a large initial 'R'.

Rae Jean McPhillips, RN, BSN  
Health Facility Surveyor  
Residential Assisted Living Facility Program

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