



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER -- GOVERNOR
RICHARD M. ARMSTRONG -- DIRECTOR

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P.O. Box 83720
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March 8, 2013

Bridgett Snyder, Administrator
Ashley Manor - Mountain Home
940 West 8th South
Mountain Home, ID 83647

License #: RC-688

Dear Ms. Snyder:

On February 7, 2013, a Complaint Investigation survey was conducted at Ashley Manor - Mountain Home. 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.

This office is accepting your submitted evidence of resolution.

Should you have questions, please contact Rae Jean McPhillips, RN, BSN, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 334-6626.

Sincerely,

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

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



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February 21, 2013

Bridgett Snyder, Administrator
Ashley Manor - Mountain Home
940 West 8th South
Mountain Home, ID 83647

Dear Ms. Snyder:

An unannounced, on-site complaint investigation survey was conducted at Ashley Manor - Mountain Home from February 6, 2013, to February 7, 2013. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00005618

Allegation #1: The facility's call system was not functional and residents could not call for assistance.

Findings #1: An unannounced complaint investigation was conducted on 2/6/13. The facility's call system consisted of "a pendant" that residents could wear around their necks. All residents' pendants were tested and were found to be in working order. From 9:30 AM until 4:00 PM, residents were observed to use their pendants to call for assistance and staff were observed responding.

Between 9:30 AM and 11:30 AM, eight residents were interviewed. All stated they had not had a problem with their pendants.

On 2/6/13 at 2:30 PM, the house manager stated that at one time, a resident's pendant was broken, however, it was replaced immediately. She stated they had a replacement available at the facility in case of breakage or loss.

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 had possible side effects from medications.

Findings #2: The identified resident's record was reviewed on 2/6/13. The record documented the resident saw her physician, on 4/17/12, due to her continued back pain. A physician's order documented the resident was to receive a new narcotic pain medication five times a day. Additionally, the physician increased the dosage of the resident's anti-anxiety medication.

An "Alert Charting" form, dated 4/17/12, documented staff were to monitor for side effects after the resident's change in medication. The nurse documented staff were to record vital signs every shift and monitor for increased sleepiness, dizziness, and low blood pressure. There were no documented abnormal vital signs or signs and symptoms of side effects from the medications.

The record documented the facility faxed the resident's physician, on 5/10 and 5/18/12, with concerns that she was spending an increased amount of time in bed sleeping. The physician faxed back, on 5/21/12, to discontinue the anti-anxiety medication and reduce the pain medication from 5 times a day to 4 times daily.

The facility implemented a system to monitor the identified resident when she had a change in her medications. Additionally, the facility notified the resident's physician when she had a change in her conditions.

Unsubstantiated. Although the allegation may have occurred, it could not be determined during the complaint investigation.

Allegation #3: Residents were not assisted with showers because staff were too busy.

Findings #3. The current residents' shower logs from 4/2012 to 2/6/2013 were reviewed. The logs documented that current residents received showers at least twice weekly. The shower logs for two residents who no longer resided were also reviewed.

One closed record documented the resident received showers twice weekly in February and March of 2012. The shower log for 4/12 documented the resident refused assistance with showers for 9 days. The log also documented that staff offered to assist her daily during that time. The shower log for 5/12 documented the resident refused assistance with a shower, once.

The facility's complaint documentation, from 4/12 through 2/6/13, was reviewed. There was no documentation of residents not receiving showers, or not being groomed

On 2/6 and 2/7/13, residents were observed to be groomed, clean, odor free and appropriately dressed in clean clothing.

On 2/6/2013 at 11:20 AM, a hospice chaplain stated he visited the facility frequently. He stated when he visited the facility, residents were clean, odor free and dressed in clean clothing.

On 2/6/13 at 12:40 PM, a caregiver stated there was enough time to assist residents with showers.

On 2/6/13 at 1:05 PM, a visitor to the facility stated she visited a friend at the facility. She stated her friend, and other residents, were clean and odor free when she was there.

On 2/6/13 at 2:20 PM, the house manager and a caregiver stated there was sufficient staff and time to assist residents with their showers. They stated if a resident did not want to shower on their scheduled day and time, staff offered to assist them later in the day.

Unsubstantiated. This does not mean the incident did not take place; it only means that the allegation could not be proven. However, the facility was cited at IDAPA 16.03.22.711.04 for not documenting the resident was informed about the possible consequences of refusing assistance with showers. The facility was required to submit evidence of resolution within 30 days.

Allegation #4: The food was not palatable and residents lost weight.

Findings #4: On 2/6/13 and 2/7/13, nine residents were observed during breakfast and lunch meals. The food being served was consistent with the planned menu.

On 2/6/13 at 12:15 PM, the residents were served steak, beets and rice. The residents stated the meal was very good. The food being served was sampled by a surveyor and the meal was flavorful and served at an appropriate temperature.

Three current residents' records were reviewed and the RN assessments documented the residents had stable weight over the past six months. One resident had gained 3.4 pounds

Two closed records were reviewed on 2/6/13. One closed record documented the resident lost weight between 4/26 and 5/10/12. The record contained two faxes to the resident's physician, dated 5/10 and 5/18/12, advising him of the resident's

Bridgett Snyder, Administrator
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weight loss. The record documented the resident usually ate between 75% and 100% of her meals.

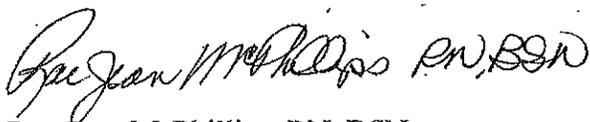
On 2/6/13 at 2:48 PM, the house manager and a caregiver stated the resident would sometimes refuse meals. They said when the resident started to lose weight around mid-May her physician was notified twice. They stated the resident was encouraged to eat meals, snacks and drink nutritional supplements. Additionally, they stated the resident's daughter frequently brought her special meals and snacks.

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 **02/07/2013**. 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) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

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