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HEALTH & WELFARE

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May 8, 2012

Reba Curtis, Administrator  
Ashley Manor Care Centers Inc - Highmont  
11099 Highmont Drive  
Boise, ID 83713

Dear Ms. Curtis:

An unannounced, on-site complaint investigation survey was conducted at Ashley Manor Care Centers Inc - Highmont on April 26, 2012. During that time, observations, interviews, and record reviews were conducted with the following results:

**Complaint # ID00005505**

Allegation #1: The facility does not have enough food to prepare the menu.

Findings #1: On 4/26/12 at 9:00 AM, the ombudsman stated during the last quarterly visit, sufficient food was observed and she had not received any complaints from residents regarding food.

On 4/26/12 at 9:30 AM, the current weekly menu was reviewed and compared with the food supply. Sufficient food was observed available to prepare the planned menu. During this time, the administrator's assistant stated, the administrator was responsible for doing the shopping; she was unaware of a time when food was not available to meet the menu. If a particular item was not available to meet the menu, a similar item would be substituted, or the administrator was available to go to the store to purchase the required items.

On 4/26/12 at 12:00 PM, the regional manager stated if the administrator required additional money for food items, in between the twice monthly shopping days, the administrator could notify her and she would transfer money online to a shopping card. She stated she was also available to shop when needed.

On 4/26/12 at 12:10 PM, lunch was observed being served according to the

planned menu.

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

Allegation #2: The residents did not receive adequate amounts of food at each meal.

Findings #2: On 4/27/12, between 9:30 AM and 10:15 AM, seven residents were observed present. Four residents were interviewable and stated they received enough food at meal times. During this time, a medical assistant student stated he was frequently at the facility during meal times, for his internship, and meals were observed to provide sufficient quantities of food; he had not heard the residents complain about not having enough food.

On 4/27/12 at 12:00 PM, the regional manager stated the food budget is adjusted based on the appetites of the residents. Facilities which have more male residents, who generally have larger appetites, are allowed a greater food budget.

On 4/27/12 at 12:10 PM, the lunch meal was observed. Food was served in proportions according to the menu; the protein source was observed to be a larger portion than what the menu documented. Additionally, an alternative protein source was observed to be available.

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

Allegation #3: Residents did not receive sufficient toe nail care.

Findings #3: On 4/26/12, at 10:00 AM, the administrator's assistant stated she had recently began working at the facility and had observed some of the residents toe nails needed more attention. Since then, the facility RN had been in to do nail care and had requested a podiatrist come in to provide additional nail care. She further stated, current caregivers were reminded to pay special attention to residents' nails during bathing times.

On 4/26/12 at 10:12 AM, the regional manager stated they had arranged for a podiatrist to come in and provide additional toe nail care to the residents, in addition to the routine toe nail care provided by caregivers.

Two diabetic resident's records were reviewed. Care notes documented the facility RN provided nail care to one resident on 4/4/12 and the other on 4/6/12. During this time, the RN documented a recommendation to have a podiatrist provide additional nail care. Care notes documented the residents' families were contacted to provide consent to have the residents treated by a podiatrist. Faxes

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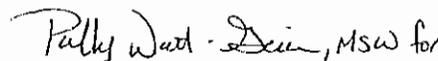
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were observed in the records, requesting the approval for the residents to receive the podiatry treatment.

Substantiated. However the facility was not cited, as they identified the problem and took steps to correct it.

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,

  
Rachel Corey, RN  
Health Facility Surveyor  
Residential Assisted Living Facility Program

RC/pwg

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