



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

July 8, 2011

Charlotte Martin, Administrator
Ashley Manor - Hyde Park, Ashley Manor LLC
1908 North 13th Street
Boise, ID 83702

Dear Ms. Martin:

An unannounced, on-site complaint investigation survey was conducted at Ashley Manor - Hyde Park, Ashley Manor LLC on July 6, 2011 and July 7, 2011. During that time, observations, interviews, and record reviews were conducted with the following results:

Complaint # ID00005056

Allegation #1: The facility did not provide adequate supervision to protect an identified resident from harm when he left the facility unattended and did not return.

Findings #1: The identified resident is his own legal guardian.

Deficiencies identified during a licensing survey conducted on 3/22/11, included the facility had not addressed when the identified resident left the facility unattended for a doctor's appointment, missed the doctor's appointment and did not return to the facility when expected. On subsequent doctor's visits, the facility opted to send staff with the resident.

A behavioral management plan, dated 3/25/11, documented staff were to remind the resident of the time he was expected back when he leaves the facility. It further documented the police had been notified in the past when the resident did not return when expected, however, the police did not bring him back to the facility because the "resident is his own person...and has answered questions appropriately".

A progress note dated 4/7/11, documented a staff member accompanied the resident to a doctor's appointment. Upon returning to the facility, the resident

Charlotte Martin, Administrator

July 8, 2011

Page 2 of 2

refused to enter the facility stating he would return later. The resident did not return for several days.

A progress note, dated 4/22/11, documented the facility administrator discussed the resident's behaviors with a family member, as well as possible solutions.

A written agreement between the facility and the resident, dated 4/22/11, documented when the resident left the facility and did not return at the assigned time, the facility will look for the resident at his known favorite places to "hang out" as well as notify the resident's family. The resident signed the agreement.

A progress note dated 4/28/11, documented a staff member accompanied the resident to a doctor's appointment. While in the waiting room, the resident went to the restroom. When he did not return to the waiting area, the staff looked for him but could not find him. They then notified the clinic staff, police and the resident's family.

A progress note dated 4/29/11, documented staff found the resident walking along a public street and encouraged him to return to the facility with them, but the resident refused.

On 7/7/11 at 11:00 AM, the administrator stated she contacted the police after seeing the resident walking along the public street and the police officer told her, "You have contacted me about this before. I can't take him anywhere he doesn't want to go...He has a rights."

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

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,



Maureen A. McCann, RN

Team Leader

Health Facility Surveyor

Residential Assisted Living Facility Program