



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

LESLIE M. CLEMENT – DEPUTY DIRECTOR
LICENSING AND CERTIFICATION
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

November 18, 2011

Roger Malm, Administrator
Ashley Manor - Harmony, Ashley Manor Llc
2703 Harmony Avenue
Boise, ID 83703

Dear Mr. Malm:

An unannounced, on-site complaint investigation survey was conducted at Ashley Manor on November 15, 2011. During that time, observations, interviews, and record reviews were conducted with the following results:

Complaint # ID00005286

Allegation #1: Medication errors were occurring and the facility RN was not addressing them.

Findings #1: On 11/15/11, three sampled resident records were reviewed. October and November 2011 medication assistance records were compared with physician orders. Medications were documented appropriately and were consistent with physician orders. Care notes, "RN notification" notes and Incident reports did not contain documented evidence of any medication errors.

On 11/15/11 at 8:00 AM, the house manager stated she was unaware of any medication errors occurring. If one were to occur, she would notify the facility RN or call 911, if it was an emergency.

On 11/15/11 at 8:15 AM and 11:45 PM, the house manager was observed providing assistance with medications; she verified the five rights before assisting residents with their medications.

On 11/15/11 at 8:32 AM, an interviewable resident stated she received her medications as prescribed.

On 11/15/11 at 9:30 AM, a caregiver stated she had worked at the facility for three months and was unaware of any medication errors occurring.

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

Allegation #2: Residents were being assisted with medications in a rough manner.

Findings #2: On 11/15/11 at 8:15 AM and 11:45 PM, medication assistance was observed. The house manager was observed assisting residents with their medications in a calm and patient manner. She stated if residents refused medications, medication aides were instructed to reapproach the resident at another time.

On 11/15/11 at 9:30 AM, a caregiver stated she had never witnessed anyone assisting residents with medications in a rough manner. She further stated, if residents refused to take their medications, staff would come back in five or ten minutes and try again.

On 11/15/11 at 10:20 AM, two family members were interviewed. They stated they observed staff members providing cares in a patient manner.

On 11/15/11 at 11:00 AM, an interviewable resident stated she had not observed residents being assisted in a harsh manner.

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

Allegation #3: Residents did not receive assistance with eating (i.e. cutting food).

Findings #3: On 11/15/11, at 11:50 AM, the lunch meal was observed. Residents were observed being assisting with eating appropriately.

On 11/15/11 at 9:00 AM, the house manager stated all residents, but one required their meat cut up and needed some cueing to eat. She further stated, a second caregiver was scheduled daily to provide extra assistance during meals.

On 11/15/11 at 9:15 AM, a caregiver stated most residents required assistance with cutting their meats up and staff monitored residents' ability to eat and provided assistance when necessary.

On 11/15/11 at 10:20 AM, two family members were interviewed over the phone and stated they had visited during meals and had observed residents receiving assistance to eat.

On 11/15/11 at 11:55 AM, an interviewable resident stated the caregivers were good at assisting residents to eat and cut foods when required.

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

Allegation #4: Residents were not assisted to drink.

Findings #4: On 11/15/11, from 7:30 AM until 12:30 PM, residents were observed being reminded and assisted to drink various beverages during medication pass, activities, prior to meals and during meals.

On 11/15/11 at 9:15 AM, the house manager stated she encouraged residents to drink a full glass of water or Ensure during medication pass, and assisted residents to drink frequently throughout the day.

On 11/15/11 at 9:30 AM, a caregiver stated she reminded and assisted residents to drink during meals, at 10:00 AM, 2:00 PM and during medication times. She further stated, she monitored residents and when they approached the kitchen area, she would offer them fluids.

On 11/15/11 at 10:20 AM, two family members were interviewed and stated they visited the facility frequently and had observed caregivers offering fluids to residents throughout the day.

Unsubstantiated.

Allegation #5: Cigarette butts littered the exterior of the facility.

Findings #5: On 11/15/11 at 7:45 AM, the exterior of the facility was observed to be clean and well maintained. Cigarette butts were not observed anywhere on the ground. A receptacle for cigarette butts was observed in the back yard patio area.

On 11/15/11 at 9:40 AM, the caregiver and house manager stated cigarette butts were kept contained and they were unaware of a time when they littered the outside of the facility.

On 11/15/11 at 10:20 AM, one family member stated the facility was always maintained in a clean manner and they did not recall a time when cigarette butts were present.

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

Roger Malm, Administrator

November 18, 2011

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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, appearing to read "Rachel S., RN". The signature is fluid and cursive, with the initials "S., RN" clearly visible at the end.

Rachel Corey, RN

Health Facility Surveyor

Residential Assisted Living Facility Program

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