



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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July 18, 2018

Shon Shulldberg, Administrator  
Ashton Memorial Living Center  
700 North Second Street, Po Box 838  
Ashton, ID 83420-0838

Provider #: 135097

Dear Mr. Shulldberg:

**Congratulations** to both you and your staff on your deficiency-free survey. In today's world with numerous regulations, it is indeed impressive to see a facility functioning as a team at this level.

Continuing to meet the needs of your residents – while recognizing and meeting the administrative needs of your business – is a daily commitment to quality ongoing assessment, care planning and consistent provision of services to each and every client. The greater challenge, of course, is to be able to work as a team to provide this high level of caring and service day after day, week after week, year after year.

Again, **Congratulations** to you and your staff for a job well done, and I challenge you to keep this same high standard in the coming year.

Sincerely,

DEBBY RANSOM, R.N., R.H.I.T.  
Bureau Chief

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135097</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/12/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>ASHTON MEMORIAL LIVING CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>700 NORTH SECOND STREET ASHTON, ID 83420</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p><b>INITIAL COMMENTS</b></p> <p>A recertification survey was conducted July 9, 2018 - July 12, 2018 at Ashton Memorial Living Center. The facility was found to be in substantial compliance with 42 CFR Part 483 Requirements for Long Term Care Facilities.</p> <p>The survey team entered the facility on .</p> <p>The surveyors conducting the survey were:</p> <p>Brad Perry, LSW, Team Leader Wendi Gonzales, RN</p>	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

07/18/2018

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.