NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
Ashley Manor - Midland	RC-536	67 South Midland Boulevard	208-461-1452
Administrator	City	Zip Code	Survey Date
Serina Williams	Nampa	83651	09/08/2023
Survey Team Leader	Survey Type		Response Due
Miller, Rebecca	Health Care Licensure and Follow-Up		10/08/2023

Item #	Rule (16.03.22)	Description
1	.260.04. Linen and Laundry Facilities and Services.	The facility did not maintain an environment free of insects, with a substantial amount of flies observed in the facility all three days of survey. In house 2, one unsampled resident, who was sleeping in a recliner in the main living area, had flies landing on their eyes and extremities. In house 1, one unsampled resident expressed frustration, on more than one occasion, with the proliferate flies.
2	.260.07. Toxic Chemicals.	Toxic chemicals were observed to be stored in areas which was accessible to cognitively impaired residents. For example: In an unlocked laundry room in House 2, spray bottles containing toxic chemicals, including Lysol disinfectant spray, Lysol toilet bowl cleaner, and Comet, were observed to be in an unsecured, portable tub on three different occasions from 9/6/23 to 9/8/23. In House 1, chemicals such as wound cleansers and hair dye were observed, unsecured, in the facility's shower room on two occasions between 9/6/23 and 9/8/23.
3	.305.03. Change in Resident Health Status.	The facility nurse did not consistently assess residents after a change of condition. For example, Resident #1 fell on 7/26/23 and was observed by staff to have new bruising to their right axilla and breast area on 8/28/23, and the facility nurse did not

		assess the resident. In addition, staff members documented Resident #1 had a cough, purple discoloration in their extremities, and were unable to obtain an oxygen saturation reading for Resident #1 on 3/30/23, but the resident was not assessed until five days later by the facility nurse. Resident #3 fell in 4/7/23, and Resident #4 fell in 8/23/23, and neither were assessed by the facility nurse. The facility nurse was unavailable for interview.
4	.320.08. Periodic Review.	Negotiated service Agreements (NSAs) were not updated to reflect significant changes in residents' health status and care needs. For example, the NSA for Resident #1, who was chair bound, documented the resident could still use a walker, but during observations, the resident was no longer capable of using a walker. In addition, the resident was also observed to require two staff members assistance in the restroom, which was not documented in the NSA. The NSA documented the resident was incontinent but did not instruct staff how often to toilet the resident, nor how often they should be repositioned to avoid skin breakdown. The NSA did not document the resident had been admitted to hospice, who was providing cares for the resident such as bathing. Resident #4's NSA did not document that hospice was providing bathing. The administrator stated the facility nurse and caregiving staff were responsible to update the residents' NSAs when there were any changes.
5	.330.06. Additional Resident Records.	The facility did not retain residents' behavior plans and all of staff members' documentation of the behaviors. For example: Resident #3 was observed to yell at staff and other residents on multiple occasions, slammed their walker on the floor while yelling for help, and called other residents "dummies." There was no behavior plan in the Resident #3's record for the staff to reference or document these behaviors. Resident #4, who was taking psychotropic medications, did not have a behavior plan in their record. Resident #4's Negotiated Service

		Agreement documented there was a behavior plan in place but did not give details on the plan such as interventions to use when the resident expressed maladaptive behaviors. The administrator stated the behavior plans had been created, but she could not locate them.
6	.330.14.a. As Worked Schedules.	The facility's as-worked schedule did not consistently document the actual times the caregivers worked at the facility, such as if the staff members came to work late, worked later than their scheduled time, or had not worked at all. For example, one staff member was documented as working on 8/6/23, but timecards documented the staff member had not worked at all that day. In addition, after Registered Nurse's as-worked schedule did not consistently document the "time out" portion, so it was unclear when the facility nurse left the facility. The administrator stated the as-worked schedule had not been updated with the correct documentation.