NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
Ashley Manor - Storybook Way	RC-833	126 North Storybook Way	208-939-4602
Administrator	City	Zip Code	Survey Date
Melissa Rodriguez	Eagle	83616	03/06/2025
Survey Team Leader	Survey Type		Response Due
Perry, Bradley	Health Care Complaint Investigation		04/05/2025

Item #	Rule (16.03.22)	Description
1	.305.03. Change in Resident Health Status.	The facility nurse did not conduct change of condition assessments when residents experienced changes in their mental and physical status. For example, when Resident #1 hit their head on 7/4/24, nor when they experienced falls on 7/8/24, twice on 8/5/24, twice on 8/19/24, and twice on 8/29/24. Resident #2 was not assessed when they were involved in resident to resident altercations on 11/30/24, 12/2/24, 12/10/24, and 1/15/25. Resident #2 was not assess on 1/30/25 when they experienced increased agitation along with frequent urination. The facility nurse stated the change of condition assessments were not completed.
2	.310.04.a. Behavior Modifying Medication.	The facility did not attempt non-drug interventions prior to requesting medications. For example: Resident #3 was prescribed Ambien on 2/27/24, quetiapine on 3/29/24, and haloperidol injections on 4/15/24 as a first resort, prior to having a behavior management plan in place. The facility's complaint log contained a complaint on 4/8/24, which documented a family member had a concern of the facility adding new psychotropic medications to Resident #3's medication regimen without cause. The former administrator stated Resident #3 did not have a behavior management plan

		for behaviors prior to using medications as a first resort.
3	.320.03. Signature, Date, and Approval of Agreement.	Negotiated Service Agreements (NSAs) were not signed and dated by Residents #2 and #3 nor their legal representatives within 14 days of completion. The former administrator stated he never had Resident #2 and Resident #3's legal representatives sign the NSAs.****Previously cited on 2/16/24.***
4	.330.06. Additional Resident Records.	The facility did not evaluate, develop interventions, nor track ongong behaviors when Resident #2 verbally bullied other residents. The facility did not develop interventions when Resident #3 consistently refused to eat which led to weight loss. The facility administrator and nurse stated Resident #2's behaviors were not adequately evaluated for these behaviors, interventions had not been developed, and tracking of these behaviors were not documented. The former administrator stated he did not develop a behavior plan when Resident #3 refused to eat.***Previously cited at 330.06.a and b.***
5	.600.02. Detached Buildings or Units.	The facility did not ensure all buildings were staffed sufficiently to ensure one staff member was in each building at all times. For example, several staff members and outside agency staff stated buildings were left unattended for short periods of time when they needed to assist residents or needed to retrieve an item in the opposite building. On 3/4/25 at 8:23 AM and on 3/5/25 at 10:45 AM, staff were observed to leave building #2 unattended. The administrator stated the buildings were left unattended due to not having enough staff to assist residents' needs.