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
Heather Marrs	Nampa	83651	04/04/2025
Survey Team Leader	Survey Type		Response Due
Oldfield, Michael	Health Care Core Deficiency Follow-Up + complaint investigation		05/04/2025

Item #	Rule (16.03.22)	Description
1	.305.02.c. Current Medication Orders and Treatment Orders.	The facility did not have current, signed orders in three of five sampled residents' records. For example, Resident #1 did not have current orders in their record for five of their medications, including their current Basaglar insulin order. Resident #2 did not have current orders for 23 of 24 medications and did not have discontinue orders for at least one medication. The facility administrator and nurse stated these orders were not present in each resident's record.
2	.310.01.g. Medication Distribution System.	The facility did not ensure residents' PRN medications were available at all times. For example, Resident #1 did not have their ondansetron available on 4/3/25 when the resident requested it for nausea. Resident #5 did not have Naloxone available on the medication cart. The facility nurse stated she was not aware the medications were not available.
3	.330. REQUIREMENTS FOR FACILITY RECORDS.	The administrator did not ensure the facility's records were complete and accurate. For example, the facility's electronic medication administration record (eMAR) had duplicate entries for three of Resident #2's medications. This resulted in inaccurate administration documentation of Resident #2's metformin, trihexyphenidyl, and calcium, and Resident #2 was given calcium three times a day instead of twice a day as

		prescribed. Resident #1's eMAR contained multiple discontinued medications, which resulted in the resident continuing to receive the discontinued medications, such as diclofenac sodium gel. The facility nurse confirmed the records were inaccurate and needed to be corrected to avoid confusion. ***Previously cited 1/16/25***
4	.330.05.b. Discharge Records.	The facility did not obtain history and physical results for Resident #2 and #5. Resident #2 was admitted to the facility on 1/28/25 and Resident #5 was admitted to the facility on 2/6/25, and their records did not contain their admission health and physical examinations. The administrator stated the marketer is responsible for obtaining all the necessary admission records before they are admitted, and they did not obtain their health and physical examinations for their records before they were admitted.