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
Nina Hutton	Nampa	83651	07/16/2025
Survey Team Leader	Survey Type		Response Due
Ramirez, Mina	Health Care Licensure and Follow-Up		08/15/2025

Item #	Rule (16.03.22)	Description
1	.310.01.c. Medication Distribution.	The facility did not maintain the medication refrigerator temperatures between 38 and 45 degrees F. In house #1, the temperatures were documented between 28 and 34 degrees with no corrective action taken on four days and temperatures were not documented 10 days in July 2025. In house #2, the temperatures were documented between 34 and 37 degrees with no corrective action taken on 11 days in July 2025. Insulin was observed in both refrigerators. The facility nurse stated she was not aware the temperatures were out of range and not being documented daily.
2	.310.04.a. Behavior Modifying Medication.	The facility did not attempt non-drug interventions prior to requesting medications for Resident #1. As-needed lorazepam was used as a first resort to address behaviors of wandering into other residents' rooms or being combative with staff on five occasions from 5/5/25 to 5/24/25. The house manager stated Resident #1 did not have a behavior management plan in place for wandering into other residents' room and staff were supposed to attempt a non-drug intervention prior to requesting medications for residents.
3	.330.06.b. Additional Resident Records.	The facility did not have behavior plans, which included at least one intervention specific to each maladaptive behavior.

		For example, Resident #1 exhibited behaviors of wandering into other residents' rooms and refusals of showers and toileting. The facility house manager confirmed interventions were not included in the Resident #1's behavior management plan.***Previously cited at 330.06 on 9/8/23***
4	.410. REQUIREMENTS FOR EMERGENCY ACTIONS AND FIRE DRILLS.	The facility could not provide documentation of any emergency egress/fire drills conducted in 2025. The house manager stated drills were completed each month from April 2025 to July 2025 but had not documented them. ***Previously cited on 6/21/22***
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 stated buildings were left unattended for short periods of time when they needed to "swap" a caregiver for a medication technician since each of the two buildings only had one staff working in each building. From 7/14/25 to 7/16/25, staff were observed to leave building #1 unattended on several occasions each day from 30 seconds and as long as three minutes. As-worked schedules documented there was only one caregiver and one medication technician for both buildings on the night shifts for 7/1/25 and 7/3/25, and on the evening shifts for 7/3/25 and 7/6/25. The house manager and administrator stated the facility buildings were left unattended for short periods of time due to not having a medication technician for each building, so the staff had to switch buildings so medications could be passed in the other building.
6	39-3321.2.c. Qualifications and Requirements of Administrator.	The facility did not ensure investigations were completed. For example: Resident #1 experienced a fall on 6/2/25 and an injury of unknown injury on 6/24/25. The facility's incident reports did not documented either of these incidents were investigated. The house manager stated she should have completed her own investigation on Resident #1's injury of unknown injury instead of leaving it up to the resident's

		hospice nurse.
7	39-3321.5. Qualifications and Requirements of Administrator.	The facility did not notify Licensing and Certification (L&C) of reportable incidents within one business day. For example, Resident #1 fell on 2/22/25 and 3/2/25 and was sent to the emergency department to be evaluated. On 6/24/25, Resident #1 was found with an injury of unknown origin and L&C was not notified of any of these incidents within one business day. The house manager stated the previous administrator had not reported these incidents to L&C.