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
Bobbi Moore	Eagle	83616	08/04/2025
Survey Team Leader	Survey Type		Response Due
Walker, Jenny	Health Care Licensure and Follow-Up		09/03/2025

Item #	Rule (16.03.22)	Description
1	.001.03. General Provider Responsibilities.	The Licensee failed to provide necessary resources to ensure the facility operated consistent with the rules and statutes at IDAPA 16.03.22 and title 39 and chapter 33. The facility did not receive sufficient support from the Licensee which resulted in multiple non-core deficiencies during the survey and the facility receiving repeat non-core deficiencies at: 151 for not providing activities, at 260.07 for not securing toxic chemicals, at 305.03 for not completing change of condition assessments, at 310.01.c for not monitoring and documenting medication refrigerator temperatures daily, at 310.04.a for using psychotropic medications as a first resort, at 320.03 for not having NSAs signed and dated by the residents or legal representatives, at 330.06 for not evaluating and implementing behavior management plans (BMP), at 410 for not conducting fire drills, at 600.02 for leaving a house unattended, and at 450 for not having a certified food protection manager, which also resulted in a failed kitchen inspection. The former administrator stated she had to work on the floor and was unable to address her administrative duties and did not receive support from the corporation (licensee) to complete the administrative duties.

2	.151. ACTIVITY REQUIREMENTS.	During observations in both buildings from 7/29/25 to 7/31/25, no activities were offered to the residents. The staff stated they did not have enough time to engage residents in activities. The administrator stated they were working on providing activities at the facility. ***Previously cited on 2/26/24***
3	.155.01. Relocation Agreements.	The facility was unable to provide written/signed agreements for transfer or relocation of residents in the event of an emergency where evacuation would be required. The administrator stated the facility did not have a relocation agreement.
4	.161.04. Designated Smoking Areas.	The facility did not have designated smoking areas clearly marked for house #1 and house #2. During observations from 7/29/25 to 7/31/25 both non-combustible metal cans were full of combustible trash mixed with ashes and cigarette butts. The facility staff stated residents and staff did not always smoke in designated areas and did empty the small ashtrays into the metal cans that was full of combustible trash materials.
5	.260.07. Toxic Chemicals.	Between 7/29/25 and 7/31/25, toxic chemicals were observed to be stored in unlocked cabinet under the kitchen sink and both doors to enter the kitchen were unsecured, which was accessible to cognitively impaired residents. The administrator stated toxic chemicals should be secured. ***Previously cited on 2/16/24***
6	.305.02.b. Quarterly Nursing Assessments.	The facility did not ensure residents received medications and treatments as ordered by their provider. For example, Resident #1 had a treatment order for the facility RN to remove and wash their glass eye weekly. Resident #1's July 2025 MAR, documented they did not receive diclofenac sodium topical gel for pain nine times, dorzolamide-timolol eye drops for glaucoma ten times, latanoprost eye drops for glaucoma 7 times, nor hydrocodone-acetaminophen 5 times. The house manager stated she had not removed the glass eye to clean it, and the medications were not ordered in time for

		the pharmacy to fill and deliver to the facility. The facility RN stated she had not completed the weekly treatment and will implement a weekly audit for medications to ensure residents receive all medications and treatments as ordered.
7	.305.03. Change in Resident Health Status.	The facility nurse did not assess residents after they experienced changes in their mental and health status. For example: Resident #3 had a wound that was followed by a home health agency. Unlicensed staff documented when home health provided wound care to Resident #3. For example home health notes documented on 2/3/25 "wound presents with purulent drainage...", on 2/14/25, "Wound healing...", on 2/17/25, wound measurements and tolerating antibiotic, on 2/24/25, "Wound presenting closed with dry, flaky skin." On 3/31/25, resident was discharged from home heath on 3/27/25 due to wound healed. Resident #3's progress notes did not document a physical assessment of the changes of the wound by the facility nurse. Resident #5 was not assessed for a change of condition when they had increased agitation and medication changes on 7/11/25. ***Previously cited on 3/06/24***
8	.310.01.c. Medication Distribution.	The facility's medication refrigerator was located in house #2 and contained insulin, did not have temperatures monitored and documented daily, nor were the temperatures maintained between 38- and 45-degrees F. The facility had documented temperatures only 19 of 31 days in May 2025, and temperatures were out of range all 19 times and as low as 28 degrees F. Temperatures were documented only 14 of 30 days in June 2025, and were out of range 9 times, as low as 32 degrees F. No temperatures were documented in July 2025. The administrator stated she was not aware the temperatures were not monitored. **Previously cited on 02/02/25 and 01/19/23***
9	.310.01.g. Medication Distribution System.	Resident #1's PRN gavilax powder was not available on the medication cart. Resident #2's PRN acetaminophen was not

		available on the medication cart. The facility nurse stated all medications, including PRNs should be available at all times for residents.
10	.310.04.a. Behavior Modifying Medication.	The facility did not attempt non-drug interventions prior to requesting medications. For example: Resident #3 was prescribed fluoxetine, quetiapine, haloperidol, and lorazepam prior to having a behavior management plan. Resident #5 was prescribed haloperidol, alprazolam, and mirtazapine prior to having a behavior management plan. The house manager stated Resident #3 and Resident #5 did not have a behavior management plan for behaviors prior to using medications as a first resort. ***Previously cited on 3/6/25***
11	.310.04.e. Psychotropic or Behavior Modifying Medication.	Resident #3 was taking fluoxetine, quetiapine, haloperidol and lorazepam and did not have current six-month psychotropic medication reviews completed. Resident #4 was taking duloxetine, and mirtazapine and did not have six-month psychotropic medication reviews. The house manager confirmed the reviews were not completed.
12	.320.03. Signature, Date, and Approval of Agreement.	Negotiated Service Agreements (NSAs) were not signed and dated by Residents #1 and #3, or their legal representatives. The facility house manager stated the NSA's had not been signed for those residents. ***Previously cited on 3/06/25 and 2/16/24***
13	.330.06. Additional Resident Records.	The facility did not evaluate, develop interventions, nor track ongoing behaviors when Resident #3 hit, yelled, resisted to cares, and spit; when Resident #4 verbally bullied other residents; or when Resident #5 had agitation and restlessness. The house manager stated they had not evaluated, developed interventions, nor track these behaviors. ***Previously cited on 3/6/25***
14	.330.13.i. Personnel Records.	Five of six staff, who passed medications, did not have documentation of delegation by the current facility nurse. The house manager was unable to locate and provide the documentation. The facility nurse stated she delegated the

		staff and could not provide the documentation in the facility.
15	.330.15.c. Fire and Life Safety Records.	The facility did not complete monthly visual inspections for all portable fire extinguishers in house #1 and house #2. The administrator stated the inspections were not completed.
16	.335.02. Standard Precautions.	During medication pass observations, medication technicians were observed administering medications to multiple residents without conducting hand hygiene between medication pass with each resident. One staff member was observed eating personal food while in the kitchen. The facility nurse stated the medication technicians should have conducted hand hygiene between each medication pass and staff should consume personal food outside of the food preparation areas.
17	.410. REQUIREMENTS FOR EMERGENCY ACTIONS AND FIRE DRILLS.	The facility failed to conduct fire drills in accordance with the rule. The last documented drill was on 12/28/23. The house manager stated they had not completed fire drills. ***Previously cited on 4/10/25***
18	.450. REQUIREMENTS FOR FOOD AND NUTRITIONAL CARE SERVICES.	The facility did not meet the standards for the Idaho Food Code. Kitchen inspection failed on 8/4/25. Mandatory re-inspection required within 10 days. The facility did not have a Certified Food Protection Manager at the time of survey. The administrator stated they did not have Certified Food Protection Manager. ***Previously cited on 2/16/24***
19	.455. FOOD SUPPLY.	The facility did not maintain a 7-day supply of non-perishable foods, or a 2-day supply of perishable foods. The food pantry in both houses were observed to have very little non-perishable foods. The refrigerators in both houses were observed to have very little food, no fresh produce, and no eggs to meet the breakfast menu the following day. The facility's meal substitutions record for July 2025, documented food items had been substituted on multiple days. On 7/29/25, a kitchen staff member stated, they did not have two of the food items to prepare for dinner and would have to find something else to prepare in its place. The house manager

		stated, budget issues had been the reason why the facility did not have the food needed to meet the menu.
20	.460.02.d. Frequency of Meals.	Between 7/29/25 and 7/31/25 snacks were not observed to be served or available to residents three times a day. The staff stated they did not have enough snacks to residents during the day or evening. The house manager stated they need to increase their food budget to provide snacks to the residents.
21	.600.02. Detached Buildings or Units.	The facility did not ensure both houses were staffed sufficiently to ensure one staff member was in each house at all times. For example: several staff members, family members, and outside agency staff stated houses were left unattended for periods of time when they needed to assist residents or needed to retrieve an item in the opposite house. On 7/31/25 at 8:13 AM and 11:35 AM, staff was observed to leave house #1 unattended. The house manager stated the houses were left unattended due to not having enough staff to assist residents' needs. ***Previously cited on 3/6/25***
22	.600.04.b. Sufficient Personnel.	Four of six staff, whose records were reviewed and worked alone, had expired CPR and First Aid certifications. Two of six staff did not have CPR or First Aid training. The facility manager and administrator confirmed the certifications were expired and two staff did not have the training.
23	.625.01. Number of Hours of Training.	Two of five staff, whose records were reviewed, did not have 16 hours of orientation training. The facility administrator confirmed the staff did not receive orientation training.
24	.625.03.k. Content for Training.	Two of six staff, whose records were reviewed, did not have training for infection control. See 335.02 above.
25	.630. TRAINING REQUIREMENTS FOR FACILITIES ADMITTING RESIDENTS WITH A DIAGNOSIS OF DEMENTIA, MENTAL ILLNESS, DEVELOPMENTAL DISABILITY, OR TRAUMATIC BRAIN INJURY.	Six of six staff, whose records were reviewed, did not have documentation of specialized training for residents with traumatic brain injury or mental illness. Five of six staff did not have documentation of training for residents with dementia. The facility administrator stated the staff did not have the specialized training.
26	39-3308 Assessment (4)b Assessments	The facility nurse did not notify the Resident #3's healthcare

		provider when they refused their eye drops three times in June 2025, and 27 times in July 2025. The nurse stated she was not aware of the refusals and had not notified the provider.
27	39-3321.2.d. Qualifications and Requirements of Administrator.	The facility did not identify and monitor patterns of accidents and incidents nor develop interventions to prevent recurrences. The house manager stated the former administrator did not track patterns of incidents and did not identify any patterns. The administrator stated they were not completed.
28	39-3321.2.e. Qualifications and Requirements of Administrator.	The former administrator did not complete investigations and written report of the findings within 30 calendar days for incidents, complaints, and allegations of abuse, neglect, or exploitation. For example: an incident report, dated 4/29/25, documented an alleged physical abuse between staff member and an unsampled resident. There was no written report of findings included with the incident report. An incident report, dated 6/2/25, documented Resident #5 had "sores" on their back with no written investigation completed. The house manager stated she and the former administrator did complete investigations on both incidents, but the former administrator did not document their findings.