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
Bauston Culton	Eagle	83616	01/15/2026
Survey Team Leader	Survey Type		Response Due
Perry, Bradley	Health Care Complaint Investigation		02/14/2026

Item #	Rule (16.03.22)	Description
1	.305.02.b. Quarterly Nursing Assessments.	The facility did not ensure residents received medications and treatments as ordered by their provider. For example, Resident #4's medication error report, dated 9/9/25, documented Resident #4's insulin dose was missed at their scheduled time of 5:00 PM and the facility nurse had given approval to give a make-up dose of insulin at 9:47 PM, due to their blood glucose reading of 422. Resident #4's September 2025 Medication Administration Report (MAR), documented between 9/4/25 and 9/17/25, their diclofenac sodium 1% gel and B-1 was not given due to being unavailable in the medication cart. Resident #3's 1/5/26 physician's order, documented to increase their acetaminophen order from twice a day to three times a day and their January 2026 MAR documented they had only received two doses a day from 1/5/26 to 1/12/26. A facility nurse stated she was unaware of the order change. On 10/2/25, Resident #2 did not receive their calcium clopidogrel, duloxetine, ferrous furosemide, haloperidol, omeprazole, or vitamin b as ordered. Staff documented on a medication error report they thought they had given the medications to Resident #2 but had not. Upon observation on 1/14/25, Resident #1's docusate and

		loperamide were not in the medication cart. The assistant administrator confirmed these medications were not in the facility.***Previously cited on 8/4/25.***
2	39-3321.1. Qualifications and Requirements of Administrator.	The facility operated without a licensed administrator from 9/7/25 through 9/21/25. According the Facility Licensing and Regulatory Enforcement System portal, the previous administrator's last day was 9/6/25, and there was a lapse of 14 days before a new administrator started on 9/22/25. The current administrator confirmed the facility was without an administrator during this time frame.
3	39-3321.2.e. Qualifications and Requirements of Administrator.	The facility did not complete investigations and/or written reports of the findings within 30 calendar days for incidents and allegations of abuse. For example: a staff observation note, dated 9/15/25, documented an alleged incident of inappropriate behavior between Resident #4 and an unsampled resident. There was no incident report or a written report of an investigation. The current administrator stated there was no documentation of the alleged incident, including an incident report nor an investigation completed by the former administrator. A nursing note, dated 12/10/25, documented Resident #1 had a new wound to their right shin. There were no written incident or investigation reports regarding the incident. The administrator stated he and the nurse had completed an investigation but had not documented their findings.***Previously cited on 8/4/25.***