# NON-CORE ISSUES

| Facility | License # | Physical Address | Phone Number |
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| Ashley Manor - Storybook Way | RC-833 | 126 North Storybook Way | 208-939-4602 |
| Administrator | City | Zip Code | Survey Date |
| Nina Hutton | Eagle | 83616 | 07/17/2026 |
| Survey Team Leader | Survey Type | | Response Due |
| Cerovski, Wendy | Health Care Complaint Investigation | | 08/16/2026 |

| Item # | Rule (16.03.22) | Description |
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| 1 | 39-3321.6. Qualifications and Requirements of Administrator. | The previous facility administrator did not notify the licensing agency within 3 business days of the change in administrator. The new administrator took over the facility on 7/1/26 and failed to notify the licensing agency. |
| 2 | .250.11. Call System. | The facility did not provide call pendants or a working call system for residents either in their rooms or for pendant use. Multiple residents in both buildings either had missing call pendants or non-working call systems in their rooms. The facility maintenance director stated new call lights needed to be installed to replace missing and/or non-working call systems. |
| 3 | .310.01.a. Medication Distribution. | Between 7/14/26 and 7/16/26, medications were observed to be unsecured on multiple occasions. For example, tubs of blister packs and other loose blister packs were observed in the offices of building #1 and building #2. The facility administrator and facility nurse stated the medications should be secured. |
| 4 | .310.01.f. Medication Distribution. | Facility residents did not receive medications and treatments as ordered. For example, Resident #1, between 6/3/26 and 6/11/26 did not receive their levetiracetam seven times. Resident #2 did not receive their Alendronate on 6/23/26, |

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| | | their duloxetine on 6/9/26, Donepezil and Omeprazole were scheduled once a day and did not receive it from 6/1/26 to 6/5/26, Ibuprofen 11 times in June 2026, oxycodone on 6/2/26 and 6/5/26, and potassium chloride from 6/21/26 to 6/23/26 as they were not available in the medication cart. Resident #2 had multiple medications not currently in the medication cart. Resident # 7's observation notes, dated between 3/17/26 and 6/2/26, documented multiple changes in diet texture orders including minced, mechanical soft and puree and was served regular snacks and ate a fast-food meal. The resident had two choking events on 3/18/26 and on 4/28/26, which required the staff to perform the Heimlich maneuver. They had difficulty swallowing food and medications several times and on 5/6/26 was "spitting up since dinner" and on 6/2/26 had vomited lunch. The facility nurses stated the orders were changed multiple times by a resident's provider and was difficult to follow. A facility nurse stated the orders were not always followed. The facility administrator stated the medication and diet orders had been an issue. |
| 5 | .310.02. Discontinued and Expired Prescriptions. | The facility did not keep a record of all drug disposals nor documented two witnesses destroyed the medications. For example, drug disposal records were missing for all or parts of the months from January through June 2026. Signatures were either missing or only contained one witness signature on medication disposals logs on 5/5/26, 5/9/26, 7/1/26, and 7/2/26. The facility nurse stated staff had not been documenting medication destruction and there should be two witnesses. |
| 6 | .310.04.a. Behavior Modifying Medication. | The facility did not attempt non-drug interventions prior to requesting medications for resident #6. Psychotropic or behavior modifying medication were used as a first resort to address behaviors which included alprazolam and lorazepam prior to the development of a behavior management plan (BMP) nor not attempting non-pharmacological interventions |

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| | | listed on the BMP. A facility nurse confirmed staff administered the medications prior to implementing a BMP and did not attempt interventions listed on the BMP after it was developed and before administering behavior modifying medications. |
| 7 | 39-3322.1 QUALIFICATIONS AND REQUIREMENTS FOR FACILITY STAFF | The facility did not arrange for sufficient trained staff to fully meet the needs of its residents and failed to provide care during all hours required in each resident's NSA. The current facility administrator and a facility nurse stated there was not sufficient staff to meet specific resident needs as identified in NSAs. For example, from 7/14/26 to 7/16/26, Resident #9 was observed to have unkempt hair, a build-up of debris and grime under their fingernails, and had on the same shirt and pants. Resident #9's record documented they had only received half of the required showers for the month of July 2026. Female Resident #14 was observed to have a significant amount of facial hair. Resident #14's NSA documented staff were to assist her on removing facial hair. On 7/14/26 and 7/15/26, meals and snacks were observed and Resident #10, #11,and #12's were not served the correct diets. For example, Resident #10 had a pureed diet, but had received a mechanical soft diet on 7/14/26, a non-pureed cupcake on 7/15/26, and a mix between a mechanical soft and pureed diet on 7/15/26, rather than a true pureed diet. On 7/15/26, an unsampled resident in building #1 was observed wandering in and out of other residents' rooms, attempted to take something out of one of the rooms before another resident stopped them, and drank from another resident's cup. During this time, building #1 only had one staff member who was assisting other residents and appeared to be unaware of the resident's wandering. On 7/15/26 at 10:02 AM, the medication technician left building #1 unattended to coordinate with the house manager and an activity staff who were outside assisting residents into the facility bus. On 7/14/26, multiple residents in building #1 |

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| | | received their morning medications late. The facility house manager stated staff were not trained and did not know how to cook. A facility nurse stated the facility did not have enough staff to meet residents' needs and staff needed more training. The administrator stated there were not enough staff and staff needed more training. |
| 8 | .335.02. Standard Precautions. | The facility did not follow standard infection control procedures. For example, a staff member was observed to handle medications with bare hands and administered them to residents, as well as not performing hand hygiene before or between each resident. Staff were observed not wearing aprons during meal service for breakfast and lunch after providing care needs to residents during the survey. On 7/14/26, two bags of raw potatoes were observed directly on the floor of the pantry in building #2. Staff were observed using the designated hand-washing sink to prepare food and also had dirty dishes in the same hand-washing sink. The administrator stated she was not aware this was happening. |
| 9 | .330.04. Behavior Documentation. | The facility did not evaluate nor develop interventions for residents who exhibited maladaptive behaviors. For example, Resident #3's progress notes documented they engaged in "verbal aggression" and "outburst." Resident #3's Negotiated Service Agreement (NSA) documented they became "verbally and physically assaultive." There was no behavior evaluation nor a plan with interventions in Resident #3's record. Additionally, Resident #9's 1/22/26 pre-admission nursing assessment documented the resident had a history of "flashing other residents and discussing sex with family members". Several notes in Resident #9's record documented they exhibited flashing and inappropriate sexual advances towards other residents. There was not a developed BMP until 6/25/26, with interventions of "Calmly tell the resident...to stop in a respectful, non-confrontational manner...or drawing attention to the behavior", among other interventions. Several staff |

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| | | stated Resident #9 would try to expose themself and say sexually inappropriate comments. On 7/14/26 and 7/15/26, Resident #9 attempted to lift their shirt to expose themselves and the house manager either loudly said or yelled across the room, "No, no, no..." and either physically placed their hands on the resident's hand or ran across the room to attempt to stop the resident. Two of the facilities previous administrators confirmed the facility did not evaluate Resident #3's behaviors nor implement interventions and Resident #9's behavior plan was not completed timely. |
| 10 | .455. FOOD SUPPLY. | On 7/15/26 the facility's food supply in building #1 and building #2 were observed to be inadequate to meet the planned menus for seven days. The facility's house manager confirmed there was not enough food to meet the menu. The house manager confirmed that on 7/1/26 when the new administrator took over, an emergency food shopping trip was made to ensure the residents' dietary needs were met and the menu was available to be served. |
| 11 | .310.01.e. Medication Distribution. | During survey, medication technicians were observed leaving medications, such as inhalers and medication cups, which contained various medications, with multiple unsampled residents without observing and ensuring they took the medication. Also, several other residents, who were cognitively impaired, were present in the area and had easy access to those medications. A facility nurse stated the medication technicians were expected to observe all residents to ensure they were taking their medications. The facility administrator and two former administrators stated the medication technicians were expected to always observe all residents take their medications and treatments. |