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
Lilly Airth	Nampa	83651	09/10/2026
Survey Team Leader	Survey Type		Response Due
Cerovski, Wendy	Health Care Licensure and Follow-Up		10/10/2026

Item #	Rule (16.03.22)	Description
1	.250.11. Call System.	The facility failed to have a working call system available for each resident. Three residents in building #2 did not have available call lights, including sampled resident #2 in room 2, and sampled resident #3, in room 3. An unsampled resident in room 5 also did not have ability to notify staff with a working call system. A medical technician in building 2 confirmed the call system was unavailable for use. The administrator was made aware and confirmed that the call system was not available to residents in some rooms.
2	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 administrator, the facility nurse, multiple staff members, and family members stated there was not sufficient staff to meet specific resident needs as identified in NSAs. For example in building #2, an incident report, dated 4/11/26 at 1:45 PM, documented Resident #3 fell in the living room from the couch while the only staff member was in another resident's room providing cares. An incident report, dated 5/5/26 at 4:00 PM, documented Resident #3 was found on the floor in the dining room, while the only staff member was in the bathroom. An

		incident report, dated 7/14/26 at 7:30 PM, documented Resident #3 found on the floor in the living room, while the only staff member was providing cares to another resident in their room. An observation note, dated 7/11/26 at 9:52 AM, documented Resident #2 was observed alone outside with 4-5 cigarette butts in their mouth that they removed from the cigarette ashtray. An observation note, dated 7/19/26 at 3:18 PM, documented Resident #2 was involved in a resident to resident physical altercation and was slapped across the face by another resident. An incident report, dated 9/6/26 at 7:29 PM, Resident #2 was involved with another resident to resident physical altercation when Resident #2 entered another resident's room and they were pulling Resident #2 out of their room, while the only staff member was providing cares to another resident in their room. The facility nurse stated the facility did not have enough staff to provide adequate supervision for Resident #2 and Resident #3. The administrator stated they did not have enough staff to meet residents' needs. The administrator stated if they had another staff member during the day and evening shift to supervise and provide cares, clean rooms, cooked meals, provide activities, in each building, then it would reduce falls and behaviors.
3	39-3321.4. Qualifications and Requirements of Administrator.	The facility failed to take corrective action when incidents and accidents occurred, and sufficient monitoring was not implemented to ensure the problem does not recur. For example, Resident #3 fell on 4/11/26, 5/5/26, 7/14/26, and 7/15/26. The facility nurse stated the corrective actions were not implemented to prevent recurrence.