

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135097	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER Ashton Memorial Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 700 North Second Street Ashton, ID 83420	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined the facility failed to ensure a bed hold notice was provided to residents or their representatives at the time of the resident's transfer to the hospital. This was true for 1 of 2 residents (Resident #6) reviewed for transfers. This deficient practice created the potential for harm if residents were not informed of their right to return to their former bed or room at the facility within a specified time. Findings include: Resident #6 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including chronic heart failure and chronic kidney disease. Resident #6's medical record documented she was transferred to a hospital on 8/12/25, and returned on 8/15/25. A bed-hold agreement was not completed for Resident #6 at time of discharge to the hospital. A bed-hold agreement was completed upon Resident #6's return to the facility on 8/15/25. On 12/9/25 at 2:40 PM, the facility billing clerk stated she completed Resident #6's bed-hold agreement document when she returned to the facility after her hospital stay like she had done for all residents.		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, it was determined the facility failed to provide respiratory services as ordered by the physician. This was true for 1 of 4 residents (Resident #1) whose records were reviewed for respiratory services. This failure created the potential for residents to experience increased fatigue and low oxygen levels. Findings include:Resident #1 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including sepsis and urinary tract infection.Resident #1's physician order for oxygen documented Oxygen PRN 2-3LPM to keep oxygen saturation >88%, start date 11/4/25.On 12/9/25 at 12:50 PM, Resident #1's medical record documented SpO2 information gathered on the following dates. - 11/11/25 at 18:29 86% R/A- 11/12/25 at 12:06 88% R/A- 11/14/25 at 11:30 88% R/A- 11/16/25 at 20:19 88% 2 lpm- 11/18/25 at 12:20 88% R/A- 11/20/25 at 13:43 86% R/AOn 12/9/25 at 2:00 PM, Resident #1's medical record had no documentation regarding nursing interventions for low SpO2. On 12/9/25 at 4:15 AM, the DNS stated nursing staff had failed to document any low SpO2 interventions for Resident #1 and should have.		

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on staff interview and review of employee personal files, it was determined the facility failed to ensure each CNA's annual performance review was completed at least once every 12 months for 1 of 1 CNAs (CNA #1) whose personnel records were reviewed for sufficient and competent staffing. This failure created the potential for incompetent CNAs providing care and increased the risk for harm for all residents living in the facility. Findings include: On 12/9/25 at 2:57 PM, review of CNA #1's employee file documented her initial hire date was 10/13/20. CNA #1's employee file did not have documentation that an annual performance review had been done. On 12/9/25 at 3:47 PM, the HR Director stated the CNAs annual performance reviews had not been done because she thought the annual competencies met the requirement for annual performance review.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview, it was determined the facility failed to ensure medications available for residents were stored appropriately; this was true for 1 of 18 resident's rooms inspected (Resident #17) and 1 of 1 medication carts audited for labeling and storage of medication. This failure created the potential for adverse effects if residents self-administered medications inappropriately or did not take their medications and created the potential for harm to a resident if they were to obtain medications which were left unattended and unsecured by staff. Findings include: 1. Resident #17 was admitted to the facility on [DATE], with multiple diagnoses including heart failure and diabetes. On 12/9/25 at 6:55 AM, observed on Resident #17's bedside table a medication cup with several pills in it. On 12/9/25 at 7:01 AM, Resident #17 stated the nurse had brought her medication in and left it on the table. Resident #17 stated she took out her thyroid medication and was waiting to take the other pills with her food. On 12/9/25 at 8:15 AM, RN #1 stated Resident #17 did not have an order to self-administer medications and it had not been documented in her care plan to self-administer medication so she should not have left the medications in her room. 2. On 12/10/25 at 8:30 AM, observed the medication cart outside the dining room. The medication cart was unlocked, and no nurse was present. On 12/10/25 at 8:32 AM, the DNS stated the cart should have been locked.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and review of the Idaho Food Code, the facility failed to appropriately store, distribute, and label foods. This deficient practice had the potential to affect all residents who received meals prepared in the facility's kitchen. This placed residents at risk for potential contamination and use of spoiled foods, and adverse health outcomes including food-borne illnesses. Findings include: The Idaho Food Code, revised February 2021, stated, 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking . refrigerated, ready-to-eat, time/temperature control for safety food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. On 12/9/25 at 7:16 AM, during a tour of the kitchen with the Dietary Supervisor the following were observed. In the Dry food storage area;- 1 gallon container of Molasses opened 12/22/23, use by date 8/17/25 with 2 other gallons unopened past their use by dates. - 1 opened container of Nesquik chocolate with no opened date or use by date.- 1 opened bag of confectionary sugar with no open or used by dates. On 12/9/25 at 7:28 AM, the Dietary Supervisor stated the opened food items should have been correctly labeled and were not.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, document reviews, policy review, and staff interview, it was determined the facility failed to ensure infection control prevention practices were maintained to provide a safe and sanitary environment. These failures had the potential to impact all residents in the facility by placing them at risk for cross contamination and infection. Findings include: The Occupational Safety and Health Administration (OSHA) Bloodborne Pathogens regulations 1910.1030, updated 10/19/21, states, Eating, drinking, smoking, applying cosmetics or lip balm, and handling contact lenses are prohibited in work areas where there is a reasonable likelihood of occupational exposure and Food and drink shall not be kept in refrigerators, freezers, shelves, cabinets or on countertops or benchtops where blood or other potentially infectious materials are present. The facility's Glucometer Cleaning Policy, undated, directed staff members to clean and disinfect glucometers after each use. The follow was observed for infection control: 1. On 12/9/25 at 6:55 AM, observed the treatment cart in the hallway by room [ROOM NUMBER] with a pink mug and a bottle of water on top of the treatment cart. On 12/9/25 at 6:58 AM, LPN #1 stated the personal drinks were hers and should not have been on top of the treatment cart. 2. On 12/10/25 at 7:05 AM, RN #2 used the glucometer (a device used to measure the amount of glucose in your blood) to check a Resident #20's blood sugar. RN #2 brought the glucometer to the medication cart and placed the glucometer in the storage box. RN #2 did not clean the glucometer before putting it away. On 12/10/25 at 8:14 AM, the DNS stated, the glucometers should have been cleaned after each use.		