NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
Truewood by Merrill, Boise	RC-1024	2600 North Milwaukee	208-373-1234
Administrator	City	Zip Code	Survey Date
Jody Stephen	Boise	83704	11/10/2021
Survey Team Leader	Survey Type		Response Due
Ramirez, Mina	Health Care Core Deficiency Follow-Up + complaint investigation		12/10/2021

Item #	Rule (16.03.22)	Description
1	.009.06.c. Use of Previous Criminal History and Background Check.	One of two employees, who required a state police background check, did not have one completed. Upon interview with the business office director, it was confirmed the ISP background check was not completed. ***Previously Cited On 3/4/21***
2	.260.06. Toxic Chemicals.	The facility was not maintained in a clean, safe and orderly manner. For example: The carpet in rooms 216 and 218 had numerous dark stains and was heavily worn in areas. The assisted living courtyard patio and concrete walkways were observed to have large cracks and raised areas. The laundry room on the first floor had laminate flooring that was raised and bubbled in appearance, the air duct was dirty with a black substance, the ceiling tiles had old water damage and stains, the dryer air duct was plugged with a towel, there were two vents on the wall with plastic shower curtains with a second curtain over them. The administrator stated it was not in the budget to make the repairs this year. ***Previously Cited On 3/4/21***
3	.300.01. Licensed Registered Nurse (RN).*	Five of five medication technicians were not delegated by the current facility nurse. The facility nurse stated they were not delegated to pass medications. ***Previously Cited On

		3/4/21***
4	.300.02. Licensed Nurse.	Resident #1 was not assessed by the facility nurse after they fell on 7/3/21 and 10/4/21. The facility nurse confirmed the assessments were not completed. ***Previously Cited On 3/4/21***
5	.215.07. Notification to Adult Protection and Law Enforcement.	The administrator failed to report all allegations of abuse to Adult Protection. For example: when a staff member "pushed" resident #3 and caused them to fall and fracture their hip. The administrator did not realize they were required to report to AP.
6	.600.04.a. Sufficient Personnel*	Multiple caregivers, residents and family members stated the facility did not schedule sufficient staff during all hours to meet the needs of the residents. For example: on 11/8/21 there were two staff members scheduled for the night shift. One staff member worked alone in the memory care unit with 27 residents which three required a two person assist and 21 residents had behaviors. One staff member worked in the assisted living unit with 89 residents and two required a two person assist. On the afternoon of 11/7/21, a family member stated they visited their loved one and they were still wearing their pajamas and their bed was not made. The facility nurse stated ideally they would have two staff scheduled for the night shift in the memory care unit and two in the assisted living unit, but sometimes only had one on each side.
7	.320.01. Use of NSA.	Residents' care needs were not completed according to their negotiated service agreements (NSA). For example: Residents #2, #6, #7 and #8 had showers scheduled twice a week and only received one shower a week since August 2021. The administrator stated she was aware of residents not receiving their showers according to their NSA.