NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
Edgewood Spring Creek Boise, LLC	RC-1006	10681 West McMillan Road	208-954-5660
Administrator	City	Zip Code	Survey Date
Donna Nelson	Boise	83713	11/12/2021
Survey Team Leader	Survey Type		Response Due
Moss, Tom	Health Care Licensure and Follow-Up + complaint investigation		12/12/2021

Item #	Rule (16.03.22)	Description
1	.215.08.b. Investigation within Thirty Days.	The administrator did not conduct an investigation within 30 days when Resident #1 had missing golf shirts on 6/21/21, nor when an unsampled resident had a ring and sunglasses missing from their room. The administrator stated missing items in a memory care unit were not uncommon because the residents frequently went into each others' rooms and moved or took items so investigations were not completed. Based on staff and family interviews, Resident #8 fell on multiple occasions in May 2021, and only one investigation was completed for a fall which occurred on 5/7/21. The administrator stated she could not provide investigations for Resident #8's falls.
2	.305.02.b. Current Medication Orders and Treatment Orders*	The facility did not ensure residents received their medications as ordered. For example, Resident #3 was admitted to the facility on 10/19/21, without their medications available to administer. Staff interviewed stated they did not have any medications to give to Resident #3 for the first few days after admission, and the resident's Medication Administration Record documented they did not receive their medications, including their thyroid medication and medications for dementia, from 10/19/21 through 10/21/21. Resident #8 did not receive 13 doses of medications, including methadone,

		sertraline and ondansetron, as they were unavailable, between 5/1/21 and 5/29/21, when the resident passed away.
3	.305.03. Resident Health Status*	The facility nurse did not conduct nursing assessments when residents experienced changes in physical or mental health status. For example, when Resident #1 eloped from the facility on 12/5/20 or after Resident #6 had a skin tear to their left elbow on 5/4/21 and a skin tear to their right and a a sacral wound on 9/16/21. Resident #8 was not assessed after they fell multiple times in May 2021. The current and former facility nurses both confirmed the assessments had not been completed. ***Previously cited on 12/9/11 and 11/7/14***
4	.330.04.c.vii. Resident Care Records*	The facility nurse stated she had assessed residents for changes in their conditions, but these assessments had not been consistently documented. For example, family stated Resident #3 had wounds to their bottom at the time of admission to the facility on 10/19/21. The facility nurse stated she had assessed these wounds prior to and on the day of admission but had failed to document this wound assessment. Resident #8 was noted to have hematuria by caregivers on 5/20/21; the former facility nurse stated they had assessed the resident for this issue but had not documented this assessment.
5	.335. REQUIREMENTS FOR INFECTION CONTROL.	The facility did not follow the Centers for Disease Control and prevention (CDC) recommendations for Covid-19, when caring for the residents, to prevent transmission of this infectious disease. For example: From 11/8/21 to 11/10/21, multiple visitors, including family members and outside agency staff, were observed entering the facility without being screened for symptoms of COVID-19. The survey team entered the facility multiple times during those dates and were also not screened for symptoms of the virus. During the survey, multiple caregivers were observed providing care to residents and then assisting in the kitchen and serving food to residents without wearing an apron.

6	.600.04.a. Sufficient Personnel*	The administrator did not schedule sufficient personnel during all hours to meet the needs of the residents. For example: Six family members stated cares, such as showers and toileting, as well as laundry, were not consistently performed according to the residents' care plans. One family member stated their loved one was observed on multiple occasions wearing saturated and soiled incontinence products, which resulted in skin breakdown. During observations between 11/8/21 and 11/10/21, an unsampled resident was observed in the same clothes all three days, and two other unsampled female residents were observed to have long chin hairs. Resident #3, whose care plan documented they needed repositioned and toileted every two hours to avoid further skin breakdown, was observed to not receive these cares every two hours during observations on 11/9/21 and 11/10/21. Seven former and current staff members, who worked during the time Resident #8 resided at the facility, stated the facility was "short staffed" during the spring and summer of 2021, and they were unable to consistently provide cares for residents, including Resident #8, according to their care plans.