NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
Gables Assisted Living and Memory Care of Caldwell	RC-1230	917 E Ustick Road	(208) 455-2324
Administrator	City	Zip Code	Survey Date
Derek Westover	Caldwell	83605	05/31/2023
Survey Team Leader	Survey Type		Response Due
Lu, Melvin	Health Care Licensure and Follow-Up		06/30/2023

Item #	Rule (16.03.22)	Description
14	.009.01. Criminal History and Background Check.	One of seven employees, whose personnel records were reviewed, did not have a Department Criminal History and Background Check. The employee was observed to work alone with residents in the memory care unit. Upon interview with the assistant administrator, it was confirmed the Department Criminal History and Background Check was not completed. ***Previously cited 12/1/21***
14	.215.08.e. Corrective Action.	The facility administrator did not implement corrective action to ensure resident falls did not recur when Resident #2 fell 13 times from 3/16/23 to 5/10/23. Resident #2's interventions after a fall on 3/15/23 were to assist the resident with ambulation to ensure they stayed steady on their feet, offer fluids between meals and encourage to drink during mealtimes, if they seem unsteady on their feet, be sure to assist them to sit down until episode resolved itself, and encourage the resident to use call light if they needed assistance with toileting. These interventions were identical 13 times after each subsequent fall. The administrator stated the facility had not developed new interventions after these falls to prevent recurrence. ***Previously cited 12/1/21***

14	.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 had a bedside x-ray performed on their hip on 2/7/23 and was not assess prior to or after the x-ray. Resident #5 had a small rash near their anus and had a couple open areas with blood on 3/3/23, returned from the hospital for being treated for pneumonia on 4/9/23, had a vomiting episode along with a bad cough with low oxygen at 80 on 4/9/23, and had a skin tear on their left arm on 5/25/23. The facility nurse stated staff did notify her of these incidents and therefore did not conduct assessments.***Previously cited 12/1/21***
14	.330.13.e. Personnel Records*	Two of seven staff member files reviewed did not contain documentation of 16 hours of orientation training. One of seven staff members file reviewed did not have documentation of dementia training and job-related continued training. The assistant administrator stated they did not have documentation for these trainings. ***Previously cited 12/1/21***