PLAN OF CORRECTION

Edgewood Spring Creek Boise, LLC
10681 West McMillan Road
Boise ID 83713

Provider ID: RC-1006

On 10/06/2023, a Health Care Licensure and Follow-Up + complaint investigation survey was conducted by Department staff at Edgewood Spring Creek Boise, LLC. As a result of the survey, core issue deficiencies were cited with the following plan of correction.

Rule Violation .550.04.d. Personal Possessions.

Describe what corrective actions will be accomplished for those residents/personnel/area found to have been affected by the deficient practice.

Locks will be installed on one cabinet or drawer in each of the residents' rooms. For any room that does not have a drawer or cabinet that can be secured, a small locking safe will be installed in the room. Each resident will be supplied with a key for their secured area.

Describe how the provider will identify other residents/personnel/areas having the potential by the same deficient practice and what corrective action(s) will be taken.

Every room will be inspected for a locking cabinet or drawer. All rooms without a secured space will be provided one as described above.

Any room with two residents will be supplied with individual locked spaces for each resident.

Describe how the corrective action will be monitored to ensure the deficient practice does not recur (QA program).

Maintenance will check the locked areas monthly to ensure that they are in place and functional.

The community will maintain a copy of the keys to ensure that the residents are able to access their belongings if they misplace their key.

Date when corrective action will be completed.

November 20, 2023

Program Comments

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
Jamie Korsgaard	Boise	83713	10/06/2023
Survey Team Leader	Survey Type		Response Due
Miller, Rebecca	Health Care Licensure and Follow-Up + complaint investigation		11/05/2023

Item #	Rule (16.03.22)	Description
1	.215.01. Administrator Responsibility.	The administrator did not ensure the facility was in compliance with IDAPA rule 16.03.22.550.04.d when residents were not provided a locked drawer or cabinet in their rooms. The administrator designee confirmed the residents did not have a locking drawer or cabinet to store their personal possessions. The facility was given technical assistance on 11/12/21 to provide a locked drawer or cabinet to each resident. ***Previously cited 7/20/2023***
2	.300.01. Licensed Registered Nurse (RN).	The licensing verification system "Nursys" documented the facility's Registered Nurse's (RN) license had expired on 8/31/23, and she had been and performing nursing duties as the facility's nurse without an active license since that date. Resident #4 and Resident #6 did not have a quarterly assessment completed by a licenced nurse since 6/26/23.
3	.305.02.b. Quarterly Nursing Assessments.	The unlicensed facility RN did not ensure residents received medications and treatments as ordered by their provider. For example, Resident #2 was ordered to receive their medications crushed, but only received their medications crushed sporadically and were mostly receiving their medications whole. The unlicensed facility RN stated Resident #1's medications were crushed to help them take it when they

		were first admitted if the resident was anxious or refused the medications though the resident did not have a history of swallowing difficulties per their pre-admission assessment. Resident #5 did not receive their Gavalax, which was ordered routine, since 6/2/23. Resident #5 also had an order for an ankle brace, which did not include direction for use including when to apply it or take it off.
4	.310.01.c. Medication Distribution.	The facility's medication refrigerator temperatures, which contained insulin, were not maintained between 38 and 45 degrees F. Temperature logs from 8/1/23 to 10/4/23, documented the temperature was not maintained between 38 and 45 degrees F for 35 out of 65 days. The unlicensed facility RN confirmed their electronic records had temperatures that were out of range.
5	.330.06.b. Additional Resident Records.	The facility did not develop a behavior plan which included specific interventions for Residents #1 and #2 when they refused medications. For example, Resident #1 refused lorazepam 6 times and olanzapine 10 times in September 2023 and Resident #2 refused quetiapine 2 times in September 2023. Multiple staff confirmed they did not have a behavior plan with interventions to reference for medication refusals. The non-licensed facility nurse confirmed the residents did not have a behavior plan with interventions for the residents' medication refusals.
6	.330.13.d. Personnel Records.	The licensing verification system "Nursys" documented the facility's Registered Nurse's license had expired on 8/31/23, and she had been and performing nursing duties as the facility's nurse without an active license since that date.
7	.625.01. Number of Hours of Training.	Two of ten staff, whose records were reviewed, did not contain documentation of 16 hours of orientation, nor had they completed orientation within 30 days of hire. All the staff confirmed they had not received 16 hours of orientation training.
8	.630. TRAINING REQUIREMENTS FOR FACILITIES ADMITTING	Four of ten staff members, whose personnel files were

	RESIDENTS WITH A DIAGNOSIS OF DEMENTIA, MENTAL ILLNESS, DEVELOPMENTAL DISABILITY, OR TRAUMATIC BRAIN INJURY.	reviewed, did not have specialized training for mental illness and developmental disability, two of ten did not have training for dementia, two of ten did not have training for developmental disability. The business office manager confirmed the staff members had not completed these specialized trainings. The administrator designee confirmed the facility admitted residents with these diagnoses.

CORE ISSUES

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Jamie Korsgaard	Boise	83713	10/06/2023
Survey Team Leader	Survey Type		Response Due
Miller, Rebecca	Health Care Licensure and Follow-Up + complaint investigation		10/16/2023

Item #	Rule (16.03.22)	Description
2	.550.04.d. Personal Possessions.	Based on observation, record review, and interview, it was determined the facility failed to protect the rights of twenty-seven out of forty residents residing in the facility. The findings include: IDAPA 16.03.22.010.20.d. A core issue is defined as "Inadequate care." IDAPA 16.03.22.011.05, documents, "Inadequate Care. When a facility...engages in violations of resident rights..." IDAPA 16.03.22.215.01 documents, “The facility’s administrator is responsible for ensuring that policies and procedures are developed and implemented to fulfill the requirements in Title 39, Chapter 33, Idaho Code and IDAPA 16.03.22.” IDAPA 16.03.22.520 documents, “The administrator must ensure that policies and procedures are developed and implemented to ensure that all residents are free from inadequate care...”

		IDAPA 16.03.22.550 documents, “REQUIREMENTS FOR RESIDENTS' RIGHTS. The administrator must ensure that policies and procedures are developed and implemented to ensure that residents’ rights are observed, promoted, and protected.” IDAPA 16.03.22.550.04.d documents, residents are to "Be provided a separate storage area in their own living area and at least one (1) locked cabinet or drawer for keeping personal property." The facility's revised October 2022 admission agreement documented under the resident rights section, each resident "be provided a separate storage area in living area with at least one locked cabinet or drawer for keeping personal property." On 10/3/23, during an inspection of every resident room in the facility there were no locking drawers or cabinets observed in twenty-seven of forty residents' rooms. Two residents stated they would like the use of a locked drawer for personal property. On 10/02/23 at 2:48pm, the maintenance staff member stated locks were provided upon request and there was no current plan to install locks in every room. They were aware that locks were not installed in every room. On 10/02/23 at 2:30pm, the business office director stated locks had been installed in some rooms but was aware not every room had a lock. On 10/02/23 at 2:58pm, the administrator designee was unaware residents' rooms required a locked box or cabinet for

		each resident. They stated families made the decision on whether to have locks installed in rooms and there was no plan to install locks in every room. The facility failed to provide twenty-seven of forty residents with a separate locking cabinet or drawer for protecting their personal property. This resulted in a violation of their rights.