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	12/29/2023
Survey Team Leader	Survey Type		Response Due
Rideout, Megan	Health Care Complaint Investigation		01/28/2024

Item #	Rule (16.03.22)	Description
1	.215.01. Administrator Responsibility.	The facility's abuse/neglect/exploitation policy did not include all elements required. For example, the policy did not contain how residents, family, and visitors would be educated regarding abuse/neglect/exploitation; specific directions for residents, visitors and outside providers to immediately contact the administrator; identify directions the administrator will do to report to adult protection within 4 hours or in the event of an emergency 911 should be called; identify the steps taken to investigate the allegation;identify where the documentation will be stored; identify systems used; the various conclusions the administrator may reach; for cases when the alleged perpetrator is a resident, staff member or visitor; interventions to prevent further abuse/neglect/exploitation are implemented and to ensure steps that will be taken to ensure the perpetrator has no further access to potential victims. ***Previous technical assistance provided on 5/5/23***
2	.215.08.a. Administrator Notification.	The administrator stated she had not been informed when an allegation of abuse was voiced by an outside agency staff member involving Resident #2 on 11/08/23. The administrator stated she knew about the allegation of abuse on 11/15/23

		when she received a call from a surveyor from Licensing and Certification, as the facility policy stated, “Anyone suspecting abuse of a resident must report any form of abuse immediately.”
3	.215.08.b. Investigation within Thirty Days.	The administrator did not consistently conduct thorough investigations into allegations of abuse of residents. For example, Resident #2 was reportedly abused by a staff member on 11/8/23 and the administrator only interviewed the alleged abuser and the resident who made the allegation. The administrator stated no interviews were conducted with other staff members or residents to identify if they had any additional information about the allegations. The administrator stated she did not conduct interviews about the alleged abusers' overall treatment of residents. ***Previously cited 7/22/22 and 5/5/23***
4	.215.08.c. Resident Protection.	On 11/08/23, Resident #2 was reportedly abused by a staff member while providing assistance with cares, the alleged abuser continued to work with residents and was not suspended pending the investigation. The alleged abuser continued working alone with residents through the time of the survey. Multiple staff members stated they were instructed to have two staff members assist Resident #2 with cares but were not provided instructions to staff to prevent the alleged abuser from caring for Resident #2. The administrator stated she was not aware this was an abusive situation; therefore, she did not remove the staff member to protect the resident.
5	.215.08.e. Corrective Action.	The administrator did not implement corrective action to ensure incidents did not recur when Resident #2 fell on 11/27/23 and expressed pain to their shoulder and ribs nor when Resident #3 fell on 11/10/23, 11/15/23, and 12/2/23, or when resident #4 sprained their ankle on 12/23/23. The administrator stated she was unaware of these situations, and the facility nurse stated he was unaware that corrective action

		needed to be taken on all incidents and accidents to prevent reoccurence.
6	.305.03. Change in Resident Health Status.	The facility nurse did not conduct nursing assessments when residents had changes in condition. For example: Resident #2 had bruises on their left ankle on 11/9/23, two falls on 11/27/23 and bruising to their hand and jaw on 11/27/23, complained of shoulder and rib pain on 11/28/23, had rib pain and weakness on 11/30/23 and a fall with rib pain 12/4/23, nor when Resident #4 sprained their ankle and went to the hospital for evaluation and treatment. The facility administrator and facility nurse confirmed no changes of condition nursing assessments were conducted. ***Previously cited at 300.02 on 5/5/23***
7	.320.01. Use of NSA.	Residents' NSA's did not clearly reflect the residents' needs nor describe the services to be provided. For example: Resident #2's NSA did not specify how to transfer the resident, a fall mat to be placed, how to approach the resident for cares, behaviors, their mobility and ambulatory ability, use of "Tubigrips" on their legs or medication changes, nor when Resident #4 sprained their ankle on 12/23/23 and required the use of ice and a brace. ***Previously cited 11/10/21 and 5/5/23***
8	.330.04.c.vi. Resident Care Records.	The facility did not have a system in place to ensure the facility nurse was notified of residents' change of condition. For example, Resident #4 sprained their ankle and required outside evaluation and treatment on 12/23.23. The facility nurse stated they did not review all caregiver documentation regarding residents' change of condition.
9	.330.04.c.vii. Resident Care Records.	The facility nurse stated he had assessed residents for changes in their conditions, but these assessments had not been consistently documented. For example, Resident #3 had a fall on 12/21/23 which resulted in bruising to the resident's face. Resident #2 had a change of condition that was assessed but not documented on 11/13/23 and 11/17/23 which resulted in

		the resident experiencing pain in their ankles and shoulder. The facility nurse stated he had assessed all of these changes in the residents' conditions but had not documented these assessments. ***Previously cited 5/5/23***
10	.330.06.a. Additional Resident Records.	The facility did not evaluate Resident #2's behaviors of interfering with cares and accusations toward male caregivers. The facility nurse confirmed the facility had not completed evaluations for Resident #2's maladaptive behaviors.