NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
Pomerelle Place	RC-1302	1301 Bennett Avenue	(208) 677-8212
Administrator	City	Zip Code	Survey Date
Lisa Junod	Burley	83318	02/29/2024
Survey Team Leader	Survey Type		Response Due
Oldfield, Michael	Health Care Initial Licensure + complaint investigation		03/30/2024

Item #	Rule (16.03.22)	Description
1	.009.01. Criminal History and Background Check.	The facility did not complete background checks for all employees who had direct resident access. For example, two of seven staff members, whose personnel records were reviewed, worked directly with residents without having a completed Criminal History Background Check. Upon interview with the administrator, it was confirmed the Department Criminal History and Background Checks were not completed.
2	.152.03.a.ii. Policies of Acceptable Admissions.	The facility did not arrange for services when Resident #6's family and two unsampled residents' families hired private duty caregivers' to provide showers to the residents' two times per week. Resident #6's private caregiver services were not coordinated with anyone at the facility and their instructions were solely directed by the family that hired them. Facility staff stated they were aware of the private duty caregivers' and were not given instructions on what to do if the private duty caregiver was unavailable. The administrator confirmed the facility did not arrange or coordinate services of the private duty caregiver for Resident #6 nor the two unsampled residents.
3	.216.02. Written Agreement.	Seven of seven resident's did not receive admission agreements when the facility underwent a change of

		ownership on 1/1/24. On 12/7/23 technical assistance was provided to the facility to review the change of ownership requirements by the residential assisted living program manager. The current facility administrator was aware that admission agreements were not completed after the change of ownership for these residents.
4	.310.01.c. Medication Distribution.	The facility did not maintain the temperatures in the medication refrigerator, which contained insulin, between 38 and 45 degrees F. The temperatures were documented as low as 25 degrees on 18 occasions in January 2024 and 10 occasions in February 2024 with no corrective action taken. The facility administrator stated she had an in-service training scheduled for March 1, 2024 to provide education to staff on this topic.
5	.320. NEGOTIATED SERVICE AGREEMENT (NSA) REQUIREMENTS.	Seven of seven residents' whose records were reviewed, did not have Negotiated Service Agreements (NSAs) which were updated to reflect residents' current needs, nor were they signed by the responsible party or resident, nor were they completed within 14 days of change of ownership. For example: Resident #6 hired a private duty caregiver to shower the resident twice per week and their NSA documented they used an outside agency but did not include how to care for the resident if they were not available. Resident #2's NSA documented only two components in their NSA; eating and bathing. The other pertinent information was not included on how to assist the resident who required two-person assistance with transfers or one-person assistance for dressing, grooming, or toileting. Resident #1's NSA did not include offering daily nutritional supplements, to provide cut-up meals, deliver meal trays three times per day, or instructions during an emergency evacuation to transfer the resident using a wheelchair. Resident #1-#7's NSAs did not contain all pertinent information, such as money management and night needs. The regional facility nurse stated the NSAs were behind and they

		have a plan to update those moving forward.
6	.630.01. Dementia.	Three of seven staff, whose records were reviewed, did not have Alzheimer's and Dementia training. The facility roster provided to surveyors at entrance documented the facility retained residents with dementia. The facility administrator stated the trainings had not been completed.
7	.630.02. Mental Illness.	Seven of seven staff members, whose personnel files were reviewed, did not contain evidence of specialized training for how to care for and serve residents with a mental illness. The facility roster provided to surveyors at entrance documented the facility retained residents with mental illness. The facility administrator stated staff had not received this training.