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
Summer Redwine	Boise	83704	05/31/2024
Survey Team Leader	Survey Type		Response Due
McClenathan, Teresa	Health Care Licensure and Follow-Up + complaint investigation		06/30/2024

Item #	Rule (16.03.22)	Description
1	.215. REQUIREMENTS FOR A FACILITY ADMINISTRATOR.	The facility operated without a licensed administrator from 2/22/24 through 3/17/24. During this time, there was not an administrator overseeing the day-to-day operations at the facility. According to a communication in the Facility Licensing and Regulatory Enforcement System portal, the previous administrator's last day was 2/21/24, and there was a lapse of 25 days before a new administrator started on 3/18/24. Multiple residents, families, and staff stated the previous administrator was not available to assist them during her time as the administrator.
2	.215.08.g. Identify and Monitor Patterns.	The facility did not consistently track and trend patterns of incidents nor develop effective interventions to prevent recurrences. For example, Resident #2 grabbed a resident's arm by the wrist and dragged them down the hall towards the common area/dining area on 1/11/24, hit another resident in the back on 3/5/24, grabbed another resident's arms "very strong" yelling at the resident on 3/15/24, hit another resident in the back on 4/5/24, and grabbed a resident’s arm and refused to let go on 4/13/24. During observations on 5/29/24 and 5/30/24 Resident #2 was observed targeting another resident and upsetting the resident. Resident #2 needed

		constant redirection from staff. Staff stated Resident #2 was “hard to handle,” and interventions were not effective. The facility nurse stated the facility did not develop new interventions for each resident-to-resident physical altercations to prevent reoccurrence nor identify the pattern of the incidents so corrective actions could be implemented.
3	.300.01. Licensed Registered Nurse (RN).	The facility's Registered Nurse (RN) did not perform the quarterly assessments within 90 days of the survey entrance for 8 of 9 sampled residents. The current nurse confirmed the assessments were not completed and she was in the process of developing a system to ensure all quarterly assessments were completed in a timely manner.
4	.305.03. Change in Resident Health Status.	The facility nurse did not consistently assess residents after changes in their conditions. For example, Resident #3 was not assessed when a caregiver found the resident "doubled over in pain at the breakfast table" on 2/12/24, nor when the resident complained of head and neck pain to caregivers on 4/20/24, 4/26/24, and 4/27/24. The resident was not assessed by the facility nurse after resident-to-resident altercations on 2/7/24, 2/17/24, and 3/5/24. Resident #2 was also not assessed after they were involved in a resident-to-resident altercation on 4/5/24. Resident #9 had severe behaviors on 3/7/24. In addition, medication technicians were not consistently calling the facility nurse to assess whether or not residents, who could not speak for themselves, required an as-needed (PRN) medication. Some medication technicians were assessing on their own whether or not residents required PRN medications and which PRN medication to give, without contacting the facility nurse, such as when Resident #3 was administered alprazolam on 4/21/24 for anxiety, when they also had buspirone available for anxiety. They would administer a PRN medication if family directed them to do so and were not calling the facility nurse. The current facility nurse stated staff members were not consistently contacting the nurse for PRN

		medications with the previous facility nurse, and the previous facility nurse had not consistently assessed residents for changes in condition. ***Change of condition assessments were previously cited on 3/4/21, 11/10/21, 5/5/23, and 12/29/23***
5	.450. REQUIREMENTS FOR FOOD AND NUTRITIONAL CARE SERVICES.	The facility did not have a Certified Food Protection Manager at the time of survey. The dietary manager confirmed their certification had expired and stated they were in the process of getting their certification renewed.