NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
Arbor Village at Hillcrest	RC-1316	1093 South Hilton Street	208-345-4460
Administrator	City	Zip Code	Survey Date
Jason Corrie	Boise	83705	11/01/2024
Survey Team Leader	Survey Type		Response Due
Ramirez, Mina	Health Care Initial Licensure + complaint investigation		12/01/2024

Item #	Rule (16.03.22)	Description
1	.009.01. Criminal History and Background Check.	Two of ten employees, whose personnel records were reviewed, did not have a Department Criminal History and Background Check. One employee, whose background check was pending, was allowed to work unsupervised with residents. Upon interview with the administrator, it was confirmed the Department Criminal History and Background Checks were not completed.
2	.215.08.d. Written Response to Complaint within Thirty Days.	The facility did not provide a written response to complainants within 30 days. For example, the complaint log from May 9, 2024 through the time of the survey on October 29, 2024 documented several complaints had been made to the administrator and none of the complainants received a written response. The administrator stated they would verbally speak to each complainant, but written responses were not provided.
3	.305.02.c. Current Medication Orders and Treatment Orders.	The facility did not have current, signed orders in four of seven sampled residents' records. For example, Resident #5's record did not contain current orders for losartan 100 MG, NAC 600 MG, olanzapine 2.5 MG, and quetiapine 25 MG. Resident #2's record did not contain orders for omeprazole and PRN ibuprofen. The facility nurse acquired current orders after

		requested by surveyors.
4	.310.01.g. Medication Distribution System.	The facility did not ensure all residents' as-needed (PRN) and scheduled medications were available. For example, Resident #1's bacitracin, diclofenac sodium gel, haloperidol, nebulizer, and lorazepam were not available in the medication cart. Resident #6's inhaler, docusate sodium, and lorazepam and one unsampled resident's acetaminophen, Mylanta and polyethylene glycol were not available in the medication cart. Resident #5's rivastigmine patch was not available seven times between 10/17/24 and 10/24/24. The facility's RN stated they were having issues receiving the medications with their new pharmacy in a timely manner.
5	.310.02.f. Discontinued and Expired Prescriptions.	The facility did not have a witness present for all resident medication destruction nor was the method of destruction documented. The facility's medication destruction log documented only one signature for all medications destroyed from May to October 2024. The Resident Care Coordinator (RCC) stated she destroyed all medications alone, unless it was a narcotic substance.
6	.320.01. Use of NSA.	Residents' Negotiated Service Agreements (NSAs) did not clearly reflect the residents' needs nor describe the services to be provided. For example, Resident #1's NSA did not include specific instructions for a one-person transfer, catheter care, delineate between hospice and facility staff services, nor wound care. Resident #4's NSA did not include specific instructions for the wound on their left leg nor their need for additional assistance with bathing. Resident #6's NSA did not include specific instructions for a one person "hands on help with bathing" two times a week nor wound care with home health for staples in their head from a fall exiting the elevator. Multiple staff stated they did not have resident specific instructions to reference when alerted to provide services to residents. The administrator verified the NSAs did not provide a description of the services to be provided.

7	.330.04.c.xi. Resident Care Records.	The administrator did not document investigations after incidents occurred. For example, Resident #6 had an unwitnessed fall exiting the elevator when they tripped due to the elevator exit not leveling up with the floor. The resident sustained two lacerations to their head and was sent to the hospital. Resident #7 experienced a fall on 6/18/24 and 8/1/24. The administrator stated he did not document his investigations or corrective actions of the above incidents.
8	.460.02.d. Frequency of Meals.	Residents were not consistently offered snacks and fluids between meals and at bedtime. For example, between 10/29/24 and 11/1/24, it was observed residents were not offered fluids or snacks unless they were in the activity room. Residents confirmed during tour that snacks were not always offered but were available in a refrigerator located in the downstairs dining room. Several residents on the second floor, including two diabetic residents, were unaware of the snacks available in the downstairs dining room refrigerator.