NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
Streamside Assisted Living and Memory Care	RC-1320	1333 South Edgewater Circle	208-442-0097
Administrator	City	Zip Code	Survey Date
Daythun Cole	Nampa	83686	12/12/2024
Survey Team Leader	Survey Type		Response Due
Lu, Melvin	Health Care Initial Licensure		01/11/2025

Item #	Rule (16.03.22)	Description
1	.215.08.e. Corrective Action.	The facility did not ensure effective corrective action was put into place to prevent recurrence for Resident #1 and Resident #6. For example, Resident #1 fell on 10/19/24, 10/21/24, 10/27/24, 10/28/24, and 10/29/24, there were no corrective actions to prevent recurrence. Resident #6 had seven falls between 6/28/24 and 11/21/24, without documentation of appropriate interventions to prevent recurrences.
2	.305.02.b. Quarterly Nursing Assessments.	The facility did not ensure residents consistently received their medications and treatments as ordered. For example, Resident #1 did not have medications available to be given as ordered, in November 2024 for 13 doses of scheduled acetaminophen nor 5 doses of olanzapine. Resident #15 did not receive their insulin as ordered on 11/17/24, 11/19/24, and 12/8/24, according to their sliding scale. Resident #14 did not receive their warfarin as ordered on 12/9/24. The facility nurse was uninformed of any issues with residents not receiving their medications as ordered.
3	.305.03. Change in Resident Health Status.	A facility nurse did not conduct nursing assessments when residents experienced changes in physical or mental health status. For example, Resident #1 was not assessed when they

		experienced scratches to their shins and were covered in blood on 10/21/24 nor on 11/2/24, 11/3/24, 11/7/24, 11/8/24, and 11/9/24 when they experienced severe itching and pain to their legs and a severe headache. Resident #1 was not assessed for a change of condition after several falls on 10/19/24, 10/21/24, and 10/27/24. Resident #2 was not assessed for a change in condition when they were up all night with nausea and diarrhea. The facility Licensed Practical Nurse (LPN) was unaware an assessment was required after each incident.
4	.310.02. Discontinued and Expired Prescriptions.	The facility did not maintain a record of medications returned to the pharmacy for destruction. The facility's medication destruction binder did not contain any entries for the last six months until the time of survey. The facility nurse and administrator confirmed records were not maintained.
5	.335.02. Standard Precautions.	The facility did not follow correct infection control procedures when caregivers were observed not washing or sanitizing their hands between resident medication passess due to not having sanitizer available on the medication carts. Staff stated they did not have convenient access to hand sanitizer. Also, facility staff was observed on 12/10/24 and 12/11/24 performing resident's blood glucose checks and administering insulin injections in the dining room area. The facility nurse acknowledged the infection control concerns.