NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
Edgewood Spring Creek Boise, LLC	RC-1006	10681 West McMillan Road	208-954-5660
Administrator	City	Zip Code	Survey Date
Brenda Ruble	Boise	83713	07/18/2025
Survey Team Leader	Survey Type		Response Due
Walker, Jenny	Health Care Licensure and Follow-Up		08/17/2025

Item #	Rule (16.03.22)	Description
1	.305.03. Change in Resident Health Status.	The facility nurse did not assess residents after they experienced a change in mental or health status. For example: Resident #1 fell on 3/22/25 and was a victim of a resident to resident physical altercation on 3/12/25; Resident #2 fell on 4/6/25, 4/19/25, and 5/31/25. Resident #3 was a victim of resident-to- resident physical altercations on 6/28/25, 7/2/25, and 7/3/25 and when they ate trash and dirt on 6/7/25. Resident #5 fell on 1/2/25 and 5/30/25 which resulted with L1 and L2 fractures. Resident #6 fell on 5/2/25 and had a bloody toenail on 6/18/25. The facility nurse stated these assessments were not completed.
2	.320.03. Signature, Date, and Approval of Agreement.	Negotiated Service Agreements (NSAs) were not signed and dated in a timely manner by Residents #3 and #4, or their legal guardians. Resident #3 was admitted on 1/27/25 and their NSA was not signed until 7/18/25. Resident #4 was admitted on 5/19/25 and their NSA was not signed until 7/18/25.
3	.330.06.a. Additional Resident Records.	The facility did not evaluate residents when they exhibited maladaptive behaviors. For example, Resident #3 had been hitting staff, going into other residents' rooms grabbing their belongings, urinating on the floor, and refusing cares. Resident #4 had been urinating on the floor and in room corners.

		Resident #7 had been getting agitated and escalating interactions with other residents into altercations. There were no evaluations for these behaviors in resident records.
4	.330.06.c. Behavior Documentation.	Facility staff did not document dates and time when each maladaptive behavior was observed. For example, multiple staff members stated Resident #7 had multiple resident-to-resident altercations since they were admitted on 8/27/24, and had only one incident documented in their record.
5	39-3321.2.d. Qualifications and Requirements of Administrator.	The administrator did not identify and monitor patterns of accidents and incidents. The administrator stated she did not have a process to do this routinely.
6	39-3321.2.e. Qualifications and Requirements of Administrator.	The administrator did not complete an investigation and written report within 30 days of each accident and incident. For example, Resident #3 was the victim of resident-to-resident altercations on 5/31/25 and 6/14/25, and had an unknown wrist injury on 4/1/25. Resident #2 fell on 4/6/25 and 4/19/25. The administrator stated the investigations were not completed.
7	39-3321.4. Qualifications and Requirements of Administrator.	The administrator did not implement corrective action after accidents and incidents. For example, Resident #3 was the victim of resident-to-resident altercations on 5/31/25, 6/28/25, 7/2/25, and 7/3/25, and had an unknown wrist injury on 4/1/25. Resident #2 fell on 4/6/25 and 4/19/25. Resident #5 fell on 1/2/25. The administrator stated corrective action was not taken.