NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
Brookdale Pocatello	RC-770	1501 Baldy Avenue	208-237-6866
Administrator	City	Zip Code	Survey Date
Nichole Borden	Pocatello	83201	07/24/2025
Survey Team Leader	Survey Type		Response Due
Bollinger, Torrey	Health Care Licensure and Follow-Up		08/23/2025

Item #	Rule (16.03.22)	Description
1	.260.06. Toxic Chemicals.	The facility was not maintained in a clean, safe, and orderly manner. For example: Room #27 had multiple cat emesis stains on the carpet, several dining room chairs were not cleanable as the cushion upholstery was wearing away, there were several stains and frayed areas to the carpet throughout the hallways, there were multiple areas in the carpeting in multiple hallways that had recessed areas in them, making them a trip hazard. The exit door at the end of hallway D was scuffed and needed re-painting.
2	.305.03. Change in Resident Health Status.	The facility nurse did not assess residents after they experienced changes in their mental and health status. For example: Resident #4 had a fall on 12/7/24 and a foot ulcer on 6/23/25, Resident #5 had a "recent" fall reported by the resident in a 5/12/25 physician's progress note, Resident #8 had falls on both 1/3/25 and 1/14/25. The facility nurse stated the change of condition assessments were not completed.
3	.305.06.b. Self-Administered Medication.	Each resident who was self-administering medications was not evaluated every 90 days to ensure they were still capable to safely self-administer medication(s). Resident #10 was assessed to self-administer medications on 1/16/25 and was not assessed again until 7/17/25. The facility nurse stated the

		self administration of medication assessments were not completed every 90 days.
4	.310.02.d. Discontinued and Expired Prescriptions.	The documentation for medication destruction was incomplete. The facility failed to maintain a medication destruction record that included the method of destruction for resident medications. A written record of all drug disposals including method of disposal must be maintained in the facility.
5	.310.04.a. Behavior Modifying Medication.	The facility did not attempt non-drug interventions prior to requesting medications for Residents #4 and #8. Psychotropic or behavior modifying medication were used as a first resort to address behaviors. The facility nurse stated they were in the process of developing behavior plans for all of the residents who needed them.
6	.310.04.e. Psychotropic or Behavior Modifying Medication.	Four of five resident's that required six month psychotropic medication reviews did not have them completed. Resident #1 and Resident #3 were taking Trazadone. Resident #4 was taking bupropion, duloxetine, and lorazepam. Resident #8 was taking clonazepam, aripiprazole, and trazodone. Resident #6 was taking duloxetine, quetiapine, Vraylar, and alprazolam. The facility administrator and facility nurse confirmed they were not completed. ***Previously cited 10/19/22***
7	.319. COMPREHENSIVE ASSESSMENT REQUIREMENTS.	The facility did not complete comprehensive assessments prior to admission to the facility for Residents #1, #2, #3, and #5. The facility administrator confirmed the assessments were not completed.
8	.330.04. Behavior Documentation.	Residents' care records were not maintained for each resident with all entries kept current and completed by the person providing the care. Three of four sampled resident records that required behavior plans did not contain documented caregiver notes or behavioral tracking with interventions prior to 7/3/25. Multiple staff members stated they verbally reported to the facility nurse when unusual events, incidents, and behaviors occurred, then the nurse addressed the issues. The facility

		nurse confirmed this was the process utilized prior to 7/3/25.
9	.330.06.b. Additional Resident Records.	The facility did not develop a behavior plan that included at least one intervention specific to each maladaptive behavior. For example: Resident #4 exhibited medication refusals, cursing at others, and paranoia that interferes with cares. Resident #8 exhibited refusal of cares and cursing at others. The administrator stated they were in the process of developing behavior plans for all of the residents who needed them.
10	.330.06.c. Behavior Documentation.	The facility did not track behaviors, including documentation of the date and time each maladaptive behavior was observed, the specific behavior that was observed, what interventions were used in response to the maladaptive behavior, and the effectiveness of each intervention prior to 7/3/25. For example: Resident #4 exhibited medication refusals, cursing at others, and paranoia that interferes with cares. Resident #8 exhibited refusal of cares and cursing at others. The administrator stated they did not develop a process for tracking behaviors prior to 7/3/25.
11	.330.15. Fire and Life Safety Records.	The facility must ensure the facility's records for fire and life safety were maintained. For example: 1. The facility could not provide documentation of the sprinkler dry systems gauges were replaced due to failed inspections from 6/7/22 and 5/15/25. The administrator confirmed the documentation could not be provided.
12	.330.15.c. Fire and Life Safety Records.	The facility did not complete monthly inspections of the portable fire extinguishers throughout the facility. The administrator stated the former maintenance supervisor did not complete the monthly inspections.
13	.404. FIRE AND LIFE SAFETY STANDARDS FOR EXISTING BUILDINGS LICENSED FOR SEVENTEEN OR MORE RESIDENTS AND MULTI-STORY BUILDINGS.	Life Safety Code standards and requirements for buildings housing 17 or more residents, were not met as evidenced by the following: 1.The facility had a failed dry system pressure gauge inspection on 6/7/22 and 5/15/25 and could not provide documentation the dry system pressure gauges were replaced

		and passed inspection.
14	.405.04. Prohibited Applications.	The facility had a gas fireplace located in the common area. All fuel fired heating devices were not inspected on an annual basis. The administrator confirmed the gas fireplace and all heating devices were not inspected.
15	.410. REQUIREMENTS FOR EMERGENCY ACTIONS AND FIRE DRILLS.	The facility failed to conduct fire drills in accordance with the rule. For example: the fire drills were completed on 1/28/25, 2/25/25, 4/25/25, and 5/26/25, not meeting the requirement of at least six per year on a bi-monthly basis and with two being conducted during the night during normal sleeping hours. The administrator stated they were not completed.
16	39-3308 Assessment (4)a Assessments	The facility nurse did not conduct quarterly nursing assessments at least once every 90 days for 10 of 10 sample residents. For example, Resident #9 was admitted on 4/3/25 and did not have a 90-day assessment completed since admission. Resident #2's last 90-day assessment was completed 2/13/25. Resident #3's last 90-day assessment was completed 4/10/25. The facility administrator confirmed the assessments were not completed.
17	39-3308 Assessment (4)b Assessments	The facility nurse did not review and implement new orders. For example, Resident #6's order for scheduled Percocet three times a day, dated 6/18/25, was not implemented. Resident #2's admission order, dated 2/11/25, for calcium 600-400 MG-UNIT was transcribed incorrectly, as 500-200 MG-UNIT. the facility nurse stated she did not implement and transcribe the orders correctly.
18	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 #4 fell on 12/7/24, Resident #5 fell on 5/12/25, and Resident #8 fell on 1/3/25 and 1/14/25. The administrator stated that investigations were not completed.
19	39-3321.4. Qualifications and Requirements of Administrator.	The administrator did not implement immediate corrective action to ensure that the problem did not recur. For example, Resident #4 fell on 12/7/24, Resident #5 fell on 5/12/25, and

		Resident #8 fell on 1/3/25 and 1/14/25. The administrator stated that corrective action was not implemented.