NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
Meadowlark Assisted Living	RC-1291	709 West North 2nd St	208-983-3793
Administrator	City	Zip Code	Survey Date
Molly VanDomelen	Grangeville	83530	09/26/2025
Survey Team Leader	Survey Type		Response Due
McClenathan, Teresa	Health Care Licensure and Follow-Up		10/26/2025

Item #	Rule (16.03.22)	Description
1	.009.06. Use of Previous Criminal History and Background Check.	One of three employees, who required it, did not have an Idaho State Police background check. The facility administrator confirmed they were not completed.
2	.151. ACTIVITY REQUIREMENTS.	During observations on 9/25 and 9/26/25, no activities were offered to the residents, other than watching "Little House on the Prairie" in the common area. Several residents stated they did not typically have activities.
3	.155.01. Relocation Agreements.	The facility provided one up-to-date relocation/transfer agreement signed on 6/16/25, however, there was no current written agreement with a second separate location. The administrator stated she only had one written agreement completed.
4	.250.09. Resident Sleeping Rooms.	The water temperatures in the facility were not maintained between 105 to 120 degrees F. For example: The temperature in the shower room was 91 degrees F. Rooms 2, 3, and 4 were 92 degrees F. The facility administrator stated there must have been something wrong with the water heater.
5	.260.06. Toxic Chemicals.	The facility was not maintained in a clean, safe, and orderly manner. For example: The kitchen countertops were observed to be worn, scratched throughout, and had holes in the top by the handwashing sink. A seam by the sink was observed to be

		separated and cracked. The edges of the countertops were observed to have scratches worn finish. The finish on cupboard doors were scratched and worn. The hood over the oven was observed to have a large amount of grease buildup and debris. The dining room tables were observed to have large areas which were scratched and worn on the tops. A tear and crack in the floor in the dining room was observed. Several walls in the dining room had missing paint. The HVAC vent in the front hallway was observed to be covered in dust and debris. Several doors and door jambs were observed to have scratches and marks.
6	.305.03. Change in Resident Health Status.	The facility nurse did not conduct nursing assessments when residents experienced changes in physical or mental health status. For example, Resident #1 had a pacemaker replaced on 5/9/25, Resident #2 had a spinal cord stimulator removed on 4/21/25 and received staples in their back. On 4/24/25, Resident #2 was complaining of back pain where the staples were. On 8/1/25, Resident #2's care notes documented, they had a small wound on their right hip. On 8/2/25, Resident #2's care notes documented they had a heart monitor. On 9/4/25 and 9/21/25, Resident #2's care notes documented, they had a wound to their right hip. According to staff progress notes, Resident #3 had falls on 5/1/25 and 8/13/25, urinalysis on 7/29/25 and 8/7/25, choked on food on 4/15/25, had difficulty swallowing medications on 6/19/25 and 6/23/25, and had a sore under there tongue on 7/26/25. The facility nurse stated she did not complete change of condition assessments for Resident #1, #2, and #3.
7	.310.01.f. Medication Distribution.	The medication technician was observed leaving a medicated cream at Resident #2's bedside table. The administrator stated they did not allow residents to self administer medications. The facility nurse stated the medication should not have been left at the bedside.
8	.310.02. Discontinued and Expired Prescriptions.	A written record of all drug disposals must be maintained in

		the facility. The facility's medication destruction log did not document non-narcotic medications that were sent back to the pharmacy to be destroyed. The administrator and facility nurse stated they did not document the medications sent back to the pharmacy to be destroyed.
9	.310.04.e. Psychotropic or Behavior Modifying Medication.	Resident #2 was taking risperidone, ambien, Trazodone, and hydroxyzine for more than six months and did not have six month psychotropic medication reviews completed. The facility nurse confirmed they were not completed.
10	.319. COMPREHENSIVE ASSESSMENT REQUIREMENTS.	The facility did not complete comprehensive assessments prior to admission to the facility for Resident #1. The facility nurse confirmed the assessment was not completed prior to being admitted to the facility.
11	.330.06.a. Additional Resident Records.	The facility did not evaluate residents when they exhibited maladaptive behaviors. For example, Resident #3 was not evaluated when the exhibited behaviors of leaving their room undressed and was resistant to care such as allowing the staff to dress them. Resident #3 was also at times resistant to taking their medications. The facility administrator stated they did not have behavior plans for any residents.
12	.330.06.b. Additional Resident Records.	The facility did not have behavior plans, which included at least one intervention specific to each maladaptive behavior for Residents #3 for behaviors as described in deficiency 330.06.a.
13	.330.14. As Worked Schedules.	The facility nurse's as-worked schedule did not include her full name, title, or the exact times she worked. The facility nurse state she did not record her exact times she was in the facility.
14	.330.15. Fire and Life Safety Records.	Based on record review and interview, the facility failed to ensure 1 of 2 of the buildings licensed for occupancy was inspected for fire, life and safety, including but not limited to: Building 2 missing Fire suppression system annual and monthly gauge and control valve inspections, five-year gauge calibration and/or internal obstruction investigation; Fire alarm annual inspection and five-year sensitivity testing;

		annual fuel-fired heating inspection; annual fire extinguisher maintenance and monthly inspections. All buildings licensed for occupancy shall be maintained and inspected in accordance with all applicable standards as reflected in NFPA 101, 2018 edition, Chapter 33; NFPA 25, 2017 edition, Chapter 5, and NFPA 72, 2016 edition, Chapter(s) 7 and 14.
15	.330.15.c. Fire and Life Safety Records.	Based on record review and observation of the fire extinguishers one of three, fire extinguishers failed the inspection report on 9/15/25, in house #1. The fire extinguisher was dated 9/2023. In house #2, two fire extinguishers were observed with monthly tags, and the facility failed to document the monthly visual inspection for the portable fire extinguishers. The two fire extinguishers were tagged August 2021. The administrator stated the failed fire extinguisher would be replaced on 9/30/25 and house #2's fire extinguishers visual inspections were not conducted.
16	.403. FIRE AND LIFE SAFETY STANDARDS FOR EXISTING BUILDINGS LICENSED FOR THREE THROUGH SIXTEEN RESIDENTS.	1. The facility failed to obtain an annual inspection of the fire alarm system for house #2. The previous inspection was conducted on 10/4/21, for house #2, this resulted in a gap of more than 3 years. The administrator confirmed the inspection had not been completed for house #2. 2. The annual inspection of the fire alarm system on 11/22/24, for house #1 documented a failed smoke detector, located in room 3, not recognized under sensitivity and reporting to the panel, along with a failed notification bell, located at the main entrance of house #1, failing to alarm with water flow. The administrator stated the company was scheduled to come out 10/7/25. 3. The facility failed to obtain an annual inspection of the sprinkler system for house #2. The previous inspection was conducted on 10/8/21, for house #2, this resulted in a gap of

		more than 3 years. The administrator stated the sprinkler system had not been completed for house #2. 4. The facility failed to remedy identified deficiency from the Emergency lighting inspection dated 9/15/25, including the identified risk of an arc fire.
17	.405.04. Prohibited Applications.	The facility failed to inspect, service, and clean fuel fired heating systems on an annually basis in both buildings. The fuel-fired heating devices were last inspected in house #1 on 1/10/24. The fuel fired heating devices had not been inspected in house #2. The administrator stated they had not been inspected on an annually basis.
18	.600.04.b. Sufficient Personnel.	Six of ten employees, who required it, did not have current CPR and First Aid certificates. The facility administrator confirmed the employees did not have current certificates and there were times the building did not have CPR and First Aid certified employees scheduled.
19	.630.01. Dementia.	Nine of ten employees, who's records were reviewed, did not have documentation of specialized training for dementia. The facility administrator confirmed the facility had residents with a diagnosis of dementia and the employees did not have the training.
20	.645.01.a. Training Requirements.	One of seven employees, who passed medications, did not have a Medication Administration Certificate. The facility administrator confirmed the employee did not have the certificates.
21	39-3321.2.d. Qualifications and Requirements of Administrator.	The facility did not identify and monitor patterns of accidents and incidents nor develop interventions to prevent recurrences. The administrator stated they did not have a system to identify and monitor patterns of incidents.
22	39-3321.2.e. Qualifications and Requirements of Administrator.	The facility administrator did not complete an investigation and written report within 30 days after each accident and incident. For example, Resident #2 had falls on 5/1/25 and 8/13/25. The administrator confirmed no investigations were

		completed.
23	39-3321.4. Qualifications and Requirements of Administrator.	The administrator did not immediately implement corrective action to ensure incidents did not recur. For example: Resident #3 had falls on 5/1/25 and 8/13/25 The administrator stated she had not completed incident reports for Resident #2 including corrective action.