NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
Grace Assisted Living at Englefield Green	RC-989	250 South Allumbaugh Way	208-322-8080
Administrator	City	Zip Code	Survey Date
Erica Bahr	Boise	83709	10/17/2025
Survey Team Leader	Survey Type		Response Due
Lu, Melvin	Health Care Licensure and Follow-Up + complaint investigation		11/16/2025

Item #	Rule (16.03.22)	Description
1	.161.04. Designated Smoking Areas.	The facility did not have a designated smoking area that was clearly marked. During an observation on 10/16/25, the designated smoking area in the parking lot near the garbage can was observed not to have a sign signifying it was the smoking area. The facility was informed and indicated a sign would be posted.
2	.310.01.c. Medication Distribution.	The facility did not maintain the medication refrigerator temperatures between 38 and 45 degrees F. The refrigerator contained insulin and was below 38 degrees for 2 days in July 2025, 6 days in August 2025, 5 days in September 2025, and 4 days in October 2025. The temperature was also not consistently documented daily. The facility nurse confirmed the temperatures were out of range and not documented daily.
3	.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 #6 had multiple wounds and their NSA did not document the correct home health and what services they were providing nor how to manage the wounds and dressings. Resident #1's NSA did not document

		they were using a transfer pole, had a tag alarm, nor they had an outside service companion. Resident #2's NSA did not document how to manage their wounds. The facility nurse stated the NSAs needed to be updated.
4	.305.02.b. Quarterly Nursing Assessments.	The facility failed to follow medication and treatment orders for residents. For example: Resident #4 was given their cataract combo drop incorrectly five times between 9/23/25 and 10/14/25 and did not receive the correct dose of furosemide from 9/21/25 to through the date of survey when the order was changed from daily to every other day. Resident #7 was ordered to receive thickened liquids and they received thin liquids during a lunch observation on 10/16/25 and a breakfast observation on 10/17/25. The facility nurse confirmed the medication and treatment orders had not been followed.
5	.330.13.e. Personnel Records.	Nine of fifteen staff member files reviewed did not contain documentation of 16 hours of orientation training. Seven of fifteen employees did not have documented evidence of mental illness and traumatic brain injury training in their personnel files and the facility retained residents with these diagnoses.
6	.645.01.a. Training Requirements.	One of eight medication technicians, whose personnel files were reviewed and administered medications to residents, did not have an Idaho Board of Nursing approved medication assistance course in their employee record. Their record contained a certification for a course that was not approved.
7	.645.02. Delegation.	One of eight staff, whose files were reviewed and assisted with medications, were not delegated by the current facility nurse. The administrator and the current facility nurse confirmed this had not been completed.
8	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 #5 had an unknown injury on 7/14/25 without an investigation. Resident #9 had five falls between

		August 2025 and September 2025 and they were not investigated. The administrator stated the investigations were not completed.
9	39-3308 Assessment (4)b Assessments	The facility nurse did not review and implement new orders. For example, Resident #4's orders for their cataract combo drops, change in furosemide instructions from daily to every other day, new pantoprazole sodium ordered 10/10/25 and new diclofenac sodium 3% gel ordered on 10/9/25. Resident #5's orders, dated 9/3/25, documented in all capital and bold they recommended Resident #5 for a 2-gram low sodium diet, weights daily, and a fluid restriction of less than 2000 milliliters total fluid intake a day. The regional nurse stated the office manager should have clarified the orders. The facility nurse stated the medication and treatment orders were implemented by office staff and not the facility nurse.