# NON-CORE ISSUES

| Facility | License # | Physical Address | Phone Number |
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| Arbor Village at Hillcrest | RC-1316 | 1093 South Hilton Street | 208-345-4460 |
| Administrator | City | Zip Code | Survey Date |
| Jason Corrie | Boise | 83705 | 01/23/2026 |
| Survey Team Leader | Survey Type | | Response Due |
| Oldfield, Michael | Health Care Licensure and Follow-Up + complaint investigation | | 02/22/2026 |

| Item # | Rule (16.03.22) | Description |
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| 1 | .260.06. Toxic Chemicals. | The facility was not maintained in a clean, safe, and orderly manner. For example: the kitchen's ambient temperature was observed to range from 54 to 67 degrees F. The hallway carpet was observed to be stained outside of rooms 123 and 142. The internet cafe had missing wall paint near the courtyard exit. Strong urine smells were observed in rooms 147 and 211, and in the hallway near room 109. The maintenance director stated the facility had been down a housekeeping position until recently and caregiving staff were supposed to pick up residents' trash everyday to reduce urine odor. The administrator stated he had bids to fix and/or replace the HVAC system for the kitchen. |
| 2 | .305.02.b. Quarterly Nursing Assessments. | The facility failed to ensure residents' medications were available and given as ordered by their provider. For example, Resident #1 missed thirty-three doses of Balance of Nature, two doses of potassium chloride, eleven doses of their eye drops, four doses of Vitamin B-12, four doses of Vitamin C, and four doses of Vitamin D3 between 12/1/25 and 1/20/26. Resident #4 missed four doses of Preservation in January 2026 and was still not available on 1/23/26, during the medication pass. Resident #10 missed three doses of sodium and eighteen |

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| | | doses of potassium chloride between 12/1/25 and 1/20/26. The facility nurse stated she was aware residents had missed doses of medications and had been working to resolve the issues. |
| 3 | .305.03. Change in Resident Health Status. | The facility nurse did not assess residents after they experienced changes in their health status. Seven of ten sampled residents were not assessed after changes of their condition. For example: Resident #1 experienced episodes of vomiting on 11/5/25 and a fall on 11/7/25. Resident #10 returned from the hospital on 7/16/25, and experienced falls on 8/1/25, 8/24/25, 9/17/25, and 12/31/25. Resident #9 experienced falls on 8/23/25 and 11/26/25. The facility administrator stated the former nurse did not complete change of condition assessments. |
| 4 | .310.01.g. Medication Distribution System. | Resident #7 did not have their as-needed (PRN) acetaminophen, amoxicillin, azelastine, deep sea nasal spray, milk of magnesia, naloxone nasal spray, and oxycodone available to them from. Resident #9 did not have their PRN diclofenac sodium 1% and meclizine available to them. Resident #1 did not have their PRN clear laxative available to them. Resident #10 did not have their PRN gabapentin and loperamide available to them. Resident #4 did not have their PRN alidophilus, januvia and melatonin available to them. The facility nurse stated she was working on a system to ensure PRN medications are available to residents. ***Previously cited on 11/1/2024*** |
| 5 | .310.02.f. Discontinued and Expired Prescriptions. | The facility did not have a witness present for all resident medication destruction. The facility's medication destruction log documented only one signature for all medications destroyed from September to January 2026. The facility nurse stated all facility medications destroyed needed two signatures. ***Previously cited on 11/1/2024*** |
| 6 | .330.04.c.xi. Resident Care Records. | The facility did not document incidents that occured. Resident #9 sustained falls on 8/3/25, 9/26/25, and 10/18/25 and these |

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| | | falls were not documented in the resident's record by the staff member who witnessed the falls. The former facility nurse referenced that Resident #9 sustained these falls on these dates in her progress notes, but there was no other documentation of these falls. The administrator stated incident and accident reports were not filled out by the staff members. ***Previously cited on 11/1/2024*** |
| 7 | .330.06.b. Additional Resident Records. | The facility did not develop a behavior plan, with at least one intervention for each maladaptive behavior, for all sampled residents. For example: Resident #7's behavior plan did not include refusals of medications and Resident #10 for refusals of medications and cares. The facility nurse stated the previous nurse did not complete a plan with interventions and one would be completed for Resident #7 and Resident #10. |
| 8 | .404. FIRE AND LIFE SAFETY STANDARDS FOR EXISTING BUILDINGS LICENSED FOR SEVENTEEN OR MORE RESIDENTS AND MULTI-STORY BUILDINGS. | The facility did not conduct one of two (semi-annual) hood cleaning inspections. The only cleaning inspection was conducted on 1/5/26. The maintenance director confirmed there was only one hood cleaning inspection completed. |
| 9 | .460.01. Food Preparation. | The facility did not provide the residents with flavorful food due to cold temperatures, burned food, and/or improper cooking of foods. For example, multiple residents, family members, and staff stated the residents' food was not flavorful because it was often cold, burned, or lacked sufficient quality to be palatable. On 1/21/26, during the lunch time observation, the kitchen’s ambient temperature was observed to range from 54 to 67 degrees F (see 260.06). The ravioli on the steam table had a temperature of 80 degrees F prior to serve out and had been 171 degrees F after it was cooked in the oven. The surveyor had to stop the meal from being served due to the low hot holding temperature and the ravioli was put back in the oven until it reached a proper hot holding temperature. Idaho Food Code documents hot food should be held at 135 degrees F. When the roasted cauliflower was initially taken out of the oven, approximately 25% of the |

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| | | cauliflower had been burned on the tops. The kitchen manager directed the cook to put the cauliflower back in the oven because it was still too tough to serve. A few minutes later it was taken out to serve and 35-40% of it was burned. The administrator stated he was aware of the food concerns. |
| 10 | .630. TRAINING REQUIREMENTS FOR FACILITIES ADMITTING RESIDENTS WITH A DIAGNOSIS OF DEMENTIA, MENTAL ILLNESS, DEVELOPMENTAL DISABILITY, OR TRAUMATIC BRAIN INJURY. | Fifteen of fifteen staff, whose records were reviewed, did not have documentation of specialized training for residents with developmental disability or traumatic brain injury after the facility admitted residents that those diagnoses. The business office manager stated that she was not aware the facility staff were in need of specialized training. |
| 11 | 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 #9 fell on 8/3/25, 8/23/25, 9/26/25, 10/18/25, and 11/26/25. Resident #4 fell on 12/13/25. Resident #6 fell on 8/20/25 and 10/22/25. Resident #1 sustained a medication error on 8/31/25 and fell on 11/5/25, 11/7/25, and 12/3/25. Resident #10 fell on 8/1/25, 8/24/25, and 9/17/25. The administrator stated investigations were not completed. |
| 12 | 39-3321.4. Qualifications and Requirements of Administrator. | The administrator did not immediately implement corrective action to ensure incidents and accidents did not recur. For example, Resident #1 who had a medication error on 8/31/25 and fell on 11/5/25, 11/7/25, and 12/3/25. Resident #6 fell on 8/20/25 and 10/22/25. Resident #9 fell on 8/3/25 and 8/23/25. Resident #10 fell on 8/1/25, 8/24/25, and 9/17/25. The administrator stated corrective actions were not implemented. |
| 13 | 39-3321.5. Qualifications and Requirements of Administrator. | The facility did not notify licensing and certification within one business day when Resident #9 fell on 10/18/25 and Resident #8 fell on 1/8/26, and were both sent to the hospital for evaluation. The facility nurse stated she was unclear of the statute on when she needed to report incidents to licensing and certification. |