NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
Twin Rivers Assisted Living and Memory Care	RC-1343	2114 Vineyard Avenue	208-743-4545
Administrator	City	Zip Code	Survey Date
Leandra Johnson, LPN	Lewiston	83501	03/03/2026
Survey Team Leader	Survey Type		Response Due
Perry, Bradley	Health Care Initial Licensure + complaint investigation		04/02/2026

Item #	Rule (16.03.22)	Description
1	.009.01. Criminal History and Background Check.	One of seven employees, whose personnel records were reviewed, did not have a Department Criminal History and Background Check. The business office manager from a sister facility confirmed the Department Criminal History and Background Checks were not completed.
2	.009.03.b. Availability to Work.	Three of four employees, whose personnel record was reviewed, provided supervision, cares, and/or housekeeping services for residents without having a completed Criminal History and Background Check. The business office manager from a sister facility confirmed the background checks had been applied for late and the employees in question most likely worked alone with residents without line-of-sight supervision until their background checks were completed.
3	.009.06.c. Use of Previous Criminal History and Background Check.	Two of two employees, whose personnel records were reviewed and required an Idaho State Police background check, did not have an Idaho State Police background check completed. Upon interview with the business office manager from a sister facility, it was confirmed the Idaho State Police background checks were not completed.
4	.155.03. Emergency Generators.	Facility is equipped with a spark ignited generator set. No

		documented monthly load testing available prior to December 27, 2025. All emergency power supply system generators shall be maintained in accordance to NFPA 110.
5	.250.10.d. Heating, Ventilation, and Air-Conditioning (HVAC).	The facility is equipped with fire dampers. No documentation was available for the last known damper inspection. Examination of the installed fire dampers identified the damper located at room 255, had paint and debris coating the fusible link.
6	.310.01.c. Medication Distribution.	The facility's medication refrigerator temperatures were not monitored and documented daily. The facility had not documented the medication refrigerator temperature in the memory care unit 12 days in January 2026 and 1 day in February 2026. The assisted living unit had not documented the daily temperature of the medication refrigerator 16 days in January 2026 and 3 days in February 2026. The facility's memory care unit did not maintain the medication refrigerator temperature between 38 and 45 degrees F for 19 days in January 2026 and 14 days in February 2026 with no corrective action taken. The facility nurse stated she looked at the documentation weekly but was unaware the temperatures were not documented daily and were out of range.
7	.330. REQUIREMENTS FOR FACILITY RECORDS.	The facility’s medication refrigeration records were not accurate and authentic. On 2/24/26, the assisted living medication refrigerator temperature logs were reviewed and a picture was taken of blanks for the daily temperatures from 1/2/26 to 1/17/26, 2/1/26, and from 2/22/26 to 2/24/25 (see 310.01.c). On the afternoon of 2/24/26, the surveyor requested a copy of the temperature logs and the following day, staff provided the logs. The copies documented temperatures and times for all of the dates which were previously blank the day before. The administrator stated he did not know who had filled in the temperature logs. This act caused the medication refrigeration logs to become inaccurate and not authentic.

8	.330.06. Additional Resident Records.	The facility did not evaluate, monitor, or develop a behavior management plan for resident #7 to manage maladaptive behaviors. For example, resident #7 often displayed aggression towards other residents, agitation, extreme frustration, causing resident to swing their cane around at both staff and residents in a threatening manner. In addition, the facility did not track or document the effectiveness of interventions used to address resident #3's behaviors. The facility nurse acknowledged there was no behavior management plan in place for resident #7 and that resident #3's behavior management plan did not include documentation of intervention outcomes.
9	.335.02. Standard Precautions.	The facility did not follow correct infection control procedures when caregivers were observed not washing or sanitizing their hands between resident medication passes nor when they donned and doffed gloves without performing hand hygiene while applying a topical ointment on a resident's back. The facility nurse stated staff were to sanitize and wash their hands during medication pass between residents and were to perform hand hygiene before and after glove use.
10	.404. FIRE AND LIFE SAFETY STANDARDS FOR EXISTING BUILDINGS LICENSED FOR SEVENTEEN OR MORE RESIDENTS AND MULTI-STORY BUILDINGS.	1) Facility houses a population with both hearing and vision impairments. Only five of the resident rooms are equipped with occupant notification, or audible/visible (AV) notification devices as required in NFPA 101, 9.6. This deficiency was identified in the building evaluation and not addressed at that time. Based on provided hearing and vision assessments of the population served, a total of 29 residents were identified with either hearing or vision impairments. Further observation and examination of resident room 152 established no AV appliance installed. That resident room was found to have the television volume measured at 65 decibels, when tested from the hallway. 2) Fire suppression shall be provided in all areas of combustible overhangs of 48 inches or greater, as identified

		during the building evaluation. None of the combustible overhangs identified have been addressed prior to the survey date, and no approved plans by the local AHJ have been reviewed for compliance. 3) The smoke barrier doors located at room 255 are equipped with a magnetic locking arrangement, without the required delayed egress releasing operation as outlined in NFPA 101, Chapter 7, Section 7.2.1.6. 4) Hazardous areas such as commercial cooking operations shall be protected as such. The main Kitchen access door was propped open with a rubber door wedge, defeating the one-hour construction requirement of the hazardous area as outlined in NFPA 101, Chapter 33, Section 33.3.3.2. 5) Smoke barriers are required to be maintained for continuity. An above-the-ceiling inspection for the smoke barrier located at room 255 identified three (3) unsealed membrane penetrations for data cabling, reducing the fire and smoke resistive properties of the barrier.
11	.600.04.a. Sufficient Personnel.	The facility did not schedule sufficient staff for all hours to meet the needs of the residents. For example, during the overnight shift, frequently only one staff member was scheduled to work in each unit. Multiple residents, families, and staff stated they did not have enough staff to meet the needs of the residents. A staff member frequently brought their child to work and on several occasions leaving residents without supervision while they cared for their child's needs. The administrator and the facility nurse stated they were in the process of hiring more staff to assist with the needs of the residents.
12	39-3316 Resident Rights (3) b.i. Dignity and Respect	The facility failed to protect residents' rights and provide a humane environment for residents. For example, multiple residents, family members, and staff stated a staff member often brought their young child to work. They stated even though the child was supposed to stay in one area of the

		facility away from residents, the child would "run wild" throughout the facility. Several residents and family members stated the child would run into residents' rooms and almost knock residents down as they ambulated in their rooms and hallways. Residents and family members stated they felt like babysitters and did not want "to pay for childcare" while paying for their or their loved ones care as well. Residents and family members stated this was the resident's home and did not need to "put up with that." Multiple staff stated the child in question could be disruptive to residents and staff because their parent was not able to take care of residents' needs and the child at the same time. The administrator stated the staff member had been allowed to bring their child to work, but the child was supposed to stay in one area and was told they would often sleep. He stated the situation was not ideal.