NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
Clement Home Assisted Living	RC-941	3909 W Clement Rd	208 376 4290
Administrator	City	Zip Code	Survey Date
Adi Mihalache	Boise	83704	03/03/2026
Survey Team Leader	Survey Type		Response Due
Walker, Jenny	Health Care Licensure and Follow-Up		04/02/2026

Item #	Rule (16.03.22)	Description
1	.009.06.c. Use of Previous Criminal History and Background Check.	Three of three employees, whose files were reviewed and required an Idaho State Police background check, did not have the check completed prior to working alone with residents. The administrator did not understand the rule regarding Idaho State Police background checks and thought if the staff transferred from a different assisted living facility it was adequate.
2	.161.04. Designated Smoking Areas.	The facility did not have designated smoking area clearly marked. During observations from 3/2/26 to 3/3/26, several residents were observed smoking under the covered patio and there was no smoking sign posted. The administrator confirmed the designated smoking area was not clearly marked.
3	.310.02. Discontinued and Expired Prescriptions.	The facility medication destruction logs did not include all components required by rule. Paper records did not include the method of destruction, did not consistently have two signatures, nor the date of destruction. On 3/3/26, the administrator and a staff member were observed to destroy two medications by flushing them down the toilet. They were unaware that was not the correct way of destroying medications. The administrator stated they will change the

		medication destruction log to include all the components to meet rule.
4	.310.03. Controlled Substances.	Controlled substances were not counted daily. For example, during the medication pass observation, the medication technician stated the facility did not implement a controlled substance tracking log for the medication technicians to sign or date daily. The administrator stated they did not count the controlled substances.
5	.330.04.c.vi. Resident Care Records.	Facility staff did not document when they notified the facility nurse of unusual events. For example, when Resident #2 was admitted to the hospital on 1/26/26 and was seen at the VA on 2/24/26 for coughing or when Resident #3 was admitted to the hospital on 9/11/25 due to low sodium and admitted to the hospital on 2/9/26 for flu-like symptoms. The facility nurse stated she was not notified by staff when these events occurred.
6	.330.04.c.vii. Resident Care Records.	The facility nurse did not document all assessments when residents experienced a change in physical or mental health status. For example, when Resident #2 was admitted to the hospital on 1/26/26 and was seen at the VA on 2/24/26 for coughing or when Resident #3 was admitted to the hospital on 9/11/25 due to low sodium and admitted to the hospital on 2/9/26 for flu-like symptoms. The facility nurse stated she did not document the change of condition assessments.
7	39-3308 Assessment (4)b Assessments	1. The facility nurse did not notify Resident #2's healthcare provider when they refused their lidocaine patch for pain 20 times from 1/20/26 to 2/25/26. The nurse stated she was not aware of the refusals and had not notified the provider. 2. The facility nurse did not review and implement new orders. For example, Resident #2's order for scheduled Famotidine 20 mg daily and isosorbide mononitrate 30 mg daily were transcribed incorrectly, as Famotidine 200 mg daily and isosorbide mononitrate 300 mg daily. The facility nurse stated

		she did not implement and transcribe the orders. The administrator stated the medication technicians transcribed the orders.