NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
Streamside Assisted Living and Memory Care	RC-1320	1333 South Edgewater Circle	208-442-0097
Administrator	City	Zip Code	Survey Date
Daythun Cole	Nampa	83686	03/05/2026
Survey Team Leader	Survey Type		Response Due
McClenathan, Teresa	Health Care Licensure and Follow-Up + complaint investigation		04/04/2026

Item #	Rule (16.03.22)	Description
1	.250.13. Secure Environment.	The facility had residents with cognitive impairments and a history of or who were at risk for elopement and did not provide a secure environment. Resident #2 eloped from the facility's secured unit on 10/4/25, by climbing the secured courtyard's fence with the assistance of a chair and was away from the facility without staffs' knowledge. Resident #2's Negotiated Service Agreement (NSA) was updated on 10/23/25 which included, "Spot checks due to residents recent elopement, staff are to check on the resident every hour.***STAFF ARE TO DOCUMENT WHAT THE RESIDENT IS DOING WHEN THEY CHECK ON [THEM]***." Resident #2's record documented staff did not document hourly checks on 2/6/26 and 2/7/26 from 10:00 PM to 5:00 AM. An incident report for Resident #2, dated 2/7/26, documented the resident eloped from their west street side window of the secured unit sometime the morning of 2/7/26 and before 6:40 AM when staff noticed they were missing. The west street side windows faced an unsecured side of the facility and the street. An emergency discharge notice, dated 2/7/26, documented Resident #2 was discharged from the facility because the

		facility "has determined that Streamside can no longer keep [Resident #2] safe due to continuous elopement..." From 3/3/26 to 3/5/26, the secured residents' rooms to the west street side were observed, which included the window Resident #2 had eloped from. The windows had a flip lock and a crank style window opener. Four of the windows had screws drilled into the stucco on the outside and all of the screws were either loose or could be pulled out and without resistance. On 3/5/26, the maintenance director stated Resident #2's window had a screw on the outside of their window, but was bent when the resident forced the window open. She stated she had ordered new locks for the memory care windows to avoid such an incident in the future and they were going to be installed that day. The resident care director stated on the night in question, camera footage was reviewed for Resident #2 and the resident had gone to bed around 2:50 AM on 2/7/26 and was not checked on by staff until 5:00 AM, when the care staff opened up the resident's door and looked in. She stated the next time the resident was checked on was when they were discovered missing at around 6:35 AM. Care staff working the AM shift stated the night care staff had told them all the residents, including Resident #2, had been checked every hour when change of shift happened around 6:00 AM on 2/7/26. The facility nurse stated after Resident #2 eloped on 10/4/25, hourly checks were implemented in order to keep the resident safe. The administrator stated Resident #2 was very smart and had cut the window screen, rolled it up, and tied it with the pull cord from the window blinds prior to exiting out the window. He stated the night shift staff on 2/6/26, did not follow Resident #2's NSA to check on them every hour. He stated after the 10/4/25 elopement they had not considered the window to be a possible elopement risk for Resident #2, because the administrator had never seen any resident elope from a window before. He stated Resident #2

		was physically able to circumvent the facility's safety measures and they were subsequently discharged. The facility failed to provide a secure environment for Resident #2 when they eloped out of their window the morning of 2/7/26, when staff did not follow Resident #2's NSA of hourly checks, when staff failed to evaluate the resident's room for possible elopement scenarios based off their physical abilities as evidenced by their elopement on 10/4/25, and when Resident #2 was able to push the window open, bend the screw, and climb out.
2	.320.08. Periodic Review.	NSAs were not updated to reflect significant changes for residents. For example, Resident #10's NSA did not document when an outside agency treatment for wound had been initiated nor when they had been discontinued, when their toileting was changed to every two-hour schedule, nor that their legs were wrapped and bandaged. Instructions were not documented for staff on how to protect the bandages during showers, or how to respond in the case of the bandages becoming dislodged or soiled. The facility resident care director confirmed Resident #10's NSA had not been updated to reflect changes in condition.
3	.330.04.c.vii. Resident Care Records.	The facility nurse did not document changes of condition for residents who had changes in physical or mental changes. For example, when Resident #4 returned to the facility after shoulder surgery on 1/30/26. On 2/4/26 Resident #9 complained of swelling in her feet and vaginal pain. On 2/23/26 Resident #9 was found with a wound on her left buttock and the follow up assessment was not documented. Resident #10 experienced reddened skin on neck, which was itchy and burning on 9/10/25, when home health services were initiated and when the services were discontinued, when they went to emergency room for cellulitis on 9/27/25, nor when they returned from the hospital after becoming septic. The facility nurse stated she assessed the residents However, did not document the assessments.

4	.410. REQUIREMENTS FOR EMERGENCY ACTIONS AND FIRE DRILLS.	The facility failed to conduct fire drills in accordance with rule. Documentation was available for 6 quarterly fire drills with no bi-monthly completed fire drills conducted from 10/7/25 to 1/26/26, with 2 drills conducted quarterly on the night shift. This documentation does not meet the requirement of at least 6 per year on a bi-monthly basis with 2 being conducted the night during normal sleeping hours. The maintenance manager stated that they had conducted fire drills quarterly and confirmed that bi-monthly drills were not completed.
5	39-3321.2.d. Qualifications and Requirements of Administrator.	