NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
Brookdale Boise Parkcenter	RC-401	739 East Parkcenter Boulevard	208-338-5600
Administrator	City	Zip Code	Survey Date
Brandy Dyer	Boise	83706	03/20/2026
Survey Team Leader	Survey Type		Response Due
Lu, Melvin	Health Care Licensure and Follow-Up		04/19/2026

Item #	Rule (16.03.22)	Description
1	.009.01. Criminal History and Background Check.	One of fifteen employees, whose personnel records were reviewed, did not have a Department Criminal History and Background Check. Upon interview with the administrator, it was confirmed the Department Criminal History and Background Check was not completed.
2	.009.06.c. Use of Previous Criminal History and Background Check.	Four of twelve employees, whose files were reviewed and required an Idaho State Police background check, did not have the checks completed prior to working alone with residents. Upon interview with the administrator, it was confirmed the Idaho State Police background checks were not completed.
3	.161.01. Combustible Supplies and Flammable Items.	The designated smoking area was observed to have multiple combustible materials within the area. For example, two gas cans and a five-gallon propane tank were observed in the staff smoking area.
4	.161.04. Designated Smoking Areas.	The facility did not have designated smoking areas clearly marked. During observations from 3/17/26 to 3/18/26, the fenced in area behind the back of the kitchen was observed to be the smoking area for staff. There was no smoking sign posted. The maintenance manager confirmed there was no posted smoking sign in the staff smoking area.
5	.310.04.e. Psychotropic or Behavior Modifying Medication.	Residents #1, #3, #6, #7, and #8 had six-month psychotropic

		medication reviews, however they were not reviewed and signed by the physician. The facility nurse confirmed the doctor had not reviewed and signed the psychotropic medication reviews.
6	.320. NEGOTIATED SERVICE AGREEMENT (NSA) REQUIREMENTS.	The facility did not provide housekeeping according to residents NSAs, which is weekly for all residents. Residents #1, #7, and #9's NSAs documented they were on a weekly housekeeping schedule, however rooms were only cleaned every two weeks. Staff, residents, and family members stated rooms were not cleaned according to schedule and typically only once every two weeks. The administrator stated they have been attempted to hire a second housekeeper but had only been staffing one housekeeper who could not keep up with the schedule. The facility did not have signed and dated NSAs for Residents #7 and #9. The administrator confirmed the signatures for the NSAs were not obtained. The facility did not update NSA when residents had a significant change in care needs. For example, Resident #7's NSA was not updated to reflect their current care needs when they had a cast on their left leg due to a fractured ankle, how long they were non weight bearing, and what changes to report to the nurse. Their NSA also documented the resident was normally independent for bathing but "may need assistance", and no instruction of what type of assistance they may need, including how to manage the resident's cast when bathing. When Resident #8'had a urinary catheter or instructions to the staff for on care or what to report the nurse, that they used a motorized wheelchair or manual wheelchair, that they had a sling and/or immobilizer to their left arm due a shoulder injury and was not to use their arm for transfers, nor when they had physical therapy. Resident #9's

		NSA was not updated when they had changes in mobility and toileting needs as a result of changes in capability with their prosthetics. The facility nurse confirmed the NSAs were not updated for these changes.
7	.330.04.c.vi. Resident Care Records.	The facility did not maintain complete and accurate records when staff failed to document they had notified the facility nurse of changes in the residents' conditions. For example: Residents #1 - #10's records contained no documentation from the caregivers in their records. Medication technicians stated they notified the nurse verbally at daily stand-up meetings, called or texted the facility nurse and did not document they had notified the facility nurse. The medication technicians also stated they would input the documentation electronically for the caregivers because they did not have access. The administrator stated the caregivers did not have access to document electronically and were supposed to complete alert charting documents but had not consistently been using the alert charting forms and the medication technicians had not been consistently documenting notifications to the nurse.
8	.330.04.c.vii. Resident Care Records.	The facility nurses did not document when changes of condition were conducted. For example, Resident #1 had chest congestion and low blood pressure on 2/1/26 and was sent out to the hospital. Resident #7 fell in June of 2025, resulting in a fractured left ankle and went to the emergency room, had surgery on 7/2/25, came back with a cast, nor any changes when the cast was removed. When Resident #8 had a catheter placed, had an injury to their shoulder as a result of a fall, including the need for a sling and/or immobilizer.
9	.330.13.i. Personnel Records.	One of eight staff who passed medications, whose files were reviewed, did not have documented delegation in their personnel files to pass medications by the current facility nurse. The facility nurse stated they delegated the staff, but delegation documentation was not maintained by the facility
10	.330.15.c.v. Fire and Life Safety Records.	Based on record review and observation of fire extinguisher

		monthly tags; the facility failed to document the monthly visual inspection of all portable fire extinguishers on the first floor of the facility. The maintenance manager stated he was unaware the fire extinguishers needed a monthly inspection.
11	.405.04. Prohibited Applications.	The facility failed to inspect, service, and clean fuel-fired heating systems on an annual basis. The maintenance supervisor stated they were unaware the gas furnaces needed an annual service inspection.
12	.645.01.a. Training Requirements.	One of eight medication technicians sampled, who administered medications to residents, did not have documentation of an Idaho Board of Nursing approved medication assistance course in their employee record.
13	39-3308 Assessment (4)a Assessments	The facility nurse did not conduct 90-day assessments in a timely manner. For example, Resident #7's 90-day assessments were conducted on 10/9/25 and 2/18/26, which were over one month late, Resident #8's assessments were conducted on 10/24/25 and 2/17/26, and Resident #10's last 90-day assessment was conducted on 10/13/25. The facility nurse and administrator stated they were behind on conducting the assessments.
14	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 #4 fell on 12/4/25, 12/6/25, 12/7/25, 1/15/26, and 2/13/26, Resident #5 fell twice on 2/2/26. When Resident #7 had falls in June 2025, 11/10/25, 12/12/25, and 1/16/26 and injured their toe on 2/18/26. When Resident #8 had falls on 6/30/25, 9/30/25, 10/24/25 and 1/26/26. The administrator confirmed that investigations were not completed.
15	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 #4 had falls on 12/6/25, 12/7/25, 1/15/26, 2/13/26, 3/2/26, and 3/14/26. Resident #5 had two falls on

		2/2/26. When Resident #7 had falls on 6/22/25, 12/12/25 and, 1/16/26 and Resident #8 had falls on 9/3/25 and 10/24/25. The administrator confirmed corrective action was not implemented.