NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
Whispering Pines Assisted Living Center	RC-1229	351 E Center St	208-897-5683
Administrator	City	Zip Code	Survey Date
Brie Moore	Downey	83234	04/08/2026
Survey Team Leader	Survey Type		Response Due
McClenathan, Teresa	Health Care Licensure and Follow-Up		05/08/2026

Item #	Rule (16.03.22)	Description
1	.009.06.c. Use of Previous Criminal History and Background Check.	One of six staff members, whose personnel files were reviewed and required an Idaho State Police background check, did not have documentation of an Idaho State Police background check in their record within thirty (30) days of obtaining the previous criminal history and background check results. Upon interview with the administrator, it was confirmed the ISP background check was not completed.
2	.260.06. Toxic Chemicals.	The facility was not maintained in a clean, safe and orderly manner. For example: Throughout the facility, doors, door jambs and walls were marred and dirty, had deep gouges and areas where the dry was chipped. Molding in several areas was missing or damaged. The sidewalks and back patio area had large areas of cracking and chipping. The carpet had dark stains throughout the facility. A storage shed was observed to have the door opened and contained a plastic gas can. A chair in the smoking area was overserved to have burn holes in the vinyl seat and cigarette ash and butts were overserved to be on the patio and furniture.
3	.305.03. Change in Resident Health Status.	The facility nurse did not conduct assessments when residents had changes in their physical or mental status. For example:

		Resident #1 was not assessed when they had a urinary tract infection in January 2026, had shoulder surgery on 2/23/26, had their shoulder in a sling, and had a wound on their back after on 2/23/26, nor after several changes in medications. The facility nurse stated she did not do assessments for changes of condition. The facility administrator in training stated the nurse did not assess the residents.
4	.320.08. Periodic Review.	Negotiated Service Agreements (NSAs) were not updated to reflect Resident #1's health status and needs. For example: When they had shoulder surgery on 2/23/26 and required assistance with activities of daily living, had a wound on their back and home health for physical therapy and wound care, nor that they had an amputated leg. The assistant administrator stated the updates to the NSA were not documented.
5	.403. FIRE AND LIFE SAFETY STANDARDS FOR EXISTING BUILDINGS LICENSED FOR THREE THROUGH SIXTEEN RESIDENTS.	The facility did not have the kitchen hood suppression system inspected every six months. The facility had no documentation of a kitchen hood suppression system inspection completed after the kitchen hood was installed in July of 2023. The facility also had no documentation of the kitchen hood being clean since installed. The administrator stated she was not aware of the kitchen hood suppression system needing inspected or cleaned and it had not been completed since installed in July 2023. ***Previously cited on 9/24/24***
6	.630.02. Mental Illness.	Five of six staff, whose records were reviewed, did not document they had mental illness training. The administrator stated the training had not been completed.
7	.630.04. Traumatic Brain Injury.	Six of six staff, whose records were reviewed, did not document they had traumatic brain injury training. The administrator stated the training had not been completed.
8	39-3308 Assessment (4)b Assessments	The facility nurse did not implement new orders. For example, Residents #1, #2 and #3 each had multiple orders for new or changes to medications, which were not implemented by the

		nurse. The facility nurse stated she reviewed the orders and the medication administration record (MAR) when she came into the facility but did not review the medications before they were given. She stated the administrator in training or house manager entered the orders onto the MAR. The administrator in training stated either they or the house manager entered the orders and the medications were given before the nurse reviewed them.