NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
Gables Assisted Living and Memory Care of Caldwell	RC-1230	917 E Ustick Road	(208) 455-2324
Administrator	City	Zip Code	Survey Date
Paige Portenier	Caldwell	83605	06/12/2026
Survey Team Leader	Survey Type		Response Due
McClenathan, Teresa	Health Care Licensure and Follow-Up		07/12/2026

Item #	Rule (16.03.22)	Description
1	.152.03.a.ii. Policies of Acceptable Admissions.	The facility utilized an outside agency caregiver for Resident #10, for which they did not arrange services and families paid the caregiver directly. Resident #10's negotiated service plan did not delineate what services would be provided by this caregiver. The administrator confirmed the family hired and paid for the services of a private-duty caregiver and did not arrange services with the facility for Resident #10.
2	.305.03. Change in Resident Health Status.	The facility nurse did not conduct assessments after residents experienced a change of condition in health status. For example, Resident #4 was started on physical therapy on 12/18/25. A caregiver note, on 12/29/25, documented they had pain "between their legs". A provider progress note, dated 8/19/25, documented the resident had been admitted to the hospital on 8/11/25 with pneumonia and sepsis due to choking on vomit at the facility. It also documented the resident returned to the facility on 8/14/25 with an antibiotic and "new onset of leg swelling", as well as note, dated 9/9/25, that the resident had a urinary tract infection. Resident #8 experienced a fall on 8/26/25 and was not assessed by the facility nurse. The facility nurse stated she thought she

		assessed Resident #4 but could not remember those change of conditions.
3	.410. REQUIREMENTS FOR EMERGENCY ACTIONS AND FIRE DRILLS.	The facility failed to conduct fire drills in accordance with the rule. Documentation was available for 3 fire drills being conducted between 2/3/26 and 5/28/26, not meeting the requirement of at least 6 per year on a bi-monthly basis with 2 being conducted during the night during normal sleeping hours. The administrator confirmed the fire drills had not been completed.
4	.600.04. Personnel Management.	The facility did not provide sufficient staff to meet the residents' needs. For example, Resident #4 was observed to be assisted with eating by an outside agency staff and the facility administrator while floor staff was assisting other residents, including assisting Resident #1 with eating in their room. Resident #10 had a private duty caregiver to assist them to eat every day at lunchtime. Also, on 6/11/36, only one staff was working in memory care and was observed to be providing care to residents, passing medications, redirecting residents with behaviors, including residents who refused their medications and training a new staff. The facility administrator stated they were going through a staffing crisis and were trying to cover shifts.
5	39-3308 Assessment (1) Initial Assessments	The facility nurse did not conduct an assessment within 30 days prior to admission to the facility. For example, pre-admission assessments were not completed for Resident #1, #2, and #3. The facility administrator stated that the assessments were not completed by the former nurse.
6	.310.04.e. Psychotropic or Behavior Modifying Medication.	The facility did not conduct six-month psychotropic medication reviews for residents who were prescribed psychotropic medications. For example: Resident #1's was prescribed trazadone, bupropion and citalopram, Resident #2's was prescribed buspirone and Resident #5 was prescribed Lorazepam and Haldol and did not have a psychotropic medication review completed. The facility administrator stated

		that six-month psychotropic medication reviews were not completed.
7	.330.04.c.v. Resident Care Records.	The facility nurse did not document when they notified providers after residents refused their medications. For example, Resident #3 refused their donepezil on 5/5/26, 5/6/26, 5/11/26, 5/18/26, 5/28/26 and 6/6/26. Resident #3 refused olanzapine on 5/4/26, 5/6/26, 5/11/26, and 5/18/26 and their quetiapine on 5/28/26 and 6/6/26. The facility nurse stated she collaborated with providers but doesn't always document when they were notified.