NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
Brookdale Lewiston	RC-595	2975 Juniper Drive	208-746-8676
Administrator	City	Zip Code	Survey Date
Hope Brackett	Lewiston	83501	07/24/2026
Survey Team Leader	Survey Type		Response Due
Walker, Jenny	Health Care Complaint Investigation		08/23/2026

Item #	Rule (16.03.22)	Description
1	.260.05. Housekeeping and Maintenance Services.	The facility failed to maintain the interior of the building to ensure cleanliness, safety, and orderly environment. For example, all surfaces including the kitchen floor, walls, shelves, and appliances, were observed to have food debris accumulation and food particles. Multiple food preparation equipment, such as the stand-up mixer and the microwave were observed to have dried food splatters on them. The dining room was observed to have an accumulation of dried liquid on the walls outside of the kitchen door and near the juice machine. The in-floor air vents in the dining room were covered with towels and coffee cups. Carpet throughout the facility hallways, common areas, and residents' rooms had multiple stains on it. For example, room #122 had badly stained carpet and a wedge had an unknown substance on it. Room #133 and room #202 had badly stained carpet. Urine odors were detected in various areas throughout the facility. For example, rooms #112, #122, #133, and #228 had pungent odors of urine. There were multiple rooms which were not vacuumed and had food and waste visible and accumulated, including room #243 which had trash, wrappers, and crumbs on floor surfaces, and room #230 had food waste on their

		room floor as well as soiled adult incontinent briefs in the bathroom area. The administrator stated the facility was working on improving the environment.
2	.335.02. Standard Precautions.	The facility did not follow standards for infection control precautions. For example, during medication pass observations, medication technicians were observed providing care needs to residents then administering medications to multiple residents without conducting hand hygiene between medication pass with each resident. During multiple meal observations from 7/21/26 to 7/23/26, multiple staff were observed not wearing aprons while serving food to residents after providing care needs to residents. The facility nurses stated staff needed to be re-educated on proper infection control precautions.
3	39-3322.1 QUALIFICATIONS AND REQUIREMENTS FOR FACILITY STAFF	The facility did not arrange for sufficient staff to fully meet the needs of its residents and failed to provide care during all hours required in each resident's NSA. For example, multiple residents, families, and staff stated there was not enough staff to meet residents' needs. Several residents stated there were never enough staff to help them in their rooms during meal times because staff had to help with meal service. Several staff stated the facility generally only had one staff member to help residents on both floors during meal times. Several residents stated their laundry was not being washed in a timely manner and had to wait up to a week to receive their laundry back. Several residents stated they had not had showers for weeks and even months. Several residents and an outside agency provider stated trash had not been consistently taken out daily and as needed. During the survey from 7/21/26 to 7/23/26, multiple residents' room trash were observed to not be taken out. From 7/21/26 to 7/23/26, Resident #7 was observed to have black dirty feet with long thick toenails. Resident #7's record documented they had not received a shower from 5/24/26 to 7/14/26. Resident #1's record documented they

		only received nine showers from 4/11/26 to 7/21/26, instead of the 28 showers they should have received during this time period. Resident #3's record documented they only received seven showers from 1/7/26 to 7/21/26, instead of the 56 showers they should have received during this time period. The facility nurses stated the facility had not always had enough staff to meet residents' needs and were in the process in hiring new staff. The nurses also stated the resident care coordinators were being pulled to the floor instead of performing other duties, including helping with re-ordering medications and performing medication cart audits (see non-core deficiency 310.01.f). The administrator stated there were not enough staff in the recent past and had been working to hire and train more staff.
4	.310.01.f. Medication Distribution.	1. Residents were not receiving their medications as ordered by the physician. For example, Resident #3 did not receive their amlodipine besylate 4 times in July 2026 and their lisinopril once in July 2026. Resident #4 did not receive their levothyroxine 23 times in May 2026, levothyroxine three times in June 2026, their tamsulosin twice in June 2026, and their vitamin D3 three times in June 2026. Resident #8 did not receive their nizerol six times in June 2026 and twice in July 2026, their fentanyl patch twice in June 2026, and their tamsulosin twice in July 2026. Resident #1 did not receive 10 doses of gabapentin in July 2026. Resident #9 did not receive their bupropion for three days in July 2026. Resident #2 did not receive multiple medications on multiple days in July 2025. The facility nurses confirmed residents did not receive their medications as ordered. ***Previously cited on 1/8/25 and 10/24/25 at 305.02.b*** 2. Residents did not have their as-needed (PRN) medications available in the facility. For example: Resident #3 did not have

		their PRN miralax, ondansetron, bisacodyl, dulcolax, and fleet enema available. Resident #6 did not have their PRN bisacodyl suppositories or milk of magnesia available. Resident #1 did not have their PRN dulcolax tablet and suppository, nor their fleet enema. The facility nurses confirmed the facility did not have residents' PRN medications as ordered. ***Previously cited on 10/24/25 at 310.01.g***
5	.305.03. Change in Resident Health Status.	The facility nurse did not conduct nursing assessments when residents experienced changes in physical or mental health status. For example, Resident #7 was started on antibiotics for cellulitis to their lower leg on 7/13/26. Resident #4 fell on 5/15/26 and received the wrong medication on 7/16/26. Resident #1 fell on 2/26/26 and 4/26/26 and experienced a medication error on 3/15/26. Resident #6's progress notes documented on 6/6/26 they had red and swollen lower extremities and on 6/11/26 they were complaining of dizziness. The facility nurse stated a nurse did not assess these residents on these ocassions.
6	39-3316 Resident Rights (3) b.iii. Dignity and Respect	The facility failed to protect residents' rights. For example, multiple residents stated the facility allowed Visitor A (Resident #4's family member) to come to the facility most every day who made them feel uncomfortable and disrespected, who interfered with staff trying to provide other residents' needs, who tried to get residents to eat food (which may or may not have been against their diet orders), who went into other residents' rooms who did not belong to Resident #4, and had driven a wedge between themselves and their tablemates because Visitor A had tried to convince them to file complaints against the administrator to get her fired. Multiple residents stated they no longer went to the dining room for meals because Visitor A would not leave residents alone and made them feel like they were being harassed. The residents stated the actions made by Visitor A had changed the feel of their home and they no longer felt respected because the

		visitor was allowed access to all of the residents in the facility, including residents' rooms. From 7/21/26 to 7/23/26, multiple observations of Visitor A were made. During at least three meals, Visitor A was observed moving from table to table, touching residents' backs and shoulders, who was not Resident #4. Visitor A was observed on multiple occasions and had stopped staff from performing their duties by talking to them regarding issues which were not associated with Resident #4 and not allowing them to leave when the care staff had visibly and verbally announced to Visitor A they needed to assist other residents. Resident #4's room was observed to have cameras in the room. One camera faced the resident's bed where care could be observed if performed in bed. Visitor A stated they were trying to advocate for as many residents as possible and even wanted to become the power of attorney for an unidentified resident, who was not their family member, who lived in the facility and who could still make decisions for themselves. Visitor A stated they had provided residents who were not Resident #4 with food, because they wanted to help them, and Visitor A stated they were not aware of the residents' diet restrictions. Visitor A stated the former facility nurse had been telling them about residents' situations they had been concerned about (which may or may not have been private health information) when she was the facility nurse. Visitor A stated they had been in other residents' rooms besides Resident #4's room. Visitor A stated they and their spouse had observed staff performing care in bed via the video camera in Resident #4's room. One of the facility nurses stated residents had complained about Visitor A being in the facility. She stated Visitor A brought in fast food hamburgers to share with multiple residents the prior week and the visitor would not have known what specialized diets the residents were on, which could have

		been detrimental to their health in various ways. She stated Visitor A frequently stopped staff, including herself, from performing their duties for other residents because Visitor A wasted their time on things not related to Resident #4's care needs. She acknowledged Visitor A could be considered a danger to the other residents based on interfering with their care. Several staff members stated Visitor A was mentally unwell and should not be around the other residents, due to dignity, respect, and safety concerns. For example, on that day a resident had passed away in their room and Visitor A was observed upstairs lingering outside of the resident's room causing interference with staff and the mourning family of their loved who just passed away. The staff stated Visitor A did not know the resident who had passed away nor the family. Visitor A was observed following the funeral home staff from upstairs all of the way into the parking lot where the funeral home's vehicle was located. (The surveyors observed Visitor A still in the parking lot after the funeral home vehicle left the parking lot.) Several staff stated they felt Visitor A was intimidating and they were fearful to go home after their shift because Visitor A would wait for them outside to harass them. A facility nurse stated Visitor A impeded staff from doing their jobs like delaying medication pass and stopping staff from providing care to other residents. She stated Visitor A had been informed multiple times to not involve themselves with other residents' care needs, but Visitor A just did not listen. The administrator stated she was aware of Visitor A's behavior but was unaware it was affecting other residents' rights. She stated at least one resident had come to her about the visitor and voiced their concerns about not being comfortable around Visitor A. She stated the visitor harassed the staff members almost daily and one staff member had asked the

		administrator if they could file a restraining order against Visitor A. The administrator stated she had warned Visitor A multiple times to not harass or delay the staff, not to go into other residents' rooms, and to be respectful of other residents in the facility, but the visitor would not always listen and violate her requests. The administrator stated she was unaware the camera in Resident #4's room pointed to an area where the resident's privacy was not protected and would work with family to get it removed. She stated she could see how residents might feel the facility was not protecting them to feel respected and dignified, as Visitor A was making them feel otherwise. She stated she had warned Visitor A not to go into other residents' rooms and was unaware it was still happening.
7	39-3309.01 NEGOTIATED SERVICE AGREEMENT	The facility failed to update residents' negotiated service agreements (NSAs) to reflect current status. For example: Resident #8's NSA documented they were on a regular (cut up) diet when they were on a nectar thick, liquid diet, documented they took their medications whole with water when they had a crush order for their medications, documented they were independent with dressing, toileting, and ambulation (with a four wheeled walker) when they were bed bound and required full assistance in these areas, and did not document they were on hospice. Resident #4's NSA did not document they were receiving hospice services including who was responsible for assisting the resident with showers. The administrator stated they were working on updating the NSAs to reflect current status of all the residents.