NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
Meadow View Assisted Living and Memory Care	RC-1347	1013 S. Johns Ave.	208-365-1122
Administrator	City	Zip Code	Survey Date
Nick Parisi	Emmett	83617	08/13/2026
Survey Team Leader	Survey Type		Response Due
Lu, Melvin	Health Care Initial Licensure		09/12/2026

Item #	Rule (16.03.22)	Description
1	.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 #1 had a wound to their right lower extremity and had been treated at a wound clinic. Resident #2 had a low blood pressure and complained of feeling "very tired" and "nauseated" on 4/5/26, complained of chest pain, headache and dizziness 4/28/26, a four-pound weight loss on 7/21/26 and had a urine analysis on 7/22/26. Resident #3 was sent to the emergency room for shortness of breath on 6/6/26 returning with a diagnosis of pneumonia. Resident #3 was not assessed upon return from the hospital. Resident #3 had a skin tear to his left arm near the elbow, he was not assessed by facility LPN. Resident #4 experienced falls on 6/1/26, 7/8/26, and 7/21/26. Resident #6 experienced burning while urinating on 4/30/26 and was not assessed, and returned from the emergency room on 6/6/26 with blood pressure issues and was not assessed. Resident #10 experienced a fall with fracture on 7/28/26 and was hospitalized on 7/29/26 and returned on 8/4/26 and was not assessed. The facility LPN did not assess resident #4 after the

		resident fell. The LPN stated she did not assess the residents after they experienced a change of conditions. The facility nurse stated she was not aware of the residents' changes of condition
2	.310.01.f. Medication Distribution.	Residents did not receive medications and treatments as ordered. For example, Resident #1 had an order for Oxygen, which was not on their medication administration record (MAR), Resident #2 also had an order for Oxygen, which was not on their MAR. Resident #8's order for Lasix dated 5/30/26 was not followed as they did not receive it seven times between 5/30/26 through 8/12/26. Resident #10 had an order to discontinue their routine morphine every 6 hours on 8/4/26, however they received it 4 times between 8/4/26 to 8/5/26. The facility LPN stated Resident #8's Lasix order needed to be clarified, and they were unaware of Resident #10's order for routine morphine had been discontinued.
3	39-3309.01 NEGOTIATED SERVICE AGREEMENT	The facility failed to maintain Negotiated Service Agreements (NSA) for residents to reflect current status. For example, Resident #1s NSA did not document that they were incontinent of urine and had a wound including instructions for care and was receiving wound care at a wound clinic, nor when they were admitted to home health services for wound care. Resident #3's NSA did not include instructions for care staff regarding the resident's suprapubic catheter. Resident #4s NSA did not reflect current status to include residents fall risk and inability to ambulate and transfer independently. Resident #10s NSA did not include wound care instructions and how to manage their hip fracture. The facility LPN stated that they did not update NSA's to reflect current resident health status.
4	.310.04.a. Behavior Modifying Medication.	The facility did not attempt non-drug interventions prior to requesting medications for Resident #8, #4 and #6. For example: Resident #8 was prescribed Seroquel 25 mg and continued to receive increase doses of Seroquel from June

		2026 to August 2026, prior to having a behavior management plan in place. Resident #8's pre-admission assessment dated, 5/27/26, documented by the LPN, Resident #8 did not have behaviors. Psychotropic or behavior modifying medication were used as a first resort to address behaviors. The regional nurse stated it appears that medications were used as a first resort for Resident #8. Resident #4 was prescribed bupropion 75mg, duloxetine 20mg, and trazadone 50mg, without an evaluation of maladaptive behavior or a behavior management plan in place. Resident #6 was prescribed olanzapine to address maladaptive behaviors on 6/8/26 without a behavior management plan in place. The facility LPN stated that medications were used prior to implementing behavior management plan.
5	39-3321.2.d. Qualifications and Requirements of Administrator.	The facility did not identify and monitor patterns of accidents and incidents nor develop interventions to prevent recurrences. For example, Resident #4 experienced falls on 6/1/26 and 7/8/26. There was no corrective action identified to prevent future falls or implement prevention measures. Resident #3 experienced incidents on 6/6/26 for shortness of breath and emergency room visit, and on 7/31/26 for a skin tear. Corrective actions were not implemented. The facility LPN stated the facility had not tracked for patterns of incidents.
6	.330.04. Behavior Documentation.	The facility did not maintain behavior management plans for residents who demonstrated behaviors. For example, Resident #6 exhibited behaviors, specifically hallucinations causing them to yell in the hallways. Resident #6 was not placed on a behavior management plan after a sustained period of maladaptive behaviors. Resident #8 exhibited agitation and yelling at staff and no behavior management plan, and Resident #9 exhibited behaviors by yelling and grabbing female residents aggressively and another time was seeking out females in their rooms without a behavior

		management plan in place. The LPN stated behavior management plans were not completed.