

NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
Table Rock Senior Living at Barber Station	RC-1271	3266 East Barber Valley Drive	208-616-1150
Administrator	City	Zip Code	Survey Date
Joel Freston	Boise	83716	04/30/2026
Survey Team Leader	Survey Type		Response Due
Lu, Melvin	Health Care Complaint Investigation		05/30/2026

Item #	Rule (16.03.22)	Description
1	.305.02.b. Quarterly Nursing Assessments.	Residents did not receive medications as ordered. For example, Resident #6 had an order on 4/2/26 to increase their escitalopram from 10 milligrams (MG) to 20 mg and they continued to receive only 10 mg until at least 4/29/26. Resident #8 had an order on 4/13/26 to change their Miralax from scheduled to PRN and they continued to receive it scheduled until at least 4/28/26. The facility nurse stated there had been issues with medications and was in the process of changing the way orders were implemented.***Previously cited 7/2/25.***
2	.310.02. Discontinued and Expired Prescriptions.	The facility medication destruction logs did not include all components required by rule. Destruction logs in the assisted living unit did always have reason, method, and two witnesses documented for all entries. The memory care unit had destruction logs for multiple medications for multiple residents which did not have two witnesses from October 2025 to February 2026. The facility nurse stated prior to their starting at the facility, medication destruction may not have been properly done and documented. The administrator stated they were unaware of the incomplete medication destruction logs.

3	.320.08. Periodic Review.	Residents #1, #4, and #7 Negotiated Service Agreements (NSAs) were not updated to reflect significant changes in their health status. For example, Resident #1's NSA documented they needed assistance with toileting to include pulling up their pants and/or other hygiene. Also, stand-by, and/or assistance with hard-to-reach areas for bathing, partial assistance with dressing, and assistance of two staff for transfers, when the resident required extensive assistance for these tasks including the use of a slide board for transfers. Resident #4's NSA stated they were a one-person transfer. Multiple Caregivers and the facility nurse reported Resident #4 required at least two staff for safe transfers. Resident #7's NSA was not updated after a fall intervention was added to check on the resident every two-hours at night after they fell on 12/1/25. The facility nurse confirmed the NSAs had not been updated to reflect residents' current needs.
4	.330.04.c.ii. Resident Care Records.	The facility did not maintain current written and signed provider orders in the facility. For instance, Resident #1's orders dated 2/7/26 did not match the medication administration record. Additionally, gabapentin, olanzapine and polyethylene were different. Bisacodyl tablets and Dulcolax rectal suppositories were not on the order. The facility nurse was unable to find more current orders with changes to the resident's medications. She stated some orders may have been scanned into the computer and deleted.
5	.600.04.a. Sufficient Personnel.	The facility did not schedule sufficient staff for all hours to meet the needs of the residents. For example, during the day and evening shift in the memory care unit, multiple staff stated they did not have enough staff to meet the needs of the residents, including toileting residents and providing adequate supervision of residents according to their NSAs. From 4/28/26 to 4/29/26, multiple residents were observed wandering into other residents' rooms without permission and two surveyors had to alert staff on at least two occasions of residents being in

		other residents' rooms. Resident #7 experienced a fall on 12/1/25 and the corrective action was to implement two-hour safety checks at night. Resident #7's NSA nor activities of daily living (ADL) logs documented they were checked every two hours at night, until they were discharged on 12/11/25. The facility nurse stated the memory care unit could always use more staff. The administrator stated the memory care unit was near the threshold of residents where they generally add an additional staff member. ***Previously cited on 7/2/25***
--	--	--