# NON-CORE ISSUES

| Facility | License # | Physical Address | Phone Number |
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| Table Rock Senior Living at Paramount | RC-1314 | 6280 North Fox Run Way | 208-639-0009 |
| Administrator | City | Zip Code | Survey Date |
| Heath Braverman | Meridian | 83646 | 02/07/2025 |
| Survey Team Leader | Survey Type | | Response Due |
| Bollinger, Torrey | health care initial licensure | | 03/09/2025 |

| Item # | Rule (16.03.22) | Description |
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| 1 | .215.08.d. Written Response to Complaint within Thirty Days. | The facility did not provide a written response to complainants within 30 days. For example, the complaint log from August to December 2024 documented multiple complaints had been made to the administrator and the complainant did not receive a written response. The administrator stated he was unaware written responses were required to be provided to the complainants. |
| 2 | .310.01.c. Medication Distribution System. | The facility did not maintain the medication refrigerator temperatures between 38 and 45 degrees F, and contained insulin. The temperatures were documented out of range two times in January 2025 and ten times in November and December 2024, with no corrective action taken. The facility nurse stated she was unaware they were out of range. |
| 3 | .310.04.e. Psychotropic or Behavior Modifying Medication. | Residents' #5, #8, and #10 had six month psychotropic medication reviews, however they did not contain updated behavioral data. The facility nurse and administrator were unaware that behavioral updates were required. |
| 4 | .260.07. Toxic Chemicals. | Toxic chemicals were observed to be stored in unlocked areas, which were accessible to cognitively impaired residents, between 2/4/25 and 2/6/25. For example, the kitchen gate in |

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| | | the memory care unit was observed unlocked, ajar, and had the key within reach for three consecutive days where multi-service cleaner and disinfectant were in an unlocked cupboard under the handwashing sink. The activities room had paint in a plastic bin which was within reach to cognitively impaired residents. |
| 5 | .330.06.a. Behavior Documentation. | The facility did not evaluate residents when they exhibited maladaptive behaviors. For example, Resident #6 was not evaluated when they exhibited behaviors of elopement, striking out at staff and residents, biting, resisting care, refusing medications, and urinating on the floor, in trash cans and laundry baskets. Resident #8 had behaviors of sexual advancements towards residents and fighting with other residents. The administrator and the facility nurse stated the residents had not been evaluated for these behaviors. |
| 6 | .330.06.b.ii. Behavior Documentation. | The facility did not review behavior management plans to ensure the effectiveness of each intervention nor add or adjust behavioral management plans to address current behaviors. For example, Resident #6s had three interventions for their aggressive behaviors, cares and medication refusals. Staff were attempting the interventions which continued to be ineffective on several occasions. Resident #8's behavioral management plan was to address wandering into other residents' rooms, however, Resident #8 was wheelchair bound at the time of survey and plan did not address fighting or yelling at other residents. The facility nurse stated she did not review the behavior plans or monitor interventions for effectiveness. |
| 7 | .625.01. Number of Hours of Training. | Three of ten staff, whose records were reviewed, did not contain documentation of 16 hours of orientation, nor had they completed orientation within 30 days of hire. The business office manager confirmed the staff had not received the training. |
| 8 | .630.02. Mental Illness. | Ten of ten staff, whose records were reviewed, did not document they had mental illness training. The business office |

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| | | manager stated the training had not been completed. |