

NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
Table Rock Senior Living at Park Place	RC-1326	616 16th Ave North	208-361-8465
Administrator	City	Zip Code	Survey Date
	Nampa	83687	06/13/2025
Survey Team Leader	Survey Type		Response Due
Ramirez, Mina	health care initial licensure		07/13/2025

Item #	Rule (16.03.22)	Description
1	.300.01. Licensed Registered Nurse (RN).	The facility did not ensure quarterly assessments for residents were completed in a timely manner. For example, Resident #1's and Resident #3's quarterly assessments were due in May 2025 and were not completed at the time of survey. The facility nurse stated he was behind on some of the assessments and was trying to catch up.
2	.330.06. Behavior Documentation.	The facility did not evaluate, develop interventions, nor track ongoing behaviors when Resident #2 exhibited exit seeking behaviors, including an elopement, nor when they consistently wandered into other residents' rooms. Resident #4 exhibited behaviors of yelling at staff and other residents, had a history of hitting staff throwing cups at other residents. An unsampled resident was observed to exhibit behaviors of yelling at staff, interfering with the care of other residents, including while residents were assisted with eating, disturbing other residents by touching and talking to them in the common area, and exit seeking behaviors including banging on the locked exit door and yelling. The facility nurse stated Resident #2's, #4's and the unsampled Resident's behaviors were not adequately evaluated for these behaviors, interventions had not been

		developed, and tracking of these behaviors were not documented.
3	.430.04. Resident Telephone Privacy.	A corded telephone provided for residents' use was located at the nurse's station in the memory care unit. Resident #4 was observed to use the phone multiple times, and their conversations could be overheard by other residents, visitors, and staff members. The administrator confirmed that phone was the only one available to residents in the memory care unit and the location did not afford privacy for residents when using the phone.
4	.600.04. Personnel Management.	The facility did not schedule sufficient personnel during all hours to meet the needs of the residents. Multiple residents, staff members, outside agency staff, and family members stated there were not enough staff to meet residents' needs. For example, on the morning of 6/11/25, the memory care unit was observed to have a caregiver and a medication technician for 20 residents, which included two residents who needed two-person assistance for transfers. Two staff stated due to Resident #2's behaviors of wandering into other residents' rooms, staff locked most of the residents' doors in the unit. Resident #2 was observed on multiple occasions walking into other residents' rooms, flushing their toilets, moving items around, and banging on the door to the assisted living side of the facility, without staff intervening on most of the occasions. When Resident #2 went into Resident #4's room, without permission, Resident #4 yelled at Resident #2 to get out. The facility nurse stated prior to the new company taking over, there were at least three staff in the memory care unit during the day. He stated the memory care unit could use another staff member. The administrator stated the facility had enough staff and stated staff needed more training to get the work done.