NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
Overland Court Senior Living	RC-1329	10250 West Smoke Ranch Drive	208-322-2900
Administrator	City	Zip Code	Survey Date
Nathaniel Figueroa	Boise	83709	09/18/2025
Survey Team Leader	Survey Type		Response Due
Cerovski, Wendy	health care initial licensure		10/18/2025

Item #	Rule (16.03.22)	Description
1	.009.01. Criminal History and Background Check.	Three of ten employees, whose personnel records were reviewed, did not have a Department Criminal History and Background Check. Upon interview with the administrator, it was confirmed the Department Criminal History and Background Checks were not completed.
2	.155.01. Relocation Agreements.	The facility did not have a current disaster/relocation agreement in the event of emergency where evacuation would be required. The surveyors were provided agreements that were between the previous facility and other locations. Additionally, the agreements were several years old, and it was unclear if the residents could relocate in an emergency.
3	.216.02. Written Agreement.	Six of eight sampled residents', who resided at the facility at the time of the recent change of ownership, admission agreements were not created and signed by all responsible parties on or before a change of ownership occurred. The administrator stated the admission agreements were not completed.
4	.260.07. Toxic Chemicals.	Toxic chemicals were observed to be stored in an unlocked area which was accessible to cognitively impaired residents. On 9/15/25 a bottle of isopropyl alcohol, a container of Comet deodorizing cleanser and a gallon container of Spectracite Bug

		Stop was observed in an unlocked closet in the memory care unit. Facility staff was informed, and the chemicals were secured.
5	.310.01.f. Medication Distribution System.	On 9/15/25 an unsampled resident was observed with a medication cup in her room containing two pills. The resident, as well as multiple other residents, stated they often take their medications unsupervised. The administrator stated they were unaware that residents were unobserved while taking medications.
6	.310.01.g. Medication Distribution System.	The facility did not ensure all ordered PRN medications were available to residents at all times. For example, during survey it was observed Resident #9 did not have their loperamide, Geri-Lanta, or Milk of Magnesia. Resident #2, did not have their odansetron, Milk of Magnesia, Bisocodyl Suppositories, and Famotadine. The medication technician confirmed that these medications were not in the facility.
7	.310.02. Discontinued and Expired Prescriptions.	The facility medication destruction logs did not include all components required by rule. For example, the narcotic destruction did not include the method of destruction, and the destruction log for non-narcotic medications did not include the full name of the of the person destroying the medication nor a witness. Also, some medications are destroyed in a "Drug buster" and not documented. The facility nurse confirmed the medication logs did not contain all components and other destructed medications were not documented.
8	.320. NEGOTIATED SERVICE AGREEMENT (NSA) REQUIREMENTS.	After a change of ownership on 6/1/25, the facility did not review and update the Negotiated Service Agreements for 8 of 8 sampled residents who resided at the facility at the time of the change of ownership. Additionally, the NSAs for 10 of 10 sampled residents did not clearly identify each resident nor describe how services were to be provided. The NSAs for all sampled residents included short statements such as "1 person assist" or "fall risk" to describe services to be provided. There were no instructions included in the NSAs for caregivers

		directing them on how they were to provide cares.
9	.330.04.c.vii. Resident Care Records.	The facility nurse did not document pre-admission assessments prior to residents moving into the facility for all residents who were admitted on the change of ownership on 6/1/25 nor for residents admitted after the change of ownership. The facility nurse stated she conducted the assessments but did not document her findings. She stated she "was not good about documenting assessments."
10	.330.08.b. Additional Resident Records.	The facility administrator did not document complaints he had received from residents and family members. On 9/17/25 at 8:52 AM the administrator stated he had received multiple complaints related to potential theft and food concerns. Specifically, that residents were missing personal items and the food had consistently been served cold. He stated none of the complaints had been documented as the facility did not have a system in place to track complaints.
11	.330.13. Personnel Records.	The facility did not maintain staff records with all required documentation. For example, ten of ten staff records reviewed did not contain documentation of multiple required components, such as orientation training, infection control training, and specialized training. Additionally, five staff records did not contain current CPR/first aid certifications. The administrator confirmed the facility did not possess the documentation.
12	.404. FIRE AND LIFE SAFETY STANDARDS FOR EXISTING BUILDINGS LICENSED FOR SEVENTEEN OR MORE RESIDENTS AND MULTI-STORY BUILDINGS.	The facility did not conduct an annual inspection of the fire alarm system. The most recent fire alarm inspection was dated December 11, 2023. The administrator was made aware of the missing inspection and could not provide documentation of a current inspection.
13	.405.04. Fuel-Fired Heating.	The facility did not conduct an annual fuel fired heating inspection. The most recent fuel fired heating inspection was dated March 3, 2022. The administrator was made aware of the missing inspection and could not provide documentation of a current inspection.

14	.410. REQUIREMENTS FOR EMERGENCY ACTIONS AND FIRE DRILLS.	The facility failed to conduct fire drills in accordance with the rule. No fire drills had been conducted since the facility obtained their license on June 1, 2025, indicating the facility did not conduct fire drills not less than bi-monthly. The administrator was informed of the missing fire drills and was unable to provide documentation of the required drills.
15	.460.01. Food Preparation.	The facility did not provide residents with flavorful food due to cold temperatures. For example, 16 residents, 2 family members and multiple staff stated the residents' food was not good because it was often cold. On 9/16/25 at 11:25 AM, the cook was observed to plate puree and mechanical soft spaghetti and then left the food on the counter uncovered until 11:37 AM. The pureed spaghetti was 110 F and the mechanical soft spaghetti was 105 F. At 11:37 AM, the plated spaghetti was covered with a plastic cover and placed on an unheated cart until 11:50 AM, when it was taken by a dietary aide to the memory care unit to serve. From 11:25 AM to 11:43 AM and from 11:50 to 12:17 PM, the steam table lids for the spaghetti and green beans were left open. On 9/16/25, the culinary services manager stated she and the administrator had received complaints from the residents regarding cold food. She stated the steam table did not work and staff poured boiling water into the table to keep food warm. The culinary services manager stated the food should have been covered to prevent food from getting cold.
16	39-3308 Assessment (4)a Assessments	The facility nurse did not conduct quarterly nursing assessments at least once every 90 days for 3 of 10 sample residents. Residents #1, #7, and #9 did not have 90 day assessments completed. The facility RCC and facility nurse confirmed the assessments were not completed.
17	39-3308 Assessment (4)b Assessments	The facility nurse did not conduct nursing assessments when residents experienced changes in physical or mental health status. For example, Resident #5 had falls on 8/22/25, 9/7, and 9/12/25 and was not assessed for a change of condition. The

		facility nurse stated that change of condition assessments were not completed.
18	39-3316 Resident Rights (1) Resident Records	The facility violated a resident's rights after they did not provide a resident or their authorized representative with their record within two days. On 9/16/25 at 1:05 PM the administrator stated an unsampled resident's authorized representative requested their records when the moved away from the facility on 7/23/25. He stated he was not allowed to release the records as he was following instructions from his corporate office. He clarified he believed the corporate office would be providing the records to the authorized representative on 9/16/25, a period of fifty-five days.