

## NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
Overland Court Generations Memory Care	RC-1330	10172 West Smoke Ranch Drive	208-322-2900
Administrator	City	Zip Code	Survey Date
Grace Hearn	Boise	83709	10/02/2025
Survey Team Leader	Survey Type		Response Due
Bollinger, Torrey	health care initial licensure		11/01/2025

Item #	Rule (16.03.22)	Description
1	.009.01. Criminal History and Background Check.	Six of six employees, whose personnel records were reviewed, did not have a Department Criminal History and Background Check after the change of ownership. Upon interview with the administrator and business office manager, there was a payment issue and the Department Criminal History and Background Checks were not completed.
2	.155.01. Relocation Agreements.	The facility did not have a current relocation written agreement developed between the facility and two separate locations to which residents would be relocated in the event the building had to be evacuated. The maintenance supervisor stated the facility did not have a current relocation agreement.
3	.216.02. Written Agreement.	For six of seven sampled residents', who resided at the facility at the time of the recent change of ownership on 6/1/25, the admission agreements were not created and signed by all responsible parties on or before the change of ownership occurred. The administrator stated they were not completed.
4	.260.06. Housekeeping and Maintenance Services.	The facility was not maintained in a clean, safe and orderly manner. For example: the outside secured courtyard exterior fences were broken, damaged, and scraped. Multiple residents' exterior windows had hard water stains, which could

		not see out the windows. Wheelchairs and a walker was stored outside on the walkway. Several hallway walls, pillars, and doors were chipped, scraped, and scuffed up caused by wheelchairs. Room 205 had cracked paint around the AC unit and the walls were scuffed up. The portable food hot box was not sustaining a warm temperature, the door was attached with a screwdriver and the power cord had exposed wires which did not allow a optimal power connection. The maintenance supervisor stated they were working on it.
5	.305.02.b. Current Medication Orders and Treatment Orders.	The facility did not ensure residents received medications and diets as ordered by their physician. For example, Resident #3 was ordered a minced and moist diet on 5/15/25. On 9/30/25, during breakfast and lunch observations, Resident #3 was served a soft and bite sized diet. Resident #7 was admitted on 9/25/25 at 3:00 PM, and had physician's orders for eliquis, gabapentin, and quetiapine twice a day. Also, Resident #7 had orders for melatonin and atorvastatin at bedtime and had orders for cetirizine, donepezil, and sertraline in the morning and these medications were not available until the evening of 9/26/25. The facility nurse was made aware that Resident #7 did not receive their medications as ordered and Resident #3 did not receive their diet as ordered.
6	.305.03. Resident Health Status.	The facility nurse did not conduct nursing assessments when residents experienced a change in physical or mental health status. For example, Resident #1 had foot pain on 7/28/25, discoloration to their coccyx on 7/31/25, red heels that required to be propped up on 8/15/25, skin concerns to both feet on 8/26/25, and an opening to their coccyx on 9/11/25. Residents #5 and #6 eloped from the facility on 7/20/25. The facility nurse stated she had not completed these change of condition assessments.
7	.310.02. Discontinued and Expired Prescriptions.	The facility's medication destruction log did not include what method of disposal was used to destroy the medications. The facility nurse stated the method of destruction was 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 6 of 8 sampled residents who resided at the facility at the time of the change of ownership. Additionally, the NSAs for 6 of 8 sampled residents did not clearly identify each resident nor describe how services were to be provided. The NSAs for these residents included short statements such as "1 person assist" or "fall risk" to describe serviced to be provided. Instructions were not included to direct caregivers on how they were to provide cares. The administrator stated they were working on getting the NSAs more detailed.
9	.320.03. Signature, Date, and Approval of Agreement.	Negotiated Service Agreements (NSAs) were not signed and dated by Residents #1, #2, #4, #5 and #6, or their legal guardians. The administrator stated they were not NSAs were not signed by the legal guardians.
10	.330.04.a. Resident Care Records.	The facility did not maintain accurate and authentic caregiver notes. Caregivers and medication technicians informed the resident care coordinator of unusual events and concerns, who then documented these in the residents' records as progress notes. The administrator confirmed the facility's system needed to be changed to allow caregivers and medication technicians the ability to document authentic notes.
11	.330.09. Resident Admission and Discharge Register.	The facility did not maintain an up-to-date admission and discharge register. The register documented the facility housed 23 residents and facility actually had 36 residents residing in it. The administrator stated the register needed to be updated.
12	.404. FIRE AND LIFE SAFETY STANDARDS FOR EXISTING BUILDINGS LICENSED FOR SEVENTEEN OR MORE RESIDENTS AND MULTI-STORY BUILDINGS.	The facility failed to obtain an annual inspection of the fire alarm system. The previous inspection was conducted on 12/12/23, with a gap of over fourteen months since the previous inspection. The maintenance supervisor stated the inspection had not been completed.
13	.405.04. Fuel-Fired Heating.	The facility failed to inspect, service, and clean fuel-fired heating systems on an annually basis. The fuel-fired heating

		<p>devices were last inspected on 10/12/23. The maintenance supervisor stated they had not been inspected on an annually basis.</p>
14	.460.01. Food Preparation.	<p>The facility did not provide the residents with flavorful food due to cold temperatures. For example, multiple residents, family members, and staff stated the residents' food was not flavorful because it was often cold. On multiple occasions, kitchen staff were observed pouring hot water into the steam tables due to them being inoperable. Kitchen staff stated this "was better than nothing." The facility's hot box utilized to transfer food from the kitchen to the memory care unit was not working properly due to the wires being exposed causing a bad power connection and the door to the hot box was held on with a screwdriver, which did not allow for an appropriate seal to keep food warm. On 9/29/25, during breakfast, scrambled eggs were served out of the hot box to residents at 101.4 degrees F. On 9/30/25, during lunch, baked fish was served out of the hot box to residents at 96.8 degrees F and carrots were served at 89.3 degrees F. Idaho Food Code documents hot food should be held at 135 degrees F. The administrator stated new steam tables and a new hot box were on order.</p>
15	.625.01. Number of Hours of Training.	<p>Five of six staff, whose records were reviewed, did not contain documentation of 16 hours of orientation after the change of ownership nor did any of the staff who were retained after the change of ownership receive training on the new company's policies and procedures. The administrator and business office manager stated they were working on getting all the staff trained.</p>