NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
Brookdale Chubbuck	RC-772	4080 Hawthorne Road	208-237-6005
Administrator	City	Zip Code	Survey Date
Mitchell Wach	Chubbuck	83202	06/05/2025
Survey Team Leader	Survey Type		Response Due
Walker, Jenny	health care licensure and follow-up		07/05/2025

Item #	Rule (16.03.22)	Description
1	.260.06. Housekeeping and Maintenance Services.	The facility was not maintained in a clean, safe and orderly manner. For example, there were multiple areas in outside entryways where walls, doors and windows had spiderwebs, dead bugs, and dirty windows. The entryway to the courtyard outside of room 324 (300 hall) had weeds growing up through the cracks of the sidewalk and on the side of the sidewalk. Also, in the entryway door, above the door, in the central courtyard had a damaged door jamb. The central courtyard had outside trim pieces missing and molding on the sidewalk near the entryway door. Also, in the central courtyard there were garbage bags filled with yard debris. There was a desk outside in front of the building, near a residents' window. The southwest side of the building had siding that had come loose and was hanging off of the southwest outside wall. Throughout the assisted living area walls and door jambs were observed to be scratched and gouged. Corners of walls were observed to be chipped and missing drywall. In the memory care unit, toilets were observed to have yellow and brown discoloration around the bases, and in several bathrooms the linoleum had bluish discoloration. Doors and door jambs were observed to be dirty, scratched, and gouged, rubber baseboards

		throughout were separating from the wall, frayed strips of carpet were observed along all walls. The dining tables and chairs were observed to be deeply scratched and marred, and the finish was worn off. Several rooms had uneven patches of paint. Also, a brick was observed to be placed against an exterior door, which opened to the courtyard, which is a fire safety hazard.
2	.330.06.c. Behavior Documentation.	The facility staff did not document ongoing tracking of behaviors, including interventions used and effectiveness of those interventions. For example, Resident #1 exhibited behaviors of masturbating in common areas, attempting to hit staff and other residents, and yelling. Resident #3 reported delusions and suspicions that other residents and staff were stealing their belongings until, "they got what they wanted". This interfered with resident cares. The facility nurse stated the documentation was not done and staff required additional training.