STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135098	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Timber Springs Transitional Care	1140 North Allumbaugh Street Boise, ID 83704

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to ensure residents' representatives were provided the opportunity to participate in the development of the resident's care plan. This was true for 1 of 3 (Resident #115) whose record was reviewed for comprehensive care plans. This failure resulted in Resident #115's initial care conference being delayed beyond regulatory timeframes, creating the potential for miscommunication and unmet care needs. Findings include: Resident #115 was admitted on [DATE] with multiple diagnoses including mild cognitive impairment, cancer of multiple lymph sites, and adult failure to thrive.A Hospice agency delineation of care form, signed 9/3/25, documented that the facility was responsible for providing the date and time of interdisciplinary team meetings.On 11/18/25 at 3:20 PM, the Clinical Resource Nurse stated that initial care conferences were to be conducted within 72 hours of admission.On 11/19/25 at 11:12 AM, the Social Worker stated care conferences were to be conducted within 24-48 hours of admission. She confirmed that Resident #115's official care conference was held on 9/16/25 (13 days after admission). The Social Worker also confirmed she had not read the delineation of care and was not informed the facility was responsible for coordinating the care conference. On 11/19/25 at 11:15 AM, surveyors requested documentation of collaboration with the Hospice agency to schedule the care conference.On 11/20/25 at 10:38 AM, the Social Worker stated she did not have documentation indicating collaboration with the Hospice agency to schedule the care conference.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff interview it was determined the facility failed to ensure grievances were acted upon when facility staff were made aware of residents' missing items. This was true for 1 of 3 residents (Resident #29) whose records were reviewed. This deficient practice created the potential for psychosocial and physical harm when Resident #29's personal items were missing and not replaced. Findings include:Resident #29 was admitted to the facility on [DATE] with multiple diagnoses including dementia and anxiety.A Comprehensive MDS Assessment,dated 8/6/25, documented Resident #29 had severe cognitive impairment.A. Resident #29's care plan, initiated 7/17/25, documented Resident #29 was at risk for a communication problem related to a hearing deficit. The care plan documented ear amplifiers were ordered, and Resident #29 preferred to keep his hearing amplifiers in his shirt pocket.Nursing progress notes documented the following:On 8/7/25, Resident #29 did not have his ear amplifiers.On 8/9/25, Resident #29's ear amplifiers were still missing.On 8/10/25, Resident #29's ear amplifiers were documented as lost.On 8/12/25, Resident #29's ear amplifiers were documented as misplaced as Resident #29 was resistant to keeping them in the medication cart and preferred to leave them in his shirt pocket. Resident #29 and his family were notified.B. On 11/10/25, Resident #29's daughter contacted the facility to alert them to her father's missing shoes.Resident #29's Inventory checklist dated 11/4/25, identified the following items were missing: 10 socks, 10 underwear, and shoes/boots.Resident #29's record did not document the facility had resolved any of Resident #29's missing items.On 11/19/25 at 4:05 PM, the Administrator and LSW stated when missing items are reported, the facility takes about one week to look around the facility and the laundry room to ensure the items are not misplaced in the facility. If the items cannot be found, the facility will replace the items.On 11/19/25 at 4:10 PM, the LSW stated no one from the facility had followed up on the missing items noted in Resident #29's discharge inventory from 11/4/25, and the items should have been replaced if they were not found.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to ensure professional standards of practice were followed. This was true for 1 of 3 residents (Resident #115) whose record was reviewed for medication management. Specifically, the facility did not implement a physician's order for Haldol prescribed for symptom management during end of life care. This failure created the potential for untreated symptoms during the death and dying process. Findings include: The National Library of Medicine website accessed on 11/19/25, defines standard of care as the benchmark that determines whether professional obligations to patients have been met.Resident #115 was admitted on [DATE] with diagnoses including mild cognitive impairment, cancer of multiple lymph sites, and adult failure to thrive.Resident #115's record documented she admitted to end-of-life services on 9/3/25 upon admission. Review of Resident #115's record located a document titled Symptom Control Prescription dated 9/3/25 and signed by a physician. The document included the following orders:Morphine 20 mg/mL, give 0.25 mL sublingually for mild pain and shortness of breath, as needed.Lorazepam 2 mg/mL, give 0.5 mL orally for mild anxiety, as needed.Haldol 2 mg/mL, give 0.5 mL orally for mild agitation/nausea, as needed.Ondansetron 4 mg orally, as needed.Bisacodyl 10 mg rectal suppository, as needed.Review of the MAR and physician orders dated 9/3/25 - 10/14/25 documented that the order for Haldol 2 mg/mL, 0.5 mL orally for mild agitation/nausea as needed, was not included or implemented.On 11/20/25 at 8:57 AM, the Interim DON stated the facility made the decision not to implement the physician's order because Resident #115 was not displaying agitation at the time of admission. When asked if a licensed nurse has the authority to supersede a physician's order, the Interim DON stated, No.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to ensure residents drug regimens were free from unnecessary medications. This was true for 1 of 3 residents (Resident #115) whose records were reviewed for unnecessary medications. Specifically, the facility administered Keflex (an antibiotic) beyond the prescribed duration without documented physician authorization or evidence of clinical justification. This failure created the potential for adverse outcomes, including the development of multi drug resistant organisms. Findings include:Resident #115 was admitted on [DATE] with diagnoses including mild cognitive impairment, cancer of multiple lymph sites, and adult failure to thrive.Resident #115's record documented an order for Keflex 500 mg by mouth twice daily for 10 days to treat a cyst infection.A review of the MAR dated 9/3/25 - 10/14/25 documented the following physician orders:A Physician order dated 9/26/25 - 10/3/25: Keflex 500 mg by mouth twice daily for 10 days.A Physician order dated 10/3/25 - 10/9/25: Keflex 500 mg by mouth twice daily for 10 days.The record documented Keflex was administered for 13 consecutive days, exceeding the prescribed 10 day course.On 11/20/25 at 8:57 AM, the Interim DON stated the antibiotic was extended past 10 days because Resident #115's cyst was worsening.On 11/20/25 at 8:59 AM, surveyors requested documentation of physician notification regarding the worsening condition and extension of the antibiotic order.On 11/20/25 at 10:15 AM, the Interim DON stated the facility did not have documentation of physician notification or a request to extend the antibiotic order.