STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135141	A. Building B. Wing	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Terraces of Boise, The	5301 E Warm Springs Ave Boise, ID 83716

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, policy review, and staff interview it was determined the facility failed to ensure residents were treated with dignity when referring to resident's as feeders who require assistance when eating, as well as serving meals at the same time to residents sitting at the same table. This was true for 4 of 4 residents (#3, #13, #17, and #22) who were observed during dining. This deficient practice had the potential to create psychosocial harm to residents if resident's felt inferior by being referred to as feeders or not being served meals at the same time. Findings include:The Facility's Dignity Policy, revised February 2021, documented residents are to be cared for in a manner which promotes and enhances their sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. Staff are expected to provide a dignified dining experience, and to always speak respectfully to residents.1. Resident #3 was admitted to the facility on [DATE] with multiple diagnoses including Alzheimer's, dementia, depression, ataxia (a lack of muscle control and coordination), and muscle weakness. Resident #13 was admitted to the facility on [DATE] with multiple diagnoses including dementia, brain bleed, repeated falls, and muscle weakness. Resident #17 was admitted to the facility on [DATE] with multiple diagnoses including dementia, muscle weakness, and dysphagia (difficulty swallowing). On 12/18/25 at 4:55 PM, before dinner service, the surveyor overheard CNA #2 orienting an agency CNA staff member. CNA #2 pointed to Resident #3, #13, and #17's table and referred to their table as a special table with feeders who would need additional help. At 5:35 PM, CNA #2 asked [NAME] #1 when the feeders table's meals would be ready to serve. On 12/18/25 at 5:55 PM, CNA #2 stated she should not be referring to resident's as feeders and she should not be pointing out that their table was special. 2. Resident #22 was admitted to the facility on [DATE] with multiple diagnoses including, Alzheimer's Disease (a progressive brain disorder that slowly destroys memory, thinking skills, and eventually the ability to carry out simple tasks), Osteoarthritis, and muscle weakness. On 12/15/25 Resident #22 was observed in the [NAME] dining room as follows: (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 12:26 PM, Resident #22 was observed seated adjacent to Resident #41. Resident #41 was served her meal and eating while Resident #22 had not been served her plate. Resident #22 asked, Are we going to get our food? At 12:32 PM, Resident #22 told Resident #41 I have nothing to eat and Can I get more of this, pointing at her drinking glass. Glass was observed almost empty. At 12:36 PM CNA #1 served regular food minced and moist with mashed potatoes with gravy. Resident #22 started eating. At 12:44 PM, Resident #22 was served with another plate of minced and moist food which consisted of mashed potatoes and parmesan chicken pesto. On 12/15/25 at 1:14 PM, when asked why Resident #22 was not served her food at the same time as Resident #41, [NAME] #1 stated, the cook that was in charge of making special diets like minced and moist, forgot about it and had to get it from the kitchen upstairs. When asked if Resident #22 always eats in the [NAME] Dining Room, [NAME] #1 stated, Yes, she always eats in this dining room. On 12/16/25 at 2:33 PM, the RD stated residents sitting at the same table should be served their meals at the same time.

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F 0602 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Idaho State LTC Reporting Portal System, policy review, record review and staff interview, it was determined the facility failed to ensure resident's rights were protected to be free from misappropriation of residents' funds. This was true for 1 of 3 residents (Resident #39) whose record was reviewed for misappropriation. This deficient practice caused emotional and financial harm when Resident #39's personal finances were used by a facility staff member. Findings include: Resident #39 was admitted to the facility on [DATE] with multiple diagnoses including a left pubic fracture, dementia, and depression. Resident #39's admission MDS assessment dated [DATE], documented Resident #39 was cognitively intact. An I&A, dated 12/4/25, was submitted to the Idaho State LTC Reporting Portal System identifying a facility staff member had stolen $1900 from Resident #39.The report documented on 12/4/25 at 11:30 AM, the Executive Director (ED) was contacted by the Boise Police Department regarding the status of an ongoing investigation into suspected financial exploitation involving a former short-stay rehabilitation resident, [Resident #39]. The investigating officer reported the police department had obtained documentation confirming [CNA #2] had used [Resident #39's] credit card to pay their personal rent and utility bills.The I&A further documented, the June 2025 incident, when [Resident #39s] family notified the facility of unexplained and unauthorized activity on the resident's credit card statement. At the time of the family's concern, the resident had recently completed a short-stay rehabilitation stay at the facility from 6/1/25 through 7/2/25. The family expressed concern the activity may have occurred during the resident's stay but were unsure due to complex family dynamics. The ED immediately assisted the family in contacting law enforcement and filing a formal police report.On 12/4/25, law enforcement informed the ED they had secured evidence linking the unauthorized charges, totaling $1,900, directly to [CNA #2]. The ED informed the family of the findings and reaffirmed the facility does not tolerate any form of abuse, neglect, or exploitation. The family stated they would check with the credit card company to confirm whether fraud charges had been removed and would follow up with the ED. The Nursing Home Administrator (NHA) was alerted to the findings immediately.On 12/17/25 at 11:34 AM, the ED stated the facility was unaware any theft had happened regarding CNA #2. He stated Resident #39 had left the facility with his family prior to any police investigations.The ED continued, When the police notified the facility of the theft, we started our internal investigations, staff trainings, and resident reviews for any additional misappropriation which might have occurred. CNA #2 was found by the police, but we have no further information regarding the case. The ED also stated the facility has been in communication with the family to make reparations; however, we cannot do more until we file for the completed case report. When asked why the facility did not address the concerns when the family first notified the facility in June 2025, the ED stated he had directed the family to contact law enforcement to file a report since the family was not sure if the charges had come from the facility or their family. The facility did not conduct any internal facility investigations at the time of the original notification in June 2025.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, it was determined the facility failed to ensure position change alarms were assessed as potential restraints and a consent from the residents' representative and physician's order were obtained prior to installation of the alarms. This was true for 2 of 3 residents (#14 and #22) reviewed for potential restraints. This deficient practice had the potential for harm if the position change alarms were improperly used and if resident's experienced physical deterioration due to lack of movement. Findings include:The State Manual Appendix PP issued 7/23/25, documented if the facility staff choose to implement alarms, they should document their use aimed at assisting the staff to assess patterns and routines of the resident. Use of these devices, like any care planning intervention, must be based on assessment of the resident and monitored for efficacy on an on-going basis.The facility's Falls and Fall Risk, Managing policy revised March 2018, documented:If falling recurs despite initial interventions, staff will implement additional or different interventions or indicate why the current approach remains relevant.If underlying causes cannot be readily identified or corrected, staff will try various interventions based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable.The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling.The use of position alarm will be monitored for efficacy and staff will respond to alarms in a timely manner. 1.Resident #14 was admitted to the facility on [DATE], with multiple diagnoses including Alzheimer's disease with late onset, muscle weakness and hypertension.A Risk for Fall care plan documented Resident #14 had tab alarm, chair, pressure alarm bed as fall prevention device, initiated 8/21/24.Resident #14's record did not include documentation a least restrictive devices were attempted prior to him using the position change alarm. Also, his record did not include an assessment of him using the chair and bed alarm as a potential restraint.On 12/16/25 at 11:38 AM, 12/16/25 at 2:07 PM, and 12/17/25 at 11:14 AM Resident #14 was observed in his wheelchair with a tab alarm attached to the back of his wheelchair, clipped on the back of his shirt. 2. Resident #22 was admitted to the facility on [DATE] with multiple diagnoses including Alzheimer's disease, muscle weakness and hypertension.A Risk for Fall care plan documented Resident #22 had a tab alarm to her bathroom door and tag alarm to her wheelchair initiated 5/6/25.On 12/16/25 at 11:38 AM and 12/18/25 at 5:06 PM Resident #22 was observed in her wheelchair with a tab alarm attached to the back of her wheelchair and clipped on her shirt.Resident #22's record did not include documentation that least restrictive devices were attempted prior to her using the position change alarm. Her record did not include an assessment of her using the chair alarm as potential restraint.On 12/18/25 at 4:25 PM, when asked about Resident #14 and Resident #22 having a tab alarm attached on their wheelchair, the DON stated it comes with some sort of fall risk assessments, residents being impulsive, and sometimes as requested by their representatives. The least restrictive interventions were also used such as providing the resident with soft touch call light or placing them closer to the nurse's station, using the tab alarm was our last resort. When asked about the resident's assessment before placing the tab alarm, the DON stated there was no assessment, only the fall risk assessment was completed. The DON also stated they did not require a consent before placing the tab alarm on the residents.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff and resident interview, it was determined the facility failed to ensure resident's missing personal item was investigated as potential misappropriation of resident's property. This was true for 1 of 1 resident (Resident #34) reviewed for misappropriation of personal property. This failure created the potential for Resident #34 to experience emotional distress due to the loss of a personal item with inherent value. Findings include:Resident #34 was admitted to the facility on [DATE] and readmitted [DATE], with multiple diagnoses including Parkinson's disease (a movement disorder that affects the nervous system), diabetes and hypertension.A Quarterly MDS assessment dated [DATE], documented Resident #34 was cognitively intact.On 12/16/25 at 9:36 AM, Resident #34 stated a ring which was given to her by her grandmother went missing. Resident #34 stated she reported it to the facility and was told they will look for it. Resident #34 stated she was told the ring had not been found yet, and they will keep looking for it.On 12/19/25 at 10:31 AM, when asked to describe her missing ring, Resident #34 stated the ring had three stones, an emerald stone in the middle and two diamonds on the side and set in gold.On 12/17/25 at 2:26 PM, the LSW stated Resident #34 asked her family member to bring the ring to the facility on her birthday at the end of July 2025, and it was reported missing two weeks after it was brought into the facility. The LSW stated they posted a picture of the ring in the facility and looked through Resident #34's room, as well as in the laundry but the ring was not found.An undated telephone text message provided by the ED documented, Also M103 [Resident #34's room] daughters in today and state they brought in a family heirloom ring (resident's grandmother's ring a diamond and emerald ring). They brought it in last Wednesday and on Friday resident told them she had lost it.On 12/17/25 at 3:40 PM the ED was asked if Resident #34's missing ring was investigated, the ED stated they put a signage of the missing ring in the facility for about a month and looked for it in her room and laundry room, but the ring was not found. When asked if CNAs who provided care to Resident #34 and other staff were interviewed, the ED stated, Yes. When asked for the documentation of what was done to look for Resident #34's ring, the ED stated they did look for the ring and staff were interviewed, but he did not have documentation of what they did to look for the missing ring. The ED stated there were no progress notes made and there should have been. He stated, We did all the right things except writing it down.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interview, it was determined the facility failed to ensure resident's MDS assessments accurately reflected their status. This was true for 1 of 1 resident (Resident #6) whose MDS assessment was reviewed. This deficient practice had the potential for negative outcomes if Resident #6 was not assessed and/or monitored due to inaccurate assessments. Findings include:Resident #6 was admitted to the facility on [DATE] and readmitted [DATE] with multiple diagnoses, including heart disease, anemia, and hypertension.Resident #6's MDS assessments documented the following: admission assessment dated [DATE], he had no impairment on his upper and lower extremities Quarterly assessment dated [DATE], he had impairments on both sides of his upper and lower extremities.Resident #6 was observed on the following days as follows: 12/16/25 at 3:05 PM, able to move his both [NAME] while his wheelchair was being push by the staff. 12/17/25 at 10:52 AM, sitting in his wheelchair in the living room of [NAME] House during activity with other residents, with his hand supporting his chin.On 12/18/25 at 2:24 PM, when asked during telephone interview regarding Resident #6's Quarterly MDS assessment of his range of motion dated 9/15/25, the MDS nurse stated she would review the MDS and would call the surveyor back.On 12/18/25 at 4:08 PM, the MDS nurse called back and stated, Resident #6's Quarterly MDS assessment dated [DATE] was mistakenly coded as with impairment on both sides of his upper and lower extremities. The MDS nurse stated it should have been coded as no impairment.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interview it was determined the facility failed to ensure care plans were revised as needed. This was true for 1 of 13 residents (Resident #8) whose record was reviewed for care plan revision. This deficient practice created the potential for harm if the Resident #8 did not receive oxygen treatment as ordered. Findings include:Resident #8 was admitted to the facility on [DATE], and re-admitted on [DATE], with multiple diagnoses including sleep apnea and chronic obstructive pulmonary disease (an ongoing lung condition caused by damage to the lungs).A physician's order, dated 11/12/25, directed staff to provide oxygen at 2 LPM via nasal cannula, at all times for every shift.Resident #8's care plan, dated 11/12/25, directed staff to provide oxygen continuously at 2 LPM via nasal cannula and to provide oxygen monitoring and management.On 12/16/25 at 9:19 AM, Resident #8 was observed lying in bed without an oxygen nasal cannula.On 12/18/25 at 11:36 AM, Resident #8 was again observed lying in bed without an oxygen nasal cannula. When asked where her oxygen nasal cannula was, Resident #8 stated she had not been using it for some time. She did not remember the exact date.On 12/19/25 at 10:14 AM, the ADON stated Resident #8 had been receiving O2 via nasal cannula continuously; however, she had been weaned off it and was using room air with oxygen saturation vitals taken twice per day. The ADON stated the care plan and physician's order had not been updated to reflect the removal of the nasal cannula for room air. The care plan should have been updated to reflect Resident #8's current oxygen treatment.

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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 policy review, observation, and interview, it was determined the facility failed to ensure medications were administered according to professional standards of practice. This was true for 1 of 7 residents (Resident #42) observed during medication administrations. This failed practice created the potential for Resident #42 to experienced adverse effects when her medications were not administered according to physician's order. Findings include: The facility's Administering Medications policy revised April 2019 documented the individual administering the medication checks the label three times to verify the right resident, right medications, right dosage, right time, and right method (route) of administration before giving the medication.Resident 342 was admitted to the facility on [DATE], with multiple diagnose including inflammatory neuropathy (condition that affects the peripheral nerves, leading to symptoms such as weakness, numbness, and pain), anemia and hypertension.A physician's order documented Resident #42 was to receive the following medications: gabapentin 300 mg capsule, one capsule by mouth one time a day for pain, ordered 12/13/25 gabapentin 400 mg capsule, one capsule by mouth at bedtime for pain, ordered 12/12/25On 12/18/25 at 9:21 AM LPN #1 prepared and administered Resident #42's morning medications which included gabapentin 400 mg one capsule.On 12/18/25 at 9:45 AM, LPN #1 reviewed the physician's order of Resident #42's medications. LPN #1 stated she gave the 400 mg gabapentin to Resident #42. LPN #1 stated, I should have given the 300 mg gabapentin.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interview it was determined the facility failed to provide respiratory services. This was true for 1 of 1 resident's (Resident #8) who was reviewed for oxygen and respiratory services. This deficient practice had the potential for Resident #8 to experience shortness of breath when her physician's order was not followed. Findings include:Resident #8 was admitted to the facility on [DATE], and re-admitted on [DATE], with multiple diagnoses including sleep apnea and chronic obstructive pulmonary disease (a lung condition caused by damage to the lungs).A physician's order, dated 11/12/25, directed staff to provide Oxygen at 2 LPM via nasal cannula, at all times for every shift. On 12/16/25 at 9:19 AM, and on 12/18/25 at 11:36 AM, Resident #8 was observed lying in bed without oxygen via nasal cannula. Resident #8 stated she had not been using her oxygen for some time and did not know the exact date it stopped. On 12/19/25 at 10:14 AM, the ADON confirmed the facility was not currently providing 2 LPM of oxygen via nasal cannula at all times as per physician's orders.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, staff interview, and policy review, it was determined the facility failed to ensure medications were secured when they were unattended by staff and to ensure pharmacy labels matched the physician's order. This was true for 1 of 1 resident (Resident #30) whose medication administration was observed. This failed practice created the potential for harm if medications were taken by another resident and should Resident #30's Oxycodone (opioid pain medication) be administered at the wrong dose. Findings include: Resident #30 was admitted to the facility on [DATE], with multiple diagnoses including stage 4 pressure ulcers of left and right heels, and hypertension (high blood pressure).1.On 12/18/25 at 12:05PM, LPN #2 entered Resident #30's room with her medications on hand. Upon entering Resident #30's room, she stated she needed to use the restroom, LPN #2 requested help from CNA to assist Resident #30 to the restroom. LPN #2 exited room with medications in hand along with dirty dishes. Upon exiting Resident #30's room, LPN #2 was observed leaving a cup containing a white powder on top of the medication cart. LPN #2 brought dirty dishes to the kitchen and returned to the medication cart. LPN #2 then took the cup with the white powder into the kitchen and mixed it with water, LPN #2 walked back to the medication cart, placing the cup containing the white powder mixed with water on top of the medication cart when a male resident asked her what soup was being served for lunch. LPN #2 was observed leaving the cup containing the white powder mixed with water on top of the medication cart and returned to the kitchen to check the menu for the male resident.On 12/18/25 at 12:15 PM when asked about the cup containing the white powder mixed with water left on top of the medication cart when she went to the kitchen to check the menu, LPN #2 stated, no Miralax (laxative used to treat occasional constipation). When asked if nursing staff was supposed to leave Miralax on top of the medication cart, LPN #2 states, No.On 12/19/25 at 10:55 AM, when asked if nurses were to leave medications unattended on top of the medication cart, the DON stated, No. 2. The facility's Labeling of Medication Containers Policy revised April 2019, documented any medication packaging inadequately or improperly labeled are returned to the issuing pharmacy. A physician's order documented Resident #30 was to receive the following: Oxycodone HCl 5 mg tablet: 0.5 tablet by mouth twice daily [6 AM and 12 PM] Oxycodone HCl 5 mg tablet: 0.5 tablet by mouth twice daily as neededOn 12/18/25 at 12:20 PM, LPN #2 prepared and administered Resident #30's medication which included the Oxycodone. The Oxycodone IR pharmacy label documented Give 0.5 tablet by mouth four times daily as needed.On 12/18/25 at 12:35 PM, when asked about the physician's order for Resident #30's Oxycodone, LPN #2 stated Resident #30 had scheduled and as needed orders for Oxycodone. When asked if the order was the same on the pharmacy's label LPN #2 stated, No. When asked what the policy was for labeling when orders change, LPN #2 stated, put an order change sticker on it. No order change sticker was observed on the medication card.On 12/19/25 at 10:55 AM, when the DON was asked if physician orders and pharmacy card labels were to match, the DON stated, Yes it should, when a provider changes the order, the pharmacy should send a new card to match. The DON stated, if nursing staff finds a pharmacy label does not match the MAR the nurse is to call the pharmacy to get a new card dispensed.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, the FDA Food Code, and staff interview, it was determined the facility failed to ensure food items were appropriately labeled, dated, and covered, dish racks and air condenser refrigerator fans were cleaned and sanitized. These deficiencies had the potential to affect the 36 residents who consumed food prepared by the facility. This placed residents at risk for potential contamination of food and adverse health outcomes, including food-borne illnesses. Findings include: Based on observation, the FDA Food Code, and staff interview, it was determined the facility failed to ensure food items were appropriately labeled, dated, and covered, and dish racks, air condenser refrigerator fans were cleaned and sanitized. These deficiencies had the potential to affect the 36 residents who consumed food prepared by the facility. This placed residents at risk for potential contamination of food and adverse health outcomes, including food-borne illnesses. Findings include: 1. The FDA Food Code Section 3-302.11 Packaged and Unpackaged Food - Separation, Packaging, and Segregation documented, food shall be protected from cross contamination by separating raw animal foods during storage, preparation, holding, and display from raw ready-to-eat foods including other raw animal food such as fish. The FDA Food Code Section 3-501.17 Ready-to-Eat, TCS (time/temperature control for safety) food, date marking, documented marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded.On 12/18/25 at 4:18 PM, the following was observed in the walk-in meat refrigerator and freezer: Refrigerator: Salmon open and uncovered, stored below raw beef. Undated, unlabeled seared cooked beef stored below raw beef. Freezer: Open and undated chicken wings, chicken tenders, and frozen scones. Uncovered shrimp cocktail, cooling from recent cooking. On 12/18/25 at 4:22 PM, the Kitchen Manager stated the food should have been covered, labeled, and dated. He further stated cooked food should be stored above raw food, and raw fish should be stored above raw beef, and it was not. 2. The FDA Food Code Section 4-501.12 Cutting Surfaces documented cutting surfaces such as cutting boards and blocks that become scratched and scored may be difficult to clean and sanitize. As a result, pathogenic microorganisms (tiny living things including bacteria, viruses, and fungi) transmissible through food may build up or accumulate. These microorganisms may be transferred to foods that are prepared on such surfaces. On 12/18/25 at 4:25 PM, it was observed in the main kitchen a white cutting board with colored stains and pitting. On 12/19/25 at 9:39 AM, during a walk through of the storage areas for [NAME], Maple, and Redwood Houses, cutting boards in the 3 houses had discoloration and pitting in the middle of multicolored boards. On 12/19/25 at 10:04 AM, the Kitchen Manager stated the cutting boards were discolored and pitted and should have been replaced. 3. The FDA Food Code Section 4-602.11 Equipment Food-Contact Surfaces and Utensils documented microorganisms may be transmitted from a food to other foods by utensils, cutting boards, thermometers, or other food-contact surfaces. Food-contact surfaces and equipment used for time/temperature control for safety foods should be cleaned as needed throughout the day but must be cleaned no less than every 4 hours to prevent the growth of microorganisms on those surfaces. On 12/18/25 at 4:00 PM, the following was observed: The condenser fan covers in the walk-in produce refrigerator had a layer of dust blowing out from fans. The clean pot and pan drying rack next to the walk-in meat refrigerator and clean side of the dishwashing area had a layer of dust on the racks surrounding the clean pots, pans, and utensils. On 12/18/25 at 4:02 PM and 4:18 PM, the Kitchen Manager stated whenever covers are seen with dust, we will put in a work order for maintenance to remove them and we missed these fan covers. The kitchen manager also stated they had not cleaned or sanitized the dish drying racks in some time as they were working through the refrigerator racks first. We should have cleaned and sanitized these racks long before they developed a layer of dust. On 12/18/25 at 4:58 PM, during dinner tray line observation at [NAME] House, the following was observed: At 5:15 PM, [NAME] #1 placed food containers on top of the cutting board and knife used for chopping foods for mechanical chopped diets. At 5:17 PM, [NAME] #1 removed the food containers and chopped up vegetables and cooked chicken without cleaning or sanitizing the cutting board and knife. At 5:19 PM, [NAME] #1 placed a sauce container back onto the cutting knife, on top of the cutting board to serve sauce on top of the chicken and vegetables. He then placed the sauce container back into the heating cart. [NAME] #1 did not clean or sanitize the cutting board and knife. At 5:20 PM, [NAME] #1 placed a drinkable straw on the same cutting board as listed above, filled up the cup with liquid food, and then placed the drinkable straw into the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135141	A. Building B. Wing	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Terraces of Boise, The	5301 E Warm Springs Ave Boise, ID 83716

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interview it was determined the facility failed to ensure sanitary laundry services were provided to the residents, hand hygiene was performed by facility staff, and medication was stored appropriately. This deficient practice had the potential for harm if facility residents were provided laundry, staff cares, and medications which were not handled with appropriate sanitation practices. Findings include: 1. On 12/17/25 at 2:35 PM, it was observed in Redwood House's laundry room, Resident #18's laundry was left wet in the washing machine. On 12/17/25 at 2:37 PM, RN #1 stated Resident #18's laundry would not have been washed earlier than 10:00 AM as CNAs will sometimes do laundry during the day if a resident requires it. She stated, the facility has a shift change at 2:00 PM in the afternoon, so the laundry would not have been waiting wet more than 4 hours. RN #1 could not provide an exact time the laundry had been started as the day shift CNAs were no longer available and there is no tracking system to know which CNA started the load of laundry. On 12/17/25 at 2:45 PM, it was observed in [NAME] House's laundry room clothes were hanging from a rack on the clean and dirty sides of the laundry room. On 12/17/25 at 2:48 PM, CNA #3 stated, Clothes hanging up on either side of the laundry room would be considered by CNA's to be clean and just waiting to be taken to the resident's room. On 12/17/25 at 3:15 PM, it was observed in Maple House's laundry room, Resident #30's wet laundry was left sitting in the washing machine. On 12/17/25 at 3:15 PM, the Housekeeping Lead stated wet laundry should be changed within an hour. On 12/17/25 at 3:24 PM, the ED stated, The side with the washers is dirty - but clothes hanging next to the outer wall hanging up could be clean. However, the dirty side should only be for dirty clothes. He further stated there is no current way to tell when the washing machine was started or how long the laundry had been sitting in the washing machines ready to move to the dryer. The ED stated CNAs train other CNAs how to do residents laundry and they should not be hanging clothes on the dirty side if they are clean. On 12/17/25 at 4:59 PM, the DON/IP stated the change of shift (between day and afternoon) might make it longer between loads (wash to dryer) but the DON/IP would not expect wet laundry to wait more than 2 hours before moving it to the dryer. She further stated clean laundry should remain on the clean side of the laundry room, not on the dirty side. On 12/17/25 at 3:29 PM, staff were observed walking into the clean side door of the main laundry room with 2 bags of dirty linen. On 12/17/25 at 3:33 PM, the Housekeeping Lead stated the staff member should have walked into the dirty side with those laundry bags. She will need to be trained. (continued on next page)

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	135141	A. Building B. Wing	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Terraces of Boise, The	5301 E Warm Springs Ave Boise, ID 83716

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. On 12/18/25 at 8:45 AM, RN #1 was observed for morning medication pass. RN #1 performed hand hygiene at 8:59 AM and began to prepare medications for Resident #43. At 9:12 AM, RN #1 entered Resident #43's room. No hand hygiene observed upon entrance to Resident #43's room. RN #1 administered medications to Resident #43, performed hand hygiene and exited the room. When asked when hand hygiene is performed, RN #1 stated, Before and after. It's difficult with a med cup and water in hand. When asked if RN #1 performed hand hygiene before entering resident #43's room RN #1 stated, I did not perform hand hygiene. 3. On 12/18/25 at 8:43 AM, five capsules were observed on top of the medication cart. There was no barrier between the five capsules and top of the medications cart, and LPN #1 was about 3-4 steps away from her medication cart talking to the ST. As soon as LPN #1 saw the surveyor, LPN #1 walked back to her cart and opened the capsule and placed them inside the pill pouch. On 12/18/25 at 9:11 AM, when asked about the capsules on top of the medication cart, LPN #1 stated she should have put the capsules inside the medication cup.