NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
Gables Assisted Living and Memory Care of Caldwell	RC-1230	917 E Ustick Road	(208) 455-2324
Administrator	City	Zip Code	Survey Date
Derek Westover	Caldwell	83605	12/01/2021
Survey Team Leader	Survey Type		Response Due
LeMaster, Veronica	Health Care Initial Licensure + complaint investigation		12/31/2021

Item #	Rule (16.03.22)	Description
1	.009.01. Criminal History and Background Check.	One of seven employees, whose personnel records were reviewed, did not have a Department Criminal history and background check. Upon interview with the assistant administrator, it was confirmed the Department Criminal history and background check was not completed.
2	.100.04. License Responsibility	Derek Westover, who was on record as the facility's current administrator, had a license that expired on 10/7/21, according to The Division of Occupational and Professional Licenses. Derek stated he was unaware that his license had expired.
3	.152.03.a.ii. Policies of Acceptable Admissions.	The facility utilized an outside agency caregiver to provide 1:1 care and supervision for Resident #6, for which they did not arrange services. The family arranged for the service and paid the caregiver directly. The administrator confirmed the family arranged this service and paid the private-duty caregiver directly.
4	.215.08.b. Investigation within Thirty Days.	The administrator did not conduct an investigation within 30 days when residents had falls. For example: Resident #4's fall on 11/6/20, Resident #5's fall on 6/16/21, Resident #6's fall on 7/7/21, Resident #8's fall on 6/17/21 and Resident #10's fall on

		7/30/21. The administrator confirmed investigations had not been completed after these incidents.
5	.215.08.e. Corrective Action.	The administrator did not ensure appropriate corrective actions were put into place to prevent recurrence of falls for Residents #5 and #6. Resident #5 fell on 6/16/20 and 9/10/20 and the administrator did not implement interventions to prevent recurrences. Resident #6 fell on 5/21/21, 6/4/21 and 6/10/21. The administrator documented after each of Resident #6's falls they were to be provided with additional supervision to prevent further falls. The incident reports for Resident #6 for 6/4/21 and 6/10/21 falls, documented the resident was found on the floor and was not provided with additional supervision during those falls. The administrator confirmed the interventions were not followed.
6	.215.08.f. Notification to Licensing Agency within One Business Day.	The facility did not notify Licensing and Certification after Resident #2 eloped from the facility on 8/3/21. The facility also did not notify Licensing and Certification after unsampled residents had incidents which required outside treatment and assessment on 12/2/20, 6/13/21 (two incidents) and 8/17/21. The administrator confirmed the incidents had not been reported to Licensing and Certification.
7	.250.13. Secure Environment.	The facility had residents with cognitive impairments who were at risk for elopement and did not provide a secure environment. For example: multiple caregivers stated Resident #1 resided in the assisted living area of the facility between August 2021 and October 2021 and the resident was very confused and would not be safe outside of the facility unsupervised. A mini-mental assessment dated 8/8/21, documented the resident scored a 5 of 30 which meant they were very confused. Resident #2 eloped from the memory care unit multiple times between July 2021 through September 2021. Multiple caregivers stated the resident eloped from the unit by going through a window, a gate, and when they were left unsupervised by caregivers. The administrator stated the

		facility retained Resident #1 and #2 too long, and the facility should have discharged the residents sooner because they were at risk for elopement.
8	.305.03. Resident Health Status*	The facility nurse did not conduct nursing assessments when residents experienced changes in physical or mental health status. For example, after Residents #6 and #8 experienced falls or after Resident #7 had a pressure ulcer on his coccyx. The facility administrator stated the residents were not assessed after they experienced a change in their condition.
9	.330.06.a. Behavior Documentation*	The facility did not evaluate Resident #7's behaviors of going into other residents' rooms, grabbing staff, pushing staff, kicking staff or pinching staff. The facility administrator confirmed the facility did not complete a behavior assessment for Resident #7.
10	.330.06.b. Behavior Documentation*	The facility did not develop a behavior plan that included specific interventions for Resident #7. See examples in non-core punch 330.06.a. The administrator confirmed the facility had not developed specific interventions for Resident #7's behaviors.
11	.330.13.e. Personnel Records*	Seven of seven staff member files reviewed did not contain documentation of 16 hours of orientation training. Two of seven staff member files reviewed did not have documentation of infection control training. The administrator and assistant administrator both stated the staff members received the trainings but the trainings were not documented. During the survey, several staff members stated they received adequate training before working alone at the facility during their orientation.
12	.335. REQUIREMENTS FOR INFECTION CONTROL.	The facility did not follow the Centers for Disease Control and prevention (CDC) recommendations for Covid-19, when caring for the residents, to prevent transmission of this infectious disease. For example: From 11/29/21 to 12/1/21, several staff members were observed wearing their mask below their noses and on their chins, multiple visitors entered the facility without

		being screened for symptoms or encouraged to wear a mask. The administrator stated when nobody was at the front desk, visitors could enter the facility without being screened for COVID-19 symptoms.
13	.645.01.a. Training Requirements*	One of four medication technicians, who administered medications to residents, was not certified to pass medications by an approved medication certification class. The assistant administrator verified the staff had been administering medications to residents without completing an approved medication certification class.