NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
Heritage Assisted Living and Memory Care	RC-1227	622 Filer Avenue West	208-733-9064
Administrator	City	Zip Code	Survey Date
Bianca Henderson	Twin Falls	83301	12/15/2021
Survey Team Leader	Survey Type		Response Due
Moss, Tom	Health Care Initial Licensure		01/14/2022

Item #	Rule (16.03.22)	Description
1	.215.07. Notification to Adult Protection and Law Enforcement.	The administrator failed to report an allegation of exploitation to Adult Protection after Resident #6 informed her two thousand dollars was missing from their room during the first week of November 2021. The administrator confirmed she did not notify Adult Protection after Resident #6 informed her of the missing money.
2	.215.08.b. Investigation within Thirty Days.	The administrator did not conduct an investigation within 30 days after Resident #6 reported to the administrator during the first week of November 2021 they were missing two thousand dollars. The administrator stated they did not complete a thorough investigation after learning the resident reported the missing money.
3	.250.14. Call System.	The facility utilized a two-way intercom call system which allowed facility staff to listen to residents in their rooms without their knowledge. Rule 16.03.22.010.15 documents call systems cannot be configured in such a way to breach a resident's right to privacy in their living quarters. The administrator confirmed facility staff could hear residents in their rooms without their knowledge.
4	.260.06. Toxic Chemicals.	The facility was not maintained in a clean,safe and orderly

		manor. For example: The memory care courtyard was observed to have several tables and chairs which were rusty and damaged, the sidewalk had several raised areas, and a crawl space ventilation guard was bent. Several areas of carpet in the common hallway of memory care were observed to have stains, a resident toilet was observed to have feces on the side and handrail of toilet and the floor behind toilets in several rooms were observed to be dirty. Trash bins in several resident rooms were observed to contain soiled briefs. Baseboards and tops of wainscoting was observed to have dust and grime. The base of the water faucet in the common area sink was observed to have a large amount of water deposits. A table in the memory care dining room was observed to have an area of peeling on the surface. Doors leading to memory care were observed to be scratched, gouged and were dirty. The front concierge desk in assisted living was observed to be scratched and have peeling paint. ***Previously cited on 7/10/20***
5	.305.06. Self-Administered Medication*	Residents #2 and #5 self injected their insulin and the nurse had not completed assessments to ensure they were safe to do so. The facility nurse confirmed the residents had not been assessed to ensure they could self inject their insulin safely. Also, Resident #5, who had an order for a set dose of insulin twice daily, changed their dose of insulin which they administered to themselves, based on their blood sugar reading, and the facility nurse stated she had not assessed Resident #5 to ensure they were capable of doing so safely.
6	.330.04.c.vii. Resident Care Records*	The facility did not document all change of condition assessments. For example: Resident #3 was documented by staff to have nausea and abdominal cramping on 9/19/21, Resident #9 was noted on 8/22/21 by caregivers to have redness and soreness on their buttocks and was pale and vomiting on 7/23/21. The facility nurse stated she had assessed all of these issues but had not documented her

		assessments.
7	.330.06.a. Behavior Documentation*	The facility did not evaluate Resident #6's behaviors of yelling and cursing at caregivers or refusing showers. The administrator confirmed the facility had not completed an evaluation of Resident #6's behaviors.
8	.330.06.b. Behavior Documentation*	The facility did not develop a behavior plan that included specific interventions for Resident #6, see examples in non-core punch 330.06.a. The administrator confirmed the facility had not developed specific interventions for Resident #6's behaviors.
9	.600.04.a. Sufficient Personnel*	The administrator did not schedule sufficient personnel during all hours to meet the needs of the residents. Multiple residents stated there were extensive wait times for call lights to be answered, and their needs were not being met as outlined in their Negotiated Service Agreements, such as trash being removed from their rooms daily and their beds being made on a daily basis. One resident stated they waited so long for their call light to be answered to be assisted to the bathroom, they had an episode of fecal incontinence. Another resident stated they had to wait over three hours for an as-needed medication they requested. Caregivers, who worked on the assisted living side of the building, stated the facility had been short staffed, and as a result, residents had to wait long periods of time for assistance after they pressed their call pendants. The caregivers stated they had worked with only two medication technicians to assist fifty-three residents in the assisted living side of the building, which made it difficult to assist residents with their needs. The administrator stated the facility had been struggling to hire staff, and she is in the process of hiring more staff.