PLAN OF CORRECTION

Edgewood Spring Creek American Falls, LLC
605 Hillcrest Avenue
American Falls ID 83211

Provider ID: RC-1005

On 01/05/2022, a Health Care Licensure and Follow-Up survey was conducted by Department staff at Edgewood Spring Creek American Falls, LLC. As a result of the survey, core issue deficiencies were cited with the following plan of correction.

**Rule Violation** .520-10 Inadequate Care - Resident Rights*

Describe what corrective actions will be accomplished for those residents/personnel/area found to have been affected by the deficient practice.

Resident #1 discharged from the community to a secured facility located in Twin Falls, ID. This occurred on 1/11/2022.
Resident #2 has been evaluated and assessed in collaboration with nursing, Hospice services and the physician related to history of behaviors prior to admission to this community, current use of medications – including clear indications and status. A behavior management plan has been developed for this resident which includes clear non-drug interventions for direct care staff to follow. The Negotiated Service Plan (NSA) has been updated to reflect these changes.

Describe how the provider will identify other residents/personnel/areas having the potential by the same deficient practice and what corrective action(s) will be taken.

Residents assessed to be at risk for elopement will be evaluated for appropriate placement and retention. Alternative placement will be sought as indicated. Residents prescribed psychoactive medications will be evaluated for clear indication and appropriate usage. If prescribed prior to admission, the nursing assessment will include a review of behavior history and indication with interventions developed as indicated. A behavior plan will be developed as indicated that will provide non-drug interventions for direct care staff. Medication indications for psychotropic and narcotic usage will be evaluated by the licensed nurse for appropriateness and directives for medication assistants.
In-service education will be provided to nursing staff on assessments, behavior management plans, and requirements when psychoactive medications are indicated by the Regional Nursing Director.
Education will further be provided to care staff on behavior management plans with emphasis on non-drug interventions prior to seeking medication intervention. Finally, education will be provided to medication assistants on clear use of PRN medications and indications for use.

Describe how the corrective action will be monitored to ensure the deficient practice does not recur (QA program).

The facility nurse or designee will observe a medication pass at least twice monthly for 3 months to observe and ensure that medications are given based on the correct indication, behavior plans are followed – including non-drug interventions and PRN (as needed) medications are provided only as indicated prior to administration and communicated to the facility nurse.
The administrator or designee will review at least 5 residents monthly for 3 months and confer with the facility nurse to determine that they remain appropriately placed and current needs are being met effectively.
The Regional Nursing Director or designee will review at least 5 residents/records monthly for the next

three months and observe for compliance with medication usage – including indication and documentation. Further observations will include need for a behavior plan and effective execution of the plan. Finally, this review will also validate appropriate placement and adequate assessment. Any concerns will be addressed with the administrator and facility nurse immediately with actions taken as indicated.
The Regional Nursing Director, administrator and facility nurse will review the QA plan after three months and determine if further targeted monitoring is required.

Date when corrective action will be completed.

February 16, 2022

Program Comments

**Rule Violation** .520-11 Inadequate Care - Acceptable Admission and Retention*

Describe what corrective actions will be accomplished for those residents/personnel/area found to have been affected by the deficient practice.

Resident # 1 discharged from the community on 1/11/2022 to a secure Memory Care facility out of the area.

Describe how the provider will identify other residents/personnel/areas having the potential by the same deficient practice and what corrective action(s) will be taken.

Residents assessed to be at risk for elopement will be evaluated for appropriate placement and retention. Alternative placement will be sought as indicated. Additionally, the community will be removing the key-pad lock on the main entrance door. The doors will be secured during nighttime hours, but during the day, the main entrance will not be secured as previously.
The facility nurse and Regional Nursing Director will review other residents identified to be at risk for inappropriate retention based on assessment risk and compared to IDAPA regulations. Actions for alternative placement will be secured if indicated.
Prior to admission, a clinical assessment will be completed to determine appropriateness of placement and ability to meet the resident's needs including, but not limited to risk of elopement. If indicated and the admission is determined to be appropriate, the plan of care will be established to effectively meet the resident's needs.

Describe how the corrective action will be monitored to ensure the deficient practice does not recur (QA program).

The Regional Nursing Director or designee will review at least 5 residents/records monthly for the next three months and observe for appropriateness of retention. This review will also validate appropriate placement and adequate assessment related to risk of elopement and other factors related to retention per IDAPA regulations. Any concerns will be addressed with the administrator and facility nurse immediately with actions taken as indicated.
The Regional Nursing Director, administrator and facility nurse will review the QA plan after three months and determine if further targeted monitoring is required.

Date when corrective action will be completed.

February 16, 2022

Program Comments

# NON-CORE ISSUES

| Facility | License # | Physical Address | Phone Number |
|---|---|---|---|
| Edgewood Spring Creek American Falls, LLC | RC-1005 | 605 Hillcrest Avenue | 208-226-1856 |
| Administrator | City | Zip Code | Survey Date |
| Joyce Foster | American Falls | 83211 | 01/05/2022 |
| Survey Team Leader | Survey Type | | Response Due |
| Perry, Bradley | Health Care Licensure and Follow-Up | | 02/04/2022 |

| Item # | Rule (16.03.22) | Description |
|---|---|---|
| 1 | .215.01. Administrator Responsibility. | The administrator did not ensure the facility's policies were implemented. For example, there were discrepancies in the controlled substance count for five separate residents in December 2021. The facility's policy on "Discrepancies-Controlled Substances" was not followed, including but not limited to: the licensed nurse or Executive Director was to conduct another count of the controlled substance and compare it to the "Narcotic Book," an investigation by the licensed nurse or Executive Director was to be completed, including "interviewing all staff who may have had access to the controlled substance after the last correct count was taken," and law enforcement was to be notified if the investigation verified the medications were missing. The administrator did not ensure the facility's "PRN Use and Psychoactive/Psychotropic Medication" policy was carried out when Resident #1 was given Norco for agitation in October, November and December 2021 when it was prescribed for back pain. The policy documented all PRN (as-needed) medications "will be administered ONLY for its prescribed use." |

| | | |
|---|---|---|
| 2 | .215.05. Responsibility for Acceptable Admissions. | The facility admitted and retained Resident #1, who required a secure environment due to a history of elopement in November 2021 and multiple, subsequent attempts at elopement and exit-seeking behaviors. The facility was provided technical assistance on 9/12/19 to "decide on the population of your facility. There cannot [be] a mixed population of residents who need a secured environment with residents who do not." |
| 3 | .215.08.b. Investigation within Thirty Days. | The facility did not conduct investigations when residents' controlled substance counts were inaccurate. For example, Resident #1 was missing one tablet of Norco on 12/27/21, and Resident #7 had a tablet of lorazepam missing on 1/3/22. An unsampled resident had three controlled substance tablets missing in December 2021, and two other unsampled residents had one tablet each of their controlled substances missing in December 2021. The facility nurse and administrator stated no investigations of these missing controlled substances had been completed. ***Previously cited on 1/19/21*** |
| 4 | .260.04. Linen and Laundry Facilities and Services. | The facility did not maintain an environment free of insects when bedbugs were observed by surveyors in the facility in room #1. A staff member stated rooms #1 and #3 had active bedbug infestations. |
| 5 | .305.02.b. Current Medication Orders and Treatment Orders* | The facility nurse did not ensure residents received their medications as ordered. For example, Resident #7 did not receive their Carvedilol for their blood pressure as ordered two times in November 2021 and one time in December 2021 nor their paliperidone, an antipsychotic medication, four times in November 2021 and one time in January 2022. The nurse confirmed Resident #7 did not receive their medications as ordered. ***Previously Cited 01/19/21*** |
| 6 | .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, when Resident #1, a confused resident who was unable to ask for their medications, experienced |

| | | |
|---|---|---|
| | | increased agitation, and the medication technicians administered Haldol and Norco without calling the facility nurse to ask permission to give these medications on 19 occasions between October and December 2021. The facility nurse stated she was not consistently contacted by medication technicians prior to administering these PRN medications to Resident #1. |
| 7 | .310.01.a. Medication Distribution. | During survey on 1/4/22 and 1/5/22, the medication room door was observed open multiple times with an unlocked medication refrigerator inside, which contained insulin and other resident medications. |
| 8 | .310.01.c. Medication Distribution. | The facility's medication refrigerator temperatures were not maintained between 38 and 45 degrees F on 28 of 31 occasions in December 2021. The facility's "clean and temperature of medication fridge log" documented the medication refrigerator was between 31 and 35 degrees 28 times during the month of December 2021. The refrigerator contained residents' medications including insulin. |
| 9 | .310.04.a. Behavior Modifying Medication. | The facility did not attempt non-drug interventions prior to requesting psychotropic medications for Resident #1 and #2. Resident #1's record documented the medications Seroquel, Haldol and Norco were initiated to address their behaviors of eloping, hitting caregivers and scratching caregivers. Seroquel was initiated for Resident #2's behavior of defecating while being assisted to transfer. Neither Resident #1 nor #2's records contained documentation the facility attempted non-drug interventions prior to the use of the behavior modifying medications. Caregivers, the facility administrator and facility nurse all confirmed non-drug interventions were not attempted prior to the use of the behavior modifying medications. |
| 10 | .310.04.e. Psychotropic or Behavior Modifying Medication. | Resident #5 was taking sertaline and did not have six month psychotropic medication reviews completed. The facility nurse stated they had been working at the facility for over six |

| | | |
|---|---|---|
| | | months and had not completed any residents' six month psychotropic medication reviews. ***Previously cited on 8/23/16*** |
| 11 | .320.03. Signature, Date, and Approval of Agreement. | NSAs were not signed and dated by parties for Residents #2, #4, #5 and #7. The administrator confirmed they were not signed by all responsible parties. The facility was provided technical assistance on 8/23/16, 9/12/19, and 3/11/21 to ensure NSAs were signed by all parties. |
| 12 | .330.06.a. Behavior Documentation* | The facility did not evaluate Resident #1's behaviors of yelling and scratching caregivers and eloping from the facility nor Resident #2's behavior of urinating on the floor or intentionally defecating while being assisted to transfer. The administrator and facility nurse both stated the facility had not completed an evaluation of Resident #1 and #2's behaviors. ***Previously cited 01/19/21*** |
| 13 | .330.06.b. Behavior Documentation* | The facility did not develop a behavior plan that included specific interventions for Resident #1 and #2, see examples in non-core punch 330.06.a. The administrator and facility nurse both stated the facility had not developed behavior plans with specific interventions to address Resident #1 or Resident #2's behaviors. ***Previously Cited 01/19/21*** |
| 14 | .335. REQUIREMENTS FOR INFECTION CONTROL. | The administrator did not ensure recognized standards, which control and prevent infections for both staff and residents, were implemented throughout the facility. For example: staff placed medications in their bare hand prior to administering them to residents, staff did not wash their hands with soap and water after changing a resident's adult brief who had diarrhea, and when staff members touched multiple surfaces with gloved hands and then touched ready-to-eat foods for residents. |

# CORE ISSUES

| Facility | License # | Physical Address | Phone Number |
|---|---|---|---|
| Edgewood Spring Creek American Falls, LLC | RC-1005 | 605 Hillcrest Avenue | 208-226-1856 |
| Administrator | City | Zip Code | Survey Date |
| Joyce Foster | American Falls | 83211 | 01/05/2022 |
| Survey Team Leader | Survey Type | | Response Due |
| Perry, Bradley | Health Care Licensure and Follow-Up | | 01/15/2022 |

| Item # | Rule (16.03.22) | Description |
|---|---|---|
| 2 | .520-10 Inadequate Care - Resident Rights* | Based on interviews, observations and record review, it was determined the facility did not promote the rights of 2 of 7 sampled residents (Residents #1 and #2) to be free from chemical restraints and to be treated in a dignified, humane manner. The findings include:<br><br>IDAPA 16.03.22.010.16. A chemical restraint is defined as, "A medication used to control behavior or to restrict freedom of movement and is not a standard treatment for the resident's condition."<br><br>IDAPA 16.03.22.010.20.d. A core issue is defined as "Inadequate care."<br><br>IDAPA 16.03.22.011.05. Inadequate care is defined as, "When a facility fails to provide...a safe living environment, engages in violations of resident rights, or takes residents who have been admitted in violation of the provisions of Section 152 of these rules." |

| | | |
|---|---|---|
| | | IDAPA 16.03.22.011.11. Maladaptive behavior is defined as, "Any behavior that interferes with resident care, infringes on any resident's rights, or presents a danger to the resident or others…"<br><br>IDAPA 16.03.22.310.04.a documents, "Psychotropic or behavior modifying medication intervention must not be the first resort to address behaviors. The facility must attempt non-drug interventions to assist and redirect the resident's behavior."<br><br>IDAPA 16.03.22.319.04 documents, prior to admission, "The facility must complete assessment information…maladaptive behaviors including: a. The resident's behavioral history, including any history of traumatic events. b. The intensity, duration, and frequency of each maladaptive behavior. c. Potential contributing environmental factors, such as heat, noise, or overcrowding. d. Any specific events that can trigger maladaptive behaviors. e. Potential contributing health factors, such as hunger, pain, constipation, infection, medications side effects; and f. Recent changes in the resident's life, such as a death in the family or changes in care."<br><br>IDAPA 16.03.22.330.06.b documents, "For residents who exhibit maladaptive behaviors, behavior management records must be maintained in the resident record including...a behavior plan that includes at least one (1) intervention specific to each maladaptive behavior."<br><br>IDAPA 16.03.22.520 documents, "The administrator must ensure that policies and procedures are developed and implemented to ensure that all residents are free from inadequate care..." |

| | | |
|---|---|---|
| | | IDAPA 16.03.22.550 documents, "The administrator must ensure that policies and procedures are developed and implemented to ensure that residents' rights are observed, promoted and protected."<br><br>IDAPA 16.03.22.550.03 documents, "Each resident has the right to humane care…Each resident has the right to be treated with dignity and respect…"<br><br>IDAPA 16.03.22.550.10 documents, "Each resident must have the right to be free from…chemical restraints."<br><br>The facility's "PRN and Psychoactive / Psychotropic Medication" policy, dated August 2020, documented "PRN medications, including psychoactive and psychotropic medications will be administered ONLY for its prescribed use...When a current physician order prescribed PRN medication, the order must specify the following: a. An objective description, written in lay terms, of the condition or behavior that indicates possible need to use."<br><br>The facility's August 2020 "Elopement Risk Prevention/Missing Resident" policy documented, under the "Intervention" section, "restraints are not to be used."<br><br>Medications:<br><br>Haldol (haloperidol): Drug class: First Generation Antipsychotic. According to PDR.net, for geriatric patients, the website documents the following: "Geriatric patients may be more susceptible than younger adults to the adverse effects of haloperidol, including tardive dyskinesia, dystonias, orthostatic hypotension, prolonged QT interval, and falls and fractures….Antipsychotics are not approved for the treatment |

| | | |
|---|---|---|
| | | of dementia-related psychosis in geriatric patients and use of haloperidol in this population should be avoided if possible due to an increase in morbidity and mortality in geriatric patients with dementia receiving some antipsychotics…The Beers Criteria consider antipsychotics to be potentially inappropriate medications in elderly patients except for treating schizophrenia, bipolar disorder, and nausea/vomiting during chemotherapy. The Beers panel recommends avoiding antipsychotics in geriatric patients with delirium, dementia, or Parkinson's disease. Non-pharmacological strategies are first-line options for treating delirium- or dementia-related behavioral problems…"<br><br>Norco (acetaminophen-hydrocodone): Drug class: Opioid agonist. According to PDR.net, for geriatric patients, the website documents the following: "Use hydrocodone with caution in geriatric or debilitated patients. Geriatric or debilitated patients are more susceptible to adverse reactions, especially sedation and respiratory depression, probably as a result of the altered distribution of the drug or decreased elimination…According to the Beers Criteria, opiate agonists are considered potentially inappropriate medications (PIMs) in geriatric patients with a history of falls or fractures and should be avoided in these patient populations, except in the setting of severe acute pain, since opiates can produce ataxia, impaired psychomotor function, syncope, and additional falls…The federal Omnibus Budget Reconciliation Act (OBRA) regulates medication use in residents of long-term care facilities (LTCFs). OBRA cautions that opioids may cause constipation, nausea, vomiting, sedation, lethargy, weakness, confusion, dysphoria, physical and psychological dependency, hallucinations, and unintended respiratory depression, especially in individuals with compromised pulmonary function. These adverse effects can lead to other |

| | | |
|---|---|---|
| | | consequences such as falls."<br><br>Risperdal (risperidone): Drug class: Serotonin-Dopamine Antagonist (SDA) Antipsychotic. According to PDR.net, for geriatric patients, the website documents the following: Antipsychotics, including risperidone, are not approved for the treatment of dementia-related psychosis in geriatric patients. All atypical antipsychotic labels include a boxed warning regarding increased morbidity and mortality (1.6 to 1.7 times vs. placebo) reported in geriatric patients with dementia receiving atypical antipsychotics. Deaths typically occurred due to heart failure, sudden death, or infections (primarily pneumonia). An increased incidence of cerebrovascular adverse events (e.g., stroke, transient ischemic attack), including fatal events, has also been reported. According to the Beers Criteria, antipsychotics are considered potentially inappropriate medications (PIMs) in elderly patients, and use should be avoided except for treating schizophrenia or bipolar disorder, and for short-term use as antiemetics during chemotherapy. Avoid use of risperidone in geriatric patients with the following conditions due to the potential for symptom exacerbation or adverse effects: delirium (possible new-onset or worsening delirium), dementia (adverse CNS effects), and Parkinson's disease (symptom exacerbation). There is an increased risk of stroke and a greater rate of cognitive decline and mortality in persons with dementia receiving antipsychotics. The Beers expert panel recommends avoiding antipsychotics to treat delirium- or dementia-related behavioral problems…"<br><br>Seroquel (quetiapine): Drug class: Atypical antipsychotic. According to PDR.net, for geriatric patients, the website documents the following: "Elderly patients may be more sensitive to the sedative, anticholinergic, and orthostatic |

| | | |
|---|---|---|
| | | effects of quetiapine…According to the Beers Criteria, antipsychotics are considered potentially inappropriate medications (PIMs) in elderly patients…There is an increased risk of stroke and a greater rate of cognitive decline and mortality in persons with dementia receiving antipsychotics….The federal Omnibus Budget Reconciliation Act (OBRA) regulates medication use in residents of long-term care facilities (LTCFs). An antipsychotic should generally be used only for the conditions listed in the guidelines (e.g., schizophrenia, mood disorder, Tourette's disorder) and meet the Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria for use. The LTCF must identify and address all possible causes of behavioral or psychological symptoms of dementia (BPSD) before considering an antipsychotic, as there is an increased risk of morbidity and mortality in elderly patients treated with antipsychotics for dementia-related psychosis…To initiate antipsychotic therapy, the patient must either be a danger to self or others or have symptoms due to mania or psychosis, and the plan of care should document attempted behavioral interventions (except in an emergency)."<br><br>1. According to their record, Resident #1 was 91 years old and was admitted to the facility on 4/23/20, with diagnoses which included "advancing dementia."<br><br>Resident #1's NSA, dated 3/23/21, documented the resident had "NO behaviors" but did have short-term memory impairment. At the time of the survey, Resident #1's NSA had not been updated after the resident began to exhibit maladaptive behaviors of elopement, attempts at elopement and pushing and yelling at staff.<br><br>Resident #1's signed admission agreement, dated 4/27/20, documented "Each resident has the right to humane care." |

| | | |
|---|---|---|
| | | Facility care notes, labeled “Resident profile - notes” for Resident #1 documented:<br><br>*10/25/21 facility LPN note: “Resident has days where [Resident #1] has increased agitation, anxiety, increased sundowning, wanting to leave the building. A request was sent to the doctor to get something to help with this. A new order was received for Trazodone…”<br><br>*11/1/21 caregiver note: “…near 7 pm, resident started to wander and try to leave the facility in which the med tech gave [them] medication that seemed to calm resident.”<br><br>*11/2/21 facility LPN note: Resident #1 had eloped from the facility; “I also contacted Dr. Seibold and got a new order for Seroquel…"<br><br>*11/4/21 facility LPN note: Resident #1 “is consistently having anxiety, agitation, and aggressive behaviors...We received the order for Seroquel 50 mg daily at 5 pm. This seems to be very effective about an hour after being medicated. The last 2 days we have administered the dose early due to [their] behaviors. Could we please change the administration time to 3:00 pm and/or add a PRN to give [them] when [Resident #1] starts getting agitated?”<br><br>*11/30/21 1:37 PM caregiver note: “Resident was very aggravated and wanted to leave. PRN was given.”<br><br>*11/30/21 6:57 PM caregiver note: “Res is still wanting to leave and high anxiety no change with medication.”<br><br>*12/15/21 facility LPN note: “…asked Dr. Seibold to look over |

| | | |
|---|---|---|
| | | [Resident #1's] medications and see if [he] could give us something to help with the agitation that [Resident #1] gets some afternoons. Dr. Seibold has stopped the Trazodone and started resident on Haldol 1 mg 1 tablet twice a day as needed for agitation."<br><br>*12/17/21 facility LPN note: Resident #1 was "consistently having anxiety, agitation, and aggressive behaviors …exit seeking, combative and attempting to hit and scratch staff…may we please get a PRN for when [Resident #1] has these increased behaviors …"<br><br>A physician's report documented Resident #1 had been prescribed generic Seroquel 50 mg, 1 tablet at 5:00 PM "for agitation, anxiety, sundowning," starting on 11/2/21. The report also documented the resident had been prescribed generic Norco 5-325 mg, 1 tablet twice daily as needed for back pain, which was originally prescribed in April 2020. The physician, as of 12/15/21, prescribed generic Haldol 1 mg, 1 tablet twice daily PRN agitation.<br><br>Resident #1's Medication Administration records from October, November, and December 2021 were reviewed and documented the following:<br><br>*In October 2021, Resident #1 received PRN Norco for "confusion" three times, and on one of the occasions, the medication technician noted they were "confused and grabbing [their] purse to leave."<br><br>*In November 2021, Resident #1 was given PRN Norco for "anxiety" and "to help relax" three times. On 11/30/21, the medication technician documented the nurse asked them to give Resident #1 Norco due to them "being very antsy to leave |

| | | |
|---|---|---|
| | | and high anxiety – Response: res is still wanting to leave and high anxiety no change with medication." The resident also began receiving Seroquel for "agitation, anxiety and sundowning" on a scheduled basis, as of 11/2/21.<br><br>*In December 2021, Resident #1 continued to receive Seroquel on a daily basis, and they received their first dose of Haldol on 12/17/21 because "res is getting very agitated that [they] can't go into the kitchen". The resident received two more doses of Haldol in December for agitation, and the nurse instructed the staff to give Haldol because they were "heading to the door." The resident was also given Norco 11 times in December for agitation; the medication technicians documented the following reasons they gave these doses of the narcotic:<br><br>*"Given for minor agitation"<br>*"Res anxiety is getting higher"<br>*"Res is getting more agitated anxiety"<br>*"Help relax res"<br>*"Res is having anxiety and wanting to leave"<br>*"Given for agitation"<br>*"To calm res"<br>*"Given to relax [them]"<br>*"Res is getting very anxious"<br>*"Res is trying to leave and getting very agitated"<br>*"Res is getting anxious to leave and agitated"<br><br>The facility reported Resident #1's 11/2/21 elopement to Licensing and Certification through FLARES. The report documented, "MD recently changed medications. When [they] eloped MD was immediately notified and he changed the medications again…the nurse and PCP have been working together to make the necessary changes with [their] medications due to the resident wants to go home…" |

| | | |
|---|---|---|
| | | An assessment by the facility RN was completed on 11/3/21, after Resident #1 had eloped from the facility on 11/2/21. The RN documented the resident was started on Seroquel on the day of the elopement as an intervention for the resident's elopement risk. The nurse documented the resident exhibited "no behaviors that require intervention."<br><br>Between 1/3/22 and 1/5/22, interviews with family and staff members were conducted, and the following comments were made:<br><br>*Resident #1 occasionally became agitated at night, and when this occurred, they would give the resident PRN Haldol, or if the resident was "really agitated", they administered Norco.<br><br>*Usually, a PRN medication was required, when Resident #1 was "persistent on leaving the building and won't re-direct."<br><br>*When Resident #1 went to the door, staff would attempt to move them away from the door, or if they yelled at staff, they would just walk away. If that did not work, they would be given medication. They were not aware of any behavior plan for Resident #1.<br><br>On 1/5/22 at 12:52 PM, the facility nurse (LPN) and administrator were interviewed. The nurse stated the resident was initially given Tylenol for pain, and then it was changed to PRN hydrocodone when the resident displayed increased attempts to leave and to calm them down. The LPN stated there was no documentation of non-drug interventions tried for Resident #1's behaviors prior to the medications being administered. |

| | | |
|---|---|---|
| | | There was no documentation in Resident #1's record documenting what non-drug interventions were attempted prior to initiating the psychotropic medications Seroquel and Haldol. The resident was also given the narcotic Norco for symptoms of agitation and anxiety. There was no evaluation of Resident #1's behaviors nor behavior plan in their record nor interventions for caregivers to assist them in intervening when the resident engaged in the behaviors.<br><br>2. According to their record, Resident #2 was 71 years old and was admitted to the facility on 11/23/21, with diagnoses which included Dementia.<br><br>Resident #2's signed admission agreement, dated 11/23/21, documented "Each resident has the right to humane care."<br><br>Resident #2's NSA, dated 11/21/21, documented the resident "displays no behaviors at this time." At the time of the survey, Resident #2's NSA had not been updated after the resident began to exhibit maladaptive behaviors of urinating on the floor or intentionally defecating while being assisted to transfer.<br><br>A physician's order, dated 12/21/21, documented Resident #2 was given the medication Seroquel 50mg daily because they were observed with "increased behaviors."<br><br>Resident #2's Medication Administration Record for November 2021 documented the resident was admitted to the facility with the medication Risperdal 0.5 mg daily for their "mood."<br><br>Resident #2's Medication Administration Record for December 2021 documented the Resident continued to take the medication Risperidone 0.5mg daily but the medication |

| | | |
|---|---|---|
| | | Seroquel 50 mg daily was started 12/21/21 for their "mood."<br><br>On 1/5/22 at 12:52 PM, the facility LPN was asked why Resident #2 was taking Risperdal, and she stated the resident was prescribed this while they resided in a previous facility, due to behaviors of inappropriate urination on the floors of the facility. The LPN stated the resident had not demonstrated that behavior since being admitted to this facility, but they had been defecating during transfers, which was suspected to be intentional. Hospice prescribed Seroquel for Resident #2 recently, and the facility nurse was unsure if this was prescribed to treat the inappropriate defecation behavior or not. The LPN stated she was unaware residents were to be evaluated for behaviors prior to admission, and to have a behavior plan in place, in case the behavior occurred at the current facility. The LPN stated there was no behavior plan in place and non-drug interventions had not been initiated for Resident #2, despite the fact the resident was taking two antipsychotic medications.<br><br>It should be noted the facility RN was unavailable for interview during the survey.<br><br>On 1/5/22 at 3:55 PM, the administrator was asked if any of the sampled residents had a current behavior plan. She stated no, and “if they had behaviors, there would be an actual behavior plan.”<br><br>There was no documentation in Resident #2’s record documenting what non-drug interventions were attempted prior to initiating the psychotropic medication Seroquel. The resident was also given the medication Risperdal since the time of their admission without an evaluation of their behaviors nor implementing a behavior plan with interventions |

| | | |
|---|---|---|
| | | for caregivers to assist them when the resident engaged in the behaviors.<br><br>The facility failed to protect Resident #1 and #2's rights to be free from chemical restraints and to be treated in a dignified, humane manner when the residents were given psychotropic medications to address behaviors without attempting non-drug interventions first, when they failed to evaluate residents to develop interventions when residents were admitted with orders for psychotropic medications and when Resident #1 was given an opioid medication to address their behavior of agitation and elopement when it was ordered for pain. These failures resulted in inadequate care. |
| 3 | .520-11 Inadequate Care - Acceptable Admission and Retention* | Based on observation, record review and interview, it was determined the facility retained 1 of 1 sampled residents (#1), who were at risk for elopement or who had eloped, due to an unsecured facility.<br><br>IDAPA 16.03.22.010.29. Elopement is defined as, “When a resident who is cognitively, physically, mentally, emotionally, or chemically impaired, physically leaves the facility premises or the secured unit or yard without personnel's knowledge.”<br><br>IDAPA 16.03.22.011.05. Inadequate care is defined as, "when a facility fails to provide the services required to meet the terms of the Negotiated Service Agreement, or provide for…supervision…a safe living environment, or engages in violations of resident rights or takes residents who have been admitted in violation of provisions of Section 39-3307, Idaho Code.”<br><br>IDAPA 16.03.22.011.11. Maladaptive behavior is defined as, “Any behavior that interferes with resident care, infringes on any resident's rights, or presents a danger to the resident or |

| | | |
|---|---|---|
| | | others…"<br><br>IDAPA 16.03.22.152.03.a.i documents, "A resident will be admitted or retained only when the facility has the capability, capacity, and services to provide appropriate care..."<br><br>IDAPA 16.03.22.152.03.b.xii. documents, "No resident will be admitted or retained who requires ongoing skilled nursing or care not within the legally licensed authority of the facility. Such residents include…A resident who has physical, emotional, or social needs that are not compatible with the other residents in the facility."<br><br>IDAPA 16.03.22.215.05 documents, "The administrator must ensure that no resident is knowingly admitted or retained who requires care as defined in Section 39-3307, Idaho Code, and Section 152 of these rules."<br><br>IDAPA 16.03.22.250.13 documents, "If the facility accepts and retains residents who have cognitive impairment and have a history of elopement or attempted elopement, the facility must provide an interior environment and exterior yard which is secure and safe…"<br><br>When a licensure survey was conducted at the facility on 9/12/19, the facility was given technical assistance to "decide on the population of your facility. There cannot [be] a mixed population of residents who need a secured environment with residents who do not."<br><br>The facility's 8/1/17 admission's policy, which was part of Resident #1's admission agreement signed by the parties on 4/27/20, documented, "A resident will be admitted or retained only when the Community has the capability, capacity, and |

| | | |
|---|---|---|
| | | services to provide appropriate care, or the resident does not require a type of service for which the Community is not licensed to provide…Furthermore, the Community has adopted the following Tenancy Criteria for determining fitness to reside at the Community…Resident does not demonstrate the desire to leave the building's premises without necessary safety awareness…"<br><br>The facility's August 2020 "Elopement Risk Prevention/Missing Resident" policy documented, "Elopement is the ability of a resident who is not capable of protecting himself or herself from harm to successfully leave the Community unsupervised, unnoticed and who may enter into harm's way…elopers are differentiated from wanderers by their purposeful, overt, and often repeated attempts to leave the Community and premises…An elopement risk assessment is completed on all residents upon admission, annually, and with any significant change in condition…Specific risk factors include…finding the resident 'lost' in the Community after admission…behavior problems…when he or she is agitated or aggressive…Actual wandering behaviors including…following staff or another resident….wandering due to boredom or lack of activity…Exit seeking: resident is intent on leaving the unit or Community, is looking for exits and hovering at exits waiting for the opportunity to leave with someone or pushing on a door." The policy documented interventions to use for residents identified at risk for elopement were to include but not be limited to: observation by staff every 30 minutes, promoting activities in full view of staff members, alternating activities to maintain the interest of the "wanderer," and "transfer to a more suitable or more secured Community, if necessary." After a resident who had eloped was found, the policy documented their "Service Plan/Care Plan" should be updated as needed. |

| | | |
|---|---|---|
| | | The facility was licensed as a 36 bed, one-story, unsecured assisted living facility. Several resident rooms also had exterior doors, which opened to an unsecured yard. The facility was located adjacent to Interstate Highway 86. There was a keypad lock engaged on the facility's front door and side doors which led to the unsecured yard, and individuals were required to enter a code on the keypad to be able to exit these doors. During the survey, some of the residents, as well as visitors, outside agencies and staff were observed to enter in the code in order to exit the facility.<br><br>According to their record, Resident #1 was 91 years old and was admitted to the facility on 4/23/20, with diagnoses which included "advancing dementia."<br><br>Resident #1's NSA, dated 3/23/21, documented the resident had "NO behaviors" but did have short-term memory impairment.<br><br>At the time of the survey, Resident #1's NSA had not been updated after the resident began to exhibit maladaptive behaviors, including the elopement from the facility on 11/2/21, subsequent attempts at elopement, as well as pushing and yelling at staff. There was also no behavior plan in the resident's record to instruct staff on how to respond to these behaviors.<br><br>An undated "Emergency Packet" form for Resident #1 documented, "Resident does try to get out of the building, and has been successful a few times. We have been able to get [them] back into the building with some reluctance on [their] part." The resident "feels that this is not [their] home and is continually looking at going home." |

| | | |
|---|---|---|
| | | The facility RN assessed Resident #1 on 11/3/21, following their elopement from the facility on 11/2/21. The RN documented the resident was started on Seroquel after they eloped. The report documented Resident #1 “occasionally wanders” and “exhibits exit seeking behaviors at times” with “Sun Downing in the evenings with periods of anxiety…” The report subsequently documented the resident “does try to get out of the building and has been successful a few times,” and the resident felt “this is not [their] home and is continually looking at going home.” The resident scored a “20” as a “Total Elopement Risk Score,” which indicated them to be “at risk.” The report documented staff were to perform “1 hour safety checks” of the resident.<br><br>An incident report, dated 11/2/21, documented Resident #1 eloped from the facility and was brought back by a member of the community. The report documented Resident #1 did not want to go back into the facility, stating they did not live there.<br><br>Resident #1's Medication Administration Records between October and December 2021 documented Resident #1 received Seroquel, Haldol and Norco for confusion, agitation, and attempts to leave the facility as noted above.<br><br>Facility care notes, labeled “Resident profile - notes” for Resident #1 documented:<br><br>*10/25/21 facility LPN note: Resident has days where they have "increased agitation, anxiety, increased sundowning, wanting to leave the building.” A second note by the LPN from the same date documented the resident was “attempting to leave the facility…”<br><br>*11/1/21 caregiver note: “…near 7 pm, resident started to |

| | | |
|---|---|---|
| | | wander and try to leave the facility…"<br><br>*11/2/21 facility LPN note: Resident #1 "was able to code [themselves] out of the front door and get out of the building…when [they] arrived back at this building, [they] did not want to get out of the car… [Resident #1] does had (sic) a problem with increased sundowning, anxiety, and agitation towards evening…."<br><br>*11/4/21 facility LPN note: Resident #1 "is consistently having anxiety, agitation, and aggressive behaviors starting between 3-4 pm daily. [They are] exit seeking, combative and attempting to hit and scratch staff who are trying to redirect [them]."<br><br>*11/30/21 1:37 PM caregiver note: "Resident was very aggravated and wanted to leave…"<br><br>*11/30/21 1:51 PM caregiver note: Resident "seems to be a little aggerated (sic) and confused, resident keeps trying to go outside and go home dpwn (sic) the hill."<br><br>*11/30/21 6:57 PM caregiver note: "Res is still wanting to leave and high anxiety..."<br><br>*12/15/21 Caregiver note: Resident #1 "is well but very confused at this time, [Resident #1] is wanting to leave the facility."<br><br>*12/17/21 facility LPN note: Resident #1 "is consistently having anxiety, agitation, and aggressive behaviors starting between 3-4 pm daily…exit seeking, combative and attempting to hit and scratch staff…the other night [Resident #1] was agitated from 3:00 to 9:00, very hard to redirect, attempting to get out |

| | | |
|---|---|---|
| | | numerous times, hitting at staff…"<br><br>The facility reported Resident #1's 11/2/21 elopement to Licensing and Certification through FLARES. The report documented, "Resident opened the door by using the code. [They] wanted to go home…A resident of the community recognized [them] …and knew that [they] now lived at Edgewood…The resident was in the car and had to be talked into coming back to Edgewood because [they] didn't believe this was [their] home." On 11/5/21 at 10:23 AM, a surveyor spoke with the administrator about this resident and was informed Resident #1 had acquired the code to the door by hearing others verbalize the code. The administrator stated they were going to change the code to the front door and re-evaluate the resident to see if the resident needed a secured environment at that time.<br><br>On 1/3/22 at 1:47 PM PM, Resident #1 appeared confused and could not answer the surveyor's questions.<br><br>On 1/4/22, Resident #1 was observed to be alone in their room between 9:08 AM and 9:53 AM, and no staff member was observed to do a "safety check" of the resident during these times.<br><br>On 1/4/22 at 10:32 AM, Resident #1 was observed to take their medications. The medication technician asked the resident if they were going to get dressed to come to lunch in awhile, but the resident appeared confused and was unable to answer the staff member's question.<br><br>Between 1/3/22 and 1/5/22, interviews with residents, family, staff members and outside agencies were conducted, and the following comments were made: |

| | | |
|---|---|---|
| | | *Resident #1 had been found in November 2021 “wandering around” American Falls. The resident had been found by two friends of the family, who brought them back to the facility. Resident #1 had been confused and forgetful at the time of the admission at the facility. Resident #1 had not been monitored closely for exit-seeking up until the time of the 11/2/21 elopement.<br><br>*Some residents had the door code, and some did not. There was one resident, specifically, who did not have the door code because “they would escape.”<br><br>*Resident #1 did not have the door code to exit the facility because “they’d try to escape.”<br><br>*Resident #1 occasionally became agitated at night, and they had to ensure the doors to the exterior were secured to prevent them from eloping.<br><br>*Resident #1 exhibited behaviors of exit-seeking, and pushing and yelling at staff. Usually, the resident “won’t re-direct”, and a PRN medication was required.<br><br>*When Resident #1 was agitated, they would go to the door and try to get out, saying “I need to go home.” This happened on more than one occasion in the last few weeks. The resident would also yell at staff when agitated.<br><br>On 1/5/22 at 12:52 PM, the facility nurse (LPN) stated she noticed Resident #1 was more agitated when the weather turned cold and dark. They started wandering more and tried to leave the facility and did get out one time. The LPN stated there was no documentation of non-drug interventions tried |

| | | |
|---|---|---|
| | | for Resident #1's behaviors prior to the medications being administered.<br><br>On 1/5/22 at 1:35 PM, the administrator stated Resident #1 eloped after the change in season and was found a few blocks away by a hospital employee. The administrator stated the resident also had two family members die within a short time frame and had several family members visit which may have led to the resident's increased agitation. The administrator stated as far as she knew, the resident had not been exit seeking lately. The administrator stated Resident #1 may not be appropriate for the facility.<br><br>Resident #1, who had cognitive impairment and confusion at the time of their admission to the facility, was retained by the facility after they began to display exit-seeking behaviors in October 2021, after they eloped from the unsecured environment in November 2021, and after multiple, subsequent attempts of elopement. This placed Resident #1 at risk for harm when they were retained in an unsecured environment, which resulted in inadequate care. |