NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
Gables of Pocatello Assisted Living	RC-1062	2805 South Grant Avenue	208-232-1091
Administrator	City	Zip Code	Survey Date
Joyce Foster	Pocatello	83204	09/16/2022
Survey Team Leader	Survey Type		Response Due
McClenathan, Teresa	Health Care Licensure and Follow-Up		10/16/2022

Item #	Rule (16.03.22)	Description
1	.215.08.b. Investigation within Thirty Days.	The administrator did not conduct an investigation within 30 days when it was discovered Resident #3 was missing two prescription tablets on 6/22/22, or when Resident #3 received the incorrect dose of insulin on 11/5/21. There was no investigation after Resident #4 sustained a large skin tear to their left lower extremity on or about 9/6/22, nor when they sustained a "blood blister," which later became infected, to their right lower extremity on or about 7/17/22.
2	.250.13. Secure Environment.	At the time of the survey, the facility had residents with cognitive impairments, who required a secure environment. The fence surrounding the grassy area, to which residents had access, was approximately four feet tall, which could not be deemed as secure as the facility housed confused residents who could physically scale this fence.
3	.305.02.b. Quarterly Nursing Assessments.	The facility did not ensure all residents' medications were available and given as ordered. Resident #1 did not received 8 doses of Gabapentin in July 2022 and 4 doses of insulin in June 2022. Resident #3 did not receive 10 doses of medications, including a cardiac medication, between July and August 2022, and on 11/5/21, they received 100 units of Basaglar insulin

		instead of the ordered 18 units. On 4/24/22, Resident #3 was given Novolin N, an intermediate insulin, instead of the ordered Novolin R, a short-acting insulin. Resident #4 did not receive 23 doses of medications between August and September 2022, including two antibiotics.
4	.305.03. Change in Resident Health Status.	Resident #1 was not assessed after they underwent a skin biopsy on 12/13/21. Resident #2 was not assessed when they expressed suicidal ideation on two separate occasions in June 2022, as well as "dry heaving," vomiting, and irregular breathing in July 2022. Resident #3 was not assessed after a caregiver noted they had a dry, hacking cough on 5/16/22, when they were noted to have low blood glucose readings, as low as 57, on several dates in May 2022, nor when they received the incorrect insulin on 4/24/22. The previous facility nurse stated she had not carried out a physical examination of the residents when they experienced these changes.
5	.310.01.a. Medication Distribution.	On three separate occasions from 9/14/22 to 9/16/22, medications, including medicated foot spray, burn spray and antifungal medication were observed to be stored in an unlocked hallway closet, which was accessible to cognitively impaired residents. The compliance officer stated they were aware the medications were unsecured.
6	.310.01.c. Medication Distribution.	The medication refrigerator log documented that between 7/9/22 and 9/14/22, the refrigerator holding residents' medications, including insulin was below the required temperature range on 18 occasions, as low as 31 degrees F.
7	.330.04.c.vii. Resident Care Records.	In May 2022, Resident #3 was noted to experience vomiting as well as have increased confusion and odd behavior, such as licking the dining room table. Resident #4 experienced a cough on 3/2/22, as well as shallow breathing, wheezing and decreased urine output in June 2022. The previous facility nurse stated these residents were assessed after the changes in their conditions, but the assessments had not been documented.

8	.330.06.b. Additional Resident Records.	The facility did not implement a behavior plan for Resident #1 when they argued, yelled, and cursed at staff regarding their roommate's care, and yelled at their roommate. The facility administrator and corporate executive stated a behavior plan had not been completed for these behaviors.
9	.330.13.h. Personnel Records.	The facility did not have documentation of criminal history and background checks for three of five sampled staff members who worked alone or worked while not in line of sight of another employee with a cleared background check.
10	.450. REQUIREMENTS FOR FOOD AND NUTRITIONAL CARE SERVICES.	The facility did not meet the standards for the Idaho Food Code. Kitchen inspection failed. Mandatory re-inspection required within 10 days.