NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
Generations Memory Care at Rathdrum	RC-1147	13400 North Meyer Road	208-687-0495
Administrator	City	Zip Code	Survey Date
Caelyn Kresch	Rathdrum	83858	03/15/2023
Survey Team Leader	Survey Type		Response Due
Miller, Rebecca	Health Care Licensure and Follow-Up		04/14/2023

Item #	Rule (16.03.22)	Description
1	.009.01. Criminal History and Background Check.	One of seven employees, whose records were reviewed, did not have a Department Criminal History and Background Check completed. One staff member stated this employee had worked alone in a house and had provided cares to residents while unsupervised. The Department of Criminal History had been unable to run a background check due to not receiving requested information on charges this employee had in California. The administrator stated the background check had not been completed. ***Previously cited 12/13/17 and 6/19/18***
2	.009.06.c. Use of Previous Criminal History and Background Check.	Three of four employees, whose personnel records were reviewed and needed a State Police background check, did not have one completed. The Administrator confirmed the Idaho State Police background checks were not completed.
3	.215.08.b. Investigation within Thirty Days.	The administrator did not conduct an investigation within 30 days, or implement corrective action, when Resident #7 sustained an injury to their left thumb on 2/22/23, which resulted in a skin tear, nor when the resident was noted by the nurse to have wounds to their left leg and right foot on 1/4/23. Home health notes documented Resident #7 sustained a fall

		on 1/18/23, which resulted in edema and tenderness in the left elbow, and they sustained a left elbow wound during a transfer on 2/25/23. The administrator stated she did not complete investigations for these incidents.
4	.215.08.f. Notification to Licensing Agency within One Business Day.	The facility did not notify Licensing and Certification (L&C) within one business day when Resident #3 had an injury of unknown injury on 12/18/22, which required evaluation at the emergency room (ER), nor when Resident #7 had a fall and hit their head on 2/18/23 and was sent to the ER. The administrator stated these incidents had not been reported to L&C.
5	.300.01. Licensed Registered Nurse (RN).	The facility's Registered Nurse (RN) did not complete all initial and/or quarterly nursing assessments for Residents #1, #2, #5, #6 and #7. The administrator stated they were "behind" on completing the quarterly assessments, and initial assessments were not always completed by an RN. ***Previously cited 6/19/18.***
6	.305.02.b. Quarterly Nursing Assessments.	The facility nurse did not ensure residents received their medications and treatments as ordered. For example, Resident #5 did not receive three doses of their cardiac medication metoprolol in January 2023 nor six medications and treatments for their yeast infection in February 2023. Resident #6 did not receive diclofenac sodium from 3/1/23 to 3/3/23, nor did they receive Jardiance between 3/7/23 to 3/9/23. As of 2/19/23, Resident #7 was ordered to have their cardiac medication metoprolol held if their systolic blood pressure was below 110 or their heart rate was below 60; on 2/22/23, the order was changed to hold metoprolol if their systolic blood pressure was below 120 or their heart rate was below 60. Between 2/19/23 and 3/14/23, medication technicians incorrectly gave metoprolol on 17 occasions, when the vital signs were outside of the ordered parameters. The facility nurse stated some residents had run out of medications, and they had been working on addressing medication reorder

		issues. She also stated the medication technicians needed additional training on following ordered parameters. ***Previously cited on 6/19/18.***
7	.305.03. Change in Resident Health Status.	Residents were not consistently assessed after they experienced a change of condition. For example, Resident #7, who had a history of chronic pulmonary disease, was not assessed when they tested positive for COVID-19 on 12/6/22. Resident #7, who fell multiple times in January 2023, was documented by the home health agency to be experiencing dizziness and low blood pressures below 90/50 on 1/11/23 and 1/18/23. Caregivers also documented the resident had systolic blood pressure below 120 or a heart rate in the 50s on nine occasions in January 2023. However, the facility nurse did not assess the resident for the dizziness or low vital sign readings in January 2023. Resident #7 was not assessed when a home health staff documented they sustained a skin tear to their left elbow during a transfer on 2/25/23. The facility nurse stated she had not assessed the resident for these changes of condition.
8	.310.01.c. Medication Distribution.	The facility did not monitor and record the daily temperature of the medication refrigerators in houses #1, #2, and #3 which stored resident medications, including insulin, on a daily basis nor keep the temperature in the required range. For example, on 3/14/23, house #2 medication refrigerator's temperature was 37 degrees. There were no temperature logs in house #2 for January or March 2023; the temperatures in February 2023 were only documented on 6 days, and on 4 of those days, the temperatures ranged from 32 degrees to 36 degrees. Houses #1 and #3 did not not have temperature logs for January and February 2023. The administrator stated she could not find the temperature logs, and staff had not been consistently documenting the temperatures for house #2.
9	.310.04.e. Psychotropic or Behavior Modifying Medication.	Of the seven sampled residents, two residents had missing psychotropic medication reviews. For example, Resident #1

		was admitted on 6/14/21 and was taking Abilify, citalopram, and donepezil for more than six months prior to 11/7/22. Resident #3 was taking Abilify, but their last review did not contain quantitative data, and no reviews were completed between 4/4/21-11/6/22. ***Previously cited on 12/13/17***
10	.330. REQUIREMENTS FOR FACILITY RECORDS.	The facility did not maintain the "shift report," which contained specific information pertaining to residents, as it was discarded after a few months. The reports were not available prior to October 2022. The administrator stated the reports had been thrown out after a few months.
11	.330.04. Behavior Documentation.	The facility's "shift reports" documented multiple resident names and information on one page, making it impossible to include each residents' information in their record. For example, the "shift reports" documented Resident #7 had redness in the left eye on 2/16/23 and neck pain per an undated "shift report" from March 2023. However, these notes were not included in Resident #7's record. The facility nurse stated staff would also text residents' information to her, and that information was not placed in the residents' charts.
12	.330.04.c.vii. Resident Care Records.	The facility nurse stated she had assessed residents after changes of condition, but these assessments had not been consistently documented. For example, Resident #2 had a wound to their right nostril/lip area. Resident #7 sustained six falls between December 2022 and January 2023 and was documented by "shift reports" to have redness in the left eye on 2/16/23 and neck pain per an undated "shift report" from March 2023. Resident #6 sustained falls on 12/15/22 and 3/6/23. The facility nurse stated she had assessed the residents for these issues but had not documented the assessments.
13	.330.09. Water Supply.	The facility did not maintain an up-to-date admission and discharge register, as the register did not accurately document who resided at the facility. The register documented 23

		residents resided at the facility, while the facility roster listed 45 residents currently living in the facility. The administrator confirmed the admission and discharge register was not accurate.
14	.625.03.k. Content for Training.	Four of seven employees did not receive infection control training. The administrator stated the employees had not completed this training.
15	.630.02. Mental Illness.	Seven of seven staff did not receive mental illness training within 30 days of hire. The administrator stated the training had not been completed by these employees, and they did have residents who suffered from mental illness living at the facility.