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
Jared Mangum	American Falls	83211	03/29/2023
Survey Team Leader	Survey Type		Response Due
Perry, Bradley	Health Care Licensure and Follow-Up		04/28/2023

Item #	Rule (16.03.22)	Description
1	.215.08.e. Corrective Action.	The administrator did not implement corrective action to ensure the incidents did not recur when Resident #4 experienced a fall on 1/6/23. Also, Resident #1 fell on 11/2/22 and the facility administrator documented on an incident report a night light would be installed in the resident's bathroom to prevent further falls. On 3/29/23 there was no night light observed in the resident's bathroom. Resident #1 stated they never remembered a light was ever in their bathroom. The administrator stated staff did not implement interventions after these incidents.
2	.300.02. Licensed Nurse.	The facility licensed nurse did not notify Resident #1's physician or outside provider after they repeatedly refused their medications between February 2022 and March 2023. For example, the resident refused their Symbicort 28 times, their duloxetine 5 times, and all of their medications on 2/23/23. The facility nurse confirmed Resident #1's physician had not been notified of the continued medication refusals.
3	.305.02.b. Quarterly Nursing Assessments.	The facility nurse did not ensure residents received their medications and treatments as ordered. For example, Resident #1 did not receive the correct dose of gabapentin between

		1/19/23 through the time of the survey on 3/29/23. The resident received gabapentin 100mg (milligrams) three times daily as a scheduled medication during this timeframe when the physician order for the medication was for 100mg up to three times daily as needed. The Regional Nursing Director verified the medication was given incorrectly.
4	.310.02.f. Discontinued and Expired Prescriptions.	The facility did not ensure the medication destruction log documented two signatures for each medication destroyed. For example, between 3/1/23 and 3/29/23 the medication destruction log documented 71 medications were destroyed and for each medication, there was only one signature. The Regional Nursing Director stated there were two people present when the medications were destroyed, but the log only had one signature.
5	.310.04.e. Psychotropic or Behavior Modifying Medication.	Resident #2 was taking duloxetine and Resident #4 was taking amitriptyline for more than six months and did not have a current six month psychotropic medication review. The Regional Nursing Director stated she could not find the reviews.
6	.330.14.a. As Worked Schedules.	The facility's as-worked schedule did not document actual times caregivers were at the facility.