NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
Heritage of Soda Springs	RC-1279	425 S Spring Creek Dr	208-547-0257
Administrator	City	Zip Code	Survey Date
Amber Adams	Soda Springs	83276	04/13/2023
Survey Team Leader	Survey Type		Response Due
Brown, Stacey	Health Care Initial Licensure		05/13/2023

Item #	Rule (16.03.22)	Description
1	.250.13. Secure Environment.	The facility had residents with cognitive impairments and a history of elopement attempts or who were at risk for elopement and did not provide a secure environment. The facility had no secured exterior environment, was adjacent to a creek, and was not far from a large reservoir. Each of the facility's exterior doors had a keypad which required a code to open the door. Some residents, who had no cognitive impairment, were provided this code, and the residents with cognitive impairment were not given the door code. Resident #6, who had cognitive impairment, attempted to elope from the facility at least twice on 4/8/23 per a caregiver note and interviews with several staff members. Resident #5, also with cognitive impairment, attempted to elope at least once or twice within the last few weeks, according to multiple staff members' interviews. The administrator and multiple staff stated these two residents required a secured environment due to their cognitive impairments and risk for elopement. During the initial tour of the facility, seven residents stated they knew the code to the facility doors. By allowing some residents to have the door code, the facility was not secure because residents with the code could inadvertently let

		confused residents elope from facility.
2	.260.07. Toxic Chemicals.	Toxic chemicals were observed to be stored in unlocked areas, which was accessible to cognitively impaired residents, on three different occasions between 4/11/23 to 4/13/23. For example, bleach, barbicide and multi-surface cleaner were observed in the unlocked salon, and a "de-limer," dish detergent, glass cleaner, pot and pan detergent, peroxide, degreaser and stainless steel cleaner were observed under the kitchen sink.
3	.305.02.b. Quarterly Nursing Assessments.	Resident #1 did not have eight doses of Gemtasa, a medication prescribed for their urinary urgency, available to them between February and April 2023. Resident #3 did not have eight doses of their prescribed eye drops Systane available to them between January and February 2023. Resident #6, who suffered from anxiety and exhibited behaviors, did not receive three doses of buspirone in April 2023. The administrator and facility nurse stated they had been having difficulty obtaining medications from their pharmacy and were in the process of correcting this problem. Prior to admission, Resident #7 had been taking 80 mg of furosemide for congestive heart failure, was admitted to the facility without an order for this medication. The resident had not received this medication since admission on 3/28/23, resulting in marked edema in bilateral lower extremities, until a new order was obtained on 4/4/23. The facility nurse stated she is unsure why this medication had not been ordered and available since the time of admission.
4	.305.03. Change in Resident Health Status.	The facility nurse did not assess all residents when they experienced a change of condition. For example, Resident #5 began to exhibit a "shuffling gait" and require assistance with transfers and ambulation, when they were previously able to ambulate on their own without an abnormal gait. The resident also became increasingly confused and was started on home health services. Resident #6 exhibited increasing behaviors in

		early April 2023 and expressed suicidal ideation to a loved one on 4/4/23. The facility nurse stated she had not assessed the resident for these changes. Resident #7 had a stage 2 pressure injury to their right buttock at the time of admission on 3/28/23, but this had not been assessed by the facility nurse since that time. The facility nurse also stated she had not reviewed caregiver notes which documented resident changes and was therefore not aware of them.
5	.310.01.g. Medication Distribution System.	Resident #1 did not have two ordered PRN medications available, including benzonatate or their albuterol inhaler. Resident #4 did not have seven PRN medications available to them since the medications were ordered on 3/20/23, and Resident #6 did not have their ordered antibiotic ointment available. The administrator confirmed the PRN medications were not available.
6	.320.08. Periodic Review.	Residents' Negotiated Service Agreements (NSAs) were not updated when there were significant changes in their care needs. For example, Resident #1's NSA documented staff were to apply antibiotic ointment to their sutures and empty their JP drain, following surgery to their right groin in January 2023, but the sutures and drain had been removed in February 2023. Resident #2's NSA did not document when they were started on hospice services or that hospice was providing bathing. Resident #5's NSA documented the resident was independent with toileting, bathing, transfers, and ambulation, when they required assistance for all those tasks including use of a walker during survey observations. Their NSA also documented they were oriented to place and time, when they were not and did not. Resident #7's NSA did not give instructions to caregivers regarding their stage 2 pressure injury, and the NSA documented the resident should be using five liters of oxygen, when the physician ordered four liters. The facility nurse confirmed the NSAs were not updated to reflect the residents' changes in care needs.

7	.330.06.a. Additional Resident Records.	The facility did not ensure two of two residents' maladaptive behaviors were assessed to create behavior management plans. For example, Resident #5 had attempted elopement from the unsecured facility on more than one occasion. Resident #6 had yelled at staff, pinched a staff member, attempted to elope on more than one occasion, and had disturbed other residents by wandering into other their rooms uninvited. The care staff stated Residents #5 and #6 did not have behavior plans in place for these specific behaviors. The administrator stated these behaviors had not been assessed, and there were no behavior plans in place for these specific behaviors.
8	.330.06.b. Additional Resident Records.	The facility did not develop a behavior plans that included specific interventions for behaviors exhibited by Residents #5 and #6, as outlined in non-core punch 330.06.a. Multiple staff members confirmed they did not have behavior plans to reference for these residents. They had tried interventions on their own such as redirection or offering food or drink, but these interventions were not always effective and at times actually caused increased agitation by Resident #6. The administrator stated these behavior plans had not been developed.