NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
Willow Place Assisted Living	RC-1233	1871 Julie Lane	208-736-3727
Administrator	City	Zip Code	Survey Date
Randall Swope	Twin Falls	83301	04/14/2023
Survey Team Leader	Survey Type		Response Due
Miller, Rebecca	Health Care Licensure and Follow-Up + complaint investigation		05/14/2023

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 Resident #3 fell in the bathroom on 12/6/2022, nor when they were found on the floor on 1/13/23. The facility nurse stated she had not completed incident reports as the resident was not injured in these incidents.
2	.250.13. Secure Environment.	The facility was licensed as a memory care and had residents living in the facility with cognitive impairments. The exterior yard was a covered patio secured by a fence with a gate. On 4/12/23, resident who had a diagnosis of dementia was sitting in a chair on the patio inside of the secured outside area. There were no staff present outside at the time of the observation. The gate had a padlock which was engaged; however, the latching mechanism could be released by pulling up on the padlock. The resident stated they would come out where they sat without staff members present. The acting administrator stated she knew the administrator knew about the gate not being able to lock and had not worked on securing the exterior gate.
3	.260.07. Toxic Chemicals.	Toxic chemicals were observed to be stored in an unlocked area, which was accessible to cognitively impaired residents on five separate occasions on 4/13/23. For example, Clorox

		cleaner and Lysol spray was under the unlocked kitchen sink.
4	.310.01.c. Medication Distribution.	The facility did not maintain the medication refrigerator, which contained insulin, within the temperature range of 38 and 45 degrees F. The temperatures were out of range 28 times in February 2023, 31 times in March 2023, 10 times in April 2023. On 4/14/23 at 10:30 AM, the medication refrigerator temperature was 29 degrees. The facility house manager confirmed the temperatures were not in range.
5	.310.04.e. Psychotropic or Behavior Modifying Medication.	Resident #2 had taken trazodone for more than six months and did not have a current six month psychotropic medication review. The facility nurse stated she had not been completing psychotropic medication reviews for anyone with trazodone because she did not think it was a psychotropic medication.
6	.330.04. Behavior Documentation.	Current care records were not maintained for each resident. The Medication Administration Record (MAR), did not clearly document a medication was refused or not available. Resident #2's record did not contain the orders to discontinue for methocarbamol 750 mg one tablet four times daily, and oxycodone 5 mg one tablet every four hours as needed for pain. Resident #3's record did not contain orders to discontinue for dalfampridine 10 mg 1/2 tablet twice a day, and terflunomide 14 mg one tablet daily. The facility nurse stated that the circled initials on the MAR for multiple days indicated medications were not available, and individual days indicated residents refused. No key code on the MARs was available to define documentation on MARs.
7	.335.02. Standard Precautions.	The facility did not follow correct infection control procedures when a caregiver was observed not washing or sanitizing their hands between residents' medication passess, did not use an alcohol pad when assisting with insulin administration, and did not wear gloves when assisting with blood glucose test and insulin administration. The facility nurse acknowledged the infection control concerns.