NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
Stonebridge Assisted Living	RC-999	110 River Rock Place	208-837-4153
Administrator	City	Zip Code	Survey Date
Catherine Deruiter	Hagerman	83332	05/26/2023
Survey Team Leader	Survey Type		Response Due
Oldfield, Michael	Health Care Licensure and Follow-Up		06/25/2023

Item #	Rule (16.03.22)	Description
1	.250.09. Resident Sleeping Rooms.	The facility's hot water temperatures were not consistently maintained between 105 degrees F and 120 degrees F. The water temperatures taken at the time of the facility tour, and again on 5/26/23, were one hundred twenty-four and one hundred twenty-five degrees Fahrenheit (124°F and 125°F) in the two shower rooms and one hundred and thirty-one degrees (131°F) in the guest bathroom.
2	.260.07. Toxic Chemicals.	Toxic chemicals were observed to be stored in unlocked areas, which were accessible to cognitively impaired residents on two consecutive days from 5/25/23 to 5/26/23. For example, multiple chemicals, including bleach, stain remover and Lime A-way were observed in a cabinet in the laundry room and Ajax cleansing powder under the kitchen sink that had a broken lock on the cabinet door. The facility administrator was informed toxic chemicals needed to be secured. The facility was given technical assistance concerning securing toxic chemicals during the 11/18/22 complaint survey.
3	.305.02.b. Quarterly Nursing Assessments.	Residents were not consistently given their medications and treatments as ordered. For example, Resident #1 was ordered to have daily weight and blood pressure checks as of 4/28/23; since that date, the resident's weight was not checked on 10

		occasions and their blood pressure was not checked on 7 occasions. Resident #1's levothyroxine dose was ordered to increase to 88 mcg per their provider's 3/29/23 note, but the resident had continued to receive 50 mcg daily through the date of the survey. Also, Resident #1's orders stated the resident should be taking three different eye drops, ibuprofen, and Eliquis, but these medications were never started. Resident #2 was ordered to receive barrier cream three times daily to their pressure injuries as of 4/5/23, but the resident continued to receive this medication twice daily in April and May 2023, through the date of the survey. The facility nurse stated the administrator was responsible to monitor the staff members to ensure the blood pressures and weights for Resident #1 were being completed, since he could not be here every day. For resident #1's medications, he did not believe these were true orders, since they were listed on the provider's (signed and dated) chart note, not a specific document titled "order" but had not contacted the provider for clarification. For Resident #2's wound cream, he stated the order should have been updated to three times a day.
4	.305.02.c. Current Medication Orders and Treatment Orders.	The facility did not consistently maintain current medication and treatment orders in the residents' charts. For example, Resident #1 had as-needed Delsym cough syrup, antacids, and docusate capsules on their Medication Administration Record(MAR), and there was no signed order for these medications with directions as listed on the MAR. Resident #2 did not have an order signed by their prescribing physician to hold their muscle relaxer cyclobenzaprine, which the facility held as of 5/24/23, nor was there a signed order to discontinue their Aleve, and this medication had been discontinued. The facility held/discontinued these medications based on the hospice nurse's order only. Resident #3 did not have current, signed orders for many of the medications listed on their MAR. Hospice had recently changed many of Resident #3's

		medications, and the updated, signed orders had not been received. The facility nurse stated he was only at the facility part-time, and the administrator had been responsible to ensure signed orders were in the residents' records.
5	.305.03. Change in Resident Health Status.	Resident #1 experienced weakness, "not feeling well" and declined a meal on 4/12/23. Resident #1 also experienced significant weight gain and elevated blood pressures in late April 2023, significant enough for their physician to order daily weights and blood pressure checks as of 4/28/23 and new medications as of 5/3/23. Since that time, Resident #1 continued to have elevated blood pressures, as high as 187/80. Resident #2 developed a "pressure sheering" wound to their left buttock, according to hospice note dated 4/3/23, as well as a pressure injury to their right buttock noted by a caregiver on 4/26/23, both of which were still present at the time of the survey. Resident #3 began to exhibit significant maladaptive behaviors, per caregiver notes, starting in January 2023, including medication and care refusals, multiple elopement attempts, and slapping staff. The facility nurse stated he had not be notified about Resident #2's wounds until yesterday, nor was he notified about the other above-mentioned issues and had not performed changes of condition assessments.
6	.320.08. Periodic Review.	Negotiated Service Agreements (NSAs) were not updated to reflect significant changes in 4 of 4 residents' care needs or health status. For example, Resident #3 and #4's NSA did not delineate between tasks that hospice and the facility would complete. Resident #1's NSA did not instruct caregivers were to put on their compression stockings in the morning and remove at bedtime and Resident #2 NSA did not instruct caregivers how to care for their buttock wounds.
7	.330.04. Behavior Documentation.	All resident care records must be completed by the person providing the care. The facility's caregiver notes were documented in a spiral notebook, with multiple residents' information all listed on the same page, not allowing this

		information to be included into each resident's record. For example, staff members documented Resident #1 had not been feeling well and not eating their meals on 2/3/23 and 4/12/23; staff documented they noticed a new sore to Resident #2's right buttock, as well as multiple maladaptive behaviors for Resident #3. None of this information made it into these residents' records. Also, each entry did not include a date, time, full name or title of the person making the entry. The facility nurse stated he had not reviewed the information in the spiral notebook and was unaware of many of the changes of condition listed in them. The facility nurse also stated he had not consistently documented each time the staff members contacted him about specific resident issues. The facility was given technical assistance concerning documentation of caregiver notes during the 11/18/22 complaint survey.
8	.330.06.a. Additional Resident Records.	The facility did not evaluate Resident #3's behaviors of yelling/cussing/slapping/swinging at staff, refusals of care and meals, going into other residents rooms, socially inappropriate behavior, and multiple attempted elopements. On 2/20/23, Resident #3 received Ativan for their agitation and elopement attempt. The administrator confirmed the facility had not completed an evaluation for Resident #3's maladaptive behaviors.
9	.330.06.b. Additional Resident Records.	The facility did not develop a behavior plan with specific interventions when Resident #3 exhibited multiple maladaptive behaviors. See non-core deficiency 330.06.a for examples.
10	.600.04.b. Sufficient Personnel.	Three of three caregivers, who worked alone, did not have current first aid training or cardiopulmonary resuscitation (CPR) certifications. The administrator confirmed these staff members did not have current first aid or CPR certifications. The administrator had two of these caregivers complete the training on 5/25/23, after surveyors had entered for survey.

11	.645.02. Delegation.	Two of four medication technicians, who passed medications, were not delegated by the current facility nurse. The current facility nurse confirmed delegation had not been completed. The facility was given technical assistance on delegation during the 4/4/22 licensure survey.