NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
Antelope Creek Living Center	RC-514	3668 W 3700 N	208-588-2700
Administrator	City	Zip Code	Survey Date
Cindy Smith	Darlington	83255	06/29/2023
Survey Team Leader	Survey Type		Response Due
Perry, Bradley	Health Care Licensure and Follow-Up		07/29/2023

Item #	Rule (16.03.22)	Description
1	.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 #2 had bruises of unknown origin on their left forearm on 2/2/23, on their left breast on 2/25/23, and on their left arm on 6/16/23. Also, when Resident #7 experienced a fall on 4/27/23 which required an assessment and treatment at the hospital, and had a bruise of unknown injury on their torso on 5/24/23. The administrator stated she should have reported these incidents to L&C.
2	.260.06. Toxic Chemicals.	The facility was not maintained in a clean, safe, and orderly manner. For example: Room #13 had a leaking radiator in the bathroom which had rotted out the flooring, exposing a large hole in the floor between floor joists. The bathroom upstairs across from room #27 had a leaking toilet with sunken flooring with water pooled up next to the left side of the toilet, bathroom D & E had a strong odor of urine from 6/26/23 to 6/29/23, the faucet in Bathroom E had a loose handle which could not be adjusted to a hot or cold setting, and a fluorescent light was missing a light cover upstairs next to room #21. The kitchen floor had broken vinyl tiles in the center of the kitchen with a broken floor board, and under the stove

		the floor had two blackened/broken vinyl floor tiles. The outside shed had a broken window with exposed jagged pieces of glass, broken siding with a birds nest in the wall of the shed, and had paint flaking off the shed on all four sides. ***Previously cited on 7/16/21***
3	.320. NEGOTIATED SERVICE AGREEMENT (NSA) REQUIREMENTS.	Seven of seven residents whose records were reviewed, did not have Negotiated Service Agreements (NSAs) which were updated to accurately reflect residents' current needs. For example: Resident #3 had total shoulder replacement surgery on 5/8/23 and the NSA was not updated to reflect current needs. Resident #4's NSA did not contain all pertinent information, such as eating, toileting, mobility, money management, shopping, night needs, emergency evacuation, or supervision. NSAs for Resident #3 and #6 were not signed by the residents, legal representatives, nor family members. The administrator stated the NSAs had not been updated, did not include all pertinent information, and needed to be signed. ***The facility previously received technical assistance on 7/16/21.***
4	.330.04.c. Resident Care Records.	The facility did not consistently document investigations of unusual events, interventions to prevent further incidents, and nursing assessments when residents experienced a change in their condition. For example: Resident #7 had bruises of unknown injury below their eye on 4/8/23, to their torso on 5/24/23; and had a fall on 4/27/23. Resident #7's chart did not contain documentation of an investigation for either bruise, and did not contain evidence of an intervention for their fall on 4/27/23. Resident #6 experienced falls on 3/10/23 and 4/7/23, and their chart did not contain change of condition assessments or interventions to prevent further falls. The administrator stated the aforementioned investigations and interventions were completed but were not documented. The facility nurse stated she assessed residents for the aforementioned changes of condition but she had not

		documented the assessments.
5	.330.14. As Worked Schedules.	The facility's as-worked schedule did not document the specific times worked, last names, nor their positions. The administrator and the facility nurse did not have an as-worked schedule. ***Previously cited on 7/16/21***