NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
The Willows	RC-1288	898 S. Meridian Street	208-782-1478
Administrator	City	Zip Code	Survey Date
Nichole Hymas	Blackfoot	83221	08/11/2023
Survey Team Leader	Survey Type		Response Due
McClenathan, Teresa	Health Care Initial Licensure		09/10/2023

Item #	Rule (16.03.22)	Description
1	.250.09. Resident Sleeping Rooms.	The facility's hot water temperatures were not consistently maintained between 105 and 120 degrees F. For example, the water temperatures taken in room #40 on 8/8/23 and 8/11/23 were 128 and 125 degrees F, respectively. The administrator stated they were unaware the water temperatures were out of range and would have maintenance personnel work on the boiler, clearing out sediment, until the temperatures were corrected to the appropriate range.
2	.260.06. Toxic Chemicals.	The facility was not maintained in a clean, safe, and orderly manner. For example, multiple walls, doors, door frames and baseboards were observed to be missing paint, gouged and soiled throughout the facility. In the front of the facility and in the back courtyard, there was loose and crumbling concrete on the walkways and concrete parking blocks, which posed a trip hazard for residents. The exterior building had damaged and missing siding, as well as broken gutter downspouts laying on the ground. The flooring in the dining area in front of the beverage bar area was sunken from a previous water leak causing a trip hazard, as multiple residents refilled their beverages in this area throughout the day. In the hallway between rooms 31 to 40 and in the memory care, there was a

		strong odor of urine observed each day from 8/8/23 to 8/11/23. Also, throughout the memory care unit, the carpet was sticky and gummy. The administrator stated the flooring repairs were being scheduled, but these had not yet been completed. The other environmental issues listed above had not yet been addressed according to the administrator.
3	.305.02.b. Quarterly Nursing Assessments.	Residents did not consistently receive their medications as ordered. For example, Resident #5's hydroxyzine was ordered as needed, but the resident received this medication on a scheduled basis from at least 7/1/23 to 8/9/23. Resident #5 had buspirone 30 mg ordered daily, but the resident only received 15 mg daily between 7/1/23 to 8/9/23. In addition, Resident #5 was ordered to receive scheduled doses of mirtazapine, risperidone, lorazepam, ropinirole and melatonin but did not receive these medications from 7/1/23 to 8/9/23. The facility nurse stated she was not aware the residents were not receiving their medications as ordered.
4	.330.04.c.vii. Resident Care Records.	The facility nurse did not document when residents experienced changes of condition. For example, there was no assessment documented when Resident #1 had a foley catheter placed, had shortness of breath and was sent to the hospital on 6/5/23 and was diagnosed with pneumonia. There was no assessment documented when Resident #1 returned from the hospital on 6/8/23, nor when they had shortness of breath, sent to the hospital, and diagnosed with COVID-19 on 6/20/23. There was no assessment documented when Resident #1 expressed suicidal ideation on 7/12/23 and was sent to the hospital. Resident #5 did not have documentation of a change of condition assessment when they had an unwitnessed fall on 7/21/23 and was sent to the emergency room with a “skin tear, deformity, Complaint of pain, Bruise, Abrasion,” as documented on an incident report by a staff member. There was no assessment documented when Resident #7 eloped from the facility on 6/22/23. The facility

		nurse stated she assessed these residents for these changes but did not document the assessments.