NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
Apple Valley Residence	RC-1199	715 North Butte Avenue	208 365 1497
Administrator	City	Zip Code	Survey Date
Marilyn Godsill	Emmett	83617	09/01/2023
Survey Team Leader	Survey Type		Response Due
Rideout, Megan	Health Care Complaint Investigation		10/01/2023

Item #	Rule (16.03.22)	Description
1	.300.01. Licensed Registered Nurse (RN).	The facility RN did not complete the comprehensive nursing assessment prior to Resident #2's admission on 7/28/23. The facility LPN stated the "over-site" RN only signed off on the assessment.
2	.305.02.b. Quarterly Nursing Assessments.	The facility did not ensure residents received their medications as ordered. For example, Resident #1 did not receive their simvastatin four times, Clopidogrel three times, hydrocodone four times, and liothyronine sodium three times in June 2023. Resident #2 did not receive their gabapentin, insulin, lisinopril, famotidine, fexofenadine, or primidone from 7/28/23 to 7/31/23. The resident also did not receive their levothyroxine twice, lisinopril six times, gabapentin twice, duloxetine three times in August 2023. On 8/12/23 the resident was seen in the Emergency Department due to diabetes mellitus with hyperglycemia and was discharged with change in orders for their insulin and from 8/12/23 to 9/1/23 the resident received the wrong dose of insulin. The facility LPN was unaware of the change in insulin nor was she aware that she could test diabetics without an order.
3	.305.03. Change in Resident Health Status.	The facility LPN did not complete a change of condition assessment when Resident #2 went to the hospital on 8/12/23

		for blood sugar levels over 500. The facility LPN stated she did not conduct a nursing assessment for that visit.
4	.330.04.c.iii. Resident Care Records.	The facility LPN did not document when staff notified her of changes of condition of residents including the need to administer as needed medications, nor how she instructed the staff. The LPN also failed to document change of condition assessments when Resident #2 went to the emergency room on 8/12/23 due to high blood sugars, nor when they returned to the facility from the hospital. She also did not document when she discussed consequences of medication refusals of medications by multiple residents.
5	.330.04.c.vi. Resident Care Records.	The staff did not notify the facility LPN when Resident #2 had blood sugar levels over 300 on 8/10/23, 8/11/23, 8/12/23, 8/14/23, and 8/30/23, nor when resident hospice agencies instructed the staff to give as needed medications. The facility LPN stated she was not notified on these occasions by staff.