NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
Royal Plaza of Olympus Retirement	RC-1265	2870 Juniper Drive	208-746-2800
Administrator	City	Zip Code	Survey Date
Kaylyn Dault	Lewiston	83501	10/02/2023
Survey Team Leader	Survey Type		Response Due
Brown, Stacey	Health Care Complaint Investigation		11/01/2023

Item #	Rule (16.03.22)	Description
1	.215.01. Administrator Responsibility.	The facility did not ensure policies and procedures were implemented. For example: The facility's undated "Missing Resident/Elopement Procedures", documented, "Upon discovery of a missing resident, immediately implement these search procedures. This initial search should last no longer than 15 minutes before completing Step 2." The policy documented Step 1 procedures included: To conduct a "thorough search of the unit...checks all rooms including bathrooms, closets, offices, kitchen areas, etc."; if the resident was not found, the director of nursing (DNS) was to call the responsible parties "to inquire if the resident is with them or if they know of the resident's whereabouts...and reports as missing to the appropriate authorities." Step 2 procedures documented staff were to "coordinate emergency team for vehicle and foot search" and "contact the police." On 6/3/23 at 8:45 PM, Resident #9 was last seen in their room. On 6/4/23, Resident #9's family member came to the facility to visit at approximately 9:30 AM, 11:30 AM, and 2:30 PM, and Resident #9's door was locked. The care staff told the family member they assumed Resident #9 was out of the facility on a walk.

		The staff dismissed the family member's concerns that no one had seen their loved one that day, even though the resident missed their morning meal and their morning medications. Resident #9's family member came back again at 4:00 PM, and the resident room's door was still locked. The family member stated they waited at the facility for 30 minutes for Resident #9's return to their room, and there was no sign of Resident #9. At that time, they asked a staff member to unlock Resident #9's room. The family member stated the staff member rolled their eyes with a dismissive attitude towards the family member and went to Resident #9's room to unlock the door. The staff member and family member entered the room and Resident #9's bed was still made and their personal belongings, including their wallet, were in the room. The family member insisted the staff member find their loved one. The staff member called the facility nurse at 4:30 PM, and the facility nurse came into the facility to look for Resident #9. The facility staff began looking for Resident #9 around the interior and exterior of the facility. The facility nurse did not report Resident #9 was missing to the police until 3 hours after they knew the resident was missing, when the policy documented they were to contact the police after 15 minutes of searching had passed, as outlined in Step 2 of the facility policy. The facility nurse stated the police officer told her Resident #9 was disturbing the peace at a department store approximately a mile away from the facility on 6/3/23 after 9:00 PM, was subsequently hit by a car around 11:45 PM, and was pronounced dead at approximately 12:30 AM on 6/4/23. The facility's "Behavior Management" policy, dated January 2022, documented the facility will "Develop and implement behavior management plans with residents who exhibit patterns of disruptive or inappropriate behavior," and "Staff should observe over a period of several days and keep a log to

		determine triggering events and patterns. Such behaviors and patterns and triggering events should then be documented in the Behavior Management Plan." This policy was not followed when Resident #1 exhibited behaviors of yelling and hitting staff in August 2023, nor when Resident #2 exhibited exit seeking and resisting care behaviors on multiple occasions per multiple staff members' interviews. Refer to citations for rules 330.06.a and b.
2	.215.08.e. Corrective Action.	Residents' interventions were not effective and appropriate to prevent recurrences. Since the last survey on 5/26/23, Residents #1, #2, #5, #6, and #8, who all had a diagnosis of dementia or cognitive impairment, sustained falls with the same intervention put into place after each fall or the intervention was inappropriate. For example, Resident #8, who had a diagnosis of dementia, had fallen 11 times between 5/28/23 to 9/22/23, including 5/28/23, 5/29/23, 5/31/23, 6/14/23, and 7/4/23, with the same intervention of "reminded resident to wear proper footwear and to call for assistance if feeling unsteady." Resident #8 fell on 8/6/23 and 8/17/23 with the intervention to "reminded resident to call for assistance if feeling unsteady." On 8/25/23 at 7:20 AM, Resident #8 fell and was reminded to use life line for assistance. Multiple staff members stated Resident #8 was marked confused and was unable to remember to use their call light for assistance. On 8/25/23 and 8/26/23, Resident #8 fell and the intervention was, "Resident will be moving to new facility," with no other intervention put into place to keep the resident safe from falling until they moved. On 9/3/23, Resident #8 fell again, with an intervention to "reminded resident to wait for help". On 9/12/23, Resident #8 fell and was sent to hospital for assessment, and the intervention was documented as, "called family about finding more appropriate facility". On 9/13/23, Resident #8 fell, and the intervention was "frequent checks on resident and try to keep [them] in common area." On 9/22/23,

		Resident #8 fell and was moved to a more suitable facility. The administrator stated she was unsure what interventions to put in place for Resident #8, other than "frequent checks," with no specific schedule to provide increased supervision to prevent further incidents for any of the aforementioned residents.
3	.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 #9 died due to an incident on 6/3/23; when Resident #8 fell on 9/12/23 and required evaluation at the hospital; nor when Resident #5 fell on 8/6/23 and required evaluation at the hospital. The administrator stated these incidents had not been reported to L&C within one business day.
4	.320.08. Periodic Review.	Negotiated service Agreements (NSAs) were not updated to reflect significant changes in residents' health status and care needs. For example, Resident #5's NSA did not address repeated falls and how staff should prevent further falls, such as increased supervision, nor that they required stand by assistance for transfers/mobility. Residents #1 and #6's NSAs documented they were oriented to person and time. Both residents were observed to be markedly confused multiple times during the survey, and several staff members stated Resident #1 and Resident #6 were confused and not oriented to person and time. The NSAs gave no instruction to staff that Residents #1 and #6 would be unsafe to leave the facility alone, and Resident #6 had a history of elopement prior to admission according to their family. The administrator stated it was the facility nurse's job to update the NSAs, and they were not up-to-date on documentation, including NSAs.
5	.330.04. Behavior Documentation.	The facility did not ensure all residents' care records were kept current, complete, and authentic. The facility's caregiver notes were documented in a spiral notebook and did not consistently include dates, times, names, and titles of the person making the entry. Staff did not sign each entry made by them during their shift. Entries were not completed by the

		person providing the cares, when staff members documented in a spiral notebook, then medication technicians or the wellness coordinator entered this information into the facility's electronic record system. Additionally, ongoing tracking of resident behaviors, which included date, time, and maladaptive behavior observed was not documented in Resident #2's record. Multiple staff members stated Resident #2 had eloped from the facility, and they did not document these occurrences in Resident #2's record. The former facility nurse stated she documented progress notes in regarding Resident #9 throughout their time at the facility, but no documented progress notes by the nurse could be found from 5/17/23 to 6/4/23. The administrator stated the facility's system for documenting caregiver notes needed to be changed.
6	.330.06.a. Additional Resident Records.	The facility did not evaluate the following behaviors: Resident #1's behaviors of yelling and hitting staff nor Resident #2's exit seeking and refusals of care. The administrator stated the facility had not completed evaluations for Resident #1 and #2, and Resident #1 was also started on an antipsychotic medication.
7	.330.06.b. Additional Resident Records.	The facility did not develop behavior plans with interventions after residents engaged in maladaptive behaviors. See non-core deficiency 330.06.a for examples.
8	.600.04.a. Sufficient Personnel.	The facility did not have sufficient personnel working every shift to meet the needs of the residents. For example, Resident #2, who had a known history of dementia and confusion, attempted to elope on multiple occasions from the facility over the past few months, and at least one time, was found off the property entirely according to staff members interviewed. Staff members, including the previous facility nurse, stated they were instructed to do "hourly checks" of this resident, but did not consistently have enough staff to sufficiently supervise this resident, particularly on the evening shifts, when the

		resident usually attempted to elope. Other residents stated they would have to locate a staff member when they noticed confused residents leaving the property, as there was no staff available in the immediate area to supervise the residents. Multiple staff members and cognizant residents stated there was not enough staff to assist and supervise the residents, particularly on the evening shifts and over the weekends. One resident stated, "I don't like weekends because there is no one here to help me." Residents stated they would activate their call light system during the evening hours for assistance with cares or to request a medication, but no staff member came to assist, forcing the resident to leave their room and seek out a staff member for assistance. One family member stated their loved one was sick within the last year, but there was not enough staff to adequately check on the ailing resident, so the family hired someone who lived in the area to go to the facility and check on the resident to ensure they were being cared for. Multiple past and present caregivers and nursing staff stated there were times, due to insufficient staffing, the residents waited extended periods for assistance, and cares such as toileting and showering were not completed. At times, staff members stated they would find residents markedly soiled, because there had been no time to toilet the resident for extended periods. The administrator stated there had been periods of time since the last survey in which there was insufficient staff at the facility, including nights and weekends when there were only two staff members in the building to assist 90 residents.
9	.645.02. Delegation.	Seven of eight current staff members passed medications between 7/5/23 to 8/15/23, without being delegated by the facility nurse, who started with the facility on 7/5/23. One of these staff members had never been delegated by the current facility nurse and continued to pass medications. The administrator acknowledged the staff had not been delegated

		by the facility nurse prior to passing medications.