NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
Autumn Haven Assisted Living, Inc.	RC-1256	924 Christian Way	208-436-3200
Administrator	City	Zip Code	Survey Date
Angie Darrington	Rupert	83350	12/13/2023
Survey Team Leader	Survey Type		Response Due
Rideout, Megan	Health Care Licensure and Follow-Up		01/12/2024

Item #	Rule (16.03.22)	Description
1	.009.01. Criminal History and Background Check.	The facility did not complete background checks for all employees who had direct resident access. For example, 1 of 4 staff members, whose personnel records were reviewed, worked directly with residents without having a completed criminal history background check. Upon interview with the manager, it was confirmed the Department Criminal History and Background Checks were not completed. The facility used a third party background check service, however, the check did not require a fingerprint check nor did it check with the Federal Bureau of Investigation.
2	.215.01. Administrator Responsibility.	The facility's abuse/neglect/exploitation policy did not include all elements required. For example, the policy did not contain how residents, family, and visitors would be educated regarding abuse/neglect/exploitation; specific directions for residents, visitors and outside providers to immediately contact the administrator; what to do if the administrator is the suspected alleged abuser; identify where the documentation will be stored; the various conclusions the administrator may reach; for cases when the alleged perpetrator is a resident; interventions to prevent further

		abuse/neglect/exploitation are implemented and to ensure steps that will be taken to ensure the perpetrator has no further access to potential victims. ***Previous technical assistance provided on 6/30/22***
3	.215.08.b. Investigation within Thirty Days.	The administrator did not conduct an investigation within 30 days when Resident #3 grabbed an unsampled resident's breast on 9/14/23, 10/12/23 and 12/4/23 nor when Resident #3 grabbed another unsampled resident's bottom on 9/18/23 or when Resident #3 tried kissing an unsampled resident on 9/19/23. The administrator stated investigations had not been completed but the facility cameras were reviewed.
4	.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 two unsampled residents' fell and sustained injuries. One resident required staples to the head at the emergency department and the other resident sustained a skin tear to the hand and required outside treatment. The facility administrator stated she was unaware these incidents needed to be reported to L&C.
5	.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 #1 and #3 on 12/11/23 were 128 degrees F. The administrator stated they were unaware the water temperatures were out of range and would turn down the temperature on the water heater until it was to the appropriate range. ***Previous technical assistance provided on 6/30/22***
6	.310.04.e. Psychotropic or Behavior Modifying Medication.	Six-month psychotropic medication reviews were not completed for two of two residents who required them. For example, Resident #2 was taking Seroquel and lorazepam, and there had been no psychotropic medication review completed since May 2022. Resident #4 was taking lorazepam and sertraline, and there were no six-month psychotropic medication review completed since May 2022. The facility nurse confirmed there were no current medication reviews for

		these residents.
7	.320. NEGOTIATED SERVICE AGREEMENT (NSA) REQUIREMENTS.	Four of four residents whose records were reviewed, did not have Negotiated Service Agreements (NSAs) which were updated to accurately reflect residents' current needs. For example: Resident #1 needed a Raizer Lifting Chair to transfer off the floor and the NSA did not include instructions for using the lifting device or instructions for caring for a catheter and when to notify the nurse. Resident #3 had behaviors of unsolicited sexual advances toward other residents and staff and the NSA did not contain documentation regarding their behaviors. Resident #1-#4's NSAs did not contain all pertinent information, such as money management, shopping, night needs, transportation, and/or supervision. The facility nurse stated the NSAs had not been updated and did not include all pertinent information. ***Previous technical assistance provided 6/30/22***
8	.330.04.c.vi. Resident Care Records.	The staff did not notify the facility nurse when Resident #1 vomited and had diarrhea on 9/13/23 and was nauseated and had diarrhea on 10/4/23. Resident #3 had a headache on 8 occasions between September 2023 and November 2023, body pain on 9/6/23, 12/6/23, 12/7/23, neck pain on 10/5/23, and left leg pain on 10/23/23. Resident #4 was dizzy on 11/15/23, 11/18/23 and when they had shoulder pain on 10/11/23 or when they had injections in their eyes and were seeing pink dots. The facility nurse stated she was not notified on these occasions by staff.
9	.330.06.a. Additional Resident Records.	The facility did not ensure the residents maladaptive behaviors were assessed. For example, Resident #3 had seven unsolicited sexual advances toward other residents between September 2023 and December 2023. The administrator stated these behaviors had not been assessed.
10	.330.06.b. Additional Resident Records.	The facility did not develop a behavior plan that included specific interventions for Resident #3's behaviors, as outlined in non-core punch 330.06.a. The administrator and facility

		nurse both stated the facility had not developed a behavior plan with specific interventions for Resident #3's behaviors.