NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
Brookdale Pocatello	RC-770	1501 Baldy Avenue	208-237-6866
Administrator	City	Zip Code	Survey Date
Jeanene Lindsey	Pocatello	83201	02/07/2024
Survey Team Leader	Survey Type		Response Due
Brown, Stacey	Health Care Complaint Investigation		03/08/2024

Item #	Rule (16.03.22)	Description
1	.215.08.e. Corrective Action.	The administrator did not ensure effective corrective actions were put into place to prevent recurrence of incidents. For example, Resident #1 fell three times in December 2023, with the most recent fall resulting in a fracture in their lumbar spine, and the only corrective action put into place was to remind the resident to use their call light. Resident #4 had three falls in January 2024, and their record did not document what interventions were put in place to prevent this from reoccurring. The previous nurse, who worked at the facility at the time of these incidents, stated they put fall mats down in Resident #4's room to prevent injury but did not implement other corrective action to prevent the falls themselves. She stated it was the previous administrator's responsibility to ensure corrective action was put into place to prevent recurrence.
2	.310.01.a. Medication Distribution.	Multiple staff members, residents, family members, and outside agency staff stated medications were observed, on several occasions, to be left unattended on the medication carts and/or in the nurse's office, with the door left open. The previous and current facility nurses stated they were unaware medications had been left unattended.

3	.320.08. Periodic Review.	Residents' Negotiated Service Agreements (NSAs) were not updated to reflect significant changes in residents' health status. For example, Resident #1's NSA was not updated after they experienced a marked decline in their condition, after being hospitalized for a fracture in their lumbar spine on 12/30/23. When Resident #1 was readmitted to the facility in January 2024, they were put on hospice, required one-person assistance for transfers and mobility, stayed in bed most of the day, and was "dependent for all ADLs except feeding," according to the hospice notes from January and February 2024. Resident #1's NSA, dated 10/11/23, had not been updated to include hospice. The NSA documented Resident #1 needed only minimal assistance and could manage most tasks, including showering and toileting, with just standby assistance. Resident #4's NSA, dated 9/18/23, documented the resident was independent with toileting, but as of December 2023, they required assistance with toileting as they were at high risk for falls. Resident #5's NSA documented they were independent with eating. However, multiple staff stated the resident required assistance with eating in the last couple of weeks before their death. Staff members stated they attempted to assist Resident #5 with eating, but the resident often refused to eat, as their condition was declining and were no longer hungry. The former facility nurse stated "stuff got missed" when the facility took away her assistant, and the NSAs were not always updated. She stated the former administrator was also responsible for updating the residents' NSAs.
4	.645.02. Delegation.	Eight of eight staff members, who passed medications, were not delegated by the current facility nurse. At the time of survey, the current facility RN stated she had worked at the facility for less than two weeks, and she had not yet had time to complete staff delegation. ***Previously cited on 10/19/22***