NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
Edgewood Spring Creek American Falls, LLC	RC-1005	605 Hillcrest Avenue	208-226-1856
Administrator	City	Zip Code	Survey Date
Jared Mangum	American Falls	83211	03/01/2024
Survey Team Leader	Survey Type		Response Due
Brown, Stacey	Health Care Licensure and Follow-Up		03/31/2024

Item #	Rule (16.03.22)	Description
1	.009.01. Criminal History and Background Check.	Two of seven employees, whose personnel records were reviewed, did not have a Department Criminal History and Background Check. Upon interview with the administrator, it was confirmed the Department Criminal History and Background Checks were not completed.
2	.215.08.e. Corrective Action.	The administrator did not ensure effective interventions were put into place for each resident to prevent recurrence of incidents and accidents. For example, during transfers, Resident #5 fell on 8/30/24, 1/13/24, and 1/16/24, with no interventions put into place to prevent further falls. Resident #6 sustained skin tears to both lower extremities on 9/8/23 and 2/25/24, as well as a "bump with blood pool underneath" of the right lower extremity on 10/5/23 and bruising of the left elbow on 2/27/24, and no interventions were put into place to prevent further injuries. Resident #7 fell at least seven times between December 2023 and February 2024, usually from falling asleep and rolling out of bed or a chair, but no corrective action was put into place to prevent further falls. The administrator stated he would be more involved with investigations of incidents and ensure corrective action

		measures were put into place and documented for each resident. ***Previously cited on 3/29/23***
3	.260.06. Toxic Chemicals.	There were multiple areas of paint missing from facility interior walls and door jambs such as in the entryway and living room, with gouges in the wood of multiple door frames, including the front door. There was a hole in the door of one of the hall bathrooms. There were multiple broken tiles in the floors of the facility, including in the hall bathroom and dining room. There were stains in the carpet of multiple resident rooms, including room 31. In the exterior of the building, there were multiple areas of broken and crumbling concrete in the walkways, with several areas where the concrete is uneven, causing trip hazards.
4	.305.02.a. Quarterly Nursing Assessments.	The facility nurse did not ensure each resident's medication orders matched the medication containers. For example, Resident #1's Lantus insulin was ordered for 10 units to be given twice daily, but the insulin pen label documented 10 units at bedtime only and did not document they were to receive a dose in the morning. Resident #1's Novolog order was for 6 units three times a day, but the insulin pen label documented 10 units three times daily. Resident #6's generic Miralax was ordered for 17 grams, three times per week, but the bottle label documented the resident should be given 17 grams every morning. Resident #6 was also ordered to receive Ayr Saline gel intranasally four times daily due to their history of epistaxis, but the tube was labeled to give three times daily. On medication pass observation, an unsampled resident was to receive ropinirole 2mg, 1/2 tablet three times daily per the bubble pack, but the order documented they were to receive this medication four times daily. The facility nurse stated she had spoken to medication technicians multiple times in staff meetings about ensuring the Medication Administrator Record, orders, and medication containers were congruent.
5	.305.02.c. Current Medication Orders and Treatment Orders.	Multiple residents' charts did not contain a copy of all

		providers' orders. For example, Resident #4's chart did not include discontinuation orders for Clearlax, aspirin, cetirizine, Chlorhexidine, and olopatadine drops, and they were no longer using these medications. Resident #5's record did not include a signed order for their antacid, and Resident #6's record did not have signed orders for Ayr Saline, duloxetine, furosemide, prednisone, and sulfacetamide solution. Resident #7 did not have a signed order for their oxygen nor a signed discontinuation order for Norco. The facility nurse stated she thought all of the signed orders were in the charts, but many of these were in her email inbox only.
6	.320.08. Periodic Review.	Residents' Negotiated Service Agreements (NSAs) were not consistently updated when they experienced a change in their conditions. For example, Resident #2's NSA documented they were independent with ambulation, however used a walker, they needed "some supervision" with bathing and no outside services were documented when they had physical therapy. Resident #3's NSA did not have documentation of resident's wound to their left lower extremity nor the burn to their right lower extremity. Resident #7's NSA documented they had "no special respiratory equipment, but the resident was using oxygen. The resident was also using a transfer pole, which was not documented in the NSA, nor did the NSA direct staff on how to care for the resident's left foot wound, such as what to do if the bandages came off after hours. The NSA stated the resident had "no behaviors that require intervention," when multiple staff members stated Resident #7 exhibited maladaptive behaviors.
7	.330.04.c.vii. Resident Care Records.	The facility nurse did not consistently document residents' change of condition assessments. For example, the facility nurse stated she assessed Resident #5 and #7 after their falls, as outlined in the citation for rule 215.08.e, but she had not documented the physical examinations she completed of these residents. She stated she also assessed Resident #3 for a

		wound on their left lower extremity, as she assessed this wound during the outside agency nurse visits, but there was only one assessment of the left leg wound documented by the facility nurse in the resident's chart. Multiple residents interviewed verified the facility nurse had been assessing them for changes in their conditions, such as wounds or after a fall.
8	.330.06.b. Additional Resident Records.	The facility did not develop behavior plans which included specific interventions for 3 of 3 sampled residents who required a behavior plan. For example, Resident #3 becomes confused and slaps staff. Resident #4 throws things when they become angry, has a history of suicidal ideation and self isolation. In Resident #7's "Notes" section of the electronic medical record, caregivers documented in the last six months, Resident #7 had repeatedly refused showers, had refused to have their blood glucose checked, had screamed at and swore at staff members and threw a plate, and told another resident to "blow me." The facility nurse stated she needed to update Resident #5's plan with specific interventions and create behavior plans for Residents #3 and #7.