NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
Mountain Springs Assisted Living Center	RC-1285	3254 Spirit Lake Cutoff Road	208.263.2273
Administrator	City	Zip Code	Survey Date
Heather Parker	Spirit Lake	83869	03/15/2024
Survey Team Leader	Survey Type		Response Due
Perry, Bradley	Health Care Initial Licensure + complaint investigation		04/14/2024

Item #	Rule (16.03.22)	Description
1	.215. REQUIREMENTS FOR A FACILITY ADMINISTRATOR.	The facility operated without a licensed administrator overseeing the day-to-day operations at the facility for 16 days from 4/5/23 through 4/21/23, for 20 days from 7/7/23 to 7/27/23, for 20 days from 8/3/23 to 8/23/23, for 12 days from 1/4/24 to 1/16/24, and for 12 days from 3/1/24 to 3/13/24. The Administrator stated the facility did not always have a licenced administrator.
2	.305.03. Change in Resident Health Status.	The facility Nurse did not conduct nursing assessments when residents experienced changes in physical or mental health status. For example, Resident #1 was not assessed when they had a bruise from hitting their hand on 1/1/24 and when they fell on 1/21/24. Resident #2 was not assessed after they wandered off the premises on 3/3/24. Resident #4 was not assessed when they had a fall on 2/6/24 and a bruise to their foot on 2/21/24. The facility Nurse stated she did not always complete a change of condition assessment on residents.
3	.310.04.e. Psychotropic or Behavior Modifying Medication.	Six-month psychotropic medication reviews were not completed for residents who required them. For example, Resident #1 was taking Olanzapine and Citalopram for longer than six months and there had been no psychotropic

		medication reviews completed. Resident #4 was taking Trazodone for longer than six months and there had been no psychotropic medication reviews completed. The Administrator was unaware the psychotropic medication reviews had to be completed every six months.
4	.600.04.a. Sufficient Personnel.	The facility did not sufficiently schedule staff during the night shift to keep residents safe when the facility only had one staff at night. In addition, staff did not act in a safe and timely manner when a confused resident eloped from the facility on 3/3/24. For example, the as-worked schedule for March 2024 documented the facility did not always have two staff during the night shift. Residents #1 and #2 had diagnoses of dementia, were observed to be confused, and according to staff, both residents needed redirection to come back into the facility. Resident #1's 12/12/23 Negotiated Service Agreement documented they had "been known to go farther away" from the building, and staff would keep the door alarm on and walk with them if they went out. The facility nurse stated she had concerns about Resident #1 who would go out the front door to feed the deer, and staff needed to redirect them back inside. An incident report for Resident #2 documented they eloped on 3/3/24 and they were found on the road. The Administrator stated according to video footage, on 3/3/24, staff watched Resident #2 go out a side door, and those staff members did not attempt to bring them back inside the facility. Resident #2 wandered off the premises and was brought in by another staff member who was on their way to work. The Administrator stated the facility did not always have two staff on at night, and after the incident with Resident #2, the facility installed an alarm for the side and front doors to alert staff when the doors were opened. The facility Nurse stated she had not assessed Resident #2 after the elopement incident to determine if they were still safe for the facility.