NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
Heritage Senior Living	RC-1116	155 + 175 East 3rd North	208-852-2273
Administrator	City	Zip Code	Survey Date
Bradley Wall	Preston	83263	05/21/2024
Survey Team Leader	Survey Type		Response Due
Lu, Melvin	Health Care Licensure and Follow-Up		06/20/2024

Item #	Rule (16.03.22)	Description
1	.009.03.b. Availability to Work.	One of ten staff members, whose personnel records were reviewed, provided supervision and cares for residents on shifts in April 2024 and May 2024 without having a completed criminal history background. The Operations Manager confirmed the background check was still pending at the time of survey, and the employee worked alone with residents without line-of-sight supervision.
2	.009.06.c. Use of Previous Criminal History and Background Check.	One of one employees, whose files were reviewed and required an Idaho State Police background check, did not have the check completed prior to working alone with residents since they started in December 2023. The Operations Manager confirmed the Idaho State Police background check result was not completed at the time of survey and the employee had been working alone with residents.
3	.154.01. Response to Accidents, Incidents, or Allegations of Abuse, Neglect, or Exploitation of Residents.	Facility staff were not adequately trained on the process for notifying the facility nurse when a resident experienced a change in their health condition, nor were they trained on how to care for residents after incidents to prevent further injury. For example, Resident #4 had a fall on 11/5/23 which resulted in a closed fracture of the left femur. The fall reportedly happened after lunch, according to the incident report

		timestamped 1:47 PM; however the facility nurse was not notified and the resident was not sent to the hospital until after 9:15 PM, as the facility was waiting on the hospice nurse and family to decide if outside treatment was required. Resident #4's Admission Agreement, signed on 2/15/20, documented in the "Emergency Transfers" section, "Residents who require immediate medical care for acute illness or injury or psychiatric intervention will be transferred to the nearest emergency community. Residents will be transferred in such an emergency without prior notice to the resident's responsible party." Resident #4 was readmitted to the facility on 11/30/23, and 11 of 11 staff members interviewed stated they were not provided training from the facility nurse on how to care for the resident appropriately with these types of injuries, including a femur fracture, nor how to prevent Resident #4 from further falls, other than to check on the resident on a frequent basis. There was an observation note, dated 5/8/24, for example, in which a caregiver documented they were teaching other staff members how to properly use the Hoyer lift with Resident #4.
4	.215.01. Administrator Responsibility.	The facility administrator did not ensure all facility policies and procedures were implemented. For example, the facility's undated "Accident/Incident Policy and Procedure" documented all incidents were to be reported to the administrator and "Community RN," and this nurse would assess every resident following an incident. The policy documented the Administrator would follow-up on the incident and would include "ways to prevent the incident from happening again..." The policy documented the Administrator would "...turn to the RN or Doctor for assistance in creating a plan for correction and updating the care plan if needed." The facility's undated "Admission Policy and Procedures" documented, "There will be a strict admission procedure to follow with each potential admit," to include assessment by

		the RN prior to admission to determine if the resident was "a good fit." However, these procedural steps were not completed for each sampled resident who experienced an incident or accident as outlined in non-core citations 154.01, 215.08.e, 305.03, 319.04, and 320.08.
5	.215.08.e. Corrective Action.	The facility did not ensure effective corrective action was put into place to prevent incidents' recurrence for five of ten sampled residents. For example, Resident #9 fell three times between 4/27/24 and 5/3/24, and there was no corrective action after these falls. Resident #4 fell thirty-one times between 12/6/23 and 5/13/24, and corrective action were not monitored for effectiveness, as the resident continued to fall. Resident #5 had seven falls between 2/9/24 and 5/11/24, and there was no corrective action put into place after four of the falls and a repeated corrective action for one of the falls. The Operations Manager acknowledged the facility had not implemented new and effective interventions after each incident to prevent recurrence.
6	.215.08.g. Identify and Monitor Patterns.	The administrator did not monitor patterns of incidents nor develop interventions to prevent recurrences. For example, Resident #4 sustained 31 falls between 12/6/23 and 5/13/24 and the same interventions were documented after each fall, including using the bed alarm and performing two-hour safety checks of the resident. Multiple caregivers stated they had noticed Resident #4 fell primarily on the overnight shift, when there were less staff members in the building, and they determined the resident fell less frequently if they repositioned the resident more frequently or sat with the resident and monitored them on a one-to-one basis. The facility owner stated the administrator had not been tracking incidents and accidents.
7	.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 on 5/14/24 in memory care rooms

		#E-4 and #E-9 were 127 and 129 degrees F. The water temperatures taken on 5/14/24 in the main building rooms #W-9 and #W-5 were 122 and 129 degrees F. The administrator was informed of the temperatures out of range on 5/14/24 and the temperatures continued to be out of range when retested on 5/15/24 and 5/16/24.
8	.260.07. Toxic Chemicals.	Toxic chemicals were observed to be stored in an unlock area which was accessible to cognitively impaired residents on three different occasions from 5/14/24 to 5/16/24. For example, the shower room in the memory care unit had dermal wound cleanser, spray disinfectant, antifungal powder and was observed to not be locked. The main building had unsecured disinfectant spray on the medication carts, observed throughout survey.
9	.300. REQUIREMENTS FOR NURSING SERVICES.	The administrator failed to ensure policies and procedures were developed and implemented to ensure nursing services were completed, including coordination of care for each resident. During survey, between 5/14/24 and 5/21/24, it was identified there were multiple nurses involved in resident care at the facility. However, it was not clearly delineated which nurses were acting as facility nurses and which nurses were acting as outside agency nursing staff. For example, when Resident #4 sustained numerous falls between 12/6/23 and 5/13/24, they were assessed for a change of condition by either the facility nurses or outside agency nurses. However, when the outside agency nurses completed residents' change of condition assessments, the facility nurses did not consistently follow up on the issues or perform their own assessments of the residents. In addition, Resident #4's hospice nurse provided training to individual facility staff members related to their recommendations for certain modalities such as Hoyer lift training, catheter care, and fall prevention training. However, the facility nurses did not follow-up on these recommendations to ensure the other

		facility caregivers received training for these modalities. Also, the recommendations by outside agency nurses for Resident #4 were not consistently reviewed by the facility nurses as many of the outside agency records were not obtained for the residents' records, nor did the facility nurses ensure the recommendations were implemented, monitored for effectiveness, and added to the residents' Negotiated Service Agreements for care staff to follow.
10	.305.02.b. Quarterly Nursing Assessments.	The facility nurse did not ensure residents received medications and treatments as ordered by their provider. For example, Resident #1 had a diet order for "finely chopped meats, shredded," and it was observed on 5/14/24 the resident received large cut-up meat during lunch. Resident #1 was ordered to receive a fentanyl patch for pain control every 3 days, and the medication was not available on 4/4/24 and 4/7/24. Resident #3 was ordered to receive metformin 500 mg twice per day, but the medication was not available from 4/7/24 to 4/9/24. Resident #6 did not have 14 doses of medications available between 3/29/24 and 5/13/24, including pravastatin and fenofibrate. Resident #7 was ordered to receive a weekly diabetic medication injection, but they had not received this injection for two weeks prior to this survey, as it was not available. In addition, medication technicians documented they held Resident #7's Novolog on 4/7/24, 4/8/24, 4/29/24 and 5/8/24 due to their "vitals" being out of range, but the resident should have received insulin on those dates, according to the provider's order, and based on their elevated blood glucose readings on those dates. The facility nurse stated she was not aware residents had not been receiving their diet and medications as ordered.
11	.305.03. Resident Health Status.	The facility nurse did not perform assessments when residents experienced a change in mental or health status. For example, Resident #9 experienced falls on 4/27/24 and 4/28/24. Resident #2 had two falls on 5/11/24 and was not assessed

		until 5/13/24 after they had a third fall. Resident #3 experienced right lower jaw pain on 4/20/24, as well as a small sore to the left side of their buttocks on 3/18/24. Resident #4 received multiple skin tears to their neck, chest, arms, and penis during the month of April 2024 due to falls and was not assessed by the facility nurse. The facility nurse stated she had not completed assessments for these incidents. Medication technicians, who worked in the memory care building, stated if a resident could not ask for a PRN medication themselves, and it appeared they needed a medication such as for pain or agitation, they assessed the resident themselves and gave the medication. They stated the only time they called the nurse was if they wanted to give a narcotic medication to the resident. In addition, the nurse stated she had not been monitoring Resident #7's glucose levels, which had been as low as 96 and as high as 293 between 4/1/24 and 5/17/24, nor had she been assessing whether or not they were receiving the correct amount of insulin according to the ordered sliding scale, since medication technicians had not been consistently documenting what amount of insulin units were given to Resident #7. ***Previously cited on 6/23/21 (at 300.02), 10/17/18, and 3/2/17***
12	.310.01. Medication Distribution.	In the facility's medication room, there were six bubble packs observed in a house supply box. Five were labeled with the facility name only, including one bubble pack of ibuprofen 200 mg, one pack of loperamide 2 mg, and three bubble packs of acetaminophen 500 mg, along with a bag of cough drops. There had been doses popped out of all of these bubble packs. There was another bubble pack of acetaminophen 325 mg labeled with an unsampled resident's name in the house supply box as well. The facility's Operation Manager stated there were bubble packs available in the medication room for some of the PRN medications not on the cart, which could be used if a resident required one of the medications. She stated

		the label was supposed to be changed to the specific resident who required a dose and placed in the medication cart for that resident's use only. However, one medication technician stated they had not been told the bubble packs needed to be relabeled with the specific resident's name and no longer use the bubble pack as a house supply.
13	.310.01.a. Medication Distribution.	On 5/14/24, surveyors observed of over-the-counter medications in Resident #5's room, including Tums, acid reducer, Vicks Vapor Rub, and hydrogen peroxide. Resident #3's roommate had their medications unsecured on the kitchen counter of their room. During 5/14/24 and 5/16/24 observations in the memory care unit, the doors to Resident #3 and #4's rooms were observed to be unlocked.
14	.310.01.c. Medication Distribution.	The temperatures for the facility's medication refrigerators, which contained insulin, were not monitored and documented daily. For example, temperatures in the main building were not documented from 4/1/24 to 5/4/24 and 5/6/24 to 5/13/24. April 2024 temperature logs for the East building documented the temperature were between 32 to 37 degrees for eight days and were not documented for six days. The Operations Manager acknowledged the lack of monitoring the temperatures.
15	.310.01.g. Medication Distribution System.	The facility did not ensure all ordered as-needed (PRN) medications were available to residents at all times. For example, during survey it was observed Resident #6 had 13 PRN medications ordered including Senna Plus, hydroseptine, and Milk of Magnesia, but only 3 (colchicine, Norco and hydroxyzine) were available on the cart. Resident #7 had 10 PRN medications ordered, including benzonatate, promethazine, and ondansetron, and none of this resident's PRN medications were available on the cart. Resident #10 did not have PRN diphenoxylate-atropine and Alka Seltzer medication available. A medication technician stated if a resident does not ask for PRN medications frequently, they do

		not keep them stocked at the facility. The facility nurse acknowledged PRN medications needed to be available for residents. The Operations Manager stated all of the PRN medications were available in the house supply in the medication room, but only cough drops, ibuprofen, acetaminophen and loperamide were available upon observation.
16	.319.03. Nursing Assessment.	The facility's Registered Nurse (RN) did not consistently assess residents prior to admission. For example, Resident #4 was admitted to the hospital after they fractured their femur on 11/5/23, and they were not reassessed by the facility RN prior to being discharged from the hospital back to the facility on 11/30/23. The facility RN did not assess Resident #6 prior to their admission on 3/12/24. The facility Licensed Practical Nurse (LPN) stated she saw Resident #6 in the hospital prior to admission, but she had not completed a full assessment, as she was unaware the resident had been diagnosed with clostridium difficile colitis while hospitalized. Resident #10 was admitted to the facility on 11/8/23, but they were not assessed by the RN until the next day. The facility's previous RN confirmed she did not consistently assess these residents prior to or on the day of admission.
17	.320.08. Periodic Review.	Residents' Negotiated Service Agreements (NSAs) were not consistently updated to reflect significant changes in their health status. For example, Resident #1's NSA did not include who was responsible for showers if hospice did not complete these, nor did it include the residents diet order of "finely chopped meats, shredded," or how to comfort the resident when they cried due to their anxiety and PTSD. Resident #4's NSA stated they were independent with toileting and eating; however the resident required assistance with eating a puree diet and two-person assistance for toileting to include catheter care, such as how to secure the catheter so it did not cause further injury as documented in the hospice notes. The NSA

		also stated, that "staff must use the mechanical lift when transfering [them]. Do not lift [them] under [their] arms or use the gait belt until further notice", and that a gel cushion was needed to be used for comfort. During observation on 5/14/24 and 5/15/24 the resident was transferred using a gait belt and two-person assistance to transfer from a wheelchair to a recliner. Resident #6's NSA was not updated when their home health nurse made recommendations, such as how to cover the resident's wounds during showers or how to respond if the resident's wound vac malfunctioned. The Operations Manager stated that NSAs needed to be updated.
18	.330.04.c.vii. Resident Care Records.	The facility nurse stated she had assessed some residents' changes in condition but had not consistently documented the assessments. For example, the facility nurse stated she frequently assessed Resident #6's extensive left lower extremity wounds, as well as a skin lesion to their left check, but she had not always documented those assessments. Resident A caregiver had documented on 2/1/24 Resident #7 felt "off balance," their "skin 'feels creepy and cannot feel bottom of feet'," and the resident did not feel like themselves. The nurse stated she assessed the resident for these symptoms but had not documented the assessments.
19	.330.04.c.xii. Resident Care Records.	The facility did not consistently document residents had been counseled on the consequences of frequently refusing care or ordered medications, nor that the provider had been notified of these refusals. For example, Resident #9 had repeatedly refused all of their prescribed, scheduled medications including losartan, amlodipine, and atorvastatin between March 2024 to May 2024. Caregivers documented over 60 times that seven medications had been refused for Resident #9. Resident #7 had repeatedly refused their fluticasone, compression stockings, and Novolog doses on multiple occasions in April and May 2024. The facility nurse stated she had talked to the residents and their providers but had not

		documented these interactions.
20	.330.05.b. Discharge Records.	The facility did not obtain history and physical results for all residents when admitted to the facility, including for Residents #1, #4, and #6. For example, Resident #6 was admitted to the facility on 3/12/24, and no history and physical within the prior six months had been obtained or reviewed by the facility. There were no diagnoses in Resident #6's chart, which would have been obtained from the history and physical report, and the resident was taking medications for multiple medical conditions including hypertension, hypothyroidism, and diabetes.
21	.330.06.b. Additional Resident Records.	The facility did not develop a behavior plan that included at least one intervention for Resident #9 when they exhibited behaviors of recurrently refusing most of their medications, including losartan, amlodipine, and atorvastatin, in March and April 2024. The facility nurse stated she had tried to talk Resident #9 about his refusals but had not developed a behavior plan for these behaviors with interventions. Multiple staff members stated Resident #8 had been combative during care, hitting and yelling at staff, particularly with bathing and toileting, but there was no specific intervention for staff to utilize, other than to "do your best to not take no for an answer" outlined in the resident's NSA. The Operations Manager stated she had not developed any further interventions for Resident #8's behaviors.
22	.330.14. As Worked Schedules.	The facility's as-worked schedules did not document the times the administrator or facility nurses were at the facility. The administrator confirmed the times for these staff were not being documented.
23	.450. REQUIREMENTS FOR FOOD AND NUTRITIONAL CARE SERVICES.	The facility did not have any staff with Certified Food Protection Manager certification at the time of survey. The Dietary Manager's certification expired January 2024.
24	.630. TRAINING REQUIREMENTS FOR FACILITIES ADMITTING RESIDENTS WITH A DIAGNOSIS OF DEMENTIA, MENTAL ILLNESS,	Seven of ten staff members, whose personnel files were reviewed, did not have specialized training for mental illness,

	DEVELOPMENTAL DISABILITY, OR TRAUMATIC BRAIN INJURY.	three of ten did not have specialized training for alzheimer/dementia, and two of ten did not have training for developmental disability. The Operations Manager confirmed the staff members had not received these specialized trainings, and the facility maintained residents with these diagnoses.