NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
Sage Grove Assisted Living	RC-1093	290 North 4064 East	208-745-6229
Administrator	City	Zip Code	Survey Date
Amy Rackham	Rigby	83442	07/26/2024
Survey Team Leader	Survey Type		Response Due
McClenathan, Teresa	Health Care Licensure and Follow-Up		08/25/2024

Item #	Rule (16.03.22)	Description
1	.154. RESIDENT SAFETY REQUIREMENTS	The facility did not ensure all staff were sufficiently trained on and complied with facility policies, including policies on documentation, how to respond to residents' behaviors, how to properly use medical equipment, and when to call the facility nurse. For example, the facility nurse stated she was often not notified of changes in the residents' conditions. She stated the house managers were supposed to review caregivers' notes and forward those notes to her in the electronic record system for her to review and follow-up on, but the house managers had not been completing this process of forwarding the notes to her. The facility nurse stated she had not consistently documented when residents called or texted her, nor had the staff consistently documented these conversations. Several family members stated new staff members were insufficiently trained on how to respond to behaviors exhibited by residents with dementia. For example, one family member stated staff members repeatedly called about their family member yelling or trying to leave the facility, when these were behaviors the resident was known to exhibit, and is the reason they had been admitted to a facility which was supposed to be secured. Caregivers documented

		their frustration with residents' behaviors, such as when one caregiver documented they gave Resident #2 Seroquel and oxycodone when they displayed maladaptive behaviors on 7/7/24 and would not stop the behavior, without attempting the other interventions in the resident's behavior plan. A caregiver documented they were frustrated with Resident #1, when the resident was coming "out of [their] room EVERY 5 MINUTES asking questions on 7/15/24." Another staff member documented they told Resident #1 that they had "memory problems" when the interventions they tried were not effective with the maladaptive behaviors. On 3/25/24 and 6/27/24, a hospice nurse documented Resident #3 "continues with injuries" to their back caused by using the incorrect sit-to-stand straps, and on 2/26/24, a caregiver documented staff members had not been using the correct equipment to secure the resident's Foley catheter, according to the hospice nurse. The administrator stated the staff member required further training on documentation, working with residents with dementia, or how and when to notify the facility nurse of issues. She stated staff should have been receiving ongoing training on the proper use of medical equipment as well. On 5/20/21, the facility had received technical assistance to ensure staff notified the facility nurse concerning residents' changes of condition.
2	.215.01. Administrator Responsibility.	The administrator did not ensure all facility policies were developed to fulfill IDAPA16.03.22. The facility's abuse/neglect/exploitation policy did not include how allegations of abuse, neglect or exploitation would be reported. For example, the policy; how residents staff, family, outside services and other will be educated on how to identify abuse, neglect and exploitation; how residents, family, outside services and others will be educated to report abuse, neglect and exploitation nor directions for reporting in the event the

		administrator/designee is the alleged perpetrator. The policy did not include the number to local adult protection office; direction to contact law enforcement within 4 hours in the event the alleged abused; sexual assault or results in serious physical injury the jeopardizes the life, health or safety of the resident with the phone number to local law enforcement and call 911 immediately in the event of an emergency. The facility was given technical assistance and provided a checklist to update the policy on 5/20/21.
3	.250.13. Secure Environment.	The facility had residents with cognitive impairments, with a history of or who were at risk for elopement, and did not provide a secure environment in both buildings. For example, in Building #1, designated as the "memory care building," Residents #5 and #6 had the code to the front door, as they did not require a secured unit. By allowing residents to have the code to the door of the memory care building, the facility was not secure for the remaining 11 residents who required a secure environment. In Building #2, which was designated as an unsecured assisted living building, at least two residents, Residents #1 and #2, were markedly confused and had a history of attempted elopement. Several cognizant residents in Building #2 stated they did have the code to the door, but some residents did not, including Residents #1 and #2, because they were "confused." Resident #1's record documented multiple attempts to leave the facility, and Resident #2's record documented at least one attempt to leave the facility. Family of one of the confused residents stated they had been told Building #2 was a locked unit. On 7/24/24, an unsampled, cognizant resident was observed to use the code to exit Building #2, and there was no staff in the vicinity to ensure the residents with dementia did not follow the resident out of the building. That same day, Resident #1 was observed to attempt to follow staff and visitors out the front door of Building #2, and was also observed to go out to Building #2's side patio

		area, unsupervised, where there was an unlocked gate. The administrator acknowledged the buildings were not adequately secured at this time for the residents with cognitive decline in both buildings. On 5/20/21, the facility received technical assistance regarding using a code on Building #2's door, which gave families the impression Building #2 was a secure memory care building when it was not.
4	.260.06. Toxic Chemicals.	The facility was not maintained in a clean, safe and orderly manner. For example, in Building #1, there was a broken gate observed to be in the courtyard as well as large areas of worn and chipped concrete on courtyard patio. The cover to a furnace was missing in room 12, the tile around the shower drain in the hallway shower room was chipped and missing and the cabinet doors in that room were deeply scratched. An area of carpet was observed have a frayed seam, a vent cover in the hallway was observed to be soiled, and the wall above it was observed to have stains. There were areas of scuff marks and missing paint in all halls and the common area bathroom in Building #2.
5	.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 7/24/24 to 7/25/24. For example, in Building #2, in the common hallway bathroom, toilet bowl cleaner and grime remover were observed unsecured. In Building #1, the laundry room was observed to be unlocked and contained greater than 15 chemicals including bleach, hospital cleaner and multiple other toxic chemicals. Under the sink of Building #1's kitchen, bleach and spray sanitizer was observed unsecured, and residents were observed going into the kitchen. Hospital spray and other chemicals were unsecured in the common hallway bathroom of Building #1. In resident room #7, witch-hazel was observed to be unsecured in the resident's bathroom. The facility received technical assistance on 5/20/21 to secure hazardous

		chemicals.
6	.305.02.b. Quarterly Nursing Assessments.	The facility nurse did not ensure all ordered medications were available for residents. For example, Resident #1 did not receive 28 of their 30 doses of vitamin B12 in June 2024; Resident #2 missed five doses of the antipsychotic quetiapine in June and July 2024; and Resident #3 did not receive at least 21 of their prescribed doses of various medications, including carafate and hydroxyzine, since June 2024. The medication technicians documented these residents did not receive these medications as they were unavailable at the facility. In addition, in June and July 2024, at least 10 doses of Resident #3's ordered medications for their bowel conditions were held due to episodes of diarrhea or fecal incontinence, with no documentation the medication technicians received direction from a nurse to hold these medications. Resident #3 was ordered to use ketoconazole 2% shampoo twice a week, but this medicated shampoo was not available at the facility during observation on 7/25/24 and had not been available for some time according to staff. The facility nurse stated she was not aware residents had not been receiving their medications as ordered.
7	.305.03. Change in Resident Health Status.	The facility nurse did not consistently assess residents when they had a change in their physical or psychological conditions. For example, Resident #1 was documented by staff to be complaining of heaviness in their chest, with arm and leg numbness, on 6/20/24; Resident #2 sustained multiple cuts to their lip while shaving themselves on 6/20/24; Resident #3 complained their "peri area stung" during care of their catheter on 6/3/24 and scratched their right knee "to the point of significant bleeding" per a caregiver's note dated 6/13/24; Resident #4 had complained of marked neck and back pain in June and July 2024 causing difficulty with transfers; Resident #5 refused lunch and complained of not feeling well on 10/27/23; Resident #6 put Purell hand sanitizer in their nose

		on 2/20/24 and sustained a fall on 2/28/24; and Resident #7 had loose stools on 10/15/23, multiple wounds on 3/6/24, a rash on 6/11/24, an abrasion on their elbow on 6/19/24, complained of severe pain on 7/2/24, went to the hospital on 7/7/24, and had increased confusion on 7/23/24. On 7/24/24, a staff member was observed to assess an unsampled resident, stating their cough was worse than usual; the staff member then administered a PRN medication to this non-cognizant resident without permission from the facility nurse. Several staff members stated had, at times, called the facility house manager or administrator for permission to give as-needed medications, when the facility nurse was not available to assess the residents by phone. The facility administrator she was not sure if the facility nurse had assessed the residents. The facility nurse stated she had not assessed the residents' changes of condition, and she was not aware staff members had been assessing residents themselves and given a PRN medication.
8	.310.01.c. Medication Distribution.	The facility's medication refrigerator temperatures were not monitored and documented daily nor were the temperature maintained between 38 and 45 degrees F. For example, in Building #1 medication refrigerator #1, which contained insulin and Ozempic was out of range 15 times in May 2024, 17 times in June 2024 and 12 times in July 2024. Medication refrigerator #2, which contained liquid lorazepam was out range 5 times in May 2024, 14 times in June 2024 and 16 times in 2024 as low as 30 degrees f. In Building #2, the medication refrigerator temperatures were not monitored on 2 days in June 2034 and 7 days in July 2024. On the days when temperatures were recorded in Building #2, the refrigerator temperature was never above 32 degrees F, as low as 20 degrees F, since May 2024. Facility house managers were not aware of the required temperature ranges for medication refrigerators.
9	.310.01.g. Medication Distribution System.	Three of three residents, whose medications were reviewed,

		did not have as-needed (PRN) medications available at the facility. For example, Resident #2 did not have five medications available, including Colace or promethazine; Resident #3 did not have seven PRN medications available, including hydrocortisone and nitroglycerin; and Resident #5 did not have Pepto-Bismol available. The facility nurse stated she was not aware not all ordered PRN medications were available for residents at the facility.
10	.310.04.e. Psychotropic or Behavior Modifying Medication.	Six of six, who required a six-month psychotropic medication review did not have them. For example, Resident #1 was receiving psychotropic medications including...2 Resident #2 was receiving medications including... Resident #3 was receiving medications including...Resident #4 was receiving medications including, Resident #6 was receiving medications including aripiprazole, clozapine and quetiapine and Resident #7 was receiving medications including aripiprazole, lamotrigine and clozapine. The facility administrator stated they were behind on performing six-month psychotropic medication reviews.
11	.319.03. Nursing Assessment.	Residents #1, #2, #4, #6, and #7, who were admitted to the facility after 7/1/20, did not receive a physical assessment by the facility nurse prior to their admission. The facility nurse stated she was not aware she needed to carry out a physical examination of the residents prior to admission.
12	.330.04. Behavior Documentation.	The facility nurse did not ensure text messages between herself and the staff were recorded in the residents' records. The facility staff nor the facility nurse consistently documented communications, including changes of residents' conditions and instructions the nurse gave to the staff. The facility nurse stated she did not consistently document her assessments, such as when Resident #4 suffered from a yeast infection under their breast in January 2024, nor when Resident #5 had a urinary tract infection and went to the hospital. The facility nurse stated she had assessed these residents but had not

		documented her assessments. In addition, the facility did not ensure all medical records and orders were obtained for residents' records, such as the records relating to Resident #5's recent hospitalization and changes to their cardiac medications.
13	.330.06.a. Additional Resident Records.	The facility did not evaluate Resident #1's behavior when they grabbed the arm of a staff member and dragged them to the front door, "yelling the whole way" that they needed to let them out of the building on 7/20/24. Resident #1 had been evaluated for their previous elopement attempts but was not evaluated when they became physically aggressive with staff. The staff member documented they felt the resident was "potentially dangerous," and their medications were not working. Resident #2 was not evaluated when they struck another resident with their walker on 7/21/22, nor when they began having "outbursts" beginning in May 2024, banging/slamming down their walker and dishes, slamming doors, and shouting profanities. On 6/27/24, Resident #2 stated they "intended to 'kill anyone who looked at [them]'." In addition, Resident #2 had not been evaluated when they attempted to elope from the facility on 1/10/23, when they were upset. Caregivers documented other residents were upset by Resident #2's behaviors. The administrator acknowledged these behaviors had not been evaluated, as she was unaware these had occurred.
14	.330.06.b. Additional Resident Records.	The facility did not develop a behavior plan with interventions for Residents #1 and #2 when they engaged in new maladaptive behaviors. See non-core deficiency 330.06.a for examples.
15	.330.14. As Worked Schedules.	The facility's as-worked schedule did not document the dates and times the facility administrator and facility nurses were at the facility. The schedule also did not include the position of all other staff. The facility administrator stated neither she nor the facility nurses recorded the exact times they were in the

		facility.
16	.645.02. Delegation.	One of one staff members, who passed medications, was not delegated by the facility nurse, and the staff worked alone on the night shift without another delegated staff. The administrator stated the staff had worked six night shifts alone and was not delegated to pass medications.