PLAN OF CORRECTION

Homestead Assisted Living Centers Inc - St. Anthony
610 North Bridge Street
Saint Anthony ID 83445

Provider ID: RC-979

On 08/13/2024, a Health Care Licensure and Follow-Up survey was conducted by Department staff at Homestead Assisted Living Centers Inc - St. Anthony. As a result of the survey, core issue deficiencies were cited with the following plan of correction.

Rule Violation .520. REQUIREMENTS TO PROTECT RESIDENTS FROM INADEQUATE CARE. [Assistance and Monitoring of Medications]

Describe what corrective actions will be accomplished for those residents/personnel/area found to have been affected by the deficient practice.

Resident number 4 has moved out of the facility on 8/15/24. For all other residents affected a complete audit of orders, medication cart, and our ECP software will be completed to ensure that the medications for each resident are accurate according to doctors orders. We will also ensure that the medications inputted into our software are accurate according to doctors orders. The initial audit has been completed, there will be continued audits to ensure compliance. The facility nurse will oversee all orders for medication. She will check to ensure that both the med cart and software match the orders.

Describe how the provider will identify other residents/personnel/areas having the potential by the same deficient practice and what corrective action(s) will be taken.

For all residents in the facility, a complete audit of orders, medication cart, and our ECP software will be completed to ensure that the medications for each resident are accurate according to doctors orders. We will also ensure that the medications inputted into our software are accurate according to doctors orders. The initial audit has been completed, there will be continued audits to ensure compliance. The facility nurse will oversee all orders for medication. She will check to ensure that both the med cart and software match the orders.

Describe how the corrective action will be monitored to ensure the deficient practice does not recur (QA program).

All new orders will be reviewed by the facility nurse and the administrator to ensure that the order matches the mar and the bubble pack. Multiple times a month, ongoing audits will check for MAR order accuracy, the removal of all discontinued medications, the removal of expired medications, all bottles and medications are labeled correctly, and make sure all prescribed medications are available to each resident.

Date when corrective action will be completed.

September 12, 2024

Program Comments

NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
Homestead Assisted Living Centers Inc - St. Anthony	RC-979	610 North Bridge Street	208-624-1088
Administrator	City	Zip Code	Survey Date
Jared Howell	Saint Anthony	83445	08/13/2024
Survey Team Leader	Survey Type		Response Due
Lu, Melvin	Health Care Licensure and Follow-Up		09/12/2024

Item #	Rule (16.03.22)	Description
1	.215.01. Administrator Responsibility.	The administrator did not ensure all facility policies and procedures were developed and implemented to fulfill IDAPA 16.03.22.520. The facility's medication policy documented the facility nurse would review the medications of each resident to determine if physician orders for medications matched the medications taken by the residents, medications must be properly labeled by a pharmacist, and if residents receive incorrect medications facility staff will work with the facility nurse and physician to take any necessary actions according to their judgement. The administrator and facility nurse did not follow the facility's medication policy.
2	.215.08.b. Investigation within Thirty Days.	The administrator did not conduct an investigation within 30 days when Resident #4 received the wrong dose of imipramide hcl and was sent to the hospital and rehabilitation center for a month, when Resident #4 fell on 4/9/24, 4/27/24, 5/2/24, 5/3/24, 5/5/24, 5/10/24, 5/11/24, 5/15/24, 5/23/24, 6/2/24, and 7/9/24, and when Resident #4 received a skin tear on their left hand.
3	.215.08.e. Corrective Action.	The facility did not ensure effective corrective action was put into place to prevent incidents' recurrence for Resident #3, #4,

		and #6. For example, when Resident #4 received the wrong dosage of imipramine hcl that was implemented from the administrator, who was not a licensed nurse and when Resident #4 fell 23 times between 4/1/24 and 8/5/24, and corrective action was to remind Resident #4 to use their call light or walker when they had cognitive deficits, and corrective action were not monitored for effectiveness, as Resident #4 continued to fall. Resident #6 fell 7 times from 5/24/24 to 8/7/24, and corrective action was to remind Resident #6 to use their call light when they had cognitive deficits, and corrective action were not monitored for effectiveness, as Resident #6 continued to fall. Resident #3 fell three times from 3/15/24 to 5/19/24, and corrective action was to remind Resident #3 to use their call light when they had cognitive deficits, and corrective action were not monitored for effectiveness, as Resident #3 continued to fall. The administrator confirmed he had not implemented new and effective interventions after each incident to prevent recurrence.
4	.215.08.f. Notification to Licensing Agency within One Business Day.	The facility did not notify Licensing and Certification within one business day when Resident #4 fell on 5/2/24 and required an assessment and treatment at the hospital and was diagnosed with a fractured right hip, or when Resident #5 fell on 3/30/24 and received a large gash on their right shin and required an assessment and treatment at the hospital.
5	.300.01. Licensed Registered Nurse (RN).	The facility nurse did not complete initial nursing assessments for Residents #1, #3, #4, and #5. The facility nurse confirmed the assessments were not completed.
6	.300.02. Licensed Nurse.	The facility nurse did not review and implement all orders for Resident #3, #4, #5, and #6, leading to incorrect transcription and misadministration of medications for each of these residents. Medications were given at the wrong dosage or not given as scheduled due to the implementation errors. For example, Resident #4 had their order for imipramine hcl implemented incorrectly on 1/12/24 and they received six

		incorrect doses that resulted in their hospitalization on 1/15/24. The facility nurse stated when they were not available to implement orders, the administrator or the administrator for a sister facility implemented orders, neither of which were licensed nurses.
7	.305.02.b. Quarterly Nursing Assessments.	The facility failed to ensure residents' medications were available and given as ordered for Resident #3, #4, #5, and #6. For example, Resident #3 did not receive their scheduled daily acetaminophen or fiber powder. Resident #4 received six wrong doses of imipramine hcl on 1/12/24 to 1/15/24 that led Resident #4 to the hospital due to overmedicating the resident. Resident #5 had an order for potassium chloride twice daily since 1/4/24 and been receiving the potassium chloride medication once a day, had an order for omeprazole 20 mg daily and fluticasone nasal spray daily and was transcribed on the medication record (MAR) as needed. Resident #5 had not been receiving the omeprazole or their fluticasone nasal spray medication daily. Resident #5 had an order for Nystatin powder to be applied to affected area twice a day for 14 days, written 1/10/24 and continued to receive to 8/8/24. Resident #5 had an order for prednisone 5 mg every other day dated 6/25/24 and last dose received was 7/1/24. The administrator stated he implemented the orders for Resident #4 as an error and Resident #5 did not want to take the medications, but did not notify the physician, just changed the orders on the MAR to what Resident #5 requested.
8	.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, for Resident #3 when a caregiver documented on 7/21/24 the resident had "extreme tenderness in [their] left hand I have never noticed before" and hospice stated they were aware of the swollen state of the resident's hand around that date and stated it was a change from the resident's baseline condition. Resident #5 received a

		skin tear on their left hand that was not assessed. The facility nurse stated they were not aware the residents experienced these changes of condition.
9	.310.04.e. Psychotropic or Behavior Modifying Medication.	Resident #1 was taking Sertraline and Alprazolam for longer than six months and Resident #2 was taking Quetiapine for longer than six months. Neither resident had six month psychotropic medication reviews that included behavioral updates. The administrator stated the facility submitted the psychotropic medication reviews, but did not include behavioral updates for either resident.
10	.319. COMPREHENSIVE ASSESSMENT REQUIREMENTS.	Residents #1 and #4 did not have comprehensive assessments completed prior to them being admitted to the facility. Resident #4 did not have comprehensive assessments when Resident #4 was readmitted on 2/15/24 and when they fractured their hip on 5/2/24. The facility nurse stated the comprehensive assessments were not completed prior to these residents being admitted and readmitted.
11	.320. NEGOTIATED SERVICE AGREEMENT (NSA) REQUIREMENTS.	The facility did not develop an interim care plan for Resident #4 to direct staff on their care when they were admitted 1/4/24 and readmitted 2/15/24. Resident #4's NSA was not completed until 6/18/24 and documented they were independent with toileting, mobility, grooming, dressing, and bathing. Resident #4s NSA was not updated to reflect they were receiving hospice services, required 1 person assistance with activities of daily living, fall interventions, and how to care for a catheter. Residents #5 and #6 had interim care plans that were not signed or dated. The facility nurse stated she was not involved with developing the care plans.
12	.310.01. Medication Distribution.	The facility had bottle supply of prescribed medications. Multiple bottles were observed in the medication cart not labeled for individual residents. For example, the administrator stated Resident #5's family supplied their Tylenol and AREDS with bulk bottles. The bottles were not labeled with the individual's name, dose, how many tablets, or how often. The

		administrator stated he was unaware the bottle medications required a label by the pharmacist or the facility nurse.

CORE ISSUES

Facility	License #	Physical Address	Phone Number
Homestead Assisted Living Centers Inc - St. Anthony	RC-979	610 North Bridge Street	208-624-1088
Administrator	City	Zip Code	Survey Date
Jared Howell	Saint Anthony	83445	08/13/2024
Survey Team Leader	Survey Type		Response Due
Lu, Melvin	Health Care Licensure and Follow-Up		08/23/2024

Item #	Rule (16.03.22)	Description
2	.520. REQUIREMENTS TO PROTECT RESIDENTS FROM INADEQUATE CARE. [Assistance and Monitoring of Medications]	Based on observations, interviews, and record reviews, it was determined the facility failed to provide appropriate assistance with medications for Residents #3, #4, #5, and #6, with the potential to affect all residents in the facility. These finding include: IDAPA 16.03.22.011.05 defines inadequate care as, "When a facility fails to provide the services required to meet the terms of the Negotiated Service Agreement or provide for...assistance and monitoring of medications..." IDAPA 16.03.22.300.02 documents the "the licensed nurse must be available to... implement new orders..." IDAPA 16.03.22.305.02.b documents the facility's licensed registered nurse must ensure, "The physician or authorized provider orders related to therapeutic diets, treatments and medications are followed…" IDAPA 16.03.22.430.05.g documents, "The following are basic

		services to be provided to the resident by the facility within the basic serves rate: Assistance with and monitoring of medications." IDAPA 16.03.22.520 documents, "The administrator must ensure that policies and procedures are implemented to ensure that all residents are free from inadequate care." The facility's undated medication policy documented the facility nurse were to review the medications of each resident to determine if physician orders for medications matched the medications taken by the residents, medications must be properly labeled by a pharmacist, and if residents received incorrect medications facility staff will work with the facility nurse and physician to take any necessary actions according to their judgement. 1. According to Resident #4's record, the resident was 71 years old was admitted on 1/4/24 with diagnoses which included dementia with mood disturbances, bipolar, depression, and anxiety. According to the Nursing 2018 Drug Handbook, imipramine hydrochloride was used for depression. The recommended indications and dosages for elderly patients: "Initially, 30 to 40 mg daily; maximum shouldn't exceed 100 mg daily." The adverse reactions of the medication were seizures. The signs of overdose of the medication were seizures, drowsiness, and stupor. A physician's progress note, dated 1/10/24, documented Resident #4 was very anxious, agitated, and had not been sleeping well at night. The progress note documented the physician, family, and the facility were trying to come up with

		a plan for Resident #4 to receive medications, including Imipramine HCL, to stabilize Resident #4's mental health issues. A physician's progress note, dated 1/11/24, documented the following physician orders for Resident #4: Titration order of the Imipramine 50 mg as follows: Start 50 mg QAM and 50 mg QPM x 5 days, then 100 mg QAM and 50 mg QPM x 5 days, then 150 mg QAM and 50 mg QPM x 5 days, then 200 mg QAM and 50 mg QPM x 5 days, then 200 mg QAM and 100 mg QPM. The January 2024 MAR, dated 1/12/24, documented Imipramine HCl 50 mg take 4 tablets by mouth every morning and 2 tablets at night for 5 days. Resident #4 received a 200 mg AM dose and 100 mg PM dose, for a total of 300 mg on 1/12/24 and 1/13/24. Resident #4 received a 200 mg AM dose and no PM dose, for a total of 200 mg on 1/14/24 and 1/15/24. An observation note, dated 1/13/24 at 7:15 PM, documented Resident #4 was walking down the hall stumbling and tripping over their own feet and the staff assisted them back to their room. The resident told staff they thought they were experiencing side effects from the new medication. An observation note, dated 1/14/24 at 1:30 PM, documented Resident #4 was "quite unsteady on [their] feet this morning… similar to what has been noted previously." Resident #4 continued to inform staff they thought it was the new medication that was causing these side effects. An addendum

		to the note, dated 1/16/24, documented the Resident #4 was admitted to the hospital on 1/15/24. A facility fall report, dated 1/13/24 at 5:45 PM, documented Resident #4 fell by the trash can. Resident #4 stated, "I just keep falling over my feet. The new meds are making me dizzy." The report documented the family, on-call nurse, and on-call manager were notified, but the resident's physician was not notified. A change of condition assessment by the facility nurse, dated 1/15/24, documented when she entered Resident #4's room, the resident was found seizing and foaming at the mouth. Resident #4 was sent to the hospital and was diagnosed with polypharmacy (drug toxicity). A physician's progress note, dated 1/15/24, documented the facility nurse "was not at work on Friday, and she did not enter the medication into the system. Another certified Med Tech had entered in the medications. Apparently, all my orders, including the titration order was present and accounted for, and the Med Tech who had entered in the incorrect order did notice it and read it, but still put in the wrong sig order for the Imipramine." A physician's progress note, dated 1/26/24, documented Resident #4 was recovering from polypharmacy of Imipramine HCL at the hospital and was recently discharged to a rehabilitation skilled nursing facility. The report documented Resident #4 was very calm and not anxious or agitated and had been "through a lot." On 8/8/24 at 10:30 AM, the administrator stated he implemented the Imipramine HCL order wrong. The administrator stated he did not implement the titration order first, he started with the maximum dosage first. The

		administrator stated the facility nurse was not available to implement the orders for Resident #4. On 8/9/24 at 11:00 AM, the former facility nurse stated she was not in the facility on 1/12/24 when the Imipramine HCL order was received and was not contacted to implement the order. The facility failed to provide Resident #4 with adequate assistance with their medications. Resident #4 received incorrect doses of Imipramine HCL resulting in hospitalization and the need for a month of rehabilitation. 2. According to Resident #5's record, the resident was 88 years old and was admitted on 12/27/23 with diagnoses which included chronic gout, sciatica pain, and melanoma. The physician's orders, dated 6/26/24, documented Resident #5 was to be administered the following medications: Potassium 10 meq take 1 tablet by mouth twice daily; Prednisone 5 mg take one pill by mouth every other day; Nystatin 100,000 unit/gram powder to be applied to affected area twice daily for 14 days; Omeprazole 20 mg take 1 capsule by mouth 30 minutes before breakfast; and Fluticasone nasal 50 mcg spray administer 1 spray into each nostril daily. The June, July, and August 2024 MARs documented Resident #5 received the following medications: *Potassium 10 meq once a day, instead of twice a day. *Prednisone 5 mg received 6/27/24, 6/29/24, 7/1/24, 7/4/24, and 7/9/24, and did not receive any subsequently.

		*Nystatin 100,000 unit/gram powder twice daily and continued to be administered past the stop date of 7/9/24. *Omeprazole 20 mg was incorrectly transcribed as needed, so Resident #5 had not received the medication daily as ordered. *Flucticasone nasal spray was incorrectly transcribed as needed, so Resident #5 had not received the medication daily as ordered. On 8/8/24 at 10:30 AM, the administrator stated Resident #5 did not want to take the omeprazole or the nasal spray daily, so the administrator changed the order to as-needed without a physician's order. On 8/9/24 at 11:00 AM, the former facility nurse stated the medications for Resident #5 were implemented incorrectly by unlicensed staff. The facility failed to provide Resident #5 with adequate assistance with their medications. Resident #5 received incorrect dosages of potassium, prednisone, nystatin powder, omeprazole and fluticasone. 3. According to Resident #3's record, the resident was 90 years old and was admitted on 3/14/2024 with diagnoses which included chronic kidney disease stage 3a, other specified diseases of liver, and white matter disease. A physician's order, dated 4/8/24, documented Resident #3 was to receive two tablets of acetaminophen 500 mg daily and two tablets acetaminophen 325 mg as needed for pain every 6 hours.

		Resident #3's MARs from March 2024 to August 2024 documented the resident's scheduled acetaminophen was changed from scheduled to as needed without a physician order on 6/22/24. The resident's August 2024 MAR indicated the resident was to receive both 500 mg and 325 mg concurrently as needed, which contradicted the physician's order. A physician's order, dated 4/5/24, documented Resident #3 was to receive Metamucil 3.4g (1 scoop) daily in the morning. Resident #3's MARs from March 2024 to August 2024 documented Metamucil was changed from scheduled to as needed without a physician's order. Subsequently, Resident #3 did not receive Metamucil daily as ordered. The facility failed to provide Resident #3 with adequate assistance with their medications. Resident #3 received incorrect dosages of acetaminophen and Metamucil. 4. According to Resident #6's records, the resident was 86 years old and was admitted on 5/24/24 with diagnosis which included COPD with Hypoxia and hip fracture. A physician's order, dated 5/23/24, documented Resident #6 was to receive docusate + senna 8.6-50 mg both scheduled twice daily and as needed. On 8/8/24, the medication technician was unable to locate as needed docusate + senna 8.6-50 mg for Resident #6. The medication technician stated the medication was not available. Resident #6's August 2024 MAR did not document docusate + senna 8.6-50 mg for the resident as a current as needed

		medication. The facility failed to provide Resident #6 with adequate assistance with their medications. Resident #3 did not have dosage of docusate + senna 8.6-50 mg as needed available. On 8/9/24 at 11:17 AM, the former facility nurse stated she did not implement all physician's orders, with orders repeatedly implemented by the administrator or the administrator of a sister facility, neither of which were licensed nurses. She stated it was standard process for the administrator to implement on Fridays and she would not review them until the following Monday, after residents received multiple doses over the weekend. On 8/9/24 at 1:19 PM, the administrator, who was not a licensed nurse, stated he implemented orders when the facility nurse was not available. He stated this often occurred on Fridays, at which time he implemented the orders and they were not reviewed by the facility nurse until the following Monday, resulting in residents receiving medications through the weekend according to the administrators implementation of orders. The administrator also stated he made changes to entries in residents' MARs in anticipation of new medication orders. Medication technicians administered medications in contradiction with medication orders while waiting for new physician's orders. The facility failed to provide assistance and monitoring of medications for Residents #3, #4, #5, and #6, with the potential to affect all residents in the facility, when the facility did not ensure all physician's orders were accurately transcribed and implemented by the facility nurse. Consequently, medications were incorrectly administered to

		residents. This resulted in inadequate care.