NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
Highland Estates	RC-1289	2050 Hiland Ave	208-678-4411
Administrator	City	Zip Code	Survey Date
Darrin Radeke	Burley	83318	02/18/2025
Survey Team Leader	Survey Type		Response Due
Ramirez, Mina	Health Care Licensure and Follow-Up		03/20/2025

Item #	Rule (16.03.22)	Description
1	.215.08.b. Investigation within Thirty Days.	The administrator did not conduct an investigation within 30 days when Resident #3 experienced six falls between 12/21/24 and 1/13/25, had a broken thumbnail which was bleeding on 10/9/24, and had an injury of unknown origin on 12/22/24, which were not investigated. Resident #1 complained of missing money from their room and staff consistently entering their room without obtaining permission prior to entering. Resident #2's mail was opened and was missing contents. The administrator stated he did not investigate these incidents.
2	.215.08.d. Written Response to Complaint within Thirty Days.	The administrator did not provide written responses to residents or family members when they complained about concerns at the facility. For example, Resident #1 complained of missing money from their room and staff consistently entering their room without obtaining permission prior to entering. Resident #2's complained their mail was opened and was missing contents. Resident #3's family member complained to the administrator that their loved ones were not receiving assistance with their ADLs, they had housekeeping concerns, and concerns of their loved one receiving their medication as ordered. The administrator stated he did not provide a written response to these

		residents.
3	.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 #3 had injuries, including bruising of unknown origin on 12/22/24 and Resident #13 had a "goose egg" to left forehead on 9/15/24. The administrator stated he was unaware of these injuries.
4	.260.06. Toxic Chemicals.	The facility was not maintained in a clean, safe and orderly manner. For example, in the assisted living area, the carpet was observed to be stained in multiple resident rooms and the two couches in the front lobby were observed to be worn and dirty. In the memory care area, the kitchen tables were observed to be scratched and gouged and no longer a cleanable surface. Multiple resident rooms were observed soiled with fecal matter and urine, baseboards were observed covered in dirt and grime, and carpet stains throughout the memory care rooms. The exterior siding in the memory care area was broken and missing vertical boards. The maintenance director stated he was working on a large list of items to be repaired or replaced.
5	.260.07. Toxic Chemicals.	Toxic chemicals such as bleach, furniture cleaner and Windex were observed to be stored in an unlocked restroom, which was also used as a storage area, in memory care which was accessible to cognitively impaired residents on four different occasions from 2/10/25 to 2/12/25. The administrator stated the room was to be locked at all times and was unaware it was not.
6	.305.02.c. Current Medication Orders and Treatment Orders.	The facility did not ensure the actual, written, signed, and dated orders were present in each residents' care record. For example, Residents #10 and #12 did not have current medication orders signed by the physician at the time of survey. The facility nurse stated they did not have current physician orders in the residents' charts.
7	.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 #3 experienced six falls between 12/21/24 and 1/29/25, had a broken thumbnail which was bleeding on 10/9/24, and had an injury of unknown origin on 12/22/24. The facility nurse stated she was unaware she needed to assess all change of conditions.
8	.310.01.g. Medication Distribution System.	Resident #4 did not have their Nystatin cream available. Resident #5 did not have their PRN loperamide, dimaphen DM, chest congestion DM, and pink bismuth available in the medication cart. Resident #8 did not have their albuterol sulfate available. Resident #10 did not have their enema available in the medication cart. The facility nurse stated she was unaware the prn medications were not available.
9	.310.02. Discontinued and Expired Prescriptions.	The facility's medication destruction logs for the past year from February 2024 to February 2025, did not document who witnessed the medication being destroyed, nor the method of destruction. The facility LPN confirmed documentation was not maintained.
10	.320.08. Periodic Review.	Negotiated Service Agreements (NSAs) were not updated to reflect significant changes in their care needs and to instruct staff on how to provide care. For example, Resident #3 was admitted to include hospice services and the NSA did not delineate what services hospice would provide, they also required total assistance to dressing and required total assistance with housekeeping, which was not on the NSA. Resident #4's NSA was not updated when they could no longer manage their own finances. Resident #10's NSA was not updated when they were admitted to hospice, required repositioning every two hours, required the use of an egg carton cushion for their wheelchair, and hospice assisted them with showers. Resident #13's NSA was not updated when they were admitted to hospice and their diet was changed to puree, nor when their mobility decreased to and required the use of a wheelchair. Resident #9's NSA was not updated to address the changing level of assistance provided by the resident's private

		duty caregiver. Resident #6's NSA was not updated after Resident #6 started physical therapy services. The nurse stated she was not involved in updating the NSAs.
11	.330. REQUIREMENTS FOR FACILITY RECORDS.	The administrator did not ensure the facility's medication administration records were complete and accurate. For example, Resident #9's record indicated cabergoline was administered daily, however it was given twice weekly as prescribed. Staff stated they inaccurately recorded administration of the medication for Resident #9. A medication technician was observed signing the medication administration record of several residents who were given medications over the prior weekend but was not documented as administered until three days after their last shift. The facility nurse stated she was unaware of these issues.
12	.330.04.c.vi. Resident Care Records.	The facility did not have a system for staff to document when they contacted the facility nurse. There was no documentation in Resident #3, #4, #10, and #12's records of nurse notifications when as needed (PRN) medications were required. The facility nurse stated she was unaware she needed to document when she gave staff permission to administer a PRN medication.
13	.330.06.a. Additional Resident Records.	The facility did not evaluate residents when they exhibited maladaptive behaviors. For example, Resident #3 was not evaluated when they exhibited maladaptive behaviors of resisting care, combativeness, kicking, biting, yelling, pulling staffs' hair, and yelling at other residents. Resident #4 exhibited behaviors of combativeness, resisting cares, and picking at skin on their face and hands causing wounds. Resident #12 exhibited behaviors of resisting cares and frequent wandering into other residents' rooms. Resident #13 exhibited maladaptive behaviors of throwing themselves onto the ground, defecating on the floor, and refusing assistance with cares. The facility administrator, LPN, and multiple staff confirmed these residents were not evaluated after they

		exhibited maladaptive behaviors.
14	.330.06.b. Additional Resident Records.	The facility did not include at least one intervention for each resident's maladaptive behaviors as described in deficiency 330.06.a
15	.330.06.c. Behavior Documentation.	The facility did not document and track including the time, date, type of maladaptive behaviors as described in 330.06.a, and specific interventions attempted and effectiveness.
16	.330.13. Personnel Records.	The facility did not maintain staff records with all required documentation. For example, medication administration certifications were not maintained for three of six sampled employees who assisted residents with their medications. Continuing education records were not maintained for three of three sampled employees who were employed for over one year. The business office manager stated staff completed the training, but the facility did not have the documentation.
17	.600.04.a. Sufficient Personnel.	The facility did not ensure sufficient personnel were present at the facility at all times, to ensure the health and safety of the residents. Multiple staff members stated Resident #12 required 1:1 supervision due to falls and multiple maladaptive behaviors, and the facility did not have adequate staff to provide for these needs. Resident #12 was also observed to attempt to remove another resident from a chair by pulling the chair and attempting to overturn it. Resident #4 was observed to stand up from their wheelchair and attempt to ambulate on their own when they required a walker and stand-by assistance for safe ambulation. During survey, it was observed there were no staff present in the area to supervise these residents during these incidents. Resident #9 who resided in the assisted living side required 2-person transfers and stated that staff were too busy in the morning to get them ready to have breakfast in the dining room, and this occurred at least once a week and sometimes more often. Staff confirmed that they were not always able to get Resident #9 to breakfast, especially when there when only two of three scheduled staff

		were present in the assisted living side of the facility.
18	.600.04.b. Sufficient Personnel.	Eight of nine sampled direct care staff did not have current first aid and/or CPR certifications. While multiple caregivers were scheduled for every shift, some shifts were staffed with only caregivers who did not have current first aid or CPR certification. The business office manager stated she was unaware they were out of compliance.