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
Jordan Snedaker	Preston	83263	02/13/2025
Survey Team Leader	Survey Type		Response Due
Oldfield, Michael	Health Care Non-Core Deficiency Follow-Up		03/15/2025

Item #	Rule (16.03.22)	Description
1	.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's physician discontinued their order for daily simvastatin on 1/27/25, but continued to receive the medication everyday to the date of the survey on 2/11/25 for a total of 15 extra doses. Resident #2 did not receive their tramadol six times nor their celecoxib four times in February 2025. Resident #4 did not receive their scheduled calcium carbonate plus vitamin D3 31 times in January 2025 and 12 times in February 2025. The facility nurse stated there had been some issues with the pharmacy not filling some orders for Resident #2 and was not aware of some of the other issues for the other residents. ***Previously cited on 5/21/24.***
2	.310.01.c. Medication Distribution.	The temperatures for the facility's East building medication refrigerator, which contained insulin, was not monitored and documented daily. For example, temperatures were not documented 15 times from 1/1/25 to 2/11/25. The Operations Manager acknowledged the lack of monitoring the temperatures.***Previously cited on 5/21/24.***
3	.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, Resident #8 had an order for morphine and lorazepam PRN and they were not available on the cart. Resident #4 had an order for nystatin powder PRN and it was not available on the cart. Resident #1 had an order for ibuprofen PRN and it was not available on the cart. The facility nurse stated all PRN medications should be available for residents at all times. ***Previously cited on 5/21/24.***
22	.330.06.b. Additional Resident Records.	The facility did not develop a behavior plan that included at least one intervention for Resident #5 when they exhibited behaviors of recurrently refusing most of their medications and cares like showering, toileting, dressing and oral care from September 2024 to February 2025. The facility nurse stated she worked with staff and tried interventions with Resident #5 that were ineffective. She stated they put Resident #5 on a behavioral modifying medication on 1/29/25 for their refusals and were looking to move Resident #5 to memory due to the refusal behaviors. The facility nurse stated she did not document the interventions she directed staff to use and that the resident care coordinator completed the behavioral plans. The resident care coordinator stated they had not developed a behavior plan for these behaviors with interventions and they were working on a process to get behavioral plans in place. ***Previously cited on 5/21/24.***