NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
The Willows	RC-1288	898 S. Meridian Street	208-782-1478
Administrator	City	Zip Code	Survey Date
Tara McLean	Blackfoot	83221	02/27/2025
Survey Team Leader	Survey Type		Response Due
Perry, Bradley	Health Care Licensure and Follow-Up + complaint investigation		03/29/2025

Item #	Rule (16.03.22)	Description
1	.310.01.c. Medication Distribution.	The facility did not maintain the medication refrigerator temperatures between 38 and 45 degrees F, nor document daily temperatures, which contained insulin. The temperatures were documented out of range 31 times, nor were not documented 11 times between 12/1/24 and 2/25/25, with no corrective action taken. The administrator stated she had been unaware of the out of range temperatures.
2	.310.01.f. Medication Distribution.	On 2/25/25 at 9:15 AM, a medication cup was observed on an unsampled resident's dresser with seven pills, they stated it was the morning dose which was saved to take later with breakfast. The facility nurse stated the medication technician should not have left the medications unattended, and they should always observe the residents take their medications.
3	.310.04.a. Behavior Modifying Medication.	The facility did not attempt non-drug interventions prior to requesting medications. For example: Resident #5 was prescribed Seroquel routinely and Vistaril as-needed (PRN) on 11/7/24 and Ativan PRN on 1/25/24 as a first resort, prior to having a behavior management plan in place. The facility nurse stated Resident #5 did not have a behavior management plan and there was no documentation regarding Resident #5's behaviors prior to using medications as a first resort.

4	.310.04.e. Psychotropic or Behavior Modifying Medication.	Resident #1 was taking Belsorma, buspirone, hydroxyzine pamoate, and sertraline; Resident #2 was taking trazadone, lorazepam, and olanzapine; and Resident #5 was taking aripiprazole, buspirone, and escitalopram oxalate for more than six months. These residents had six month psychotropic medication reviews that did not include behavioral updates. The facility nurse stated they ceased to include updates when they started using a new form provided by the pharmacy.
5	.320.08. Periodic Review.	Negotiated Service Agreements (NSAs) were not updated to reflect significant changes in Resident #2's and Resident #6's NSA. Resident #2's NSA was not updated after their mobility and transfer status changed from occasional assistance needed to requiring assistance from two staff, nor when they were being showered by hospice twice a week. Resident #6's NSA was not updated to reflect they were on services with home health to manage a wound. The facility administrator stated they had not been updated to reflect these changes in condition.
6	.330.04.c.vii. Resident Care Records.	The facility nurse stated he had assessed residents for changes in their conditions, but these assessments had not been consistently documented. For example, Resident #4 experienced fever, lethargy, was "very weak," and was sent to the hospital on 2/5/25; when Resident #5 was started on an antibiotic for a urinary tract infection (UTI) without documenting signs and symptoms on 11/1/24, and when they were unresponsive and sent to the ER for an evaluation on 1/20/25. The facility nurse stated he had assessed all of these changes in the residents' conditions but had not documented these assessments.***Previously cited on 8/11/23***
7	.335.02. Standard Precautions.	The facility did not follow correct infection control procedures when a medication technician was observed not washing or sanitizing their hands prior to checking Resident #1's blood glucose level after opening the resident's door and did not wear gloves. Also, the medication technician did not use gloves

		when checking an unsampled resident's blood glucose and administered insulin, nor when they administered an unsampled resident's eye drops and touched their eyelid. The facility nurse stated staff should be wearing gloves and sanitizing their hands when appropriate.