NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
Palouse Hills Assisted Living	RC-1194	1401 North Polk Street	208-882-3438
Administrator	City	Zip Code	Survey Date
Linda Vestal	Moscow	83843	02/08/2023
Survey Team Leader	Survey Type		Response Due
Bollinger, Torrey	health care licensure and follow-up		03/10/2023

Item #	Rule (16.03.22)	Description
1	.151. ACTIVITY REQUIREMENTS.	During observations at the facility between 2/7/23 to 2/8/23, no activities were observed to be offered to the residents. Two staff members stated activities were provided only every few days, due to lack of staffing, and were not consistent.
2	.215.08.b. Investigation within Thirty Days.	The administrator did not conduct an investigation within 30 days when Resident #7 had injuries of unknown origin to their forehead on 7/27/22, and to their right leg, which was later found to be a broken hip on 8/28/22, and sustained falls on 11/3/22 and 1/3/23; Resident #4 sustained a fall on 12/15/22; and Resident #5 sustained a fall on 1/24/22. The administrator and facility nurse both stated the investigations had not been completed.
3	.215.08.e. Corrective Action.	The administrator did not implement corrective action to ensure the incidents did not recur when Resident #7 had injuries of unknown origin to their forehead on 7/27/22, and to their right leg, which was later found to be a broken hip on 8/28/22, and sustained falls on 11/3/22 and 1/3/23; Resident #4 sustained a fall on 12/15/22; and Resident #5 sustained a fall on 1/24/22. The administrator and facility nurse both stated the investigations had not been completed.
4	.305.03. Resident Health Status.	The facility nurse did not conduct nursing assessments when

		residents experienced changes in physical or mental health status. For example, when Resident #3 had a fall on 11/24/22 and had a stroke October 2022 which caused blindness. Resident #4 had an infected left elbow and was admitted to the hospital on 1/7/23. Resident #7 sustained falls on 11/3/22 and 1/3/23. Change of condition assessments were not completed for these residents.
5	.310.01.c. Medication Distribution System.	The facility did not maintain the medication refrigerator, which contained insulin, temperatures between 38 and 45 degrees F. For example, in January 2023, the temperatures were out of range the entire month and were as low as 32 degrees F., and in February 2023, the temperatures were out of range 8 times.
6	.310.04.e. Psychotropic or Behavior Modifying Medication.	Resident #1 was taking Risperdal and Remeron for longer than six months and did not have six-month psychotropic medication reviews completed. Resident #2 was taking haloperidol and lorazepam for longer than six months and did not have six-month psychotropic medication reviews completed. Resident #3 was taking Lexapro, lithium, risperidone, and temazepam for longer than six months and did not have six-month psychotropic medication reviews completed. Resident #5 was taking Lexapro, Seroquel, and lorazepam for longer than six months and did not have six-month psychotropic medication reviews completed. The facility nurse stated the medication reviews were not completed.
7	.330.04.c.i. Resident Care Records.	The facility did not document comprehensive assessments for Residents #1, #3, #4, #5, and #7. The administrator stated the assessments were completed but not documented.