

NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
Heritage Assisted Living and Memory Care	RC-1227	622 Filer Avenue West	208-733-9064
Administrator	City	Zip Code	Survey Date
Bianca Henderson	Twin Falls	83301	07/10/2020
Survey Team Leader	Survey Type		Response Due
Brown, Stacey	Health Care Complaint Investigation		08/09/2020

Item #	Rule (16.03.22)	Description
1	.260.06. Housekeeping Services and Equipment.	The Twin Falls Manor building was not maintained in a clean, safe and orderly manner. Examples include but are not limited to: the COVID unit had a strong urine odor; two toilets were dirty with what appeared to be feces; debris on the floors; one resident complaint of insects; trash cans full, bags of trash laying on the floors of several residents' rooms; new oxygen tubing was stored where there was also a bag of soiled depends; a handrail in the main hallway was split and had sharp edges; used washcloths on counter in the shower room; hallway - carpets stained and scratches and gouges in the walls; broken blinds in several residents' rooms; and some mattresses appeared stained and dirty. Outside courtyards the patio and walkway were littered with debris, and the concrete was uneven, posing trip hazards. A pole with a sharp end was protruding from the planter on the patio. Lawn and other equipment was observed about the courtyard and building exterior. The patio chairs for residents to use were worn and torn. On the exterior of the building, weeds were present throughout the yard; organic matter was growing in the rain gutters; resident rooms' screens were off the windows; rusty

		equipment was observed, along with a hospital bed, construction debris, trash, and cigarette butts; one of the air conditioning units appeared unstable and was being propped up with a board; water lines to the roof's air conditioning unit hung down, within reach, along the walkway; a large animal trap was observed; and several motorized units with exposed, running fan blades and wires, were observed.
2	.300.02. Licensed Nurse.	The Twin Falls Manor building did not ensure that a licensed nurse was available at all times to visit the facility when residents experienced a change of condition. For example, Resident #1 who had a diagnosis of COVID-19, reported symptoms of shortness of breath and fatigue to their family on the morning of 6/13/20. The family also stated that the resident seemed disoriented at that time. The family requested the facility nurse assess this resident, but the facility nurse was unavailable and informed the family that she would assess the resident later that evening, resulting in a 6-8 hour delay in assessment. Subsequently, on 6/17/20, the family of Resident #1 was again concerned about the health of the resident, but the facility nurse did not perform an assessment at that time, deferring to paramedics for an assessment of the resident. The resident's condition resulted in an inpatient hospital stay from 6/17/20 through 7/6/20.
3	.600.04.a. Sufficient Personnel*	The Twin Falls Manor building, in which residents diagnosed with COVID-19 resided, did not employ and schedule sufficient personnel to provide care during all hours, to ensure residents' health, safety, comfort, and supervision, and to ensure the interior and exterior of the facility was maintained in a safe and clean manner. Three residents complained that all of their needs were not being met by staff, including assistance with bathing, snacks not consistently being offered, call lights going unanswered especially at night, and their rooms not being cleaned. Five out of five sampled residents' task sheets documented cares were not being completed, as described in

		the Negotiated Service Agreements (NSA), including, but not limited to safety checks at night, bathing, resident room cleaning, and monitoring for symptoms of COVID-19 such as oxygen saturation levels, shortness of breath, and cough. For example, Resident #4 had only received two showers between 6/23/20 through 7/8/20, when the NSA indicated the resident was supposed to receive two showers per week. Residents #2 and #3 each received only two showers between 6/24/20 and 7/8/20, when the NSA indicated they were to receive two showers per week. Interviewed residents, families, staff members and outside agencies stated there did not appear to be sufficient staff to meet the residents' needs. {Previous rule 600.06.a}
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