

NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
Caring Hearts	RC-1303	3480 E Center	208-417-1007
Administrator	City	Zip Code	Survey Date
Alice Nason	Pocatello	83201	03/29/2024
Survey Team Leader	Survey Type		Response Due
Lu, Melvin	health care initial licensure		04/28/2024

Item #	Rule (16.03.22)	Description
1	.305.02.b. Current Medication Orders and Treatment Orders.	The facility nurse did not ensure residents received medications and treatments as ordered by their provider. For example, Resident #3 was ordered to receive hydrocodone-acetaminophen two times per day as of 3/14/24 but continued receiving this medication four times per day from a previous order. The resident was administered 56 doses from 3/14/24 to 3/27/24, when they should have only received 28 doses. On 3/7/24, Resident #6 was ordered to receive fluticasone once daily, but the resident had been receiving this twice daily through the date of the survey. Resident #7 was ordered to have all medications crushed, other than extended release medication, but on 3/27/24, the resident was observed to receive whole tablets for their afternoon medications. In addition, during observations, a medication technician gave a blood pressure medication to a resident prior to checking their blood pressure as ordered by their provider. The facility nurses stated they were unaware residents were not receiving their medications and treatments as ordered.
2	.310.02.f. Discontinued and Expired Prescriptions.	The facility did not ensure the medication destruction log documented two signatures for each medication destroyed. From 2/7/24 to 3/21/24 only one signature was documented

		for medication destruction. The administrator stated the facility does destroy medications with two staff; however they had forgotten to document the second signature.
3	.320.08. Periodic Review.	Residents' Negotiated Service Agreements (NSAs) were not consistently updated to reflect significant changes in their health status. For example, Resident #2's NSA documented they only needed to be cued to eat during meals, but at the time of the survey, the resident could no longer feed themselves and had to be fed by a staff member. The NSA for Resident #6, who had a history of pressure injuries on their bottom, did not document pertinent information such as ensuring wedges or cushions were being used in their wheelchair or to lay the resident down at least two hours in the morning and two hours in the afternoon as ordered by hospice and what to do if the resident refused. The NSA did not document how staff should respond to Resident #6's chronic genitourinary problems, related to their chronic Foley catheter use, such as what to do if the resident experienced pus coming from their penis, which frequently occurred according to staff interviews, who would change the catheter and how often, and what staff should watch for related to their "split" penile meatus. The facility nurses and administrator stated the NSAs needed to be updated.
4	.335.02. Standard Precautions.	The facility did not follow correct infection control procedures when a medication technician (MT) in building #1 was observed multiple times not washing or sanitizing their hands between residents' medication passes. The same MT was observed assisting a resident off the couch and then passed another medication without sanitizing their hands. Also, the MT grabbed the open end of a plastic spoon out of a container with an unsanitized hand, mixed the crushed medications in yogurt, spilled some of the crushed medications on the medication cart, and used a finger to scoop up the medication into the cup. In addition, a MT in building #3 did not use gloves

		<p>when administering nasal spray. Finally, building #1 did not have paper towels in the shared bathroom which was used by multiple residents and staff toileting residents. The facility nurses and administrator acknowledged the infection control concerns.</p>
5	.620. REQUIREMENTS FOR TRAINING OF FACILITY PERSONNEL.	<p>Staff were not sufficiently trained for various tasks for all three buildings. For example, several staff members were not aware of Resident #1's behavior management plan (BMP). The staff did not know where to find the BMPs for any resident in building 1 and therefore were not following the interventions listed. One staff member stated they used the same interventions for all residents with behaviors, and multiple staff documented in Resident #1's behavior tracking the interventions they did use were "ineffective." Pureed diets were not followed to reflect the correct consistency nor were vegetables in the pureed food included in the lunch observation in building #1 on 3/28/24. Multiple staff stated Resident #6 needed more than one person to transfer them, while other staff were able to transfer the resident by themselves. Not all staff were adequately trained on how to safely transfer Resident #6 alone. Staff were not destroying medications according to the facility policy when MT destroyed medications when residents refused their medications and did not have another staff witness when they disposed of the medication into the sharps container. The facility nurses and administrator stated staff needed more education for these issues.</p>