NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
Quail Ridge Assisted Living	RC-502	797 Hospital Way	208-233-8875
Administrator	City	Zip Code	Survey Date
Ann Kolsen	Pocatello	83201	02/09/2024
Survey Team Leader	Survey Type		Response Due
Perry, Bradley	health care complaint investigation		03/10/2024

Item #	Rule (16.03.22)	Description
1	.215.08.d. Written Response to Complaint within Thirty Days.	The facility did not provide a written response to complainants within 30 days. For example, the complaint log from May 2023 to December 2023 documented six complaints had been made to the administrator and none of the complainants received a written response. The administrator stated written responses were not provided to the complainants.
2	.310.04.a. Psychotropic or Behavior Modifying Medication.	The facility did not attempt non-drug interventions prior to requesting medications for Resident #6's behaviors. In July 2023, Resident #6 was documented by staff members to have been hitting, kicking and yelling at staff, throwing trash at other residents, trying to kick other residents, and yelling at other residents in the dining room. In a 7/24/23 progress note, the administrator documented she had called Resident #6's family about their behaviors "towards the other residents and staff." On 7/28/23, the administrator documented the family had taken the resident to their provider and was prescribed the antipsychotic medication Seroquel on a scheduled basis. There was no behavior evaluation or plan put into place before the resident was started on the medication. As the behaviors continued, in November 2023, hospice prescribed as-needed Haldol and lorazepam as well. The facility administrator stated

		they should have implemented a behavior plan before starting the medications for behaviors.
3	.330.06.a. Behavior Documentation.	The facility did not evaluate residents when they exhibited maladaptive behaviors. For example, Resident #5's behaviors of extensive use of their call light, pulling their call light while banging on the handrail in the bathroom, and yelling out for help from staff was not evaluated. On 12/17/23, Resident #5 called out for assistance 24 times in one day and called for assistance a total of 1594 times from June 2023 to December 2023 without an evaluation of these behaviors. In many instances, staff stated Resident #5 would call for assistance immediately after staff left their room. Resident #6, according to progress notes as early as July 2023, Resident #6 had been hitting, kicking and yelling at staff, throwing trash at other residents, trying to kick other residents, yelling at other residents in the dining room, as well as going into other residents' rooms, sleeping in their beds and throwing their belongings. Resident #7's behaviors of entering other residents' rooms and taking their belongings, taking decorations off other residents' doors, taking or tearing down decorations from the common area and yelling and cursing at staff when they tried to intervene. The facility nurse stated he had not considered these things as behaviors because they didn't happen "all at once" and only happened every month or so until recently. The administrator stated the facility nurse should have evaluated the residents for these behaviors. ***Previously cited on 11/30/22 at rule 319.04 for not evaluating residents' maladaptive behaviors***
4	.330.06.b. Behavior Documentation.	The facility did not develop a behavior plan that included specific interventions for Resident #5, Resident #6 and Resident #7's behaviors, as outlined in non-core punch 330.06.a. Multiple staff confirmed they did not have a behavior plan with interventions to reference. The facility nurse and the administrator stated they did not have behavior

		plans in place. ***Previously cited on 11/30/22 for not implementing interventions for residents' behaviors.***