NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
Homestead Assisted Living Centers Inc - St. Anthony	RC-979	610 North Bridge Street	208-624-1088
Administrator	City	Zip Code	Survey Date
Brandon Nite	Saint Anthony	83445	05/07/2021
Survey Team Leader	Survey Type		Response Due
Perry, Bradley	health care licensure and follow-up		06/06/2021

Item #	Rule (16.03.22)	Description
1	.009.05.b. New Criminal History and Background Check.	The facility did not obtain new criminal history background checks (CHBC) for two staff members whose previous CHBC were completed more than three years prior to their date of hire. For example, the facility nurse was hired on 3/4/21 and their previous CHBC was completed on 11/18/16. Also, the dietary manager was hired on 7/5/16 and their previous CHBC was completed on 4/5/10.
2	.215.05. Responsibility for Acceptable Admissions.	The facility administrator admitted and retained residents who required a secured facility along with residents who were cognitively intact and did not require a secured facility. For example Resident #2 was retained despite multiple residents' complaints of Resident #2 coming into their room and scaring them and laying in their beds. Also Resident #10 was admitted to an unsecured facility despite their history of wandering and confusion. Subsequently, Resident #10 eloped from the facility at least twice.
3	.215.08.f. Notification to Licensing Agency within One Business Day.	The administrator did not report to Licensing and Certification when Resident #6 fell on 11/2/20 and sustained a collapsed lung and required evaluation and treatment at the hospital nor did they report Resident #7's injury of unknown origin

		sustained to their left leg in April 2021.
4	.250.13. Secure Environment.	The facility was not approved as a secured environment. Surveyors observed that a code was required to exit each of the facility's exterior doors, except for the exterior doors located in three resident rooms, which were not locked. Staff members stated the coded doors were used to keep residents who had a history of wandering safe. Several residents, without cognitive impairment, stated they did have the code to the doors and could exit the facility on their own. There were at least two residents, Residents #2 and #9, observed with a diagnosis of dementia, who were confused and would not be safe alone in the community nor be able to find their way back if they eloped from the facility. Resident #9 resided in one of the rooms with the unlocked exterior door. On 5/4/21, surveyors observed staff searching for Resident #2 and could not find them for at least ten minutes. The facility had reported to licensing and certification that Resident #10 who was cognitively impaired, left the facility premises without personnel's knowledge.
5	.260.07. Toxic Chemicals.	The facility did not secure all toxic chemicals when the facility had cognitively impaired residents. For example, a bottle of toilet cleaner was observed unsecured in the common hallway bathroom, and a spray bottle of disinfectant was observed in the unsecured salon.
6	.300.02. Licensed Nurse.	The facility nurse did not conduct nursing assessments when residents experienced changes in physical or mental health status. For example, Resident #5 had six falls between 11/2/20 and 3/30/21 and was not assessed after each fall. Also, when Resident #3 insisted on going the emergency room (ER), "Because nothing was being done" about their "bowels being inactive", and the resident "having to dig out" their impacted bowel. In addition, Resident #7 was not assessed after a fall on 4/2/21. ***Previously cited on 6/11/13 and 6/10/16 at rule 305.03***

7	.305.02.a. Current Medication Orders and Treatment Orders*	The facility did not ensure residents medication administration record (MAR), bubble packs, and provider orders were congruent. For example, an unsampled resident's MAR instructions had three different directions for senna. The order for their lidocane was for twice daily use, but the MAR also documented to give it every six hours on one line and three times a day on another line. Another unsampled resident had an order and MAR for 50 milligrams (mg) of trazodone, but two separate bubble packs documented and contained 50 mg and 150 mg tablets.
8	.310.01.g. Medication Distribution System.	The facility did not ensure medications were available for Resident #1 and three unsampled residents. For example, an unsampled resident did not have their as needed lorazepam, atropine, scopalomine, or their inhaler. Another unsampled resident did not have their albuterol inhaler nor hydroxyzine available.
9	.310.03. Controlled Substances.	Five controlled substances for three unsampled residents' were not counted daily, nor did the facility ensure the count was accurate for those being counted. For example, one resident's morphine had not been counted since it was received at the facility on April 8, 2021, and another resident's lorazepam and morphine had never been counted since it was received in the facility in April 2021. In addition, the count of an unsampled resident's clonazepam was incorrect and not reconciled. The count documented 26 tablets, but there were only 25 tablets in the bubble pack.
10	.319.03. Nursing Assessment.*	The facility nurse did not assess residents prior to their date of admission. For example, Resident #10 was admitted on 7/17/20 but did not receive an initial assessment. Resident #2 was admitted on 11/9/20 but was not assessed by the nurse until 11/20/20. Resident #3 was admitted on 2/12/21 and was not assessed by the nurse until 2/21/21.
11	.330.14. As Worked Schedules.	The facility's as worked schedule did not document the dates and times of the operations director, the dietary manager, or

		the facility nurse were at the facility. The schedule did not document the titles of the facility employees.
12	.335.03. Reporting of Individual with an Infectious Disease*	The facility did not follow public health district or Centers for Disease Control and Prevention (CDC) recommendations for COVID-19, when caring for the residents, to prevent transmission of this infectious disease. For example: From 4/29/21 to 5/3/21, 11 visitors signed into the facility log, and only two visitors had their temperatures checked. There was no documentation any of the 11 visitors were screened for Covid-19 symptoms. Between 5/3/21 to 5/6/21, at least three staff members and three visitors were observed to not be wearing masks when in the facility, nor were the surveyors screened for Covid-19 symptoms during this period.

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Perry, Bradley	health care licensure and follow-up		05/17/2021

Item #	Rule (16.03.22)	Description
1	.000. Initial Comments.	The following core deficiency was cited during the licensure survey conducted between May 3, 2021 and May 7, 2021 at your residential care/assisted living facility. The surveyors conducting the survey were: Brad Perry, LSW Team Leader Health Facility Surveyor Stacey Saenz, RN Health Facility Surveyor Teresa McClenathan, RN Health Facility Surveyor Health Facility Surveyor Abbreviations and Definitions: NSA = Negotiated Service Agreement RN = Registered Nurse
2	.520-11 Inadequate Care - Acceptable Admission and Retention*	Based on observation, record review and interview, it was

		determined the facility admitted and retained 2 of 2 sampled residents (#2 and #10), who were at risk for elopement or who had eloped, due to an unsecured facility. IDAPA 16.03.22.011.05. Inadequate care is defined as, "when a facility fails to provide the services required to meet the terms of the Negotiated Service Agreement, or provide for room, board, activities of daily living, supervision, first aid, assistance and monitoring of medications, emergency intervention, coordination of outside services, a safe living environment, or engages in violations of resident rights or takes residents who have been admitted in violation of provisions of Section 39-3307, Idaho Code." IDAPA 16.03.22.152.05.a. "A resident will be admitted or retained only when the facility has the capability, capacity, and services to provide appropriate care..." IDAPA 16.03.22.250.13. "If the facility accepts and retains residents who have cognitive impairment, the facility must provide an interior environment and exterior yard which is secure and safe." The facility's undated "Admission/Retention" policy, which was also part of the Admission Agreement was provided by the Manager of Operations on 5/5/21. The policy documented, "No person with physical, emotional or social needs that are not harmonious with the other residents in the facility will be admitted or retained…Any Resident that is admitted with a cognitive impairment will be provided with an interior environment and exterior yard, which is secure and safe…The resident shall be re-evaluated by the primary physician for non-department clients and Department clients for progression of the resident's dementia requiring a transfer to a

		facility with greater supervision and security…" The facility's undated "Missing Resident" policy documented, "All precautions to create a secure environment will be implemented without physically or mentally restricting the Alzheimer['s] resident. The resident's safety is the primary objective and concern of the facility's staff." The facility was a 36 bed one story unsecured assisted living facility. Resident rooms 19, 20, and 21 also had exterior doors, which opened to an unsecured side yard, which was adjacent to a two-lane highway. The facility's resident roster for 5/3/21 documented 16 out of 28 residents residing in the facility had a cognitive impairment which included either Alzheimer's disease, a developmental delay, or both. 1. According to their record, Resident #10 was 82 years old and was admitted to the facility on 7/17/20 and discharged on 8/5/20, with diagnoses which included dementia. Resident #10's NSA, dated 7/31/20, documented they required supervision if evacuated during an emergency and "may not remember" taking their medications. Under behaviors the NSA documented, "Resident likes to go check on [Resident #10's] home in town. Resident will normally ask for assistance. Staff will either walk with or drive resident to [Resident #10's] home…No supervision beyond that previously described." The NSA did not document the resident had eloped or was at risk for elopement nor did it describe Resident #10's cognitive

		impairments. Resident #10's record did not include an admission assessment to determine if the resident was appropriate for admission to the facility. Resident #10's undated "Interim Plan of Care" did not document the resident was at risk for elopements. An incident report, dated 7/18/20, documented Resident #10 had wandered out of the facility to their home "a few blocks away" and someone from the community had reported seeing them. The facility's plan had been to move them to a secured facility on 7/20/20. Resident #10's record did not document they were moved to a secured facility. An incident report dated, 8/5/20, documented Resident #10 was found missing at 9:30 AM and was found down the street at 9:48 AM. Resident #10 was discharged to a secured facility on 8/5/20. Facility "Observation notes" documented: *7/19/20 at 4:30 PM, Resident #10 "went out the door next to [another Resident]'s room and set off the alarm. By the time I got to the door, [Resident #10] had already walked across the field across the street." The staff member eventually redirected the resident and another staff member picked them up in a car. The note further documented, "I was informed [Resident #10] will be moving to a locked facility." *7/20/20 at 12:00 PM, the administrator documented, "[Resident #10] will continue to stay with us for the time being. Please continue to take time to monitor [Resident #10]

		as [Resident #10] stays within our facility." *7/24/20 at 4:15 AM, Resident #10 had their bags packed and "keeps looking out the window. Looks like [Resident #10]'s getting ready to run again." *7/25/20 at 10:15 PM, Resident #10 "has been pacing the halls and looking out the windows." The resident stated that someone should be coming to pick them up to take them home. Resident #10 "has also been testing the side doors to see if the[y] are locked." *7/26/20 at 6:30 and 6:45 AM, "Resident left building to wander outside." Resident #10 "figured out that" they could walk out the front door if they waited "long enough for the alarm to go off." *7/26/20 at 10:00 AM, Resident #10 "decided to go home." Resident #10 left the facility with staff and the resident stated they "would like to walk home everyday to see [Resident #10's] house." *8/5/20 at 5:30 AM, Resident #10 "has been trying to get out all night long." Staff Member H stated Resident #10 had wandered a lot and "would try to escape daily." They stated, "We are not a locked unit" and Resident #10 "was not safe here." On 5/6/21 at 11:30 am, the administrator stated prior to moving into the facility, Resident #10, who lived only a short distance from the facility, had come to the facility on one occasion very confused and would not leave. He stated the facility had to call police to have the resident removed from

		the premises. Subsequently, when Resident #10's family requested they be admitted to the facility, the administrator stated they were wary about admitting this person, due to prior experience with the resident's confusion. The administrator stated he was not sure if the facility completed an assessment prior to Resident #10's admission and had taken the family's word that he would be safe in the facility. The administrator stated Resident #10 was "not as safe as he could have been" in the facility because they were confused, had attempted to elope, and had eloped from the facility. Resident #10 was admitted to the facility without a preadmission assessment, was confused, and eloped at least two times from an unsecured environment, which placed Resident #10 at risk for harm when wandering away from the facility unsupervised. 2. According to their record, Resident #2 was 78 years old and was admitted to the facility on 11/10/20 with diagnoses which included dementia. Resident #2's NSA dated 11/10/20, documented under behaviors, "Resident sometimes gets confused and will wander toward other rooms; staff to redirect during these times." On 5/3/21 at 2:30 PM, Resident #2 was observed wandering in the hallway. Staff Member C asked the resident if they were looking for their room and the resident was redirected. The resident was observed to be confused and was not able to identify where their room was. Staff Member C stated Resident #2 was always confused and unable to find their own room most of the time and had to be redirected. Staff Member C stated Resident #2 wandered into other residents' rooms "all the time and scared them." Staff Member C stated the

		resident thought the other residents' rooms was their room. On 5/3/21 at 3:30 PM, Resident #2 appeared confused and stated they were in Wyoming. The resident was unable to name the facility, the city they were in or indicate the location of their room. On 5/4/21 at 11:02 AM, Staff Member B stated an exterior door of Room 21 had been unlocked. Staff Member B stated the resident who resided in that room was confused, spoke in mostly "garbled" speech, and would not be safe in the community on their own. On 5/4/21 at 11:05 AM, two staff members were observed looking for Resident #2 in the facility due to the resident's habit of wandering into other residents' rooms. At 11:15 AM the staff stated they located the resident. On 5/5/21 at 8:25 AM, the exterior door in Room 21 was observed to be unlocked. On 5/6/21 at 8:15 AM, the door from the facility to the clubhouse, which had an unlocked exterior door, was observed to be propped open. The house manager was alerted, and the door to the clubhouse was closed. Facility "Observation notes" documented: *11/19/20 at 3:34 AM, Resident #2 "has been wandering a lot lately during the night shifts" and believed they were at work. The note also documented the resident was found in another resident's room. "Continue to redirect [Resident #2] from other residents' rooms at night."

		*11/29/20 at 12:00 AM, when Resident #2 "…wanders keep an eye on them, or they will go into someone else's room." *12/20/20 at 9:00 AM, Resident #2 wandered the halls all night and pulled the fire alarm believing they were turning off Christmas lights. *4/21/21 at 10:30 PM, "I know this will be difficult to do, but can we all try and really pay attention to [Resident #2's] wandering and where [they] are going please?" They are making a couple of residents feel unsafe. Two residents reported Resident #2 going into their rooms. It further documented to "keep a sharp eye out…" for Resident #2 "heading for those two rooms" and to remind them they cannot go in there. Facility complaint logs, dated 5/3/21, documented two separate residents complained about Resident #2 wandering into their rooms, sleeping in their bed, and using a resident's bathroom without permission. The facility's administrators written response was to put up signs and to train staff to redirect [Resident #2] "more effectively. If this continues to be an issue, we will look to move [Resident #2] to a different room, or possibly a different building." Between 5/3/21 to 5/7/21, residents, a family member, and staff stated the following regarding Resident #2 and other confused residents: *Resident #12 stated Resident #2 went into their room while they were asleep and "startled and scared" them. The resident stated they locked their door at night and placed a folding chair in front of the door to alert them that someone was in their room. The resident stated on another occasion, they

		found Resident #2 in their bed and Resident #2 had "wet the bed" and "had to clean up the mess," and wash the sheets. Resident #12 stated they had tried to makes friends with Resident #2 to see if that would stop them from entering in their room uninvited, but stated Resident #2 was "so confused" that they did not know what Resident #12 had been talking about. *Resident #3 stated Resident #2 would often come, uninvited, into their room. Sometimes, they would find Resident #2 using their bathroom, and other times, Resident #2 would be found sleeping in their bed. They stated they did not have a key to their room to be able to lock the door and keep Resident #2 out. They stated they put a suitcase in the doorway of their room to alert them if that resident was entering their room. *Resident #13 stated Resident #2 was confused and would go into their room uninvited. Resident #13 stated they locked their door so Resident #2 would not wander into their room. *Resident #2's family member stated Resident #2 had dementia. The family member stated the resident did not know where they were and believed they lived in Wyoming. They stated the resident would "definitely" not be safe if they left the facility alone. *Staff Member A stated there were alarms and keypads on the doors "because we have some wandering people." *Staff Members D and E stated some of the residents had the code to the door. They stated Resident #2 did not have the code, was confused and would not be safe to leave the facility unattended.

		*Staff Members F and G stated Resident #2 was “always” confused. They stated Resident #2 would not be safe outside the facility unattended and did not have the door code. *Staff Members A and B stated Resident #2 would not be safe outside the facility unattended. On 5/3/21 at 1:19 PM, the facility’s house manager stated, “all residents and visitors have the door code.” On 5/6/21 at 11:30 am, the administrator stated Resident #2’s, “forgetfulness and memory” were their “biggest issues”. The administrator stated the house manager had “begun the process” of moving Resident #2 to a secured memory unit. Resident #2 was retained by the unsecured facility for more than five months after Resident #2 demonstrated significant confusion, wandered into other resident’s rooms and attempting to elope from the facility. This impinged on the rights of the other residents and placed Resident #2 at risk of harm if Resident #2 succeeded in eloping from the un-secured facility. The facility failed to assess Resident #10 prior to their admission to ensure they were safe to live in an unsecured environment and retained Resident #2 after they became confused and began attempting to leave and wandering into other resident’s rooms. Both residents had significant cognitive impairments and were at risk for elopement. This placed the residents at risk for harm when they were admitted and retained to an unsecured environment.