



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

C.L. "BUTCH" OTTER – GOVERNOR  
RICHARD M. ARMSTRONG – DIRECTOR

TAMARA PRISOCK – ADMINISTRATOR  
DIVISION OF LICENSING & CERTIFICATION  
JAMIE SIMPSON – PROGRAM SUPERVISOR  
RESIDENTIAL ASSISTED LIVING FACILITY PROGRAM  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: 208-364-1962  
FAX: 208-364-1888

March 17, 2015

Kathleen Little, Administrator  
Cottage Investors LLC dba The Cottages of Nampa  
5023 East Victory Road  
Nampa, Idaho 83687

Provider ID: RC-950

Ms. Little:

On January 22, 2015, a complaint investigation was conducted at The Cottages of Nampa. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level(s):

- Core issues, which are described on the Statement of Deficiencies, and for which you have submitted a Plan of Correction.
- Non-core issues, which are described on the Punch List, and for which you have submitted evidence of resolution.

Your submitted plan of correction and evidence of resolution are being accepted by this office. Please ensure the corrections you identified are implemented for all residents and situations, and implement a monitoring system to make certain the deficient practices do not recur.

Thank you for your work to correct these deficiencies. Should you have questions, please contact Gloria Keathley, LSW, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 364-1962.

Sincerely,

GLORIA KEATHLEY, LSW  
Team Leader  
Health Facility Surveyor

GK/sc

cc: Jamie Simpson, MBA, QMRP Supervisor, Residential Assisted Living Facility Program



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January 26, 2015

CERTIFIED MAIL #: 7007 3020 0001 4050 8737

Nicole Ellis, Administrator  
The Cottages of Nampa  
5023 East Victory Road  
Nampa, Idaho 83687

Provider ID: RC-950

Ms. Ellis:

Based on the complaint investigation conducted by Department staff at The Cottages of Nampa between January 21, 2015 and January 22, 2015, it has been determined that the facility failed to protect residents from abuse.

This core issue deficiency substantially limits the capacity of The Cottages of Nampa to furnish services of an adequate level or quality to ensure that residents' health and safety are protected. The deficiency is described on the enclosed Statement of Deficiencies.

You have an opportunity to make corrections and thus avoid a potential enforcement action. Correction of this deficiency must be achieved by **March 8, 2015**. **We urge you to begin correction immediately.**

After you have studied the enclosed Statement of Deficiencies, please write a Plan of Correction by answering **each** of the following questions for **each** deficient practice:

- ◆ What corrective action(s) will be accomplished for those specific residents/personnel/areas found to have been affected by the deficient practice?
- ◆ How will you identify other residents/personnel/areas that may be affected by the same deficient practice and what corrective action(s) will be taken?
- ◆ What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?
- ◆ How will the corrective action(s) be monitored and how often will monitoring occur to ensure that the deficient practice will not recur (i.e., what quality assurance program will be put into place)?
- ◆ By what date will the corrective action(s) be completed?

Return the **signed** and **dated** Plan of Correction to us by **February 8, 2015**, and keep a copy for your records. Your license depends upon the corrections made and the evaluation of the Plan of Correction you develop.

Nicole Ellis  
January 26, 2015  
Page 2 of 2

Pursuant to IDAPA 16.03.22.003.02, you have available the opportunity to question the core issue deficiency through an informal dispute resolution process. If you disagree with the survey report findings, you may make a written request to the Supervisor of the Residential Assisted Living Facility Program for an IDR meeting. The request for the meeting must be in writing and must be made within ten (10) business days of receipt of the Statement of Deficiencies. The facility's request must include sufficient information for Licensing and Certification to determine the basis for the provider's appeal, including reference to the specific deficiency to be reconsidered and the basis for the reconsideration request. If your request for informal dispute resolution is received more than ten (10) days after you receive the Statement of Deficiencies, your request will not be granted. Your IDR request must be made in accordance with the Informal Dispute Resolution Process. The IDR request form and the process for submitting a complete request can be found at [www.assistedliving.dhw.idaho.gov](http://www.assistedliving.dhw.idaho.gov) under the heading of Forms and Information.

Please bear in mind that non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference. Your evidence of resolution (e.g., receipts, pictures, policy updates, etc.) for each of the non-core issue deficiencies is to be submitted to this office by **February 21, 2015**.

One (1) non-core deficiencies cited was identified as a repeat punch.. Please be aware, any non-core deficiency which is identified on three consecutive surveys will result in a civil monetary penalty.

Also, be aware that any variance allowing the administrator to serve over other facilities is revoked as of the date of the exit conference. The facility must now employ a single, licensed administrator who is not serving as administrator over any other facilities. Failure to do so within thirty (30) days of the date of the exit conference will result in a core issue deficiency.

If, at the follow-up survey, the core deficiency still exists or a new core deficiency is identified, or if any of the repeat non-core punches are identified as still out of compliance, the Department will have no alternative but to initiate an enforcement action against the license held by Cottage Investors Iii Llc - The Cottages Of Nampa.

Enforcement actions may include:

- imposition of civil monetary penalties;
- issuance of a provisional license;
- limitation on admission to the facility;
- requirement that the facility hire a consultant who submits periodic reports to Licensing and Certification.

Our staff is available to answer questions and to assist you in identifying appropriate corrections to avoid further enforcement actions. Should you have any questions, or if we may be of assistance, please contact us at (208) 364-1962 and ask for the Residential Assisted Living Facility program. Thank you for your continued participation in the Idaho Residential Care Assisted Living Facility program.

Sincerely,



JAMIE SIMPSON, MBA, QMRP  
Program Supervisor  
Residential Assisted Living Facility Program

JS/sc

Residential Care/Assisted Living

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>13R950</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY COMPLETED<br><br><b>C</b><br><b>01/22/2015</b> |
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| NAME OF PROVIDER OR SUPPLIER<br><br><b>COTTAGE INVESTORS LLC DBA THE COTTAGE</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5023 EAST VICTORY ROAD<br/>NAMPA, ID 83687</b> |
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| R 000 | <p><b>Initial Comments</b></p> <p>The following deficiency was cited during the complaint survey conducted between 1/21/15 and 1/22/15 at your residential care/assisted living facility. The surveyors conducting the survey were:</p> <p>Gloria Keathley, LSW<br/>Team Coordinator<br/>Health Facility Surveyor</p> <p>Donna Henscheid, LSW<br/>Health Facility Surveyor</p> <p>Survey Definitions:<br/>BMP = Behavior Management Plan<br/>Hx = History<br/>ISP = Idaho State Police<br/>NSA = Negotiated Service Agreement<br/>RN = Registered Nurse</p>  | R 000 | <p>To whom it may concern:</p> <p>In Response to a recent survey that occurred on 01/21/2015 to 01/22/2015 where the following deficiency 16.03.22.510 was cited. The facility corrective plan.</p> <p><b>What corrective action(s) will be accomplished for those specific residents/ personal/ areas found to have been affected by the deficient practice?</b></p> <p>Once staff member found residents 3&amp;4 house supervisor was notified, house supervisor then notified adult protection, Nampa Police, and licensing and certification. Resident #3 was taken in to custody. Resident #4's family was contacted in which she was taken back home with family members. Going forward all residents being admitted to the facility will consent to having a national database background check completed on them before admission. The administrator will continue to assess residents prior to admission utilizing their medical records and interview with family members.</p> |  |
| R 006 | <p><b>16.03.22.510 Protect Residents from Abuse.</b></p> <p>The administrator must assure that policies and procedures are implemented to assure that all residents are free from abuse.</p> <p>This Rule is not met as evidenced by: Based on record review and interview, it was determined the facility admitted 1 of 1 sampled residents (Resident #3), with a known history of sexually assaultive behaviors and did not provide sufficient supervision to protect the other residents. As a result, female residents residing in the facility were not protected from abuse. The findings include:</p> | R 006 | <p><b>How will you identify other residents/ personnel/ areas that may be affected by the same deficient practice and what corrective action(s) will be taken</b></p> <p>All current resident family members have consented to this same background check. The administrator will continue to assess residents prior to admission utilizing their medical records and interview with family members.</p>   |  |

Bureau of Facility Standards  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Residential Care/Assisted Living

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| R 006 | <p>Continued From page 1</p> <p>IDAPA 16.02.33.510 documents, "The administrator must assure that policies and procedures are implemented to assure that all residents are free from abuse."</p> <p>The facility is a ten bed, secured facility which primarily admits elderly residents. At the time of the survey, the facility had seven elderly female residents. Only one of the residents was interviewable. The office is located in the back of the building in a corner of the sun porch.</p> <p>According to his record, Resident #3 was a 76 year old male admitted to the facility on 11/4/13 with a diagnosis of dementia with sexual inappropriateness.</p> <p>According to her record, Resident #4 was a 69 year old female admitted to the facility on 5/27/14 with a diagnosis of early onset severe Alzheimer's disease.</p> <p>An "Addendum to Cottage Admission Agreement," signed by the administrator and Resident #3's Power of Attorney (POA), dated 11/4/13, documented, "On 11/4/13 you [POA's name] disclosed to us that your loved one [Resident #3's name] has been accused but not convicted of a sexual crime. On 11/4/13 our Director of Excellence, Kathleen Little, checked the ISP Sex Offender Registry and found no such name and or conviction. If after time of admission there is a conviction then you agree to remove him from the Cottage premises immediately."</p> <p>Faxes from a medical clinic, dated 11/4/13, documented the following clinic notes:</p> <p>*7/2/13 - The resident was brought into the clinic</p> | R 006 | <p><b>what measures will be put in place or what systemic changes will you make to ensure that the deficient practices does not recur?</b></p> <p>The facility has updated the resident admission agreement to state that all residents being admitted to the facility will consent to having a national database background check completed prior to admission.</p> <p><b>How will the corrective action(s) be monitored and how often will monitoring occur to ensure that the deficient practices will not recue (i.e., what quality assurance program will be put in to place)</b></p> <p>The corrective actions will be monitored during mock surveys completed by the Director of Operations, as well as by the house manager periodically.</p> <p><b>By what date will the corrective action(s) be completed?</b></p> <p>The corrective actions have been effective as of 02/05/2015</p> <p><i>Muehler 3-13-15</i></p> |  |
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Residential Care/Assisted Living

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| R 006 | <p>Continued From page 2</p> <p>because "he had recently got out of jail due to a violation of his no contact order with his ex-girlfriend, and he has demonstrated sexually inappropriate behavior. His young neighbor, who is 35 years old, was out earlier today and he grabbed her breast. He came walking out in his underwear....It sounds like he probably does need to go into assisted living somewhere such as The Cottage...."</p> <p>*7/5/13 - The resident's "housemate" called the clinic and stated the resident "raped" a neighbor girl on 7/3/13. The housemate stated, "I came out of the bathroom from getting my shower and he was on top of her....I had to remove him off her like a dog. Her rape kit was positive for semen." It documented the resident was sent to jail.</p> <p>*7/5/13 - Resident #3's son went to the clinic to update the physician about the resident's status. He told the physician the resident was in jail. The son stated he could not understand why the housemate "left him alone with the younger woman."</p> <p>*11/4/13 - The resident's son called the clinic to let them know the resident was "trying" to get into the Cottage of Nampa and he needed to obtain a history and physical and signed physician's orders.</p> <p>A progress note, dated 11/4/13, documented Resident #3 was a new resident and had "possible behavior issues."</p> <p>There was no documentation that a behavior plan was put into place at admission to protect the female residents residing in the facility. Nor was there any documentation the staff had been informed of Resident #3's past history of sexual</p> | R 006 |  |  |
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| R 006 | <p>Continued From page 3</p> <p>assault.</p> <p>An NSA, dated 11/7/13, documented the resident had "inappropriate sexual behavior, undressing inappropriately, unwanted touching of others...Some possible recent inappropriate sexual behaviors. Staff to monitor for any signs of inappropriate issues and report to facility administrator or facility nurse."</p> <p>A "Behavior Management" note written by the RN, dated 4/3/14, documented the goal was to "decrease" Resident #3's "sexual inappropriateness with staff and visitors."</p> <p>Hospice Notes documented the following:</p> <p>*11/22/13 - "Patient has a Hx of inappropriate sexual behavior with a recent episode of a sexual assault to a neighbor. He was released from jail under the supervision of his son."</p> <p>*1/31/14 - Patient having "increased difficulty urinating...Patient has a history of inappropriate sexual behavior and history of sexual assault. I do not feel comfortable at this time doing a prostate check on this patient."</p> <p>*5/13/14 - "...he is still sexually inappropriate with staff." When asked if there was anything the hospice nurse could get him, the resident responded "sex."</p> <p>"Behavior Tracking Tools" documented the following behaviors:</p> <p>*2/15/14 - The resident was sexually inappropriately talking to another resident. (There were no interventions or results were documented).</p> | R 006 |  |  |
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| R 006 | <p>Continued From page 4</p> <p>*3/28/14 - The resident stated he "would like to get into" a caregiver's pants. The caregiver "chose to ignore" him and the resident replied he "would like to do it and walked away."</p> <p>*3/30/14 - The resident made verbal sexual comments to a caregiver. The caregiver asked him "politely" to not talk to her that way. The resident "proceeded" to talk inappropriately.</p> <p>*3/31/14 - The resident was asking the caregiver sexual questions such as to "see/smell my pussy." The caregiver asked the resident to "politely" stop.</p> <p>Caregiver progress notes documented the following:</p> <p>*12/13/13 - The resident had "several" instances of "intensely inappropriate sexual behavior towards staff and guests."</p> <p>*1/16/14 - Resident #3's "inappropriate behaviors have increased."</p> <p>A quarterly nursing assessment, dated 2/2/14, documented Resident #3 continued to make inappropriate sexual comments.</p> <p>A quarterly nursing assessment, dated 5/6/14, documented Resident #3 continued to talk sexually inappropriately to staff and residents "very often." The resident had "not been physically sexually inappropriate with anyone."</p> <p>An incident report, dated 6/5/14, documented a caregiver noticed Resident #4 was not in the living room where she had last seen her. The caregiver found Resident #4 in Resident #3's</p> | R 006 |  |  |
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Residential Care/Assisted Living

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| R 006 | <p>Continued From page 5</p> <p>room. Resident #4 was "undressed" and Resident #3 had his pants down "exposing himself to the female resident." The caregiver put a blanket around Resident #4 and directed her out of Resident #3's room. It was reported to management. Management called Adult Protection, Licensing and Certification and the police. Resident #3 was arrested and removed from the facility.</p> <p>At the time of the incident, the facility had one caregiver and a house manager on duty. However, the house manager was in the office which is located in the back of the building in a corner of the sun porch.</p> <p>On 1/21/15 at 2:25 PM, Resident #1 stated there was a male resident who "got in trouble trying to get a woman into bed with him." Resident #1 stated the resident was arrested and no longer lived at the facility.</p> <p>On 1/21/15 at 2:35 PM, a caregiver stated she worked the night shift when the incident happened. She stated the other caregivers warned her that Resident #3 "said things" that were "sexual" in nature. She stated she had only worked at the facility a short time and she was "warned," but was told the behaviors were "rare." The caregiver stated she was not told of the resident's specific assaultive behaviors or what to do protect other residents.</p> <p>On 1/22/15 at 8:15 AM, the facility RN stated she arrived at the facility after the police had arrived and the resident had "propositioned the female deputy." The RN stated she was uncertain if Resident #3 came to the facility with a history of abuse, but thought he came from home or jail. She stated, "I don't know why he was here."</p> | R 006 |  |  |
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| R 006 | <p>Continued From page 6</p> <p>On 1/22/15 at 9:57 AM, a caregiver stated Resident #4 was sitting on the couch while she took another resident to the bathroom. She stated at the time she was working alone. The caregiver stated when she came out of the bathroom, Resident #4 was gone. She opened the door to Resident #3's room and found Resident #4 with her shirt off and "everything hanging out." She stated Resident #3's pants were off and his briefs were half way down his legs. When she asked Resident #3 what he was doing, he replied, "None of your business." The caregiver assisted Resident #4 out of the room and contacted the house manager. She stated the house manager "ripped into him" and told the resident, "this is the last thing you will do here." She stated no one provided one to one supervision to Resident #3 until the police arrived. However, she stated the house manager checked on him periodically.</p> <p>On 1/22/15 at 10:00 AM, the same caregiver stated when she first started work, she was not told "a whole lot" about Resident #3's behaviors. She heard he was "naughty" and was a sex offender. She stated Resident #4 was younger, wandered around and was "more his type."</p> <p>On 1/22/15 at 11:10 AM, Kathleen Little stated she was not the administrator when Resident #3 was admitted, but was the administrator when the incident occurred. Kathleen, stated Sondra Winters was the admitting administrator. Kathleen stated Sondra called her to talk about Resident #3's admission. Kathleen stated, Sondra told her Resident #3 had a history of sexual behavior, but she was "unsure about what was true and what wasn't." Kathleen stated she checked the sex offender registry and his name was not found and Resident #3 was admitted. Further, Kathleen</p> | R 006 |  |  |
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Residential Care/Assisted Living

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>COTTAGE INVESTORS LLC DBA THE COTTAGE</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5023 EAST VICTORY ROAD<br/>NAMPA, ID 83687</b> |
|--|--|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|--------------------|---|---------------|---|--------------------|
| R 006              | <p>Continued From page 7</p> <p>acknowledged that Resident #3 should not have been admitted.</p> <p>The facility admitted Resident #3 who had a known history of sexually assaultive behaviors. The facility did not ensure Resident #3 had increased supervision nor did they provide detailed instructions to staff on how to protect female residents from sexual abuse. This resulted in abuse.</p> | R 006         |   |                    |





IDAHO DEPARTMENT OF  
HEALTH & WELFARE

C.L. "BUTCH" OTTER – GOVERNOR  
RICHARD M. ARMSTRONG – DIRECTOR

TAMARA PRISOCK – ADMINISTRATOR  
DIVISION OF LICENSING & CERTIFICATION  
JAMIE SIMPSON – PROGRAM SUPERVISOR  
RESIDENTIAL ASSISTED LIVING FACILITY PROGRAM  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: 208-364-1962  
FAX: 208-364-1888

January 26, 2015

Nicole Ellis, Administrator  
The Cottages of Nampa  
5023 East Victory Road  
Nampa, Idaho 83687

Provider ID: RC-950

Ms. Ellis:

An unannounced, on-site complaint investigation survey was conducted at The Cottages of Nampa between January 21, 2015 and January 22, 2015. During that time, observations, interviews or record reviews were conducted with the following results:

**Complaint # ID00006533**

**Allegation #1:** The facility did not protect residents from sexual abuse

**Findings:** Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.510 for not protecting residents from sexual abuse. The facility was required to submit a plan of correction.

**Allegation #2:** The facility did not ensure medications were available as ordered.

**Findings:** Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.305.02 for not ensuring residents' medications were available as ordered by the residents' physician. The facility was required to submit evidence of resolution within 30 days.

If you have questions or concerns regarding our visit, please call us at (208) 364-1962. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,

GLORIA KEATHLEY, LSW  
Health Facility Surveyor  
Residential Assisted Living Facility Program

GK/sc