

C.L. "BUTCH" OTTER - GOVERNOR RICHARD M. ARMSTRONG - DIRECTOR JUDY A. CORDENIZ – ADMINISTRATOR LICENSING AND CERTIFICATION P.O. Box 83720 Boise, Idaho 83720-0009 PHONE 208-334-6626 FAX 208-364-1888

July 13, 2012

Jeffrey Mikesell, Administrator Rose Terrace Country Homes 5672 West Rhode Island Spirit Lake, ID 83869

License #: RC-807

Dear Mr. Mikesell:

On May 25, 2012, a Complaint Investigation was conducted at Rose Terrace Country Homes. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level(s):

• Non-core issues, which are described on the Punch List, and for which you have submitted evidence of resolution.

This office is accepting your submitted evidence of resolution.

Should you have questions, please contact Maureen A. McCann, RN, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 334-6626.

Sincerely.

Maureen A. McCann, RN

Team Leader

Health Facility Surveyor

Residential Assisted Living Facility Program

Marreen & MCCarr, Rr.

Reset Form

Print Form

ASSISTED LIVING Non-Core Issues Punch List



MEDICAID LICENSING & CERTIFICATION - RALF P.O. Box 83720 Boise, ID 83720-0036 (208) 334-6626 fax: (208) 364-1888

Facility Name Rose Terrace	Physical Address 5672 West Rhode Island	Phone Number 208 623-6154
Administrator Jeffrey Mikesell	City Spirit Lake	Zip Code 83869
Team Leader Maureen McCann	Survey Type Complaint and Follow-up	Survey Date 05/25/12

NON-CORE ISSUES

Item #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	L&C USE
1 300.01	300.01	The facility nurse signed delegation forms without completing on-site observations of medication aides assisting with	7/3/12/10	
		medications.		
2	350.02	The administrator did not investigate incidents, accidents and complaints within 30 days.	7/3/12	
3	350.04	The administrator did not provide a written response to complainants within 30 days.	7/12/12	
1	350.07	The facility did not send reportable incidents and accidents to Licensing and Certification.	7/13/12 me	
5 600.05	600.05	The administrator did not provide adequate supervision of the day to day operations at the facility, such as: He was not reviewing	7/13/12	
		documentation and addressing issues regarding residents. Further, he had not documented staff concerns that had been reported	luc	
		to him.		
5	705.02	The administrator did not sign an admission agreement for Resident #1.	7/13/2	
7	725.01	The admission discharge register was not kept current:		7
8	730.02	The administrator did not maintain staff work schedules for three years.	7/3/12	
Response F 06/24/12	L Required Date	Signature of Facility Representative	Date Signed 5/25/	1/2

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June 25, 2012

Jeffrey Mikesell, Administrator Rose Terrace Country Homes PO Box 177 Spirit Lake, ID 83869

Dear Mr. Mikesell:

An unannounced, on-site complaint investigation survey was conducted at Rose Terrace Country Homes from May 24, 2012, to May 25, 2012. During that time, observations, interviews, and record reviews were conducted with the following results:

Complaint # ID00005582

Allegation #1: An identified male resident was sexually inappropriate with female residents.

Findings #1:

Between 5/24/12 and 5/25/12, seven caregivers stated the identified male resident was sexually inappropriate with staff, particularly before or after he experienced a seizure. They further stated they had not witnessed him being sexually inappropriate with other residents. They stated he had a relationship with one of the female residents, who they felt was pursuing him.

On 5/24/12 at 4:20 PM, the administrator/nurse stated, the resident was sexually inappropriate with staff but not with other residents. The administrator stated when the resident had a relationship with a female resident, he had contacted the local ombudsmen and the residents' families for guidance.

On 5/25/12 at 4:10 PM, the female resident was interviewed. She was observed to be alert and oriented. She stated, "I was madly in love with him." She further expressed being sad that he no longer resided at the facility.

The facility's incident reports and progress notes were reviewed. There was no documentation the resident had been sexually inappropriate with other residents. Further, the resident's behavior management plan identified the resident's behaviors as, "kicking, punching, banging fist on wall/door, and yelling."

Jeffrey Mikesell, Administrator June 25, 2012 Page 2 of 2

Unsubstantiated. Although the allegation may have occurred, it could not be determined during the complaint investigation.

As no deficiencies were cited as a result of our investigation, no response is necessary to this report. Thank you to you and your staff for the courtesies extended to us on our visit.

Sincerely,

Maureen McCann

Health Facility Surveyor

Residential Assisted Living Facility Program

MM/tfp

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



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June 25, 2012

Jeffrey Mikesell, Administrator Rose Terrace Country Homes PO Box 177 Spirit Lake, ID 83869

Dear Mr. Mikesell:

An unannounced, on-site complaint investigation survey was conducted at Rose Terrace Country Homes from May 24, 2012, to May 25, 2012. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00005381

Allegation #1: The RN did not complete an assessment when residents had a change of condition.

Findings #1:

Between 5/24/12 and 5/25/12, seven caregivers stated the facility nurse was called when residents had a change of condition; such as falls, injuries, illnesses and medication responses. The facility nurse stated he was contacted by caregivers when residents had a change of condition. He further stated if he was not available, the on-call nurse would direct caregivers on what needed to be done for the resident.

Nurse assessments were observed documented either in the facility's progress notes, on nurse assessment forms or on incident and accident reports.

Unsubstantiated. This does not mean the incident did not take place; it only means that the allegation could not be proven.

Allegation #2:

Unlicensed staff bubble-packed medications.

Findings #2:

On 5/24/12 and 5/25/12, four caregivers stated the facility nurse bubble-packed medications one time per week or when needed. The four caregivers further stated they had not heard of or witnessed other caregivers packaging medications. On 5/24/12 at 4:20 PM, the facility nurse/administrator stated he bubble-packed over the counter medications and the pharmacy packaged the prescription medications for the facility.

Jeffrey Mikesell, Administrator June 25, 2012 Page 2 of 3

Unsubstantiated. Although the allegation may have occurred, it could not be determined during the complaint investigation.

Allegation #3:

Two identified facility staff worked unsupervised prior to completing a criminal history and background check.

Findings #3:

On 5/25/12 at 3:20 PM, the owner stated one person was a volunteer and was not paid for the occasional maintenance work he completed around the facility. The owner also stated the other person was a caregiver who had not yet completed a background check, but had only worked 3 shifts and never worked alone before she quit. However, the owner could not produce the work schedule to determine if the staff had worked alone. Several attempts to reach the staff member for interview were unsuccessful.

Unsubstantiated. Though the allegation may have occurred, it could not be determined during the complaint investigation. However, the facility was cited at IDAPA 16.03.22.730.02 for not maintaining staff work schedules.

Allegation #4:

The RN did not delegate nursing tasks to unlicensed staff in accordance with the Board of Nursing Rules.

Findings #4:

Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.300.01 for the facility nurse signing delegation forms for unlicensed staff without completing an on-site observation and training. The facility was required to submit evidence of resolution within 30 days.

Allegation #5:

A caregiver worked alone and unsupervised without CPR, First Aid and Medication Certifications.

Findings #5:

On 5/25/12 the identified caregiver's record was reviewed. The record did not contain documented evidence the caregiver had completed CPR, First Aid or Medication Certification courses.

On 5/25/12 at 3:20 PM, the owner stated the caregiver only worked 3 shifts before she quit, and never worked alone. However, the owner could not produce the work schedule to determine if the caregiver had worked alone. Two caregivers were interviewed that remembered the identified caregiver. One stated the identified caregiver worked alone and the other stated the identified caregiver did not work alone. Several attempts to reach the caregiver for interview were unsuccessful.

Unsubstantiated. Though the allegation may have occurred, it could not be determined during the complaint investigation due to conflicting information. However, the facility was cited at IDAPA 16.03.22.730.02 for not maintaining staff work schedules.

Jeffrey Mikesell, Administrator June 25, 2012 Page 3 of 3

Allegation #6:

The carpeting throughout the facility was worn.

Findings #6:

Substantiated. However, the facility was not cited as they acted appropriately by replacing the carpeting in the living room and hallways prior to the complaint investigation. Further, the facility had begun replacing carpeting in the resident's

rooms.

Allegation #7:

A dog was allowed in the kitchen area when food was being prepped and cooked.

Findings #7:

On 5/24/12 and 5/25/12, a volunteer was observed with a small dog on a leash, sitting on the volunteer's lap in the living room. The owner was also observed with a small dog at the facility, but the dog was not observed in the kitchen area. Six caregivers that worked various shifts stated they did not recall a time when there was a dog in the

kitchen.

Unsubstantiated. This does not mean the incident did not take place; it only means that the allegation could not be proven.

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, on **May 25, 2012**. The completed punch list form and accompanying evidence of resolution (e.g., receipts, pictures, policy updates, etc) are to be submitted to this office within thirty (30) days from the exit date.

If you have questions or concerns regarding our visit, please call us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,

Maureen McCann

Health Facility Surveyor

Residential Assisted Living Facility Program

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MM/tfp

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



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

JUDY A. CORDENIZ - ADMINISTRATOR LICENSING AND CERTIFICATION P.O. Box 83720 Boise, Idaho 83720-0009 PHONE 208-334-6626 FAX 208-364-1888

June 22, 2012

Jeffrey Mikesell, Administrator Rose Terrace Country Homes PO Box 177 Spirit Lake, ID 83869

Dear Mr. Mikesell:

An unannounced, on-site complaint investigation survey was conducted at Rose Terrace Country Homes from May 24, 2012, to May 25, 2012. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00005399

Allegation #1: Unlicensed staff bubble-packed medications.

Findings #1: On 5/24/12 and 5/25/12, four caregivers stated the facility nurse bubble-packed

medications one time per week or when needed. The four caregivers further stated they had not heard of or witnessed other caregivers packaging medications. On 5/24/12 at 4:20 PM, the facility nurse/administrator stated he bubble-packed over the counter medications and the pharmacy packaged the prescription medications for the

facility.

Unsubstantiated. Although the allegation may have occurred, it could not be

determined during the complaint investigation.

Allegation #2: An identified resident's bubble pack was mislabeled with another resident's name.

Findings #2: Substantiated. However, the facility was not cited as they acted appropriately by

identifying and removing the mislabeled medication prior to the survey.

Allegation #3: The facility RN was not available to implement new medications orders.

Findings #3: On 5/24/12 at 4:20 PM, the facility RN stated either he or the nurse from a "sister"

facility, implemented new orders by entering them onto the medication assistance

Jeffrey Mikesell, Administrator June 25, 2012 Page 2 of 3

record (MAR). He also stated the software system allowed the nurse to transcribe medications from outside of the facility. Three medication aides stated the facility RN implemented all new orders by entering them onto the MAR.

Unsubstantiated. Although the allegation may have occurred, it could not be determined during the complaint investigation.

Allegation #4:

The RN did not complete an assessment for two identified residents who had a change of condition. The first resident fell and fractured a hip and the second resident fell and put his head through a wall.

Findings #4:

On 5/24/12, both identified resident's records were reviewed. The first identified resident's record documented the resident had fallen on 1/19/12 and was sent to a local hospital for evaluation. The identified resident was sent back to the facility on 1/20/12 with a diagnosis of a urinary tract infection. On 1/21/12, the identified resident continued to complain of pain in her left hip. Once again the resident was transported via ambulance to a local hospital where she was diagnosed with a left hip fracture. The facility nurse documented the resident's condition on an incident and accident form. The second identified resident's record was reviewed and there was no documentation the resident had fallen and put his head through a wall.

Between 5/24/12 and 5/25/12, seven caregivers stated that when a resident had a change of condition, the facility nurse was notified. The facility nurse either directed the caregivers over the phone or would come to the facility, if needed. Further, the caregivers denied an incident when the second identified resident fell and put his head through the wall.

On 5/24/12 at 4:40 PM, the facility nurse stated the caregivers called him or called the on-call nurse if he was not available. He further stated he always completed a follow-up if a resident had a change in condition. He further denied knowledge of an incident when the second identified resident fell and put his head through the wall.

Unsubstantiated. This does not mean the incident did not take place; it only means that the allegation could not be proven.

Allegation #5:

The facility did not document incidents and accidents.

Findings #5:

On 5/24/12 and 5/25/12, progress notes, daily logs, and incident and accident reports were reviewed. There were multiple entries found in the above documents. Three caregivers stated they documented all incidents, however, they did not all agree where they should document. The house manager stated incidents were being documented in various places and she planned to review the process with staff.

Unsubstantiated. This does not mean the incident did not take place; it only means that the allegation could not be proven.

Allegation #6:

The administrator did not complete an investigation on all incidents, accidents and complaints.

Findings #6:

Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.350.02 for not completing investigations within 30 days. The facility was required to submit evidence of resolution within 30 days.

Allegation #7:

The facility did not report required incidents and accidents to Licensing and Certification.

Findings #7:

Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.350.07 for not reporting required incidents and accidents to Licensing and Certification. The facility was required to submit evidence of resolution within 30 days.

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, on **May 25, 2012**. The completed punch list form and accompanying evidence of resolution (e.g., receipts, pictures, policy updates, etc) are to be submitted to this office within thirty (30) days from the exit date.

If you have questions or concerns regarding our visit, please call us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,

Maureen McCann

Health Facility Surveyor

Residential Assisted Living Facility Program

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c:

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