



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: 208-334-6626
FAX: 208-364-1888

November 2, 2012

Rose Ann Mikesell, Administrator
Rose Terrace Cottages
1821 East Sherman Avenue - Suite 5
Coeur D'Alene, ID 83814

License #: RC-855

Dear Ms. Mikesell:

On October 17, 2012, a Complaint Investigation was conducted at Rose Terrace Cottages. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level(s):

- A non-core issue, which was 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 McCann, RN, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 334-6626.

Sincerely,

Maureen McCann, RN
Team Leader
Health Facility Surveyor
Residential Assisted Living Facility Program

mmc/

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



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Rose Terrace Cottages
1821 East Sherman Avenue - Suite 5
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Dear Ms. Mikesell:

An unannounced, on-site complaint investigation survey was conducted at Rose Terrace Cottages from October 16, 2012, to October 17, 2012. During that time, observations, interviews, and record reviews were conducted with the following results:

Complaint # ID00005612

Allegation #1: An identified caregiver did not treat an identified resident with dignity and respect.

Findings #1:

On 12/17/12 at 9:40 PM, the facility administrator stated during a conversation with a family member, the family member identified a caregiver who had been rude to a resident. The administrator immediately spoke to the caregiver and encouraged the caregiver to take two (2) weeks leave. Further, the administrator scheduled the entire care staff to attend a mandatory in-service from an outside speaker regarding the appropriate way to speak with residents.

Between 10/16/12 and 10/17/12, seven (7) residents denied the identified caregiver had ever spoken to them rudely. The identified resident was unavailable for interview.

Between 10/16/12 and 10/17/12, the identified caregiver was observed interacting with residents in an appropriate manner.

Unsubstantiated. During the survey, the survey team was unable to substantiate the allegation of a caregiver being rude to a resident. However, the facility had responded appropriately to the allegation prior to the survey, when the caregiver was encouraged to take time off and the entire care staff were required to attend mandatory training regarding the appropriate way to speak with residents.

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,

A handwritten signature in cursive script, appearing to read "Maureen McCann". The signature is written in black ink and is positioned above the typed name.

Maureen McCann, RN
Health Facility Surveyor
Residential Assisted Living Facility Program

mmc/mmc

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



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November 1, 2012

Rose Ann Mikesell, Administrator
Rose Terrace Cottages
1821 East Sherman Avenue - Suite 5
Coeur D'Alene, ID 83814

Dear Ms. Mikesell:

An unannounced, on-site complaint investigation survey was conducted at Rose Terrace Cottages from Invalid Datetime, to Invalid Datetime. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00005742

Allegation #1: An identified resident was assisted with his blood glucose checks and insulin injections at the dining room table, which made other residents uncomfortable.

Findings #1: Between 10/16/12 and 10/17/12, three (3) residents, two (2) caregivers, the administrator and the nurse stated residents were no longer assisted with blood glucose checks and insulin injections at the dining room table.

On 10/17/12 at 1:50 PM, the administrator and nurse stated they had received complaints from other residents that they were not comfortable with this practice; therefore, the policy was changed a couple weeks ago.

On 10/16/12, at 11:50 AM, a resident was observed being assisted with an insulin injection in the public restroom near the dining room.

Substantiated. However, the facility was not cited as they acted appropriately by identifying the problem and corrected it prior to the survey.

Allegation #2: A staff member discussed an identified resident's medical diagnosis with another resident.

Findings #2: Between 10/16/12 and 10/17/12, five (5) residents, five (5) staff, the administrator and the nurse denied they had ever heard a staff member discuss a resident's medical diagnosis with another resident. The caregivers further stated they conduct change of shift reports in the laundry room to protect the residents' private information. During the survey, staff were not observed to discuss residents' private information in public.

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

Allegation #3: The facility did not provide an identified resident with a low sodium diet.

Findings #3: A physician's order dated 9/10/12, documented the identified resident was to have a low sodium diet.

Between 10/16/12 and 10/17/12, four (4) staff and three (3) residents, the administrator and the nurse stated that all residents were on a low-sodium diet, because salt was not added during food preparation. Several of the caregivers stated salt could be added to the food at the table. The identified resident was no longer at the facility and could not be located for interview.

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

Allegation #4: Residents do not routinely receive a copy of their admission agreement when admitted to the facility.

Findings #4:

Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.220 for not providing residents a copy of their admission agreement upon admission. The facility was required to submit evidence of resolution within 30 days.

Allegation #5: The facility did not provide a phone residents could use in private.

Findings #5: Between 10/16/12 and 10/17/12, four residents, two (2) staff, the administrator and the nurse stated cordless phones were available that the residents could take to their rooms if they wanted to talk in private.

On 12/16/12, cordless phones were observed in each building at the facility.

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

Allegation #6: An identified resident was not treated with dignity and respect by a facility owner.

Findings #6: A facility "Complaint Report" form, dated 9/27/12, documented facility staff had contacted the police, because the identified resident was "yelling and scarring" other residents. One of those residents was crying. The incident report further documented, the administrator/owner and the co-owner came to the facility. The co-owner was reported to have spoken to the identified resident in a "stern" voice, telling him to stop scaring the other residents.

Between 10/16/12 and 10/17/12, four (4) staff, five (5) residents and the administrator, denied observing or hearing the co-owner not treat the identified resident with dignity and respect. Two (2) residents and the administrator admitted the co-owner spoke to the identified resident in a loud, stern voice when explaining to him it was not acceptable to frighten other residents in the facility.

Unsubstantiated. Though the allegation may have occurred, it could not be determined during the complaint investigation due to conflicting information.

Please bear in mind that a non-core issue deficiency was identified on the punch list, a copy of which was reviewed and left with you during the exit conference, on 10/17/12. 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, RN
Health Facility Surveyor
Residential Assisted Living Facility Program

Rose Ann Mikesell, Administrator
November 1, 2012
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mmc/mmc

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

