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March 3, 2014

Lisa Junod, Administrator
Rosetta Assisted Living - Hiland
1919 Hiland
Burley, Idaho 83318

Ms. Junod:

An unannounced, on-site complaint investigation survey was conducted at Rosetta Assisted Living - Hiland on February 20, 2014. During that time, observations, interviews, and record reviews were conducted with the following results:

Complaint # ID00006332

Allegation #1: Residents were inappropriately assisted with eating, as they were fed in a reclined position.

Findings: The identified resident was observed, on 2/20/14, eating breakfast while seated at the dining room table. The resident ate pancakes independently. A caregiver was observed to verbally cue the resident to drink his milk and the resident did so independently. The resident was also observed to ambulate independently away from the table after breakfast. Additionally, caregivers were observed to appropriately assist other residents with their meals.

On 2/20/14 between 8:00 AM and 3:00 PM, five caregivers, the facility nurse and administrator stated they had never observed, or heard of a time, when the identified resident was fed while in a reclined position. They stated that no residents were fed in a reclining position.

On 2/20/14 at 12:00 PM, the identified resident's family member stated she visited the resident daily and was pleased with the care the resident received by the facility staff.

The identified resident's care plan, documented the resident "can feed self" but may require assistance or cueing.

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

Allegation #2: Residents were not assisted with toileting.

Findings: On 2/20/14 at 8:00 AM a tour of the facility was conducted. All residents' rooms and the common areas were observed to be clean and odor free.

On 2/20/14 at 8:05 AM, the identified resident was observed seated at the dining room table. There was no odor detected while seated next to the resident. At 8:10 AM, the resident's room was observed. The resident's bed was not yet made. The sheets were observed to be dry. There was a cloth furniture protector placed on a large chair in the resident's room. The protector was also dry. There were no odors detected in the resident's room or bathroom.

The identified resident was observed several times throughout the day on 2/20/14. At no time was there an odor observed near the resident, in his room or bathroom. Caregivers were observed periodically assisting the resident to the bathroom.

On 2/20/14 between 8:00 AM and 3:00 PM, five caregivers, the facility nurse and administrator stated the resident was incontinent of urine around the clock, but all staff were aware of this and assisted him frequently to the bathroom. They further stated, if the resident had been incontinent staff assisted him to change his clothing and wash him as needed.

On 2/20/14 at 12:00 PM, the identified resident's family member stated she visited the resident daily and was pleased with the care he received from the facility staff.

The identified resident's care plan, documented the resident "goes by himself at times, usually total staff assist."

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

Allegation #3: Residents were not assisted with grooming after meals.

Findings: On 2/20/14 at 8:00 AM, an unannounced survey was conducted. Three residents were observed to be sitting in the dining area eating breakfast and one resident was lying on a couch asleep. Two of the residents in the dining area were observed to be wearing clothing "protectors." All 4 residents were observed to be well groomed and dressed in clean clothing.

Between 8:00 AM and 8:20 AM, the facility was toured. The facility's other 7 residents were observed to be well groomed and dressed in clean clothing.

On 2/20/14 between 8:00 AM and 3:00 PM, five caregivers, the facility nurse and administrator stated that if a resident, or their clothing, had food on them after eating a meal they were cleaned up right away. They stated residents frequently wore clothing "protectors" during meals to avoid staining their clothing.

On 2/20/14 at 2:20 PM, the ombudsman stated she visited the facility during meal times, or shortly after meals, whenever possible. She stated that when she had visited the facility, the residents and their clothing, were clean.

On 2/20/14 at 3:35 PM, a resident's family member stated she visited the facility daily. She stated she had no concerns regarding her family member's, or other residents' grooming.

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

Allegation #4: The facility locked a resident in a closet as part of elopement drills.

Findings: On 2/20/14 between 8:00 AM and 3:00 PM, five caregivers, the facility nurse and administrator were interviewed regarding the facility's elopement drills. They stated the administrator, or assistant administrator, would randomly conduct an elopement drill. They stated an employee would "hide" with a resident, either inside or outside, while the other employees would look for the resident. They stated that at no time was the resident left alone or locked in a closet.

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

Allegation #5: Staff were instructed to start a "real stove fire" to conduct a fire drill.

Findings: On 2/20/14 at 9:45 AM, the administrator stated the facility had fire drills at least quarterly. She stated, if for any reason the alarm system was activated staff were to treat it as a fire and evacuate the residents from the facility. Additionally, the staff were to document on the fire drill form, who was present and how long it took them to evacuate the building. She stated that at no time were staff instructed to start a fire so the facility could conduct a fire drill.

On 2/20/14 between 10:55 AM and 3:20 PM, five caregivers and the facility nurse were interviewed regarding fire drills. All six stated they had never been instructed to start a fire in order to conduct a fire drill. They stated if the fire alarm went off for any reason, such as smoke from burnt popcorn, they were to treat it as a fire and evacuate the residents. Additionally, they stated they were suppose to document who participated in the drill and how long it took them to evacuate the building.

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

Allegation #6: Activities were offered to select residents only.

Findings: On 2/20/14 at 9:55 AM, the administrator stated the staff on duty were responsible to provide the activities. She stated staff were to encourage all residents to join in the activities.
On 2/20/14 at 10:15 AM, caregivers were observed to ask, each resident if they wanted to participate in an exercise activity. Additionally, a few minutes into the activity, staff were observed to reapproach and encourage a resident who had initially refused to participate in the activity.

On 2/20/14 between 10:55 AM and 3:20 PM, five caregivers were interviewed regarding activities. They said each resident was asked if they wanted to participate activities. The caregivers said if a resident refused they would reapproach them later and asked again. They stated residents had the right not to participate, but they offered different activities such as baking, puzzles, exercise, one on one time and

dancing.

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

Allegation #7: Facility staff removed mold from food items, such as cheese and sour cream, then served the food to residents.

Findings: On 2/20/14 at 8:00 AM, the facility's refrigerator was inspected. None of the food items were observed to have mold on them, nor were any observed to be past their "pull dates." All leftover foods were observed to be labeled and date marked.

On 2/20/14 at 9:55 AM, the administrator stated if staff observed food to be moldy, or to be passed pull dates, the food was to be discarded. Additionally, she stated if leftover food had been in the refrigerator for more than 3 days it was to be discarded.

On 2/20/14 at 2:20 PM, the ombudsman stated she visited the facility during meal times, or shortly after meals, whenever possible. She stated, she had not observed moldy cheese, sour cream, or other food when she inspected the facility's refrigerator during her visits.

On 2/20/14 between 8:00 AM and 3:00 PM, five caregivers, the facility nurse and administrator stated if food was moldy it was thrown out. They stated if there were left overs from previous meals, they were only kept for 3 days.

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

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,

Rae Jean McPhillips, RN, BSN
Health Facility Surveyor
Residential Assisted Living Facility Program

RM/sc