



IDAHO DEPARTMENT OF
HEALTH & WELFARE

G.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

November 4, 2014

Barbara Jeanne McCrary, Administrator
The Cottages of Emmett
411 East 12th Street
Emmett, Idaho 83617

Provider ID: RC-698

Ms. McCrary:

On August 28, 2014, a state licensure/follow-up survey and complaint investigation were conducted at The Cottages of Emmett. 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 Maureen McCann, RN, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 364-1962.

Sincerely,

MAUREEN MCCANN, RN
Team Leader
Health Facility Surveyor

MM/sc

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



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Boise, Idaho 83720-0099
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FAX: 208-364-1888

September 8, 2014

CERTIFIED MAIL #: 7007 3020 0001 4050 8548

Barbara Jeanne McCrary, Administrator
The Cottages of Emmett
411 East 12th Street
Emmett, Idaho 83617

Provider ID: RC-698

Ms. McCrary:

On **August 28, 2014**, a state licensure/follow-up survey and complaint investigation were conducted by our staff at The Cottages of Emmett. As a result of the survey, core issue deficiencies were cited. Enclosed is a Statement of Deficiencies.

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)?
- ◆ What date will the corrective action(s) be completed by?

Return the **signed** and **dated** Plan of Correction to us by **September 21, 2014**, and keep a copy for your records. Your license depends upon the corrections made and the evaluation of the Plan of Correction you develop.

Barbara Jeanne McCrary, Administrator

September 8, 2014

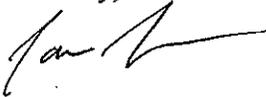
Page 2 of 2

You have available the opportunity to question cited deficiencies 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 Care Program for a Level 1 IDR meeting. The request for the meeting must be made within ten (10) business days of receipt of the statement of deficiencies (**September 21, 2014**). The specific deficiencies for which the facility asks reconsideration must be included in the written request, as well as the reason for the request for reconsideration. The facility's request must include sufficient information for Licensing & Certification to determine the basis for the provider's appeal. If your request for informal dispute resolution is received after **September 21, 2014**, 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 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. The completed Punch List form and accompanying evidence of resolution (e.g., receipts, pictures, policy updates, etc.) are to be submitted to this office by **September 27, 2014**.

Should you have any questions, or if we may be of assistance, please call our office at (208) 364-1962.

Sincerely,



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

JS/sc

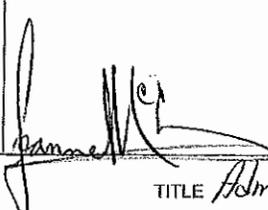
Enclosure

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R698	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/28/2014
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NAME OF PROVIDER OR SUPPLIER COTTAGE INVESTORS LLC DBA THE COTTAC	STREET ADDRESS, CITY, STATE, ZIP CODE 411 EAST 12TH STREET EMMETT, ID 83617
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(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
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{R 000}	<p>Initial Comments</p> <p>Surveyor: 23017</p> <p>Surveyor: 23026</p> <p>The following core deficiency was cited during the Follow-up survey and Complaint investigation conducted between 8/27/14 and 8/28/14 at your residential care/assisted living facility. The surveyors conducting the survey were:</p> <p>Maureen McCann, RN Team Coordinator Health Facility Surveyor</p> <p>Rachel Corey, RN Health Facility Surveyor</p> <p>Karen Anderson, RN Health Facility Surveyor</p> <p>Polly Watt-Geier, MSW Health Facility Surveyor</p> <p>Survey Definitions: ADL = activities of daily living BM = bowel movement BMP = behavior management plan C & S = culture and sensitivity Mg = milligram NSA = Negotiated Service Agreement R/O = rule out UA = urine analysis UTI = urinary tract infection</p>	{R 000}	<p>Response To Core:</p> <p>New experienced & licensed administrator has replaced administrator who was in charge at time of Initial survey. New administrator had been in place 2 weeks. On August 14, 2014 I had a Care Conference with resident #5 that included Cottages president Mark Maxfield, Ombudsman Dale Eaton, our facility nurse, assistant administrator Karen Mendoza, myself and the residents spouse. This meeting was to try and come up with a plan to be able to care for resident #5. Several ideas were developed, and I called a staff meeting for 8/15/14 to share the ideas we had. On 8/29/14 we discharged the resident. (this was the last day survey was in building.)</p> <p>All staff were in-serviced 9/19/2014 on our Behavioral management policy which also includes monitoring and interventions. As well as our medication policy.</p> <p>The New procedure will be that during the routine weekly meeting between myself and facility nurse we will review the behavior binder that will include behavioral plans and monitors. Administrator shared IDAPA rule 152 Admission Policy) that refers to acceptable admission and finished with a question and answer session.</p>	
{R 008}	<p>16.03.22.520 Protect Residents from Inadequate Care.</p> <p>The administrator must assure that policies and procedures are implemented to assure that all</p>	{R 008}	 <p>9/19/2014</p>	

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

TITLE Administrator (X6) DATE

Bureau of Facility Standards

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{R 008}	<p>Continued From page 1</p> <p>residents are free from inadequate care.</p> <p>This Rule is not met as evidenced by: Surveyor: 23017</p> <p>Surveyor: 21389</p> <p>Surveyor: 23026</p> <p>Surveyor: 20828</p> <p>Based on observation, interview and record review, it was determined the facility retained 1 of 3 sampled residents (Resident #5) who was violent and a danger to others. The findings include:</p> <p>According to IDAPA 16.03.22.152.05.e, a resident will not be admitted or retained who is violent or a danger to himself or others.</p> <p>Resident #5's record documented, he was a 64 year old male, who was admitted to the facility on 3/12/14 with a diagnosis of dementia.</p> <p>A Temporary Care Plan, dated 3/12/14, documented Resident #5 had no behaviors.</p> <p>Resident Progress Notes, documented the following:</p> <p>*4/14/14 at 10:58 PM, Resident #5 was "swearing and yelling" at a caregiver on the night shift. The progress note documented, the resident told the caregiver to get in the car and leave the facility and then the resident "slapped" her on the left side of her face. The caregiver documented "I walked away and he followed me in the office. I called the RN and told him what happened."</p>	{R 008}		

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{R 008}	<p>Continued From page 2</p> <p>*5/7/14 at 7:50 AM, Resident #5 had aggressive behaviors and was blocking the office door so the caregiver could not leave the office. The resident was verbally aggressive and "grabbed" the front of a caregiver's shirt. The note documented, the caregiver tried to redirect him but he still proceeded to come towards her and "grabbed" the caregiver's arm. The caregiver stayed in a bathroom while another caregiver tried to redirect him, but the resident was aggressive with her as well. A third caregiver tried to intervene, but the resident remained aggressive. A house manager intervened and was able to redirect him.</p> <p>*6/30/14 at 3:08 PM, the resident had been "more agitated lately."</p> <p>*7/15/14 at 3:04 PM, Resident #5 was refusing assistance with toileting and was "really aggressive."</p> <p>*7/16/14 at 2:35 PM, the resident was pacing a lot today. Refused assistance to change into regular clothes and out of pajamas.</p> <p>*7/17/14 at 3:08 PM, the resident was "harder to cue to use the bathroom or get dressed."</p> <p>*7/17/14 at 10:49 PM, the resident "started urinating in different places in the building. Last week it was in his bedroom and in his bathroom trash can. Tonight it was in the office...."</p> <p>*7/21/14 at 3:52 PM, "Resident made a mess in his bedroom and bathroom, urine and BM everywhere had to extract carpet in the room."</p> <p>*7/24/14 at 2:14 PM, "Resident had been in a very bad mood lately is showing more and more signs of aggression everyday is getting harder</p>	{R 008}		

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{R 008}	<p>Continued From page 3 and harder to redirect."</p> <p>*8/8/14 at 2:42 PM, "Resident still has been having some behaviors. We try to talk to him but it doesn't help, it makes it worse."</p> <p>*8/8/14 at 12:13 AM, the resident became very aggressive and would not leave his "clean attends on." The note documented, the caregiver told the resident he could not come out in the hallway without wearing his "underwear" (undressed). The resident pushed the caregiver away from the entrance of his doorway. The caregiver called the house manager and the nurse to request help. The note further documented, the house manager and a nightshift caregiver arrived and between the 4 caregivers they were able to assist the resident with his care needs.</p> <p>*8/11/14 at 5:28 AM, the resident "showed aggression towards me and started throwing things (pillows, cookies, silverware), yelling, putting his fists in my face and swearing...He peed on his floor and told me he made a mess and I tried to clean it up he kicked at me and yelled get out. I tried avoiding him so I wouldn't upset him but he started to follow me around making me feel very uncomfortable, like he was going to hurt me...I had to stay in the office most the night to avoid upsetting him and being followed..."</p> <p>*8/14/14 at 1:57 PM, the resident was upset asking for his wife and "what am I gonna [sic] do?" Staff redirected the resident out of the kitchen to the living area to watch the television. "Another resident said something then he told her to shut up..."</p>	{R 008}		

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{R 008}	<p>Continued From page 4</p> <p>*8/14/14 at 3:05 PM, A meeting was held with family, facility staff and the Ombudsman to discuss "issues and solutions." Such as, daily scheduled activities for him. "The wife will get a UA for C&S before she goes back home to R/O something easily treatable like a UTI. Will give the Seroquel some time to work."</p> <p>A Nursing Assessment, dated 6/30/14, documented the resident had exhibited behaviors such as being, "verbally offensive/abusive, anxious/worried, wandering in the building, suspicious and accusatory." The nurse documented the resident was so demented that "you are unable to know what triggers his behaviors and he is not redirected for very long." She further documented, the resident was not prescribed any medications.</p> <p>There was no documentation the nurse had assessed the resident after being informed by caregivers that Resident #5 had been swearing, yelling, slapping, kicking and grabbing at them.</p> <p>A fax to the physician, dated 7/15/14, documented the resident was "urinating in inappropriate places" and was "often verbally and physically threatening toward the staff." There was no written response on the fax, from the physician.</p> <p>An order was faxed from the physician, on 8/10/14, to start the resident on "Seroquel 50 mg" every night.</p> <p>The facility did not have a NSA to guide caregivers on how they were to provide care to a resident who resisted and would become aggressive when caregivers tried to assist him with his ADLs.</p>	{R 008}		

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{R 008}	<p>Continued From page 5</p> <p>The facility did not evaluate Resident #5's behaviors or have documented interventions for caregivers to implement to be able to safely redirect the resident when he was violent and aggressive. There was no documentation of what interventions were tried to redirect Resident #5 when he became verbally and physically aggressive.</p> <p>On 8/27/14 at 9:15 AM, Resident #5 was observed to be a strong, 64 year old male who was intensely pacing back and forth in front of the office door and the entrance to the kitchen. When interviewed the resident was not able to answer questions.</p> <p>On 8/27/14 at 9:18 AM, the resident's room was observed to have dried feces on the carpet and on the bathroom floor. There was a strong urine odor in his room and in the hallway near his bedroom.</p> <p>On 8/27/14 at 9:20 AM, a caregiver stated Resident #5 had exhibited behaviors mostly towards staff. She stated the resident did have behaviors of urinating throughout the facility. The caregiver stated there were times, when caregivers needed additional help to assist the resident with his care needs. She stated caregivers would call the house manager to come in and help with the resident. She further stated there was no documented behavior plan in place.</p> <p>On 8/27/14 at 11:15 AM, the nurse stated, Resident #5 had exhibited behaviors such as, throwing water on a caregiver, refusing ADL assistance, urinating in inappropriate places throughout the facility and was verbally and physically threatening towards staff. She stated</p>	{R 008}		

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{R 008}	<p>Continued From page 6</p> <p>his behaviors have increased over the past few weeks and that she and the administrator had been working on ideas for activities to keep him busy and hopefully decrease his behaviors.</p> <p>On 8/27/14 at 1:58 PM, the house manager stated the resident had not exhibited behaviors until the last few weeks. She stated, they were waiting until September to start a behavior management plan.</p> <p>On 8/27/14 at 2:45 PM, the administrator stated because Resident #5 behaviors had increased, we had a meeting with the Ombudsman, staff members and the resident's spouse. She stated, Resident #5 was started on an antipsychotic medication and staff have been taking him on daily walks, and he was doing better. The administrator further stated, she had planned another meeting with the staff, Ombudsman and the resident's spouse in September, to develop a behavior management plan.</p> <p>On 8/28/14 at 9:45 AM, a caregiver stated she had only one episode when the resident threw a glass of water on her. She stated when he exhibits behaviors "we walk away from him or take him for a walk outside."</p> <p>On 8/28/14 at 10:10 AM, another caregiver stated, Resident #5 had aggressive behaviors towards caregivers. She stated some caregivers were afraid to provide care to Resident #5 because he becomes aggressive and resistive when cares were being provided. The caregiver stated the resident's behaviors occurred more often in the evening and night shift, and were often a result of staff trying to assist him with ADLs or redirect him.</p>	{R 008}		

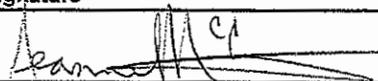
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{R 008}	<p>Continued From page 7</p> <p>On 8/28/14 at 11:15 AM, a telephone interview was conducted with the previous administrator. He stated when Resident #5 was admitted it was expected he would have some behaviors due to the adjustment of moving in. However, his behaviors continued to increase and he began refusing cares and not wanting help from caregivers. He confirmed the interim care plan was in place but the NSA or BMP were not developed.</p> <p>The facility did not evaluate Resident #5's behaviors to determine if they could retain him and provide his ADL needs. Further, the facility failed to provide support, direction and training to staff on safe, effective, interventions. The facility retained Resident #5 for five months while he was verbally and physically aggressive towards staff. The facility did not have the capacity to manage his behaviors. This placed Resident #5, other residents and staff members in danger. This resulted in inadequate care.</p>	{R 008}		



Facility COTTAGES OF EMMETT, THE	License # RC-698	Physical Address 411 EAST 12TH STREET	Phone Number (208) 365-9490
Administrator Jeanne McCrary	City EMMETT	ZIP Code 83617	Survey Date August 28, 2014
Survey Team Leader Maureen McCann	Survey Type Complaint Investigation and Follow-up	RESPONSE DUE: September 27, 2014	
Administrator Signature 	Date Signed 8/28/2014		

NON-CORE ISSUES

Item #	IDAPA Rule #	Description	Department Use Only	
			EOR Accepted	Initials
1	009.06.c	1 of 6 staff did not have the required State Police background check completed. ****PREVIOUSLY CITED ON 3/3/14****	10/16/14	UUC
2	225.01	The facility did not evaluate Resident #5's and #6's behaviors. ****PREVIOUSLY CITED ON 3/3/14****	10/16/14	UUC
3	225.02	The facility did not develop interventions for Resident #5's and #6's behaviors. ****PREVIOUSLY CITED ON 3/3/14****	10/16/14	UUC
4	260.06	The facility (building #1) was not maintained in a clean manner such as: The carpet was worn and stained, a urine odor was present throughout the building, feces and urine stains were present in several bathrooms.	10/16/14	UUC
5	305.02	Resident #7's Coumadin orders were not signed by a physician.	10/16/14	UUC
6	305.03	The facility nurse did not assess all residents' changes of condition such as: A) Resident #1's low blood sugars and a fall with complaints of pain. Resident #3's wound status. Resident #6's significant weight loss and decreased mobility needs. ****PREVIOUSLY CITED ON 3/3/14****	10/16/14	UUC
7	304.04	The facility nurse did not make recommendations for Resident #1's low blood sugars and Resident #6's dietary needs. (The resident's dentures went missing and the resident experienced a significant weight loss.)	10/16/14	UUC
8	305.07	The facility nurse did not seek clarification when there was a discrepancy between Resident #1's insulin orders. ****PREVIOUSLY CITED ON 3/3/14****	10/16/14	UUC
9	320.01	NSAs were not reflective of residents' current care needs such as: Resident #3's bedbound status and pureed diet. Resident #4's wound care and 2-person assistance transfers. Resident #5 did not have an NSA. Fruther, Resident 6's NSA was not updated when the resident experienced a significant change in condition to include initiating hospice services and dietary needs. ****PREVIOUSLY CITED ON 3/3/14****	10/16/14	UUC
10	330.03	The facility did not ensure the unauthorized use of residents' records when staff electronically documented using other caregivers electronic signatures.	10/16/14	UUC
11	350.02	The administrator did not investigate all incidents, accidents, complaints, and bruises of unknown origin. ****PREVIOUSLY CITED ON 3/3/14****	10/16/14	UUC
12	350.04	The administrator did not provide a written response to all complainants.	10/16/14	UUC
13	350.05	The facility did not report suspicious bruising of unknown origin to Adult Protection.	11/4/14	UUC



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Survey Team Leader Maureen McCann	Survey Type Complaint Investigation and Follow-up	RESPONSE DUE: September 27, 2014	
Administrator Signature 	Date Signed 8/28/2014		

NON-CORE ISSUES

Item #	IDAPA Rule # 16.03.22	Description	Department Use Only	
			EOR Accepted	Initials
14	550.23.b	Residents' #1, #5, #6 and #7's rates were increased without amending the residents' NSA's	11/4/14	MC
15	600.06.a	The facility did not schedule sufficient staff to assist with 2 person transfers and to appropriately supervise residents with behaviors in building #1.	10/16/14	MC
16	711.089.c	The facility did not document all unusual events and their response such as: Resident #1's hospitalization for low blood sugars, Resident #2's skin tears or when residents' medications were not available.	10/16/14	MC
17	310.04.e	The facility did not complete the required psychotropic medication reviews for Resident #6.	10/16/14	MC
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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
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September 8, 2014

Barbara Jeanne McCrary, Administrator
Cottage Investors LLC dba The Cottages of Emmett
411 East 12th Street
Emmett, Idaho 83617

Provider ID: RC-698

Ms. McCrary:

An unannounced, on-site complaint investigation survey was conducted at The Cottages of Emmett between August 27, 2014 and August 28, 2014. During that time, observations, interviews, and record reviews were conducted with the following results:

Complaint # ID00006456

Allegation #1: The facility nurse did not assess residents after falls.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.305.03 for not assessing residents after changes of condition. The facility was required to submit evidence of resolution within 30 days.

Allegation #2: Residents were not assisted with eating.

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

Allegation #3: The facility did not respond appropriately when several residents experienced signs and symptoms of a stomach virus.

Findings: Unsubstantiated, however the facility was issued a deficiency at 16.03.22.711.08.c for not documenting the occurrence as an unusual event.

Allegation #4: The facility falsified documentation.

Findings: Unsubstantiated. Based on record review and staff interviews, it could not be determined that documentation was falsified regarding notifying a family member after an incident. However, the facility received a deficiency at 16.03.22.330.03, for not ensuring the accuracy of electronic records, when staff documented under other staffs' names.

Barbara Jeanne McCrary, Administrator

September 8, 2014

Page 2 of 2

Allegation #5: The facility did not implement any preventative measures when residents lost weight.

Findings: Substantiated. Although based on interview and record review, it could not be determined the identified resident had lost weight, it was determined a current resident had lost weight and the facility nurse had not made any recommendations. The facility received a deficiency at 16.03.305.04 for the facility RN not making recommendations when a resident had experienced weight loss.

Allegation #6: The facility did not respond appropriately when a resident had low blood sugar levels.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.305.03 and 305.04 when the facility RN did not assess a resident after having low blood sugars, or when the nurse did not make recommendations to staff. The facility was required to submit evidence of resolution within 30 days.

Allegation #7: The administrator is not at the facility sufficiently to supervise the day to day operations.

Findings: Unsubstantiated. However, the facility received a deficiency at 16.03.22.350.02 for the administrator not investigating all incidents, accidents and complaints.

Allegation #8: The administrator did not provide a written response to complainants.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.350.04 for the administrator not providing a written response to all complainants. The facility was required to submit evidence of resolution within 30 days.

Allegation #9: The facility inappropriately raised residents' rates.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.550.23.b for raising residents' rates without amending their Negotiated Service Agreements. The facility was required to submit evidence of resolution within 30 days.

Allegation #10: The facility did not store insulin appropriately.

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

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,



MAUREEN MCCANN, RN
Health Facility Surveyor
Residential Assisted Living Facility Program

MM/sc

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



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The Cottages of Emmett
411 East 12th Street
Emmett, Idaho 83617

Provider ID: RC-698

Ms. McCrary:

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Complaint # ID00006516

Allegation #1: The facility did not have appropriate staff in numbers to meet the residents' needs.

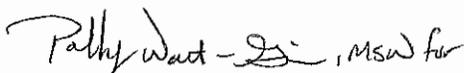
Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.600.06.a for not scheduling sufficient staff to provide residents with their mobility and supervision needs. The facility was required to submit evidence of resolution within 30 days.

Allegation #2: The facility did not investigate injuries of unknown origin.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.350.02 for the administrator not investigating injuries of unknown origin. 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,


MAUREEN MCCANN, RN
Health Facility Surveyor
Residential Assisted Living Facility Program

MM/sc

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