PLAN OF CORRECTION

Cottages Senior Living I LLC dba The Cottages of Emmett
411 East 12th Street
Emmett ID 83617

Provider ID: RC-1187

On 08/19/2022, a Health Care Complaint Investigation survey was conducted by Department staff at Cottages Senior Living I LLC dba The Cottages of Emmett. As a result of the survey, core issue deficiencies were cited with the following plan of correction.

Rule Violation .520. REQUIREMENTS TO PROTECT RESIDENTS FROM INADEQUATE CARE. [Acceptable Admission and Retention]

Describe what corrective actions will be accomplished for those residents/personnel/area found to have been affected by the deficient practice.

At the time of the survey resident #5 had already been discharged. It had also been communicated to resident #5"s wife that he was not able to be readmitted after his hospital stay.

Describe how the provider will identify other residents/personnel/areas having the potential by the same deficient practice and what corrective action(s) will be taken.

Facility will make sure nurse assessment is done prior to admission. Temporary care plans will be provided to staff till NSA is written. Training on behavior plans will be given and staff will be notified if new behavior plans are implemented.

Describe how the corrective action will be monitored to ensure the deficient practice does not recur (QA program).

Admin and nurse will discuss the appropriateness of each placement to ensure care needs can be met and any maladaptive behaviors addressed. Admin will review all behavior plans quarterly and as needed.

Date when corrective action will be completed.

October 03, 2022

Program Comments

NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
Cottages Senior Living I LLC dba The Cottages of Emmett	RC-1187	411 East 12th Street	208-365-9490
Administrator	City	Zip Code	Survey Date
Katy Tullis	Emmett	83617	08/19/2022
Survey Team Leader	Survey Type		Response Due
Brown, Stacey	Health Care Complaint Investigation		09/18/2022

Item #	Rule (16.03.22)	Description
1	.215. REQUIREMENTS FOR A FACILITY ADMINISTRATOR.	The facility did not have an approved plan of operation for the facility's previous administrator to manage this facility as well as another facility between 6/20/2022 and 7/18/2022. The previous administrator stated she was responsible for both of these facilities during this period of time, but a plan of operation for this arrangement had not been submitted to Licensing and Certification for approval.
2	.215.05. Responsibility for Acceptable Admissions.	The previous facility administrator admitted Resident #5 on 6/6/22, with a known history of physical aggression towards other residents in two separate facilities. According to the 5/20/22 History and Physical from St. Luke's Hospital, two previous facilities had discharged the resident for these behaviors. Resident #5's spouse stated their loved one had been "physical" with other residents at these two previous facilities and had been discharged and hospitalized each time due to their physically-aggressive behaviors. The previous administrator stated she admitted this resident despite their past history of physical aggression towards others, because she believed her staff were well trained in dementia-related behaviors. She stated she was not informed by staff of

		Resident #5's continued aggressive behaviors after admission, until 7/8/22 when Resident #5 and another resident's family member were involved in a physical altercation. Resident #1 was also retained at the facility even though the resident was verbally and physically aggressive with other residents and staff.
3	.215.08. Procedures for Investigations.	The facility administrator did not complete investigations for incidents or accidents. For example, Resident #1 experienced a fall on 7/17/22 and was involved in resident-to-resident verbal altercations, and Resident #5 was involved in multiple incidents of resident-to-resident or resident-to-visitor physical and verbal altercations in June and July 2022. There was no documentation of investigations being completed by the administrator for these incidents, including what interventions were put into place to prevent recurrence. The previous administrator stated she had not been informed of all of these incidents and therefore had not completed an investigation of each.
4	.319. COMPREHENSIVE ASSESSMENT REQUIREMENTS.	Residents #1, #3, #4 and #6 did not have demographics documented, nursing assessments, or maladaptive behaviors assessed prior to being admitted to the facility. Resident #5 did have not have their maladaptive behaviors assessed prior to admission. These residents were assessed after they were admitted to the facility. For example: Resident #5, who had a known history of physical aggression towards other residents, was not completely evaluated for these behaviors prior to admission. The first documentation of Resident #5's behaviors was in the 6/6/22 Temporary Care Plan, completed after the resident was admitted, which documented "behaviors from past are aggression, anxiety, depression." This evaluation did not document the complete behavioral history, the intensity, duration and frequency of the behaviors, what triggered the aggression, what potential environmental factors could contribute to the behaviors, or what interventions staff

		members should utilize to respond to the aggression.
5	.330.06.b. Additional Resident Records.	The facility did not initiate behavior management plans for residents who exhibited maladaptive behaviors. For example, Resident #1 exhibited verbal and physical aggression toward staff and residents, Resident #3 wandered into other residents rooms and moved their belongings, and Resident #5 exhibited verbal and physical aggression to residents and visitors. The facility did not have behavior management plans in place with specific interventions to address these behaviors. The facility's current administrator stated there were residents who exhibited maladaptive behaviors, for which there was not a specific behavior plan, and there were other residents whose behavior plans did not outline their current behaviors nor the interventions with which staff should respond.
6	.335.02. Standard Precautions.	The facility did not follow the Center for Disease Control and Prevention (CDC) recommendations for COVID-19 when caring for residents to prevent transmission of COVID-19. For example, surveyors and visitors were not consistently screened upon entrance to the facility on 8/16/2022 and 8/17/2022, staff were observed not wearing their masks appropriately (under their nose or on their chin), and visitors were not wearing a mask.
7	.600.04.a. Sufficient Personnel.	The administrator did not schedule sufficient personnel during all hours to meet the needs of the residents. Of those residents willing and able to be interviewed, eight residents stated there was insufficient staff to meet their needs, especially in Building #2, as there was often only one caregiver attending to residents, who did not have time to complete all duties. They stated their rooms and bathrooms were not being adequately cleaned, bed linens were not changed regularly, and the staff did not have adequate time to prepare their meals. They stated there were days staff would often prepare something "quick" for a meal, because they did not have time to prepare the meal listed on the planned menu. Other times,

		they were "in so much of a hurry," the residents were served undercooked meats. One resident stated staff were often called from Building #2 to help in Building #1, the "memory care" building, which left insufficient staff in Building #2. Four family members and five staff members also stated there was insufficient staff to meet all the residents' needs and supervise the residents especially in Building #1. One staff member stated on the weekends when administrative personnel were not at the facility, they could not complete all tasks and meet the residents' needs. One family member, whose loved one was unable to be interviewed, stated they had observed their loved one's incontinence brief to be so soaked with urine, and it was down between their knees. Another family member stated they often observed their loved one with a "rank smell" of urine, and their face and clothes were "covered" in dried food, even their eyebrows. They stated the only time they visited when their loved one was clean was on a day when hospice had been there to attend to them. The current administrated stated she recognized the facility needed additional staff, especially on the evening shift.

CORE ISSUES

Facility	License #	Physical Address	Phone Number
Cottages Senior Living I LLC dba The Cottages of Emmett	RC-1187	411 East 12th Street	208-365-9490
Administrator	City	Zip Code	Survey Date
Katy Tullis	Emmett	83617	08/19/2022
Survey Team Leader	Survey Type		Response Due
Brown, Stacey	Health Care Complaint Investigation		08/29/2022

Item #	Rule (16.03.22)	Description
2	.520. REQUIREMENTS TO PROTECT RESIDENTS FROM INADEQUATE CARE. [Acceptable Admission and Retention]	Based on interviews, observations, and record reviews, it was determined the facility admitted and retained Resident #5 when these residents posed a danger to others. The findings include: IDAPA 16.03.22.001.02. “The purpose of a residential assisted living facility is to provide…a safe, humane, and home-like living arrangement.” IDAPA 16.03.22.011.05. Inadequate care is defined as, "When a facility...engages in violations of resident rights, or takes residents who have been admitted in violation of the provisions of Section 152 of these rules." IDAPA 16.03.22.011.11. Maladaptive behavior is defined as, “Any behavior that interferes with resident care, infringes on any resident's rights, or presents a danger to the resident or others.” IDAPA 16.03.22.152.03.a.i. - "A resident will be admitted or

		retained only when the facility has the capability, capacity, and services to provide appropriate care..." IDAPA 16.03.22.152.03.a.iii. – "A resident will be admitted or retained only when the facility has the personnel, appropriate in numbers and with appropriate knowledge and skills to provide such services." IDAPA 16.03.22.152.03.b.xii. - "No resident will be admitted or retained...who has physical, emotional or social needs that are not compatible with the other residents in the facility..." IDAPA 16.03.22.152.03.b.xiii. – "No resident will be admitted or retained who requires…care not within the legally licensed authority of the facility. Such residents include: A resident who is violent or a danger to themselves or others." IDAPA 16.03.22.215.05. - "Responsibility for Acceptable Admissions. The administrator must ensure that no resident is knowingly admitted or retained who requires care as defined in Section 39-3307, Idaho Code, and Section 152 of these rules." IDAPA 16.03.22.550.03.a.iii. – "Each resident has the right to humane care and a humane environment, including the following: The right to a safe…living environment." The facility's campus consisted of two buildings; one building was a secured memory care unit, and the other building was an unsecured assisted living. At the time of the complaint survey, there were 12 residents residing in the memory care building and 13 residents in the assisted living building. The facility's admission and retention policy, found within the

		admission agreement revised 9/30/21, documented, “A resident will not be admitted or retained who has physical, emotional, or social needs that are not compatible with the other residents in the home.” In addition, the admission agreement documented, “No resident will be admitted or retained who requires…care not within the legally licensed authority of the home. Such residents include…A resident that is violent or a danger to themselves or others.” According to their record, Resident #5 was 71 years old and was admitted to the facility on 6/6/22, with diagnoses including Alzheimer’s dementia with behavioral disturbance. The resident was discharged from the facility on 7/13/22. According to the 5/20/22 hospital History and Physical, Resident #5 was admitted to the hospital due to “aggressive behavior,” after they struck a female resident at the facility in which they both resided. The report documented two previous assisted living facilities had discharged the resident for behaviors. The resident had previously been prescribed two separate antipsychotic medications for their “agitation/aggression,” but these failed to control the resident's behaviors. The report documented the resident had “advanced Alzheimer’s dementia with aggressive behaviors who presents with aggressive behavior.” Resident #5 remained hospitalized until they were discharged to this facility on 6/6/22. A “Level of Care Assessment Form,” dated 6/2/22, documented the resident required “regular re-direction for learning and living skills.” The “behavior plan/monitoring” option on the form was not circled, and there was no documentation of the resident’s history of aggressive behavior.

		An undated "Social History & Personal Portfolio" form, signed by the assistant administrator, documented the resident "…is in a very confused state and gets agitated due to [their] inability to understand what is going on." There was no documentation of the previous aggression towards others. A "Temporary Care Plan" dated 6/6/22 documented, "Resident is diagnosed with alzheimers – behaviors from past are aggression, anxiety, depression – staff to report all behaviors and interventions." A Behavior Plan, dated 6/6/22, documented behaviors as, "Resident paces halls, will start rearranging furniture fidgeting with objects," with no mention of the resident's verbal or physical aggression towards others. The interventions were to redirect to a quiet area or engage in one-on-one conversation with staff. On 7/13/22, an intervention of taking the resident for a walk outside or to garden was added to the behavior plan, although the verbal and physical aggression was not added to the list of maladaptive behaviors.) An unsigned initial nursing assessment, dated 6/8/22, documented the resident was taking multiple psychotropic medications, including extended release divalproex, quetiapine, and sertraline. The report documented the resident had behaviors of "resisting ADL assistance," "verbally offensive/abusive," "aggressive reaction to touch," "suspicious/accusitory [sic]," "wandering/searching," "anxious," "tapping/waving hand/feet," and "pacing." The box for "hitting/kicking" was not checked, despite the documentation of Resident #5 previously striking another resident in a former facility. The assessment documented others were not at risk from Resident #5.

		Resident #5's NSA, dated 6/9/22, documented Resident #5 had a “behavioral plan that staff are to follow with instructions on redirection” but gave no further details on the resident’s behaviors. The resident’s medical record was reviewed, and facility caregiver notes documented the following: *6/19/22: “Resident was agitated and pacing the facility. {Resident #5] was standing beside the couch in the living [sic] when [they] upset another resident. Some words were exchanged and resident came after the resident sitting on the couch and hit [them] with [their] hat. Other resident stood up and they both started pushing each other.” *6/20/22: “Resident became physical with a family member that was here visiting” their resident. *7/7/22: “Resident was agitated and pacing the facility. [Resident #5] became physical with a family member that was here visiting” their resident. *7/7/22 (2nd report): Another resident’s family member was there feeding their loved one, when Resident #5 “attacked” the family member while screaming profanity at this family member. *7/8/22: “The resident was punching and fighting residents and staff. [Resident #5] was refusing to leave the situation.” *7/8/22 (2nd report): Resident #5 and another resident’s family member “got into a physical altercation.” Two other residents became involved, and “there was pushing and

		punches being thrown." Staff intervened, but one staff member "was hit in the eye and back of head." The police were called by the other resident's family member. *7/9/22: Resident #5 "was trying to touch another residents food." The second resident hit Resident #5's arm, and Resident #5 in turn "slapped the resident in the face." *7/11/22: "The resident was trying to force [themselves] into another residents room." When staff told them to leave the room, "…[Resident #5] continued trying to punch the other resident while yelling vulgar remarks toward the other resident." There were no investigation reports completed for the above-mentioned resident-to-resident and resident-to-visitor altercations. On 7/14/22, after Resident #5 had been discharged from the facility, the previous administrator entered a progress note, which documented, "Staff have recently reported to me about aggressive behavior resident has been having toward residents…resident has been in several events causing physical altercations." Records from Resident #5's primary care provider, Keystone Medical House Call, documented the following: *6/7/22: Diagnosis of dementia with behavior disturbance. The resident's antipsychotic medication was increased at that time. *6/23/22: Resident #5 was "kicked out of 2 other facilities due to aggression toward staff and residents. [Resident #5] has had aggression to staff and family…stands too close to other residents. Hits/curses/yells…no improvement in behaviors since transitioning from quetiapine to risperidone." The

		provider noted the resident had been hospitalized "…in March and again in May, both times for agitation and aggression." *7/11/22: Staff noted patient was increasingly anxious. Antipsychotic medication increased. *The primary care provider notes documented an increase or change in the resident's antipsychotic medications at least six times between 6/7/22 and 7/12/22, due to ongoing behaviors. A discharge notice, dated 7/12/22, was issued to Resident #5's family, which documented an immediate discharge was being issued because "…our efforts have failed to provide" the resident with the "quality of care [Resident #5] is needing," due to the resident's "advanced dementia and behaviors." The notice documented Resident #5's behaviors were "above our level of care." The notice documented, "There has been multiple incidents reported by staff where [Resident #5] has been violent both verbally and physically." The notice also documented, "…we will continue to provide the same cares…" until "an appropriate environment" could be found for the resident. The resident was not immediately discharged, however, since Licensing and Certification received a Reportable Incident on 7/13/22. The report documented earlier that day, Resident #5 entered the room of another resident, and a physical altercation ensued. It was also documented, "This has been the 3 [sic] event resident has been in we have been in [sic] within the last 4 days," and an immediate discharge was issued to Resident #5, according to the Reportable Incident report. Between 8/16/22 and 8/19/22, interviews with families and staff members were conducted, and the following statements

		were made: *Staff member A stated Resident #5 was “aggressive and combative with staff and other residents from day one.” They stated there was a behavior plan for Resident #5, but it did not include their aggressive, maladaptive behaviors. The staff member stated the interventions in the behavior plan “weren’t working.” They stated the administrator at that time was “never here to talk to” concerning Resident #5’s behaviors, as she was working at another facility. *Staff member B stated they were told there was a behavior plan for Resident #5, but they had not been trained on it, so they were unsure how to handle the resident’s behaviors. They stated the plans were kept in the office and were inaccessible to caregiving staff, and they were not taught how to access the behavior plans in the electronic medical record. *Staff member C stated Resident #5 became violent and a danger to others when provoked, and there was no behavior plan they were aware of for this resident. They stated Resident #5 was “triggered” when someone would tell the resident to stop doing something, such as when a family member of another resident would tell Resident #5 to stop touching their loved one. The staff member stated they were instructed to redirect Resident #5 when they displayed maladaptive behaviors, but the resident would “not take redirection.” They stated the caregiving staff were unsure what to do with Resident #5 when redirection was unsuccessful. *Staff member D stated Resident #5 “could be violent,” depending upon how the resident was approached. *Staff member E stated the resident exhibited maladaptive

		behaviors since the time of admission, and the resident was triggered easily, was violent, and posed a danger to others. To address Resident #5's maladaptive behaviors, they stated other than redirection, the only intervention they were aware of was medication. The staff member stated Resident #5 had been evaluated by the previous administrator prior to admission, and there was documentation the resident had been discharged from two previous facilities for behaviors. *Staff member F stated Resident #5 exhibited behaviors, including going into other resident's rooms. There were times Resident #5 was violent and a danger to others, depending on how the staff approached the resident. *Staff member G stated Resident #5 had been aggressive since admission. *Staff member H stated Resident #5 had been involved in physical altercations with other residents and visitors. *Staff member I stated Resident #5 and another resident had been involved in verbal altercations, and other residents were scared of Resident #5. *Another resident's family member stated Resident #5 was a danger to others. The family member stated they were at the facility several days a week to visit their loved one. On four separate occasions, the family member observed Resident #5 touch their loved one, which upset the family member since their loved one could no longer speak and ask Resident #5 to stop touching them. The family member stated when they asked Resident #5 to stop, the resident became violent, "swung at me" multiple times, and "threatened to kill me." On one occasion, Resident #5 grabbed the family member's arms

		and would not let go, which left bruises on both of their arms and a “blood blister” on one arm. They observed Resident #5 hit caregivers in the head at least three times during the incidents as well. *Resident #5's family member stated this was Resident #5’s third assisted living facility, after being discharged from two previous facilities for being “physical” with other residents. They stated Resident #5 had to be hospitalized after each discharge, due to their physically-aggressive behaviors. They were aware that Resident #5 had been in physical altercations at this facility as well. They stated after Resident #5 was discharged from The Cottages, they were admitted to a fourth facility but was subsequently discharged after five days due to behaviors. On 8/17/22 at 3:12 PM, the previous administrator stated she was aware Resident #5 was discharged from two previous facilities due to physical aggression towards others when she admitted the resident. She stated she felt the other facilities’ management plans had “not been right” for Resident #5, and said, “I thought we could do a better job with our staff here at the facility.” She stated after Resident #5 was admitted, she was not informed by staff of Resident #5's continued verbal and physically-aggressive behaviors until 7/8/22 when Resident #5 and another resident's family member were involved in a physical altercation. On 8/19/22 at 9:40 AM, the facility’s previous nurse stated she assessed Resident #5 at St. Luke’s Hospital on 6/2/22, although a copy of this assessment was not available for review. She stated she was told by the previous administrator Resident #5 had a prior history of discharges from other facilities due to behaviors. She had not reviewed the records from these

		previous facilities or the hospital records which documented previous behaviors, nor did she speak with the resident's family at the time of her preadmission assessment of Resident #5. On 8/17/22 at 3:46 PM, the current facility nurse stated she had not been working at this facility during the period Resident #5 resided at the facility. On 8/19/22 at 11:02 AM, the facility's current administrator stated she became the facility's administrator after Resident #5 had been discharged from the facility and therefore had no firsthand knowledge of Resident #5's behaviors while residing at the facility. The facility admitted Resident #5, who had a known history of physical aggression towards other residents in two separate facilities, and the resident was retained at the facility for five weeks, even after physically assaulting other residents, staff members, and visitors. The facility failed to provide adequate care when they did not have the capability, capacity, and services to provide appropriate care to Resident #5 who posed a threat to others. The facility failed to protect residents, conduct investigations, and implement training for staff to provide appropriate care to Resident #5 who had verbal and physical maladaptive behaviors. This placed 100% of the residents and staff in the facility at risk for injury and violated the residents' rights to live in a safe and home like environment. This resulted in inadequate care.