PLAN OF CORRECTION

Rosetta of Twin Falls
1177 Eastridge Court
Twin Falls ID 83301

Provider ID: RC-1171

On 09/27/2022, a Health Care Core Deficiency Follow-Up survey was conducted by Department staff at Rosetta of Twin Falls. As a result of the survey, core issue deficiencies were cited with the following plan of correction.

Rule Violation .550.04.d. Personal Possessions.

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

All resident have a lock box with key in their respective rooms, secured to the wall or side table depending on the design of the box. Each resident has a key on lanyard so the key does not get lost.

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.

Lock boxes were purchased for the number of licensed beds at the facility

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

All lockboxes have been purchased and placed in each resident room. In the event the box is damaged, it will be replaced.

Date when corrective action will be completed.

September 28, 2022

Program Comments

NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
Rosetta of Twin Falls	RC-1171	1177 Eastridge Court	208-734-9422
Administrator	City	Zip Code	Survey Date
Katie Brahosky	Twin Falls	83301	09/27/2022
Survey Team Leader	Survey Type		Response Due
Walker, Jenny	Health Care Core Deficiency Follow-Up		10/27/2022

Item #	Rule (16.03.22)	Description
1	.009.01. Criminal History and Background Check.	One of five employees, whose personnel records were reviewed, did not have a department criminal history and background check and had worked alone with residents. The administrator confirmed the employee did not complete a criminal history and background check.
2	.260.06. Toxic Chemicals.	The facility was not maintained in a clean, safe, and orderly manner. For example: There was no screen in the window of Rooms 1, 2, 3, and 10. Rooms 5 and 11 screens were installed on 9/26/22, while surveyors were in the building, with screens that were bent. The front and back yard were observed to have multiple weeds throughout. The backyard grass was overgrown. Outside of bedroom 5's window, the yard had trenches where the sprinkler system had broken and was not safely barricaded in the secured backyard. Room 8's bathroom sink was rusted around the drain. Outside of doorway to Rooms 8 and 10, the trim around the doorway and door were scraped with missing paint. The doorframe around the kitchen door was missing inside and outside of the kitchen entryway. The administrator stated they were currently fixing all the concerns. ***previously cited 12/3/21 and 7/1/22.***
3	.305.02.b. Quarterly Nursing Assessments.	The facility did not ensure residents received their medications

		as ordered. For example, Resident #2's signed physician orders documented they were to receive Alprazolam (xanax) 1 mg twice daily as needed, Amantadine 100 mg twice daily, and Baclofen 10 mg twice daily. Resident #2's medication administration record did not include Alprazolam or Amantadine and they did not receive those medications. Resident #2 was receiving Baclofen 10 mg three times a day, instead of twice daily as ordered.Resident #2's medication administration record documented they received Diazepam 5mg twice daily without a a physician's order to receive the medication. Resident #4 had an order for Clindamycin 300 mg three times started on 9/24/22 and they had not received it. The administrator stated they were reviewing the orders with the pharmacy. ***previously cited on 7/1/22.***
4	.305.03. Change in Resident Health Status.	The facility nurse did not assess residents after they experienced a change of condition. For example, Resident #3 had a fall on 9/5/22 and was sent to the ER for acute knee pain. Resident #4 had a fall on 9/8/22 and was sent to the ER for a fall with a closed head injury, and also when they fell on 9/9/22. The administrator stated the facility nurse did not assess Resident #2 and #4 after they fell and were sent to the ER.
5	.330.14. As Worked Schedules.	The facility's as-worked schedule did not document the specific times, last name, and title for the administrator. The facility nurse and the maintenance supervisor did not have an as-worked schedule. The staff schedules did not include positions and exact times they were at the facility. The administrator confirmed they were not completed. ***previously cited on 7/1/22.***

CORE ISSUES

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Katie Brahosky	Twin Falls	83301	09/27/2022
Survey Team Leader	Survey Type		Response Due
Walker, Jenny	Health Care Core Deficiency Follow-Up		10/07/2022

Item #	Rule (16.03.22)	Description
2	.550.04.d. Personal Possessions.	Based on observation, record review, and interview, it was determined the facility failed to protect the rights of 4 of 4 sampled residents, as well as the rights of all other residents residing in the facility. The findings include: IDAPA 16.03.22.010.20.d. A core issue is defined as "Inadequate care." IDAPA 16.03.22.011.05, documents "Inadequate Care. When a facility...engages in violations of resident rights..." IDAPA 16.03.22.215.01 documents, “The facility’s administrator is responsible for ensuring that policies and procedures are developed and implemented to fulfill the requirements in Title 39, Chapter 33, Idaho Code and IDAPA 16.03.22.” IDAPA 16.03.22.520 documents, “The administrator must ensure that policies and procedures are developed and

		implemented to ensure that all residents are free from inadequate care..." IDAPA 16.03.22.550 documents, "REQUIREMENTS FOR RESIDENTS' RIGHTS. The administrator must ensure that policies and procedures are developed and implemented to ensure that residents' rights are observed, promoted, and protected." IDAPA 16.03.22.550.04.d documents, residents are to "Be provided a separate storage area in their own living area and at least one (1) locked cabinet or drawer for keeping personal property." The facility's "Residents' Rights" policy documented each resident will "be provided with a separate storage area in [their] own living area and at least one (1) locked cabinet or drawer, if the resident is capable of managing lock and key, for keeping personal property." During the previous licensure survey on 7/1/22, the facility was given technical assistance to provide each resident with a locking drawer or cabinet for their personal property. During the initial tour on 9/26/22 between 11:00 AM and 12:00 PM, there were no locking drawers or cabinets observed in the living areas for 13 of 13 rooms, and for all 13 residents residing in the facility. On 9/26/22, six residents stated they were not provided with a locked drawer or cabinet for keeping personal property. On 9/26/22, one staff member stated residents' rooms did not have a locked drawer or cabinet, and another staff member

		stated they were unaware if residents' rooms had a locked drawer or cabinet. On 9/27/22 at 10:00 AM, the administrator designee stated residents' rooms did not have a locked drawer or cabinet. On 9/27/22 at 1:15 PM, the administrator stated residents' who resided at the facility were not provided with a separate locking drawer or cabinet for their belongings. The facility failed to provide 13 out of 13 residents with a separate locking cabinet or drawer for protecting their personal property. This resulted in a violation of their rights.