NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
Cottages Senior Living I LLC dba The Cottages of Mountain Home	RC-1184	735 South 5th West	208-580-1121
Administrator	City	Zip Code	Survey Date
Nancy Flores	Mountain Home	83647	12/29/2022
Survey Team Leader	Survey Type		Response Due
Brown, Stacey	Health Care Licensure and Follow-Up		01/28/2023

Item #	Rule (16.03.22)	Description
1	.250.13. Secure Environment.	The facility failed to provide a secure environment for their residents, with at least one of the more cognitive residents, Resident #2, was provided the door code and could go in and out of the facility at will. The administrator stated the door codes would be changed, and no resident will be given the new door code. In addition, on 12/28/22 and 12/29/22, a surveyor was able to walk from the fenced courtyard, which was used by all residents, through the unlocked doors in the garage, and out to the unsecured yard and street. The administrator stated she would ensure the garage doors would remain locked, so the exterior environment would be secured.
2	.260.07. Toxic Chemicals.	On two separate occasions between 12/28/22 and 12/29/22, toxic chemicals, including disinfectants, were observed to be stored in unlocked areas (laundry room, hallway closet, shower room), which were accessible to cognitively-impaired residents. The facility also did not secure the chemicals, including disinfectant for hair styling instruments, in the unlocked salon, observed twice on these same dates.
3	.330.04.c.vii. Resident Care Records.	The facility nurse stated she had assessed residents, but these assessments had not been consistently documented. For

		example, Resident #3 did not have an initial nursing assessment in their chart. Resident #2 had been assessed to safely continue taking their own medications during their quarterly assessments, but the nurse stated she had not documented these self-medication assessments. Resident #4 sustained falls on 9/17/22, 10/18/22, 11/28/22, and 11/29/22. The facility nurse stated she had assessed resident #4 after their falls but had not documented these assessments.
4	.330.04.c.xi. Resident Care Records.	The facility administrator did not ensure all investigations of incidents and accidents, including the facility's response with corrective action, were documented. For example, Resident #1 eloped from the facility on 11/15/22, and Resident #4 fell on 11/18/22, 11/28/22 and 11/29/22. The administrator stated she completed these investigations and implemented corrective action to prevent recurrence but had not documented these items.
5	.330.14. As Worked Schedules.	The facility's as-worked schedule did not document the exact times each staff member worked at the facility, including the facility nurse, nor the last names of all facility employees. The administrator stated these items were missing from the as-worked schedule. ***Previously cited on 5/30/19 at rule 730.02***
6	.600.04.b. Sufficient Personnel.	One caregiver, who worked alone on the overnight shift, did not have current CPR and first aid training certifications. The administrator stated this employee had a card for these certifications, which did not list an expiration date, and therefore she was unsure if the staff member's certifications were current.