# NON-CORE ISSUES

| Facility | License # | Physical Address | Phone Number |
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| Cottages Senior Living III LLC dba The Cottages of Boise | RC-1183 | 6300 North Roe Street | 208-853-1255 |
| Administrator | City | Zip Code | Survey Date |
| Nicole Ellis | Boise | 83714 | 04/21/2023 |
| Survey Team Leader | Survey Type | | Response Due |
| Oldfield, Michael | Health Care Licensure and Follow-Up + complaint investigation | | 05/21/2023 |

| Item # | Rule (16.03.22) | Description |
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| 1 | .151. ACTIVITY REQUIREMENTS. | During observations from 4/18/23 through 4/21/23, no activities were offered to the residents other than residents who were asked if they wanted to join a "drums" activity in Building #2 on 4/20/23. There was a calendar for activities that documented two activities per day, but these activities were not offered in Building #1 during observations. Multiple residents in Building #1 stated they were not offered activities and were "bored." |
| 2 | .215. REQUIREMENTS FOR A FACILITY ADMINISTRATOR. | The facility did not have a licensed administrator for 24 days between 3/31/22 to 4/24/22. The administrator confirmed the facility did not have an administrator during that time frame. ***Previously cited on 2/9/22*** |
| 3 | .215.08.b. Investigation within Thirty Days. | The administrator did not conduct an investigations within 30 days when Resident #5 fell on 2/1/23 and eloped on 2/24/23, and when Resident #4 was assisted to the floor on 2/12/23 and had a skin tear to their right hand on 2/14/23. The administrator stated the investigations had not been completed. |
| 4 | 216.01. Pre-Admission. | The facility did not provide information on the interim care plan for staff to provide supervision to Resident #8 from |

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| | | eloping the facility. Resident #8's pre-admission assessment, dated 4/7/23, documented they were a possible "flight risk/exit" and had "recent episodes of getting lost." The facility nurse stated she verbally provided her assessment to the administrator regarding Resident #8 being a flight risk and they did not document the concerns on the interim care plan. |
| 5 | .250.13. Secure Environment. | The facility had residents with cognitive impairments and a history of or who were at risk for elopement and did not provide a secure environment. Resident #6 and Resident #8, who had cognitive impairments, eloped from the facility on 4/11/23 and were away from the facility for several hours and were found in another state. The facility was not secured because the garage door was inadvertently unlocked in the outside secured area, which allowed Resident #6 and Resident #8 to elope from the facility. ***Previously cited on 5/13/21*** |
| 6 | .305.03. Resident Health Status* | The facility nurse did not conduct nursing assessments when residents experienced changes in physical or mental health status. For example, when Resident #5 fell on 2/1/23 and when they eloped on 2/24/23 and sustained minor scratches on both arms. When Resident #6 and Resident #8 eloped on 4/11/23 to another state, stayed in the hospital overnight, and returned to the facility on 4/12/23. The facility nurse stated she did not complete the change of condition assessments. ***Previously cited on 5/13/21*** |
| 7 | .310.01.c. Medication Distribution. | The facility did not maintain the medication refrigerator, which contained morphine and lorazepam, at temperatures between 38 and 45 degrees F. In February 2023 temperatures were documented below 38 degrees eighteen times, in March 2023 twenty times, and in April 2023 three times. The administrator stated the temperatures were not in range. |
| 8 | .310.04.a. Behavior Modifying Medication. | The facility did not attempt non-drug interventions prior to requesting medications to manage resident behaviors. Resident #6 was prescribed routine Haldol four times a day for |

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| | | elopement and agitation and did not have a behavior management plan in place. Resident #4 was prescribed routine risperidone twice a day for agitation and did not have a behavior management plan in place. Resident #5 was prescribed routine buspirone three times a day, divalproex sodium twice a day, lorazepam twice a day, quetiapine three times a day, and trazodone at bedtime for elopement and wandering into other residents' rooms. The administrator stated Resident #6's behavior management plan was in the process of being completed. The facility nurse confirmed Resident #4 and Resident #5 did not have behavior management plans in place. |
| 9 | .310.04.e. Psychotropic or Behavior Modifying Medication. | The facility did not complete six month psychotropic medication reviews for 3 of 8 sampled residents who were taking psychotropic medications for longer than six months. For example: Resident #1 was taking fluoxetine, and lorazepam. Resident #2 was taking citalopram and divalproex. Resident #3 was taking levetiracetam, olanzapine, and risperidone. The administrator stated the previous administrator had not completed the reviews. |
| 10 | .319. COMPREHENSIVE ASSESSMENT REQUIREMENTS. | Resident #4 was admitted on 7/21/20 and Resident #5 was admitted on 6/15/21. Neither resident's assessments included demographics, nursing nor maladaptive behaviors being assessed prior to being admitted to the facility. The administrator stated the assessments were not completed. |
| 11 | .320.01. Use of NSA. | Residents' Negotiated Service Agreements (NSA) did not clearly reflect the residents' needs nor describe the services to be provided. For example: Resident #4's NSA did not include their hospice services were being coordinated nor how to care for their wounds. The facility nurse stated the NSA should have been updated to reflect what services hospice was providing and how to care for Resident #4's wounds. |
| 12 | .320.03. Signature, Date, and Approval of Agreement. | NSAs were not signed and dated by Residents #1, #2, #3, #4, and #5 nor their legal representative, Power of Attorney, or |

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| | | conservators. The administrator in training confirmed the NSAs were not signed and dated when they were completed. |
| 13 | .330.04.c.vii. Resident Care Records. | The facility did not document all change of condition assessments. For example: Resident #1 exhibited suicidal ideation on 4/5/23 and Resident #2 was documented by staff they were lethargic, sleeping more, and refused physical therapy and occupational therapy on 3/24/23 and when they fell on 4/10/23. The facility nurse stated she had assessed all of these incidents/health concerns but did not documented her assessments. |
| 14 | .330.06.a. Additional Resident Records. | The facility did not complete evaluations for Residents #1, #2, #3, #5, #6 and #8. For example: Resident #1 behaviors of suicidal thoughts and threats. Resident #2 behaviors of verbal abuse. Resident #3 with behaviors of refusal of medications, fixation, and verbal aggression. Resident #5's behaviors of eloping to a field next to the facility and wandered into others rooms. Resident #6 and #8 with behaviors of eloping to another state. The administrator stated they had not completed evaluations and they were in the process of completing them. |
| 15 | .330.06.b. Additional Resident Records. | The facility did not complete behavior plans that included specific interventions for Resident #1, #2, #3, #5, #6 and #8 behaviors, as outlined in non-core punch 330.06.a. The administrator stated they had not completed the behavior plans and they were in the process of completing. |
| 16 | .330.14. As Worked Schedules. | The facility's as-worked schedules did not document the times the facility nurse nor the maintenance supervisor were at the facility. |