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	05/11/2023
Survey Team Leader	Survey Type		Response Due
Rideout, Megan	Health Care Licensure and Follow-Up		06/10/2023

Item #	Rule (16.03.22)	Description
1	.215.01. Administrator Responsibility.	The administrator did not follow their facility Admission Agreement Addendum, which stated residents will not be given the exit code to the front nor side doors; however Resident #6 was provided with the code to the secured memory care unit.
2	.216.02. Written Agreement.	The facility did not develop a new, written, and signed Admission Agreement when Resident #1 was admitted to the facility on 6/04/21. The facility administrator was not aware a new Admission Agreement must be created when a resident was admitted from another facility within the same company.
3	.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. During the survey between 5/08/23 through 5/11/23, it was identified that Resident #6 knew the code to the facility doors and to the courtyard gate. The facility was not secure because the resident with the code could inadvertently let cognitively impaired residents elope from the facility. The facility administrator and multiple staff stated the resident had the code to the secure environment, which presented an elopement risk for those with cognitive

		impairments.
4	.310.04.e. Psychotropic or Behavior Modifying Medication.	The facility did not complete six-month psychotropic medication reviews for 1 of 3 sampled residents who were taking psychotropic medications for longer than six months. Resident #1 was taking queitapine since 10/27/22 and trazadone since 12/6/21. In addition, 3 of 3 sampled residents did not have behavioral updates included on the psychotropic medication reviews. The administrator stated she was unaware that behavioral updates needed to be included in the review.
5	.319. COMPREHENSIVE ASSESSMENT REQUIREMENTS.	The facility did not conduct a preadmission comprehensive assessment, including the nursing assessment, or an assessment level of assistance required when Resident #1 was admitted to the facility on 6/4/21. The administrator from a sister facility stated a preadmission assessment was not completed and they were not aware of what was required when the resident was admitted from another facility within the same company.
6	.330.10.b. Personnel Records.	During the survey between 5/8/23 through 5/11/23, Resident #5 was observed to be nonverbal and unable to communicate needs with the caregiver. An unidentified resident was assisting with supervision of Resident #5 in the activity room. An administrator of a sister facility stated that there is an interim care plan; however, upon interview with caregivers, they were not sure how to communicate or calm the resident during behaviors, or document cares for this resident. The facility administrator did not maintain complete and current records for Resident #2 and Resident #5 for hourly adult day care.
7	.630. TRAINING REQUIREMENTS FOR FACILITIES ADMITTING RESIDENTS WITH A DIAGNOSIS OF DEMENTIA, MENTAL ILLNESS, DEVELOPMENTAL DISABILITY, OR TRAUMATIC BRAIN INJURY.	Three of five staff members, whose personnel files were reviewed, did not have specialized training for traumatic brain injury or dementia, and the facility retained residents with these diagnoses. The facility administrator confirmed the staff members had not received these specialized trainings.

8	.640. CONTINUED TRAINING REQUIREMENTS.	Two of five staff members, whose personnel files were reviewed, did not contain eight hours of job related continued training. The administrator confirmed the training was not completed.
9	.645.02. Delegation.	Three of five medication technicians, whose passed medications, were not delegated by the current facility nurse. The facility administrator confirmed delegation had not been completed.