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	10/04/2024
Survey Team Leader	Survey Type		Response Due
Walker, Jenny	Health Care Licensure and Follow-Up + complaint investigation		11/03/2024

Item #	Rule (16.03.22)	Description
1	.009.01. Criminal History and Background Check.	One of eight employees, whose personnel records were reviewed, did not have evidence of a completed Department Criminal History and Background Check. Upon interview with the administrator, it was confirmed the Department Criminal History and Background Check was not completed and the employee had worked shifts alone.
2	.215.08.f. Notification to Licensing Agency within One Business Day.	The facility did not notify Licensing and Certification within one business day when Resident #3 fell on 6/11/24 and 7/15/24 and required assessment and treatment at the hospital. The administrator stated the incidents were not reported to Licensing and Certification.
3	.260.07. Toxic Chemicals.	Toxic chemicals were observed to be stored in unlocked areas, which were accessible to cognitively impaired residents, between 10/1/24 and 10/3/24. For example, the laundry room in the memory care unit was observed unlocked and ajar for three consecutive days where "RX Surface Disinfect", multi-service cleaner, carpet deodorizer, and degreaser was in an unlocked cupboard. The activities room had paint and salon products in an unlocked cabinet.
4	.300.01. Licensed Registered Nurse (RN).	The facility Registered Nurse (RN) did not perform initial

		assessments for 3 of 8 sampled residents. For example: Residents #4 was readmitted to the facility on 7/9/24 with a suprapubic catheter and did not receive an initial assessment. Resident #5's initial assessment was completed by the Licensed Practical Nurse (LPN) when they were admitted on 7/1/24. Resident #1 did not receive an initial assessment after they were admitted on 9/27/24. The facility's RN stated the LPN had completed the initial assessments.
5	.300.02. Licensed Nurse.	The facility nurse did not review and implement all orders for Resident #1, #2, #3, #4, and #5. For example, Resident #1 was admitted to the facility on 9/27/24 with a total of 16 medications. Of those 16 medications, the facility obtained medication orders for nine medications and did not obtain orders for the remaining five medications including an antibiotic to treat a urinary tract infection. Also, the facility nurse did not ensure five medications were appropriately labeled to ensure staff administered their medications as ordered. The facility administrator stated a non-nurse staff implemented medication orders.
6	.305.02.a. Quarterly Nursing Assessments.	The facility nurse did not ensure each residents' medication orders matched the medication labels. For example, Resident #1 had no orders or labels on the containers with specific directions from their provider to receive vitamin D3 and cranberry supplements two times per day, Tylenol 500 milligrams as-needed (PRN), calmoseptine, triple antibiotic ointment, bacitracin, and sulfamethoxazole antibiotics. The facility's RN and administrator stated they were not aware the orders did not match the labels on the medications, nor were they aware there were missing labels.
7	.310.01. Medication Distribution.	The facility had a family member bring in multiple bottles of medications for a resident. For example, the administrator stated Resident #1's family supplied their Tylenol and supplements with bulk bottles. The medications were not labeled with the resident's name, dose, how many tablets, or

		how often they were to be given. The administrator and facility RN stated they were unaware there were bottled medications for this resident.
8	.310.01.g. Medication Distribution System.	The facility did not ensure all residents' as-needed (PRN) medications were available. For example, Resident #2's antacid was not available in the medication cart. Resident #4 did not have calcium antacid and polyethylene glycol; Resident #5 did not have acetaminophen and "restless leg PM". The facility's RN stated she was unaware all PRNs were not available in the medication cart.
9	.310.04.e. Psychotropic or Behavior Modifying Medication.	The facility did not include behavioral updates on residents' six-month psychotropic medication reviews. For instance, Resident #4 was taking lorazepam and zolpidem and the six-month medication review did not include behavioral updates. Resident #3 was taking citalopram, Depakote, quetiapine, and trazodone and the six-month psychotropic medication review did not include behavioral updates. Resident #2 was taking sertraline and did not have a six-month psychotropic medication review completed. The facility administrator stated Resident #4's medication review did not include behavioral updates to the provider and Resident #2 did not have a six-month psychotropic medication review completed. ***Previously cited on 5/11/23***
10	.320. NEGOTIATED SERVICE AGREEMENT (NSA) REQUIREMENTS.	The facility did not have a completed, signed, or implemented a Negotiated Service Agreement (NSA) for Resident #6 when they were admitted to the facility on 2/24/24 until they passed away on 5/20/24. The facility administrator stated it had not been completed.
11	.320.01. Use of NSA.	Residents' NSAs did not clearly reflect all residents' needs nor adequately describe the services to be provided. For example, Resident #2's NSA did not include specific instructions for catheter care, delineate between hospice and facility staff services, nor what signs or symptoms of infection to monitor and who to notify. Resident #4's NSA did not indicate which

		home health agency was caring for this resident, what services were to be provided by that agency, and specific instructions for suprapubic catheter. Resident #5's NSA did not indicate or have specific instructions for a two person transfer implemented after a change of condition assessment completed by the LPN on 8/27/24.
12	.330.04.a. Behavior Documentation.	The facility 90-day nursing assessments were not consistently dated, timed, and signed on the date of completion by the person completing them. For example, Resident #2's 90-day assessment, dated 5/10/24, was completed by the facility RN on 6/7/24. Resident #3's 90-day assessment, dated 9/2/24, was completed by the facility RN on 8/15/24, which was completed a month earlier. Resident #4's 90-day assessment, dated 9/18/24, was completed by the facility RN on 10/1/24. The facility administrator stated she was unaware they had different dates.
13	.330.04.c.i. Resident Care Records.	Residents #1, #5, #9, #10, and #11 comprehensive assessments were not dated, timed, and signed on the day of completion. For example: Resident #1 was assessed via facetime by the facility RN on 9/26/24 and the completion date was 10/1/24. Resident #5 was assessed on 6/28/24 at their home by the facility RN and the completion date was 7/11/24. Resident #9's comprehensive assessment was not completed and was admitted to the facility on 10/2/24. Resident #10's comprehensive assessment documented the facility RN assessed at their home on 9/17/24 and the completion date was 9/18/24. Resident #11's comprehensive assessment documented the facility RN assessed at their home on 9/23/24 and the completion date was 9/30/24. Resident #9's family member stated the administrator and the facility LPN came to their home for the comprehensive assessment. The facility LPN stated she did not complete the assessments for Resident's #1, #5, #9, #10, and #11. The administrator stated the facility LPN and herself had completed the comprehensive assessments for

		Resident's #1, #5, #9, #10, and #11. The administrator stated the facility LPN collaborated with the facility RN to make the decision if the residents were appropriate to be admitted to the facility.
14	.330.04.c.vii. Resident Care Records.	The facility nurse stated she had assessed residents for changes in their physical and mental conditions, but these assessments had not been consistently documented for four of four sampled residents. For example, Resident #3 had 13 falls from June 2024 to September 2024 and had 8 undocumented corrective actions to prevent recurrence. Resident #6 started hospice on 5/16/24 and had two falls on 5/17/24 and 5/19/24 with a rapid decline until they passed on 5/20/24. The facility's RN stated she had assessed the residents for these issues, but had not documented her assessments.
15	.600.02. Detached Buildings or Units.	The facility did not ensure all buildings were staffed sufficiently to ensure one staff member was in each building at all times. For example, on 10/2/24, the caregiver in Building #1 was observed, at 1:30 PM, leaving residents unattended going out to the secure courtyard with other residents. Multiple residents in Building #1 were observed wandering who were a high fall risk with the laundry door open with access to toxic chemicals. Multiple staff members stated buildings were left unattended for short periods of time when they "switched" between buildings, particularly when one building did not have a medication technician and had to leave one building to pass medications in the other building on the night shift. The as-worked scheduled one staff member to work in each building on the night shift from August 2024 to October 2024. Three residents stated staff called over to the other building to have a staff member come over to help with transfers, leaving the other building unattended. The administrator stated she knew the staff were switching buildings when they had only one medication technician scheduled on the night shift.
16	.600.04.b. Sufficient Personnel.	One of eight direct care staff, whose files were reviewed, did

		not have current first aid and cardiopulmonary resuscitation (CPR) certifications. According to the as-worked schedules, the staff member worked alone on multiple nights in August, September, and October 2024. The administrator stated the staff member was unable to get a copy of their CPR/first aid certification and the staff member told the administrator it may have been expired anyway. The administrator stated the staff member was instructed to renew their CPR/first aid certification.