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
Karen Mendoza	Emmett	83617	07/30/2026
Survey Team Leader	Survey Type		Response Due
Bollinger, Torrey	Health Care Complaint Investigation		08/29/2026

Item #	Rule (16.03.22)	Description
1	.305.03. Change in 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 #6 fell on 1/11/26 and fractured their hip, when Resident #3 experienced rash, redness, and irritation to their groin area, when Resident #2 fell on 6/13/26 and 7/15/26, and when Resident #5 fell on 3/19/26 and 4/9/26 and fractured their hip. The facility LPN stated there were gaps in assessments and documentation of assessments.
2	.310.01.e. Medication Distribution.	The medication technicians did not observe residents take their medications. On 7/28/26, Resident #2 was observed at the dining room table with all their AM medications in a medication cup. Resident #2 then poured the medications out onto a napkin while waiting for breakfast without the medication technician observing Resident #2 taking their medications. After Resident #2 received their breakfast, they began taking their medications and dropped one on the floor. A caregiver was sweeping the dining room floor and picked up the medication and notified the managers in the office. The facility LPN stated the medication technician should have

		observed Resident #2 taking their medications.
3	39-3308 Assessment (4)b Assessments	The facility nurse did not review and implement new physicians' orders. For example, Resident #2's orders for ferrous sulfate were to be given 1 tablet every other day. The July 2026 medication administration record (MAR) documented two tablets every other day and their orders for metoprolol 200 mg documented to hold the medication if the systolic blood pressure was less than 140 or their pulse was less than 60. Staff were not checking the blood pressure and pulse prior to administering the medication. The administrator stated her and the house manager implemented the orders and they documented them incorrectly. The facility LPN stated the administrator and the house manager implemented the orders incorrectly.
4	39-3309.01 NEGOTIATED SERVICE AGREEMENT	Residents' Negotiated Service Agreements (NSAs) were not updated to reflect their current status. For example, Resident #3's NSA documented they were independent in dressing, grooming, and transfers when they required hands on assistance in these areas. Resident #3's NSA did not include any information regarding wound care, the utilization of a bed alarm, and that they received home health services. Resident #2's NSA did not document they had an external dialysis port nor how to monitor for signs and symptoms of infection. Resident #2's NSA documented they were receiving showers two times a week, when they had not received a shower for months due to having a port. Resident #5's NSA did not document they had a foley catheter, how to manage the catheter, nor monitor for signs and symptoms of infection. The facility LPN stated the NSAs needed to be revised. ***Previously cited on 10/4/24 at 320.01***
5	39-3322.1 QUALIFICATIONS AND REQUIREMENTS FOR FACILITY STAFF	The facility did not arrange for sufficient trained staff to fully meet the needs of its residents and failed to provide care during all hours required in each resident's NSA. For example, Resident #2 had an external dialysis port inserted to their right

		upper chest and they stated they did not receive showers because of their port. The facility LPN stated she was unaware Resident #2 was not receiving their showers due to staff not being trained on how to cover the port or how to monitor for signs and symptoms of infection. Resident #5 fell on 4/9/26 and sustained a hip fracture without surgical repair. The facility staff were not trained on how to position or transfer Resident #5 for comfort. The facility LPN stated she did not train the staff on how to keep Resident #5 comfortable during repositioning and transferring.