



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

C.L. "BUTCH" OTTER – GOVERNOR  
RICHARD M. ARMSTRONG – DIRECTOR

TAMARA PRISOCK – ADMINISTRATOR  
DIVISION OF LICENSING & CERTIFICATION  
JAMIE SIMPSON – PROGRAM SUPERVISOR  
RESIDENTIAL ASSISTED LIVING FACILITY PROGRAM  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: 208-364-1962  
FAX: 208-364-1888

July 10, 2014

Michel Gifford, Administrator  
Rosetta Assisted Living - Delphic  
1590 Delphic Way  
Pocatello, Idaho 83201

Provider ID: RC-693

Ms. Gifford:

On June 5, 2014, a state licensure/follow-up and complaint investigation were conducted at Rosetta Assisted Living - Delphic. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level(s):

- Core issues, which are described on the Statement of Deficiencies, and for which you have submitted a Plan of Correction.
- Non-core issues, which are described on the Punch List, and for which you have submitted evidence of resolution.

Your submitted plan of correction and evidence of resolution are being accepted by this office. Please ensure the corrections you identified are implemented for all residents and situations, and implement a monitoring system to make certain the deficient practices do not recur.

Thank you for your work to correct these deficiencies. Should you have questions, please contact Rae Jean McPhillips, RN, BSN, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 364-1962.

Sincerely,

RAE JEAN MCPHILLIPS, RN, BSN  
Team Leader  
Health Facility Surveyor

RM/sc



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June 12, 2014

**CERTIFIED MAIL #: 7007 3020 0001 4050 8425**

Michel Gifford  
Rosetta Assisted Living - Delphic  
1590 Delphic Way  
Pocatello, Idaho 83201

Provider ID: RC-693

Ms. Gifford:

Based on the state licensure/ follow-up survey and complaint investigation conducted by Department staff at Rosetta Assisted Living - Delphic between June 4, 2014 and June 5, 2014, it has been determined that the facility failed to protect residents from inadequate care.

This core issue deficiency substantially limits the capacity of Rosetta Assisted Living - Delphic to furnish services of an adequate level or quality to ensure that residents' health and safety are protected. The deficiency is described on the enclosed Statement of Deficiencies.

You have an opportunity to make corrections and thus avoid a potential enforcement action. Correction of this deficiency must be achieved by **July 20, 2014**. **We urge you to begin correction immediately.**

After you have studied the enclosed Statement of Deficiencies, please write a Plan of Correction by answering **each** of the following questions for **each** deficient practice:

- ♦ What corrective action(s) will be accomplished for those specific residents/personnel/areas found to have been affected by the deficient practice?
- ♦ How will you identify other residents/personnel/areas that may be affected by the same deficient practice and what corrective action(s) will be taken?
- ♦ What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?
- ♦ How will the corrective action(s) be monitored and how often will monitoring occur to ensure that the deficient practice will not recur (i.e., what quality assurance program will be put into place)?
- ♦ By what date will the corrective action(s) be completed?

Return the **signed and dated** Plan of Correction to us by **June 25, 2014**, and keep a copy for your records. Your license depends upon the corrections made and the evaluation of the Plan of Correction you develop.

Michel Gifford

June 12, 2014

Page 2 of 2

In accordance with IDAPA 16.03.22.003.02, you have available the opportunity to question cited deficiencies through an informal dispute resolution process. If you disagree with the survey report findings, you may make a written request to the Supervisor of the Residential Care Program for a Level 1 IDR meeting. The request for the meeting must be made within ten (10) business days of receipt of the Statement of Deficiencies. See the IDR policy and directions on our website at [www.assistedliving.dhw.idaho.gov](http://www.assistedliving.dhw.idaho.gov). If your request for informal dispute resolution is not received within the appropriate time-frame, your request will not be granted.

Please bear in mind that non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference. Your evidence of resolution (e.g., receipts, pictures, policy updates, etc.) for each of the non-core issue deficiencies is to be submitted to this office by **July 5, 2014**.

If, at the follow-up survey, the core deficiency still exists or a new core deficiency is identified, the Department will have no alternative but to initiate an enforcement action against the license held by Rosetta Assisted Living - Delphic.

Enforcement actions may include:

- imposition of civil monetary penalties;
- issuance of a provisional license;
- limitation on admission to the facility;
- requirement that the facility hire a consultant who submits periodic reports to Licensing and Certification.

Our staff is available to answer questions and to assist you in identifying appropriate corrections to avoid further enforcement actions. Should you have any questions, or if we may be of assistance, please contact us at (208) 364-1962 and ask for the Residential Assisted Living Facility program. Thank you for your continued participation in the Idaho Residential Care Assisted Living Facility program.

Sincerely,



JAMIE SIMPSON, MBA, QMRP  
Program Supervisor  
Residential Assisted Living Facility Program

JS/sc

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13R693	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING	(X3) DATE SURVEY COMPLETED  06/05/2014
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NAME OF PROVIDER OR SUPPLIER  
ROSETTA ASSISTED LIVING - DELPHIC

STREET ADDRESS, CITY, STATE, ZIP CODE  
1590 DELPHIC WAY  
POCATELLO, ID 83201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>Initial Comments</p> <p>The following deficiency was cited during the licensure survey and complaint investigation conducted between June 4, 2014 and June 5, 2014 at your residential care/assisted living facility. The surveyors conducting the survey were:</p> <p>Rae Jean McPhillips, RN, BSN Team Coordinator Health Facility Surveyor</p> <p>Gloria Keathley, LSW Health Facility Surveyor</p> <p>Abbreviations and Definitions used in this report:</p> <p>*cm - centimeter *Maceration - a breakdown of the connective fibers of the skin tissue, caused by increased moisture. Maceration increases the chances of wound infection and prolongs healing time. *Serosanguinous - a thin, watery discharge that is pale red to pink in color caused by red blood cells. *Slough - a layer or mass of dead tissue</p>	R 000		
R 008	<p>16.03.22.520 Protect Residents from Inadequate Care.</p> <p>The administrator must assure that policies and procedures are implemented to assure that all residents are free from inadequate care.</p> <p>This Rule is not met as evidenced by:</p>	R 008	<p>We respectfully disagree with the assessment of inadequate care, but respect the decision to cite the facility for keeping a resident whose wound was not showing bi-weekly improvement.</p>	

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13R693	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  06/05/2014
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NAME OF PROVIDER OR SUPPLIER  ROSETTA ASSISTED LIVING - DELPHIC	STREET ADDRESS, CITY, STATE, ZIP CODE 1590 DELPHIC WAY POCATELLO, ID 83201
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 008	<p>Continued From page 1</p> <p>Based on observation, interview and record review it was determined the facility retained 1 of 1 sampled residents (#2) who had a wound that did not improve bi-weekly. The findings include:</p> <p>Resident #2's record documented she was an 85 year-old female who was admitted to the facility on 5/8/11 with a diagnosis of dementia.</p> <p>Hospice notes documented the following information regarding Resident #2's right foot:</p> <p>*3/10/14 - There was a red area with 3 small blisters.</p> <p>*3/26/14 - Two blisters on the heel were brown, intact and were hardening.</p> <p>*4/4/14 - The blister had cracked open showing a "red beefy area".</p> <p>*4/14/14 - The blister had opened and the wound bed was red, gray and white.</p> <p>*4/16/14 - The wound seemed to be worsening.</p> <p>*4/21/14 - The wound bed was macerated with black, red and white tissue. Additionally, there was a moderate amount of serosanguinous drainage.</p> <p>*4/25/14 - The wound had increased drainage and odor.</p> <p>*4/28/14 - The open area of the wound measured 4.5 cm x 3.5 cm, with a total area of 7 cm x 5 cm. The wound bed was black/red with moderate drainage and odor present. Another hospice note, dated the same day, documented the wound had increased drainage and odor.</p>	R 008	<p>Continued from page 1</p> <p><b>What corrective action(s) will be accomplished for those specific residents/personnel/areas found to have been affected by the deficient practice?</b></p> <p>Resident #2 was given a thirty (30) day notice on June 5, 2014, related to wound on right foot that did not improve bi-weekly. Administrator and facility nurse assisted family in finding an appropriate care center. Resident is moving out June 17, 2014.</p> <p><b>How will you identify other residents/personnel/areas that may be affected by the same deficient practice and what corrective actions will be taken?</b></p> <p>Facility R.N. will do in-depth follow up on progress notes left by outside services in regards to all residents. Facility R.N. will perform wound assessments and coordinate plan of care with outside services. Administrator will not keep residents whom have wounds that do not meet Assisted Living regulations.</p> <p><b>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not reoccur?</b></p> <p>See above statement</p>	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13R693	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING	(X3) DATE SURVEY COMPLETED  06/05/2014
NAME OF PROVIDER OR SUPPLIER  ROSETTA ASSISTED LIVING - DELPHIC		STREET ADDRESS, CITY, STATE, ZIP CODE 1590 DELPHIC WAY POCATELLO, ID 83201	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R008	Continued From page 2  *5/2/14 - A large amount of serosanguinous drainage with moderate bleeding was noted and the wound edges were macerated. The wound bed was red/black and an odor was present.  *5/5/14 - The assisted living staff reported to the hospice nurse they had noticed a "rank" odor which they described as "death" coming from the right heel dressing. The hospice nurse documented the wound had increased drainage and odor.  *5/19/14 - The wound "seemed to have worsened" and had an increased odor.  *5/24/14 - The nurse documented she did an additional visit to do a dressing change because of the drainage. The dressing had "thick yellow drainage," which smelled "foul."  *6/2/14 - The wound had increased drainage and odor. The wound bed was yellow/black with an increased odor and macerated edges.  *6/4/14 - There was a moderate amount of bloody and greenish drainage with an increased odor. Additionally, the wound bed was noted to be grayish black in color, with the wound edges irregular and macerated.  *6/5/14 - purulent serosanguinous drainage was moderate and the wound bed had dark slough tissue that could not be removed with cleaning.  On 6/4/14 at 3:30 PM, Resident #2's wound was observed to be covered in dark gray slough, with drainage that had a slight odor. The hospice nurse stated, "the wound looks worse than when I saw it a couple of weeks ago."	R008	How will the corrective action(s) be monitored and how often will monitoring occur to ensure that the deficient practice recur (ie, what quality assurance will be put into place)?  Facility Administrator and Facility R.N. will meet weekly to discuss progress of wounds in the building.  By what date will the corrective actions be completed?  Corrective action will be completed by June 17, 2014.	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:  <b>13R693</b>	(X2) MULTIPLE CONSTRUCTION A. <b>BUILDING:</b> _____  B. WING		(X3) DATE SURVEY COMPLETED  <b>06/05/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>ROSETTA ASSISTED LIVING - DELPHIC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1590 DELPHIC WAY POCATELLO, ID 83201</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 008	<p>Continued From page 3</p> <p>On 6/5/14 at 8:15 AM, the facility administrator and the facility nurse confirmed Resident #2 had a wound on her right foot that was not improving bi-weekly.</p> <p>The facility retained Resident #2 who had a wound that did not improve bi-weekly.</p>	R 008		

<b>Facility</b> Rosetta Assisted Living - Delphic	<b>License #</b> RC-693	<b>Physical Address</b> 1590 Delphic Wy	<b>Phone Number</b> (208) 238-9215
<b>Administrator</b> Michel Gifford	<b>City</b> Pocatello	<b>ZIP Code</b> 83201	<b>Survey Date</b> June 5, 2014
<b>Survey Team Leader</b> Rae Jean McPhillips RN, BSN	<b>Survey Type</b> Licensure and Complaint Investigation		<b>RESPONSE DUE:</b> July 5, 2014
<b>Administrator Signature</b>	<b>Date Signed</b>		
<i>Michel Gifford</i>	6-5-14		

**NON-CORE ISSUES**

Item #	IDAPA Rule # 16.03.22.	Description	Department Use Only	
			EOR Accepted	Initials
1	260.06	The facility's environment was not maintained in a clean, orderly and safe manner as evidenced by: a window in a resident's room did not have shades/curtains, a resident's room had two holes in the wall located by the door, a roll of vinyl was observed in a resident's room, the toilet roll holder in bathroom was broken, several screws were observed on a resident's bathroom vanity, caulking around some toilets were "yellowed", there was a buildup behind the washer/dryer, floor and ceiling vents need dusting, there were scratches were observed on closet doors, and there were several areas in the facility the paint was scraped off the walls.		
2	711.08	The facility's caregivers did not document in residents' records changes of condition or when they notified the facility nurse of those changes.		
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Residential Assisted Living Facility Program, Medicaid L & C  
3232 W. Elder Street, Boise, Idaho 83705  
208-334-6626

Page 2 of 2  
Date 6/5/14

Establishment Name Kosette AL Delphic	Operator Michael Grifford
Address 1590 Delphic Way, Portland 93201	
County Estab #	EHS/SUR.#
	License Permit #

OBSERVATIONS AND CORRECTIVE ACTIONS (Continuation Sheet)

#12: The facility used a sanitizer that was not approved for kitchen use -

Evidence of resolution due 6/15/14

#22: The facility did not have a consumer advisory for undercooked eggs posted - Undercooked eggs were observed for a breakfast, needs -  
COS: the facility was educated on the risks and a consumer advisory was given to the facility

Person in Charge Michael Grifford	Date 6-5-14	Inspector [Signature]	Date 6-5-14
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