IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

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October 17, 2007

Doris Foruria, Administrator
The Cottages of Emmett
1920 Mayflower Wy
Meridian, ID 83709-8573

Dear Ms. Foruria:

On October 2, 2007, a complaint investigation survey was conducted at The Cottages of Emmett. The survey was conducted by Sydnie Braithwaite, RN and Polly Watt-Geier, MSW. This report outlines the findings of our investigation.

Complaint # ID00002725

Allegation 1: The facility did not follow physician's orders for an identified resident when Premarin cream and Levaquin were ordered in March 2007.

Findings: The identified resident's record contained a physician's order dated March 9, 2007, which documented "Premarin cream apply to urethra at night daily." The record also contained a second physician's order dated March 12, 2007, which documented "Levaquin 500 mg by mouth once a day for 3 days." Review of the identified resident's March 2007 Medication Assistance Record (MAR), revealed the resident was assisted with premarin cream every night beginning March 10, 2007 to the present. The MAR, also revealed Leavaquin was given daily for 3 days from March 12, 2007 through March 14, 2007.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation.

Allegation 2: The facility did not protect a resident's right to access medical care as they did not assure a resident was able to access mecial appointments.

Findings: During the complaint investigation, the resident was not available as she was away from the facility.

Review of the identified resident's record documented the facility or family would transport the resident to her medical appointments. On October 2, 2007 at 10:06 a.m., the administrator stated she arranged and transported the identified resident to her medical appointments and was not aware of a time when the resident missed an appointment. On October 2, 2007 at 12:56 p.m., a friend of the resident stated she was not aware of a time the resident was not taken to a medical appointment.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation.

Allegation 3: The facility administrator did not handle a resident's complaints appropriately.

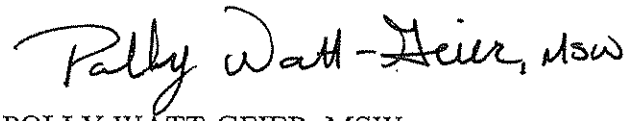
Findings: During the complaint investigation, the resident was not available as she was away from the facility.

On 10:06 am., the administrator stated the identified resident did intermittently complain about missing items, but the items were usually found by the resident in her room within a few days. She also stated the resident gave her items to other residents in the facility and the administrator would collect and label them. The administrator would then return the items to the resident. Additionally, she stated the complaints were always investigated and resolved. On October 2, 2007 at 12:56 p.m., a friend of the resident stated the resident does become frustrated that she cannot always do things independently and does relate concerns to the administrator.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation.

As no deficiencies were cited as a result of our investigation, no response is necessary to this report. Thank you to you and your staff for the courtesies extended to us on our visit.

Sincerely,



POLLY WATT-GEIER, MSW
Team Leader
Health Facility Surveyor
Residential Community Care Program

PWG/sc

c: Jamie Simpson, MBA, QMRP, Supervisor, Residential Community Care Program
Polly Watt-Geier, MSW, Health Facility Surveyor

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Dear Ms. Foruria:

On October 2, 2007, a complaint investigation survey was conducted at The Cottages of Emmett. The survey was conducted by Sydnie Braithwaite, RN and Polly Watt-Geier, LSW. This report outlines the findings of our investigation.

Complaint # ID00003140

Allegation #1: Staff assisted residents with medications without delegation.

Findings: 3 of 3 personnel records documented the caregivers had been delegated by the nurse to assist residents with their medications. On October 2, 2007 at 1:05 p.m., two caregivers stated they had been delegated to assist the residents with medications. On October 2, 2007 at 8:42 a.m., the administrator stated all of the caregivers had been delegated by the nurse to assist residents with their medications.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation.

Allegation #2: Staff were not appropriately assisting residents with their medications as staff did not watch residents ingest their medications.

Findings: On October 2, 2007 between 8:19 a.m. and 8:31 a.m., a caregiver was observed watching two residents as they ingested their medications. The caregiver stated that she always made sure the residents swallowed their pills.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation.

Allegation #3: Facility staff were not practicing safe or proper infection control to include: not

wearing gloves while preparing ready to eat foods or when changing soiled attends

Findings: The facility's Infection Control Policy was reviewed on October 2, 2007. It included procedures for the caregivers to follow when handling any type of bodily fluid; correct disposal of gloves and waste; and good hand washing guidelines. On October 2, 2007 between 2:35 p.m. and 3:48 p.m., gloves and wipes were observed in each resident's bathroom. On October 2, 2007 between 8:15 a.m. and 8:31 a.m., four caregivers were seen using appropriate glove use and handwashing during meal time preparation and when providing cares to the residents. On October 2, 2007 at 1:05 p.m., a caregiver stated she always wore gloves during meal preparation and wore gloves when assisting residents with cares. She also stated she frequently changed her gloves and washed her hands during meal preparation and after assisting residents with their care needs.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation.

Allegation #4: Two identified residents were not assisted with their toileting or mobility needs.

Findings: The two identified residents' records documented both residents needed assistance with toileting and mobility by the caregivers. Between October 1, 2007 and October 2, 2007, the residents were observed to be clean. Their clothes were not stained and there was no detectable odor of urine or feces. Between October 1, 2007 and October 2, 2007, both residents were observed being assisted with mobility and toileting by the caregivers. On October 1, 2007 at 2:47 p.m., a hospice nurse stated she had never seen either of the identified residents not being taken care of appropriately at any time. On October 2, 2007 at 10:24 a.m., a caregiver from a home health agency stated that one of the identified resident was "always very clean." Additionally, she stated she had never found soiled linens, feces or had been aware the resident had skin breakdown related to a lack of care being provided.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation.

Allegation #5: Unlicensed caregivers were administering insulin by injecting an identified resident with her insulin.

Findings: The identified resident no longer resided at the facility at the time of the complaint investigation.

On October 1, 2007 at 3:00 p.m., the administrator stated there were currently no residents that required insulin injections. She stated there had been a former resident who required daily insulin injections. When the resident was at the facility, the nurse would pre-fill each syringe and the resident was able to inject herself with verbal instructions/cues from the caregivers. On October 2, 2007 at 1:05 p.m., a caregiver

stated if a resident was on insulin they would need to inject their own insulin and the nurse would pre-fill the syringes. On October 2, 2007 at 3:18 p.m., a caregiver stated that she verbally reminded the identified resident to inject the insulin, when assisting her with the insulin.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation.

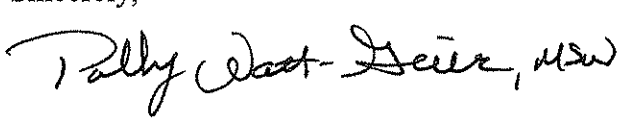
Allegation #6: Facility caregivers were not practicing safe or proper infection control when they disposed of dirty needles in the garbage rather than in a sharps container.

Findings: On October 2, 2007 at 8:52 a.m., a red Sharps container was observed on the floor of the medication room. On October 2, 2007 at 8:50 a.m., a caregiver stated there was one resident who checked his blood glucose level three times a week. A new lancet was used for each check, and then the lancet would be placed by the caregiver into a sharps container found in the medication room. On October 2, 2007 at 10:10 a.m., a resident was interviewed about his blood glucose checks. He stated the caregivers used lancets but they would put them into a sharps container after checking his blood glucose levels.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation.

As no deficiencies were cited as a result of our investigation, no response is necessary to this report. Thank you to you and your staff for the courtesies extended to us on our visit.

Sincerely,



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