



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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February 27, 2020

Jodie Katsilometes, Administrator
Elegant Residential Living
1256 Wright Avenue
Pocatello, ID 83202

License #: RC-1202

Dear Jodie Katsilometes:

On January 6, 2020, a Fire Life Safety Survey was conducted at Elegant Residential Living. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level(s):

«POCEORAcceptanceBlock»

This office is accepting your plan of correction and evidence of resolution.

Should you have questions, please contact Sam Burbank, Health Facility Surveyor, Facility Fire Safety and Construction Program, at (208) 334-6626, option 3.

Sincerely,

A handwritten signature in blue ink that reads "Jamie Simpson". The signature is fluid and cursive, with the first name "Jamie" and last name "Simpson" clearly distinguishable.

Sam Burbank
Health Facility Surveyor
Facility Fire Safety & Construction Program

SB/lj

NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
Elegant Residential Living	RC-1202	1256 Wright Ave	208-478-9400
Administrator	City	Zip Code	Survey Date
Jodie Katsilometes	Pocatello	83202	01/06/2020
Survey Team Leader	Survey Type		Response Due
Burbank, Sam	Fire Life Safety and Sanitation Licensure		02/06/2020

Item #	Rule (16.03.22)	Description
1	.405.01. Medical Gases.	Extension cords ad multiple plug adapters are prohibited: Bldg 4 - Rm 7 & 10 using 3-1 extension cord - (non-grounded); Bldg 3 - Rm 3 & 5 using 3-1 extension cord; Bldg 1 Rm 15 using 3-1 extension cord.
2	.405.03. Medical Gases.	Medical gas cylinders such as oxygen shall be secured by a rack or chained in accordance with NFPA 99: Bldg 4 - Rm 3 had (1) unsecured oxygen cylinder; Bldg 1 - Rm 14 had (2) unsecured oxygen cylinders; Bldg 2 - Rm 8 had (2) unsecured oxygen cylinders.
3	.405.05. Structure, Maintenance, Equipment to Assure Safety.	1) Bldg 4 - Rm 2 had wreath decoration that the hook for hanging on the door prevented the door from closing. 2) Cadet heater @ storage unit of Bldg 1 blocked without 3 feet of clearance.
4	.410.02. Fire Drills.	All shifts shall be trained by quarterly fire drills: No day shift fire drills in 3rd quarter for all buildings; No NOC shift fire drills for 4th quarter for all buildings.

CORE ISSUES

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Item #	Rule (16.03.22)	Description
2	.520-09 Inadequate Care - Safe Living Environment	According to IDAPA 16.03.22.011.08 Inadequate care is defined as, "When a facility fails to provide the services required to meet the terms of the Negotiated Service Agreement...a safe living environment, or engages in violations of resident rights or takes residents who have been admitted in violation of the provisions of Section 39-3307, Idaho Code." According to IDAPA 16.03.22.260.01, "The facility must have an adequate water supply that is safe and of a sanitary quality." According to IDAPA 16.03.22.250.06(d), "Toilet and Bathrooms. Each facility must provide:...Each tub, shower, and lavatory with hot and cold running water" According to IDAPA 16.03.22.250.10, "Plumbing. All plumbing in the facility must comply with local and state codes. All plumbing fixtures must be easily cleanable and maintained in good repair. The temperature of hot water at plumbing fixtures used by residents must be between one hundred five degrees (105°F) Fahrenheit and one hundred twenty degrees

		(120°F) Fahrenheit." According to IDAPA 16.03.22.550.03 (iii) "REQUIREMENTS FOR RESIDENTS' RIGHTS. The administrator must assure that policies and procedures are implemented to assure that residents' rights are observed and protected...Humane Care and Environment. a. Each resident has the right to humane care and a humane environment, including the following:...iii. The right to a safe and sanitary living environment." During the facility tour conducted on 1/6/20 from approximately 10:30 AM to 11:00 AM, Building 3 water temperatures tested at seven (7) resident room locations and the common bath shower, established a water temperature on the hot side of 58 degrees Fahrenheit. Staff on duty interviewed at approximately 11:00 AM, stated they were aware the building had no hot water. When asked if they knew when the hot water loss occurred, staff stated they were not sure, but estimated it was at least a week prior to the survey date. From approximately 11:15 AM to 11:30 AM, four (4) residents were interviewed about the loss of hot water in their home. Residents were asked if they knew of the hot water loss and if they had been provided adequate bathing. Two (2) residents stated they were offered the opportunity to bath at one of the other buildings and had accepted that arrangement. One (1) stated she was aware of the hot water loss and did not wish to bath at one of the other buildings as she felt the cold and snow outside would present a risk to her health. The resident further stated she was very susceptible to pneumonia. Further asked if she had been able to bath as she chose, she stated she was given cold water wash-cloth bath(s) by her bathing aide. The fourth resident interviewed stated she was aware of the hot water loss, but was not offered an opportunity to bath at one of the other homes. She further
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		stated she would not have accepted that arrangement as the outside cold and snow would expose her to greater risk of illness, specifically that she was susceptible to pneumonia. During observation and physical testing of the kitchen dishwasher conducted on 1/6/20 at approximately 11:45 AM to 12:00 PM, the interior of the dishwasher was observed to have plates, silverware and glasses positioned on the upper, lower and utensils racks. Water temps taken from the interior of the tank during two (2) separate tests, revealed the temperature was 73 degrees Fahrenheit. Both temperatures were obtained during the use of the hot water temp boost feature of the machine and after the machine's cycle had indicated it was in "wash" feature. At approximately 12:15 PM, staff present in the kitchen were asked how sanitation was achieved for dishes and utensils and what method staff used to wash hands for food preparation. Staff stated they used boiling water for sanitation. Further asked if they had any boiling water prepared for this purpose, they stated they did not. At this time a second staff member was observed to put on an apron and began preparing food. The staff was observed to use a portable Alcohol-Based hand sanitizer located on the nursing cart parked at the south side of the kitchen. Staff was not observed washing their hands in boiling water prior to handling the food being removed from the oven. Additionally, review of the Idaho Food Code section 4-501.110(A) and (B) lists a temperature range for mechanical warewashing equipment between 120 to 165 degrees Fahrenheit, depending on application and type of equipment and if chemicals are used. Review of section 4-703.11(B) established the sanitation of equipment and utensils required a temperature of 160 degrees. Based on the temperature(s) obtained, adequate sanitation of utensils and dishware could not be established. Observation of the hand sanitation
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		practices of the staff observed preparing food for residents, adequate sanitation of food preparation employees could not be confirmed to be in accordance with Idaho Food Code 2-301.12. Interview of the Administrator at approximately 1:00 PM on 1/6/20 established the loss of hot water in Building 3 had been identified on 12/26/19. The Administrator stated she had contacted a plumbing vendor to remedy the issue. Water temp records provided on 1/6/20 confirmed the lack of hot water on 12/26/19 and temperatures were documented at 43 degrees Fahrenheit at sinks and the bathroom. Water temps were not documented from the dishwasher. Records indicated water temps taken by facility staff at the same areas were documented as rising on 12/29 and 12/30 and reached 103 degrees Fahrenheit on these dates. The Administrator stated the responding plumbing vendor had taken 1 of the 2 on-demand water heaters off-line in the effort to isolate the building hot water loss. Documentation of water temps taken by staff on 12/31 revealed the water temps had decreased to 70 degrees Fahrenheit and the areas tested did not include any temps for the dishwasher. Due to the extent and nature of the findings, the facility failed to provide hot running water for eleven days up to the survey. This resulted in residents inability to bathe as desired, staff and residents having inadequate methods for sanitizing their hands, both after care and prior to food preparation and the facility's inability to properly sanitize eating utensils and dishware, resulting in inadequate care.
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