



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

March 4, 2015

Anna Capell, Administrator
Bridge at Post Falls
515 North Garden Plaza Court
Post Falls, Idaho 83854

Provider ID: RC-976

Ms. Capell:

On January 7, 2015, a state licensure/follow-up/revisit survey was conducted at Post Falls Retirement LLC - dba - The Bridge at Post Falls. 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 Gloria Keathley, LSW, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 364-1962.

Sincerely,

Karen Anderson, RN
for

GLORIA KEATHLEY, LSW
Team Leader
Health Facility Surveyor

GK/sc

cc: Jamie Simpson, MBA, QMRP Supervisor, Residential Assisted Living Facility Program



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P.O. Box 83720
Boise, Idaho 83720-0009
EMAIL: ralf@dhw.idaho.gov
PHONE: 208-364-1962
FAX: 208-364-1888

January 23, 2015

CERTIFIED MAIL #: 7007 3020 0001 4050 8715

Anna Capell, Administrator
Bridge at Post Falls
515 North Garden Plaza Court
Post Falls, Idaho 83854

Ms. Capell:

On January 7, 2015, a state licensure survey, follow-up survey and complaint investigation were conducted by department staff at the bridge at post falls. The facility was issued a core issue deficiency for inadequate care for failing to provide coordination of outside services. This is a repeat deficiency. The facility was previously cited for inadequate care for failing to provide coordination of outside services on June 20, 2014.

This core issue deficiency substantially limits the capacity of The Bridge at Post Falls to provide for residents' basic health and safety needs. The deficiency is described on the enclosed Statement of Deficiencies.

PROVISIONAL LICENSE:

As a result of the survey findings, a provisional license is being issued effective January 23, 2015 and will remain in effect for a period of six months. The following administrative rule for Residential Care or Assisted Living Facilities in Idaho (IDAPA 16.03.22) gives the Department the authority to issue a provisional license:

935. ENFORCEMENT REMEDY OF PROVISIONAL LICENSE.

A provisional license may be issued when a facility is cited with one (1) or more core issue deficiencies, or when non-core issues have not been corrected or become repeat deficiencies. The provisional license will state the conditions the facility must follow to continue to operate. See Subsections 900.04, 900.05 and 910.02 of these rules.

The conditions 1- 6 of the provisional license are as follows:

CONSULTANT:

- 1. A licensed nurse consultant**, with at least three years experience working in a residential care or assisted living facility environment in Idaho, shall be obtained and paid for by the facility, and approved by the Department. This consultant must be properly licensed through the Idaho Board of Nursing and may not also be employed by the facility or the company that operates the facility. The purpose of the consultant is to assist the facility in identifying and implementing appropriate corrections for the deficiencies. Please

provide a copy of the enclosed consultant report content requirements to the consultant. The consultant shall be allowed unlimited access to the facility's administrative, business and resident records and to the facility staff, residents, their families and representatives. The name of the consultant with the person's qualifications shall be submitted to the Department for **approval no later than February 6, 2015.**

2. **A weekly written report** must be submitted by the Department-approved consultant to the Department commencing on **February 13, 2015.** The reports will address progress on correcting the core deficiency identified on the Statement of Deficiencies as well as the non-core deficiencies identified on the punch list. When the consultant and the administrator agree the facility is in full compliance, they will notify the Department and request a follow-up survey be scheduled.

BAN ON ADMISSIONS:

3. **Ban on all new admissions.** Readmission from the hospital will be considered after consultation between the facility, consultant, the resident/family and the Department. The ban on new admissions will remain in effect until the Department has determined that the facility has achieved full compliance with the Department's licensing and certification requirements. The following administrative rule for Residential Care or Assisted Living Facilities in Idaho (IDAPA 16.03.22) gives the Department the authority to impose a remedy of a limit on admissions:

920. Enforcement Remedy of Limit of Admissions.

*02. Reasons for Limit on Admissions. The department may limit admissions for the following reasons:
c. Enforcement Action "B" or "C" is taken as described in Sections 900.04 and 900.05, of these rules.*

Enforcement Action B has been taken, as the facility failed to correct the core issue deficiency cited in the June 20, 2014 survey. The limitation on admissions shall remain in effect until the department determines the facility has achieved full compliance with IDAPA 16.03.22.

PLAN OF CORRECTION:

4. 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?

An acceptable, **signed and dated** Plan of Correction must be submitted to the Division of Licensing and Certification within **ten (10) calendar days of your receipt of the Statement of Deficiencies.** You are encouraged to immediately develop and submit this plan so any adjustments or corrections to the plan can be completed prior to the deadline.

EVIDENCE OF RESOLUTION:

5. Non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference on January 7, 2015. The following administrative rule for Residential Care or

Assisted Living Facilities in Idaho (IDAPA 16.03.22) describes the requirements for submitting evidence that the non-core issue deficiencies have been resolved:

910. Non-core Issues Deficiency.

01. Evidence of Resolution. *Acceptable evidence of resolution as described in Subsection 130.09 of these rules, must be submitted by the facility to the Licensing and Survey Agency. If acceptable evidence of resolution is not submitted within sixty (60) days from when the facility was found to be out of compliance, the Department may impose enforcement actions as described in Subsection 910.02.a through 910.02.c of these rules.*

The seven (7) non-core issue deficiencies must be corrected and evidence (including but not limited to receipts, pictures, completed forms, records of training) must be submitted to this office by **February 6, 2015.**

CIVIL MONETARY PENALTIES

6. Of the seven (7) non-core issue deficiencies identified on the punch list, two (2) were repeat punches. One (1) of the repeat deficiencies, 16.03.22.350.02 was cited on each of the last three (3) previous surveys, 11/29/11, 9/2/11 and 6/20/14.

16.03.22.350.02 - The facility administrator did not conduct investigations into all accidents, incidents and complaints within 30 days.

The following administrative rules for Residential Care or Assisted Living Facilities in Idaho give the Department the authority to impose a monetary penalty for this violation:

IDAPA 925. ENFORCEMENT REMEDY OF CIVIL MONETARY PENALTIES.

01. Civil Monetary Penalties. *Civil monetary penalties are based upon one (1) or more deficiencies of noncompliance. Nothing will prevent the Department from imposing this remedy for deficiencies which existed prior to survey or complaint investigation through which they are identified. Actual harm to a resident or residents does not need to be shown. A single act, omission or incident will not give rise to imposition of multiple penalties, even though such act, omission or incident may violate more than one (1) rule.*

02. Assessment Amount for Civil Monetary Penalty. *When civil monetary penalties are imposed, such penalties are assessed for each day the facility is or was out of compliance. The amounts below are multiplied by the total number of occupied licensed beds according to the records of the Department at the time noncompliance is established.*

b. Repeat deficiency is ten dollars (\$10). (Initial deficiency is eight dollars (\$8)).

For the dates of 10/9/2014 through 1/7/2015:

Penalty	Number of Deficiencies	Times number of Occupied Beds	Times Number of days of non-compliance	Amount of Penalty
\$10.00	1	76	90	\$ 68,400

Maximum penalties allowed in any ninety-day period per IDAPA 16.03.22.925.02.c:

# OF OCCUPIED BEDS IN FACILITY	INITIAL DEFICIENCY	REPEAT DEFICIENCY
3-4 BEDS	\$1,440	\$2,880
5-50 BEDS	\$3,200	\$6,400

51-100 BEDS	\$5,400	\$10,800
101-150 BEDS	\$8,800	\$17,600
151 OR MORE BEDS	\$14,600	\$29,200

Your facility had 76 occupied beds at the time of the survey. Therefore, your maximum penalty is: \$10,800.

Send payment of \$10,800 by check or money order, made payable to:

Licensing and Certification

Mail your payment to:

**Licensing and Certification - RALF
PO Box 83720
Boise, ID 83720-0009**

Payment must be received in full within 30 calendar days from the date this notice is received. Interest accrues on all unpaid penalties at the legal rate of interest for judgments. Failure of a facility to pay the entire penalty, together with any interest, is cause for revocation of the license.

ADMINISTRATIVE REVIEW

You may contest the provisional license, requirement for a consultant or civil monetary penalty by filing a written request for administrative review pursuant to IDAPA 16.05.03.300, which states: **the request must be signed by the licensed administrator of the facility, identify the challenged decision, and state specifically the grounds for your contention that this decision is erroneous.** The request must be received no later than twenty-eight (28) days after this notice was mailed. Any such request should be addressed to:

**Tamara Prisock, Administrator
Division of Licensing and Certification - DHW
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036**

Upon receipt of a written request that meets the requirements specified in IDAPA 16.05.03.300, an administrative review conference will be scheduled and conducted. The purpose of the conference is to clarify and attempt to resolve the issues. A written review decision will be sent to you within thirty (30) days of the date of the conclusion of the administrative review conference.

If the facility fails to file a request for administrative review within the time period, this decision shall become final.

INFORMAL DISPUTE RESOLUTION

Pursuant to IDAPA 16.03.22.003.02, you have available the opportunity to question the core issue deficiency 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 Assisted Living Facility Program for an IDR meeting. The request for the meeting must be in writing and must be made within ten (10) business days of receipt of the Statement of Deficiencies. The facility's request must include sufficient information for Licensing and Certification to determine the basis for the provider's appeal, including reference to the specific deficiency to be reconsidered and the basis for the reconsideration request. If your request for informal dispute resolution is received more than ten (10) days after you receive the Statement of Deficiencies, your request will not be granted. Your IDR request must be made in accordance with the Informal Dispute Resolution Process. The IDR

request form and the process for submitting a complete request can be found at www.assistedliving.dhw.idaho.gov under the heading of Forms and Information.

FOLLOW-UP SURVEY

An on-site, follow-up survey will be scheduled after the administrator and consultant submit a letter stating that all deficiencies have been corrected and systems are in place to assure the deficient practices remain corrected. If at the follow-up survey, the core issue deficiency still exists, a new core issue deficiency is identified, non-core deficiencies have not been corrected, or the facility has failed to abide by the conditions of the provisional license, the Department will take further enforcement action against the license held by Post Falls Retirement LLC - dba - The Bridge at Post Falls. Those enforcement actions will include one or more of the following:

- Revocation of the Facility License
- Summary Suspension of the Facility License
- Imposition of Temporary Management
- Continuation of the Ban on Admissions
- Additional Civil Monetary Penalties

Division of Licensing and Certification staff is available to assist you in determining appropriate corrections and avoiding further enforcement actions. Please contact our office at (208) 364-1962 if we may be of assistance, or if you have any questions.

Sincerely,



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

JS/sc

Enclosure

cc: Medicaid Notification Group

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R976	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/07/2015
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BRIDGE AT POST FALLS

515 NORTH GARDEN PLAZA COURT
POST FALLS, ID 83854

(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 follow-up and complaint investigation survey conducted between 1/5/15 and 1/7/15 at your residential care/assisted living facility. The surveyors conducting the survey were:</p> <p>Gloria Keathley, LSW Team Coordinator Health Facility Surveyor</p> <p>Rae Jean McPhillips, RN, BSN Health Facility Surveyor</p> <p>Karen Anderson, RN Health Facility Surveyor</p> <p>Matt Hauser, QMRP Health Facility Surveyor</p> <p>Abbreviations used:</p> <p>cm = centimeters HH = home health LLE = left lower extremity NSA = negotiated service agreement POC = plan of care RN = registered nurse SN = skilled nursing</p>	{R 000}	<p>What corrective action(s) will be accomplished for those specific residents/personnel/areas found to have been affected by the deficient practice?</p> <p>Resident #8 no longer resides in facility.</p> <p>Facility nurse assigned to Resident #8 is no longer employed at facility.</p> <p>Outside Agency involved in care of Resident #8 has been informed of care coordination concerns. Facility and Agency Staff had a meeting on 1/27/15. A letter of understanding was signed by the Agency.</p>	
{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>How will you identify other residents/personnel/areas found to have been affected by the deficient practice? What corrective action(s) will be accomplished?</p>	

Bureau of Facility Standards

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

TITLE

(X6) DATE

Anna Capell

Assisted Living Manager

1/29/15

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R976	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/07/2015
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NAME OF PROVIDER OR SUPPLIER BRIDGE AT POST FALLS	STREET ADDRESS, CITY, STATE, ZIP CODE 515 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854
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{R 008}	<p>Continued From page 1</p> <p>Based on record review and interview, it was determined the facility did not provide coordination of outside services for 1 of 3 sampled residents (#8) who received home health services for wound care. The findings include:</p> <p>I. Coordination of Outside Services</p> <p>IDAPA 16.03.22.011.08, states inadequate care is "When a facility fails to provide...coordination of outside services."</p> <p>Resident #8's record documented she was a 73 year-old female admitted to the facility on 12/16/14 with a wound on her left lower leg. The resident was on home health services for wound care at the time of the survey.</p> <p>The facility's resident roster, presented to surveyors on 1/5/15, documented Resident #8 did not have wounds, but received services from home health.</p> <p>An NSA, dated 12/12/14, documented Resident #8 received services from home health, but did not document the reason she was receiving the services.</p> <p>A facility nursing assessment completed by the RN, dated 12/12/14, documented Resident #8 had a 3 cm wound on her left lower leg. The nursing assessment documented home health was providing speech, physical and occupational therapy. The assessment, which was completed prior to Resident #8's admission, did not document Resident #8 received wound care.</p> <p>A facility nursing note, dated 12/23/14 and titled "care coordination," documented home health</p>	{R 008}	<p>Residents with outside agency involvement could be affected. Charts will be reviewed and updated to reflect coordination of care.</p> <p>Facility staff involved in caring for residents and coordinating services could be affected. Nurses on duty at the time of survey were instructed in documentation expectations for wounds.</p> <p>Outside Agencies providing care in the facility could be affected. Facility will meet with active Outside Agencies to discuss the coordination of services, rules regarding family involvement in plan of care, documentation, plans of care and communication regarding wound care.</p>	
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Bureau of Facility Standards

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{R 008}	<p>Continued From page 2</p> <p>was to "provide wound care to LLE hematoma...." Additionally, the note documented, "Family to provide dressing changes when HH SN not available."</p> <p>Facility nursing notes, dated 12/31/14 and 1/5/15, documented the facility received nursing notes and a POC from the home health agency.</p> <p>There was no other documentation from the facility nurses regarding the status of Resident #8's wound.</p> <p>A home health POC, dated 12/17/14 and signed by Resident #8's physician, documented wound care consisted of a "vinegar/salt solution pad" applied to the wound, twice a day and left in place for 30 minutes. The POC documented home health would apply the "pad" once a day, twice a week for the first 5 weeks, then once a week for the next 3 weeks. The POC did not address who was responsible for wound care twice a day for the other 5 days.</p> <p>Home health notes documented they were at the facility on, 12/19, 12/23, 12/27 and 12/31/14 to provide wound care, once a day for Resident #8.</p> <p>There was no documentation Resident #8 received wound care twice a day as ordered by her physician.</p> <p>On 1/6/15 at 11:45 AM, a caregiver who assisted Resident #8, stated she thought home health came to the facility a "couple" of times a week. She stated she was unaware Resident #8 had a wound. Additionally, she stated the resident's daughter was at the facility "almost daily."</p> <p>On 1/6/15 at 11:50 AM, the facility nurse, who</p>	{R 008}	<p>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</p> <p>Training will be provided by Administrator for nurses related to Coordination of Care Expectations.</p> <p>Training has been provided by Regional Director of Operations for GM, Administrator and Resident Care Director related to updating facility NSA with Outside Agency and Wound Information.</p> <p>Facility nurses and Outside Agency Nurses will collaborate on assessment, treatment and documentation of wounds. Whenever possible, nurses will assess wounds together.</p>	
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{R 008}	<p>Continued From page 3</p> <p>was responsible for the oversight of residents living on the same floor as Resident #8, was interviewed. She stated, "I cannot tell if it's improving - I've never seen it." She stated, she saw the resident's daughter almost daily, but did not know when, or if, she provided wound care.</p> <p>On 1/6/15 at 12:05 PM, Resident #8 stated her daughter provided wound care "mostly on the holidays." Additionally, she stated "I don't think the facility nurse has ever seen it."</p> <p>On 1/6/15 at 1:53 PM, Resident #8's daughter stated she was at the facility almost daily. She stated, "I assess it [the wound] and if it needs it, I change the dressing [vinegar/salt pad]." She stated she changed the pad "at least 3 times a week."</p> <p>Resident #8's physician ordered wound care to be provided twice a day. Wound care should have been done 40 times, from 12/17/14 through 1/5/15. However, there were only 4 documented instances of wound care provided by home health. Resident #8's daughter stated she provided wound care about 3 times a week, but did not communicate to the facility or home health which days, or when she provided wound care.</p> <p>The facility failed to coordinate Resident #8's care to ensure she received wound care twice a day as ordered by her physician. This failure resulted in inadequate care.</p>	{R 008}	<p>Resident status will continue to be discussed at the daily stand up meeting. Residents with new orders for Outside Agency Involvement or Wound Care will be reviewed and NSA updated as necessary.</p> <p>The facility roster will be reviewed by the Administrator and RN weekly to ensure all residents with wounds and Outside Agencies are reflected on roster.</p> <p>The facility will continue meeting with Outside Agencies on a weekly basis. The agenda for the meeting will be modified address coordination of care. Plans of care will be reviewed and updated during the meeting.</p>	

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{R 008}	Continued From page 4	{R 008}	<p>How will the corrective action(s) be monitored and how often will monitoring occur to ensure that the deficient practice does not recur?</p> <p>Weekly audit of Outside Services will be completed by Consultant through survey.</p> <p>Weekly Conference Call with Regional RN will be conducted to review Outside Agency Coordination of Care. The Administrator, RN and Consultant will participate. The purpose of the call will be to discuss current orders and review plans of care and resident progress.</p> <p>By what date will the corrective action(s) be completed?</p> <p>February 20, 2015</p>	
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Facility Bridge At Post Falls, The	License # RC-976	Physical Address 515 N Garden Plaza Ct	Phone Number (208) 773-3701
Administrator Anna Capell	City Post Falls	ZIP Code 83854	Survey Date January 7, 2015
Survey Team Leader Gloria Keathley, LSW	Survey Type Complaint Investigation and Follow-up	RESPONSE DUE: February 6, 2015	
Administrator Signature <i>Anna Capell</i>	Date Signed <i>January 7, 2015</i>		

NON-CORE ISSUES

Item #	IDAPA Rule #	Description	Department Use Only	
			EOR Accepted	Initials
1	16.03.22. 300.01	The facility nurse did not complete quarterly nursing assessments for Residents #5 and #7. **Previously cited 6/20/14**	2-23-15	SK
2	305.06.b	The facility nurse did not conduct an assessment every 90 days to ensure Residents #7 and #10 were capable of self administration of medications.	3-2-15	SK
3	310.04.c	The facility did not monitor Resident #6 to determine if there was a need to continue her psychotropic medication.	3-2-15	SK
4	330.02	The facility did not retain documentation regarding residents' cares for 3 years.	3-2-15	SK
5	350.02	The facility administrator did not conduct investigations into all accidents, incidents and complaints within 30 days. **Previously cited on 11/29/11, 9/2/11, 6/20/14**	3-3-15	SK
6	350.04	The facility administrator did not provide a written response to complainants within 30 days.	3-3-15	SK
7	711.08.d	There was no documentation that staff contacted Residents #3 & #5s' physicians when they had blood glucose levels above/below parameters set by the physicians.	3-2-15	SK
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IDAHO DEPARTMENT OF
HEALTH & WELFARE

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FAX: 208-364-1888

January 20, 2015

Anna Capell, Administrator
Bridge at Post Falls
515 North Garden Plaza Court
Post Falls, Idaho 83854

Provider ID: RC-976

Ms. Capell:

An unannounced, on-site complaint investigation was conducted at The Bridge at Post Falls between January 5, 2015 and January 7, 2015. During that time, observations, interviews, and record reviews were conducted with the following results:

Complaint # ID00006639

Allegation #1: The facility had residents who were cognitively or visually impaired sign admission agreements without explaining the agreement.

Findings: Unsubstantiated. This does not mean the incident did not take place; it only means that the allegation could not be proven.

Allegation #2: The facility did not provide a response in writing to a complainant when meal trays were left in a resident's room longer than a day.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.350.04 for not providing a written response to a complainant within 30 days. The facility was required to submit evidence of resolution within 30 days.

If you have questions or concerns regarding our visit, please call us at (208) 364-1962. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,

GLORIA KEATHLEY, LSW
Health Facility Surveyor
Residential Assisted Living Facility Program

GK/sc