



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. 'BUTCH' OTTER -- Governor
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TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T -- Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
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August 14, 2015

Robert Nahmensen, Administrator
Coeur d'Alene Health Care & Rehabilitation Center
2514 North Seventh Street
Coeur d'Alene, ID 83814-3720

Provider #: 135052

Dear Mr. Nahmensen:

On July 31, 2015, a health survey was conducted at Coeur d'Alene Health Care & Rehabilitation Center by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3.) **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.**

Robert Nahmensen, Administrator
August 14, 2015
Page 2 of 4

After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **August 27, 2015**. Failure to submit an acceptable PoC by **August 27, 2015**, may result in the imposition of civil monetary penalties by **September 16, 2015**.

The components of a Plan of Correction as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained; and
- Include dates when corrective action will be completed in column (X5).

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying non-compliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

Robert Nahmensen, Administrator
August 14, 2015
Page 3 of 4

We are recommending that Centers for Medicare & Medicaid Services (CMS) Region X impose the following remedy:

- A 'per instance' civil money penalty of \$500.00 for the instance on July 31, 2015 described at F 315 (S/S:G).

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **January 21, 2016**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, CMS will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

go to the middle of the page to **Information Letters** section and click on **State** and select the following:

- BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process
2001-10 IDR Request Form

Robert Nahmensen, Administrator
August 14, 2015
Page 4 of 4

This request must be received by **August 27, 2015**. If your request for informal dispute resolution is received after **August 27, 2015**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2.

Sincerely,

A handwritten signature in cursive script that reads "Nina Sanderson (SN)".

NINA SANDERSON, L.S.W., Supervisor
Long Term Care

NS/lj
Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/14/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/31/2015
NAME OF PROVIDER OR SUPPLIER COEUR D'ALENE HEALTH CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814	
(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) COMPLETION DATE
F 000	INITIAL COMMENTS The following deficiencies were cited during the annual federal recertification and complaint survey of your facility. The surveyors conducting the survey were: Linda Hukill-Neil, RN, Team Coordinator Rebecca Thomas, RN Kendra Deines, RN, BSN Angela Morgan, RN, BSN The survey team entered the facility on 7/27/15 and exited on 7/31/15. Survey Definitions: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status cm = Centimeters CNA = Certified Nurse Aide DCS = Director of Clinical Services E = Employee LN = Licensed Nurse LSW = Licensed Social Worker MAR = Medication Administration Record MCO = Manager of Clinical Operations MDS = Minimum Data Set assessment MG = Milligrams NS = Director of Nursing Services PRN = As Needed RDCS = Regional Director of Clinical Services TAR = Treatment Administration Record	F 000	Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or correctness of the conclusions set forth on the statement of deficiencies, the plan of correction is prepared and submitted solely because of the requirements under State and Federal law. This Plan of Correction will serve as the Facility's allegation of substantial compliance	
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.	F 166		

RECEIVED
OCT - 8 2015
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Cathy Ann Jenkins, RN, JN* TITLE: 9/30/15 DATE: Revised 10/7/15 CAG/ML/PC

A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 166	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to fully resolve and apprise residents of the progress of grievances for 2 of 15 sampled residents (#s 6 & 14). The deficient practice placed residents at risk of personal information not being protected, or being unable to access community resources. Findings Included:</p> <p>1. Resident #14 was re-admitted to the facility on 12/3/14 with multiple diagnoses including bipolar disorder.</p> <p>The 7/14/15 MDS Assessment coded the resident had a BIMS of 15 (cognitively intact) and had no behaviors of any kind.</p> <p>The 4/23/15 "Concerns" form for Resident #14 documented a missing brown wallet and specified there were credit cards in the wallet. The laundry staff was asked about it; they had not seen it but would keep looking. It documented a follow up was completed on this investigation on 4/29/15, "complete-wallet not found. Resident was offered to have cards canceled but declined."</p> <p>On 7/27/15 at 1:00 p.m. Resident #14 brought up concerns during the Resident Group Interview that grievances were not being resolved and that residents were not being kept up to date with the progress of the investigation of these grievances. In particular, he brought up concerns regarding his missing wallet and the items in the wallet.</p> <p>On 7/30/15 at 9:35 a.m., Resident #14 said his</p>	F 166	<p>1. On 4/23/15 residents #14 reported a missing brown wallet which included credit cards. The resident was offered to have cards canceled, but resident declined. The Activity Director provided the resident another wallet approximately two weeks after the wallet was reported missing and transported the resident to the bank to replace his bank card. On 6/26/15 RR #16 (daughter of resident #6) reported a hand made doll was missing. The resident's room was searched, staff interviewed and no one recalled seeing the doll. The facility was unable to find the doll. A follow up interview with resident #6 and RR #16 was conducted to explain that the facility could not recover the missing doll. The facility offered to replace the doll, both resident #6 and RR #16 declined, they did not want a police report to be filed. The facility provided residents #14 and #6 a lock box / storage area to secure personal items. Documentation on the grievance form reflects action taken and resident satisfaction with the resolution.</p>	

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F 166 Continued From page 2

Driver's License, Social Security card, Medicare card, Medicaid card, bus pass, and one credit card were in the missing wallet. When asked what the facility did to resolve the grievance, he said they searched his room, he canceled the credit card himself, but the facility did not offer to replace the other cards. He said the Activity Director was going to look into replacing the bus pass but he had not heard back on the progress of this or the progress of looking for the wallet. He said the wallet was not replaced.

On 7/30/15 at 10:00 a.m., E #13, who was appointed by the facility as the resident services director, confirmed the wallet was not offered to be replaced and that her resolution focused on the credit cards, but no other cards. She said the residents are verbally updated on the progress of these investigations, however, this is not documented.

2. On 7/28/15 at 1:00 PM, a Group Interview with 9 residents was conducted. Four residents reported they had problems with resolution to their Grievance Concerns. Random Resident (RR) #16 stated she was lucky if her grievance concerns got fixed, and the facility had not resolved her concern to her satisfaction. She felt like the facility blamed the residents.

3. Resident #6 was admitted to the facility on 7/18/14 with diagnoses of Alzheimer's Disease, chronic airway obstruction, and diabetes mellitus.

On 7/29/15 at 3:00 PM, the SSD was shown the 6/26/15 Grievance Concern for Resident #6, which had been reported by the resident's daughter, Random Resident (RR) #16. E #13

F 166

2. Current residents who filed grievances from 4/1/15 to present have been re-interviewed to ensure satisfaction with proposed resolutions. Resident grievances are reviewed at the daily morning stand up meeting until resolved to resident satisfaction. The LSW will review grievance logs during her visits and meet with residents who have filed grievances/concerns to ensure that they are satisfied with resolution.

3. Resident's personal items will be inventoried upon admission, when new items are brought in and removed. The inventory checklist will be reviewed at the quarterly care conference. A certified letter will be mailed to each resident's responsible person of record to explain the inventory process. Residents will be offered secure storage for belongings such as lock box or locked drawer/cabinet storage in their rooms. The ED met with the consultant LSW and facility Resident Services Coordinator to review the grievance resolution process to include apprising the resident of the progress toward resolution.

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F 166	Continued From page 3 stated the resident moved from Room 403 to Room 111 about a month ago, and the handmade doll had not made the move to Room 111. She stated she interviewed staff about the missing doll, but no one had seen it. When asked if she had offered to file a police report, the E #13 stated, "I didn't do that, no." E # 13 stated RR #16 was worried at first but didn't express concern after that. She stated [name of Administrator] had originally taken the concern and she had been instructed by the Administrator to ask staff if they had seen the missing doll. She stated she was advised to tell Resident #2 and RR #16 to take any items of value home. The E #13 stated, unfortunately, this doll had not been placed on the resident's Inventory Sheet. The E #13 stated she was told the doll was special to Resident #2, but had not asked the value of the doll. The E #13 stated, "I should have asked if she wanted to file a police report, I don't know if [name of Administrator] did."		<i>Cont. #3</i> The facility staff will be in-serviced on the grievance process to include documentation of action taken, proposed resolution, and follow up to ensure the resident is satisfied with the outcome of the resolution. The staff will be educated on maintaining resident inventory checklist upon admission, when new items are brought in and/or removal of items from facility.		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure residents who wished to self-administer medications were safe to do so. This was true for 1 of 9 sample residents (#1). The failure created the potential for medication errors if the residents		4. The ED will meet with residents monthly to obtain feedback regarding the overall satisfaction with the grievance process. Performance Improvement tool PI 250-AX Problem Resolution System will be utilized to evaluate resident / family satisfaction with problem resolution. The ED / designee will audit the resident grievance log weekly to ensure a five day resolution. Follow up interviews are completed to ascertain resident satisfaction with proposed resolution. Results of the audit will be reported to the monthly QAPI committee to ensure substantial compliance. 5. Date of compliance 10/9/15		

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F 176 Continued From page 4

were not competent to self administer their medications. Findings included:

Resident #1 was admitted to the facility on 6/9/15 with multiple diagnoses including metastatic lung cancer, opiate abuse disorder, Schizophrenia and psychosis.

The resident's Physician's Orders documented:
7/8/15: Morphine ER 30 mg - Give 1 tablet by mouth twice a day;
7/10/15: Oxycodone 5 mg - Give 1 tablet by mouth every 4 hours;
7/10/15: Oxycodone 5 mg - Give 1 tablet by mouth every 4 hours as needed for break through pain; and,
7/18/15: Cipro 250 mg - Give 1 tablet by mouth twice a day times 5 days.

On 7/28/15 at 9:05 AM, 10:35 AM, 1:50 PM, and 3:30 PM, Resident #1 was not in her room nor her presence observed at the facility. The facility's daily log book to check in and out documented the resident had left the facility on 7/28/15 at 8:30 AM and still had not checked back in at 3:30 PM.

On 7/30/15 at 3:28 PM, the DCS was interviewed about Resident #1's medications and the administration of them. The DCS said the resident does leave the facility often, so in order to accommodate the resident's needs they would package the resident's medications with the name of the medication and the time of each dose, which the resident could then take with her. The DCS showed the surveyor a copy of 4 medication packages, dated 7/22/15, when the resident had left the facility for the day. The packages had the names of the medications, the dosage, amount of tablets per package, and the

F 176.

1. Resident # 1 no longer resides at the facility.
2. Current resident medication profiles were audited and one resident expressed the desire to self-administer personal vitamins. The self-administration assessment was completed on August 11, 2015.
3. Licensed nurses will be in-serviced on the medication self-administration policy, which includes an assessment of the resident's ability to self-administer medication and the safe storage of medications in the resident's room.
4. DCS / designee will conduct medication profile audits weekly x 4 weeks, then monthly thereafter to ensure residents who wish to self-administer medications are appropriately assessed. Results of the audit will be reported to the monthly QAPI committee x 3 months to ensure substantial compliance.
5. Date of compliance 10/9/15

10/9/15

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F 176	Continued From page 5 time to take the medications. On 7/22/15 the resident had taken, 1 tablet of Morphine 30 mg to take at 8 PM, 1 tablet of Cipro 250 mg to take at 5 pm, and 4 tablets of Oxycodone 5 mg to take 2 tablets at 10 AM and 2 tablets at 2 PM. On 7/31/15 at 9:40 AM, the RDCS was asked for documentation to show Resident #1 had been evaluated for being safe in the self administration of medications. The RDCS acknowledged the resident's record did not contain any documentation for this.	F 176	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to maintain an environment which enhanced residents' dignity while waiting for their meals. This was true for Random Resident #13. This failed practice created the potential for residents to experience a lack of dignity and decreased self-esteem. Findings included: On 7/30/15 at 12:25 PM, Resident #13 was observed during the lunch meal sitting in a tilt and space wheelchair along with 2 other residents at the dining table. The resident's head was bent downward toward his chest and slightly turned to his left side. The resident was observed to have	F 241	1. Resident # 13 was taken back to his room for hygiene and clothing change when grooming needs were identified. He was returned to the dining room after care was provided. Staff will ensure the resident is properly groomed prior to being taken to the dining room and throughout the dining process to ensure a dignified dining experience. 2. An observation audit of current residents eating in the dining room was completed and no other residents were found to be lacking attention to personal hygiene. A member of the Mock Survey team or the charge nurse will act as the dining room monitor to ensure residents are groomed prior to the meal and throughout the dining

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F 241	<p>Continued From page 6</p> <p>nasal discharge hanging from his nasal cannula, approximately 1-1/2 " long. Additionally, the resident was observed to have copious amounts of clear oral secretions from his mouth, down his neck, and extended to his upper left chest. The MDS coordinator, who was sitting at the table, stated the resident needed to be cleaned up and was observed to take the resident to his room.</p> <p>On 7/31/15 at 9:45 AM, the DCS stated she had observed the resident to have drool on his upper left chest with a wet shirt and saw him come back with a clean shirt.</p> <p>F 250 483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>SS=F</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and medical record review, it was determined the facility lacked the involvement of the licensed social worker (LSW) and the LSW's oversight of the Social Service designee, and failed to ensure care referrals for residents in the facility, and preparing to discharge from the facility, through discharge planning. This was true for 4 of 12 sample residents (#s 1, 2, 6, & 10) and any other resident whom needed medically related social services. The deficient practice placed residents at risk when the LSW failed to provide counseling referrals and ongoing</p>	F 241	<p>process. A dining room observation tool will be used during the dining process. The dining room monitors will be trained on the use of the tool to enhance resident dignity in the dining room setting.</p> <p>3. Facility staff will be in-serviced on promoting care of the residents in a manner that will respectfully maintain and enhance each resident's dignity. "Performance Improvement tool PI-250 1 Dignity and Privacy" will be utilized to ensure residents are cared for in a dignified manner.</p> <p>4. The findings of the dining room monitor will be reported at the daily morning meeting. Variances will be trended to determine further staff training needs. The ED / designee will conduct a weekly dining room audit to ensure resident dignity is maintained during the dining experience. Results of these audits will be reported to the monthly QAPI committee to ensure substantial compliance.</p> <p>5. Date of compliance 10/9/15</p>

10/9/15

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F 250	Continued From page 7 discharge planning for Residents #1 and #2, arrange diabetic podiatry appointments for Resident #6, and ensure communication between facilities for Resident #10 regarding medications, medical equipment, and continuity of care upon the resident's transfer. Findings included: 1. Resident #1 was admitted to the facility on 6/9/15 with multiple diagnoses including metastatic lung cancer, opiate abuse disorder, Schizophrenia and psychosis. The resident's Admission MDS assessment, dated 6/14/15, coded the resident was cognitively intact with a BIMS of 15, fluctuating delirium behavior with disorganized thinking, feelings of being down, depressed and hopeless, and rejection of cares. Resident #1's Social Service progress notes documented: 6/11/15 - "...Daughter is very involved. Resident reports having cancer and has only about 6 months to live...Discharge plan will only be discussed at annual care conf. [conference]..." 6/24/15 - "...possibly moving to a group home setting, which may be a more appropriate fit for her. Resident reported she will think about it..." 6/26/15 - "...Assisted resident with faxing information to Idaho Housing..." 6/30/15 - "...refused any psychiatric treatment...Recent increase in pain medication...signed herself out this morning and instructed facility to cancel transportation for appt. [appointment]...Resident reports she has her own transportation set up...Depending on these results, resident will remain in facility, move to hospice or utilize HUD housing. Discharge plan will be discussed at each care conference..."	F 250	1. Resident # 1 no longer resides at the facility. Resident #6 had a podiatry appointment scheduled on 8/27/15 @ 2:45 pm. Resident's # 6 and # 16 were asked if they would like to notify the police regarding the missing doll and both declined. Resident # 10 chose to leave the facility AMA; therefore, no orders for medication or treatment were obtained. His medications were returned to the pharmacy per policy. 2. An audit of current resident medically-related psychosocial needs will be conducted by the facility and reviewed with the consultant LSW. Medically-related psychosocial needs include but are not limited to disruptive behaviors; professional counseling; podiatry, hearing, or ophthalmology needs; psychoactive medication use; grievances; and discharge planning. The consultant LSW will assess resident needs and make recommendations. The consultant LSW will follow up on recommendations weekly to ensure resident medically-related social services are met. The consultant LSW will document in the resident's medical record as well as provide the facility a visit log outlining recommendations and actions.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/14/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/31/2015
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F 250	Continued From page 8 7/1/15 - "...signed herself out and was out greater than 8 hours on 6/30...she spoke to ombudsman several times and made statements that made them worry about her safety...resident was seen out of facility the day before wheeling down the street, crossing without looking in front of oncoming traffic. With the above information and family input ...MD and Psych service at [local hospital's name] we developed a plan to assist...res's [resident's] safety. 911 was notified and within 10 mins [minutes] res [resident] was found..." 7/1/15 - "...PT [physical therapy] reported seeing resident digging through facility mailbox...reported seeing the mailbox overflowing so thought she'd bring some in...took the mail from resident and distributed accordingly..." 7/6/15 - "...informed resident that she needs to use her call button for assistance rather than calling the main number. Resident stated, "I will call the main number when I don't get my meds..." 7/7/15 - "...Administrator and Social Services Director presented resident with 30 day notice of discharge, due to disruptive behaviors towards other residents and also lack of following care plan and medications. Resident asked both of us to leave her room..." 7/14/15 - "...call from [group home's name] and [another group home's name]. Resident denied due to behaviors and non-compliance. Will continue assisting resident find alternate placement..." On 7/29/15 at 9:00 AM, Resident #1 was interviewed in regards to the facility assisting her with a discharge plan. Resident #1 stated the facility had issued her a discharge notice but had "sabotaged" her every step of the way in trying to	F 250	(cont) If the resident destabilizes between visits the facility will notify the consultant LSW for further assistance to stabilize the resident. 3. The ED met with the facility representative and consultant LSW to review the scope of responsibility to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. 4. ED / designee will conduct weekly audits of consultant LSW visit log and medical record documentation and interview residents to ensure the resident psychosocial needs are met. The consultant LSW will attend the facility QAPI committee at least monthly. Results of the audit will be reported to the monthly QAPI committee x 3 months to ensure substantial compliance. 5. Date of compliance 10/9/15		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 250	<p>Continued From page 9</p> <p>find herself other living arrangements. Resident #1 stated she trusted no one at the facility and so she had no one that would address her concerns.</p> <p>2.. Resident #6 was originally admitted to the facility on 7/18/14, and again on 3/17/15, with diagnoses of Alzheimer's Disease, chronic airway obstruction, and diabetes mellitus.</p> <p>a. On 7/28/15 at 9:45 AM, Resident #6 stated she felt she needed to be seen by a Podiatrist for ingrown toenails since she was a diabetic. When asked if she had spoken with the facility regarding her toenails, the resident stated she had told someone but the facility had not made her an appointment.</p> <p>On 7/31/15 at 7:22 AM, the DCS was asked if the facility had documentation following up on the recommendation for Resident #6. The DCS stated she would check, however, no further information was provided. The DCS was asked how the facility ensured diabetic residents were seen by a Podiatrist and stated the nurses were making a list.</p> <p>b. Record review of the Grievance Concerns documented a 6/26/15 concern for a hand made doll which was stolen from Resident #6's room and was reported by the resident's daughter, Random Resident #16. The concern did not mention a room number.</p> <p>On 7/29/15 at 3:00 PM, the SSD was shown the 6/26/15 Grievance Concern reported by RR #16. When asked if she had offered to file a police report, the SSD stated, "I didn't do that, no...!"</p>	F 250	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/14/2015
FORM APPROVED
OMB NO. 0938-0391

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F 250 Continued From page 10

should have asked if she wanted to file a police report, I don't know if [name of Administrator] did."

On 7/30/15 at 11:35 AM, during the Group Interview, Random Resident (RR) #16, stated she had filled out a grievance concern for a missing doll which had been stolen from her mother's room (Resident #6), and stated frustration with the way the grievance had been handled.

On 7/31/15 at 11:35 AM, RR #16 stated she would have filed a police report if the facility had offered this option, and would have felt like the facility was more concerned about the missing doll.

3. Resident #2 was admitted to the facility on 4/4/15 with diagnoses of quadriplegic C5-C7, incomplete, depression, chronic pain and neurogenic bladder and bowel.

The resident's admission MDS Assessment, dated 4/10/15, and most recent quarterly MDS Assessment, dated 6/3/15, both documented the resident was cognitively intact with a BIMS Score of 15, and had symptoms of depression.

The resident's Antidepressant Care Plan, initiated 4/4/15, documented behaviors of anger, self isolation, crying, and sarcasm as a defense mechanism and included non-pharmacological interventions to help the resident cope with her frustrations and loss of independence.

Record review of the June and July 2015 Behavior Symptom Monitoring Flow Records documented behaviors of anger, verbal abuse to staff, and kicking staff out of the room.

F 250

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/14/2016
FORM APPROVED
OMB NO. 0938-0391

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F 250	<p>Continued From page 11</p> <p>Record review did not contain evidence of a LSW involvement in the resident's plan of care or involvement in helping the resident obtain counseling.</p> <p>On 7/29/15 at 3:00 PM, the SSD stated the LSW came in one time per month and they usually went through resident charts, checked for code status, POST (Idaho Physician Orders for Scope of Treatment), discharges and other concerns. The SSD stated the LSW would leave her a list of recommendations. She stated she spoke with the LSW on the phone approximately one time per week. The SSD was asked to provide documentation of monthly visits and recommendations which the LSW had made for residents in the facility, however, no evidence of the LSW's oversight of the SSD was provided.</p> <p>On 7/30/15 at 8:45 AM, the facility provided a copy of the LSW's time sheets for the months of April, May, and June of 2015. However, there was no evidence of recommendations or oversight of the SSD made by the LSW.</p> <p>On 7/31/15 at 8:00 AM, the DCS was asked to explain Resident #2's behaviors. She stated the resident was angry and would take her frustration out on whomever was with her in her room. She stated the resident was very vocal and got angry when she was asked a question, like if she wanted to have a pillow between her legs. The resident would say, "I'll tell you if I want a pillow," but then would get angry if it wasn't offered. When asked if the resident had been offered counseling, the DCS stated it had offered, however, the resident refused to let the facility arrange for services as she wanted to be in</p>	F 250		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/14/2015
FORM APPROVED
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F 250	<p>Continued From page 12</p> <p>charge of her care. The resident told the DCS she would contact counseling services through her tribal agency. When asked if counseling services had been arranged, the DCS stated, "Not to my knowledge."</p> <p>4. Resident #10 was admitted on 1/29/15 with multiple diagnoses including difficulty in walking, muscle weakness, and depressive disorder.</p> <p>A note by the E #13 on 4/30/15 documented during a care conference with the POA of Resident #10 she had concerns about his care and was in the process of searching for a Certified Family Home in the area to transfer the resident to. It continued, "For now, resident will remain in the facility. Discharge plan will be discussed at each care conference."</p> <p>On 5/5/15 E #13 documented "Resident discharged AMA [Against Medical Advice]." No other information was included in this note.</p> <p>A corresponding note, in its entirety, by LN #8 On 5/5/15 documented, "Res [resident] had appt [appointment] with [MD #6] at 3 PM. [Transport service] here with res chair and no res. He reports he was called to pick up the WC. Contacted [MD #7's] office, receptionist reports [Resident's POA] took the resident to another facility. Res is AMA." Two more notes immediately following document the POA was called about the resident's belongings, and the POA arrived at the facility to gather his belongings.</p> <p>On 5/5/15 at 4:40 p.m., a doctor's order was</p>	F 250			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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F 250	<p>Continued From page 13</p> <p>written by LN #8 and signed by the NP, stating the resident left with the POAAMA.</p> <p>On 7/30/15 at 5:35 p.m., the Administrator was asked about the policy & procedure for medications of residents that leave AMA, and what happened with Resident #10's medications upon leaving AMA. He said usually the medications would be sent back to the pharmacy. However, he was unable to find specific procedures regarding medications of Residents that discharge AMA.</p> <p>It could not be determined that the facility was providing social services assistance to the POA, who had a goal of discharging the resident to a Certified Family Home. It could not be determined the resident had access to DME (including the wheelchair) upon the resident's transfer to the group home. It could not be determined the facility communicated with either MD #6 or #7 about the discharge or what should happen with the Resident's medications. It could not be determined the Resident's information was communicated upon discharge to ensure continuity of care.</p>	F 250		
F 253 SS-D	<p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure</p>	F 253	<ol style="list-style-type: none"> 1. Resident # 12 no longer resides at the facility. Resident # 14's refrigerator temperature log is up to date. 2. The Director of Housekeeping conducted an audit of resident refrigerators and found them to be clean, temperature log up to date and within an acceptable temperature range, and no outdated food items. 	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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F 253	<p>Continued From page 14</p> <p>temperaturas were documented for resident room refrigerators. This was true for 2 of 2 Random Residents (#s 12 & 14). This had the potential to cause foodborne illnesses and decrease the quality of life for residents who kept refrigerated food in their rooms. Findings included:</p> <ol style="list-style-type: none"> On 7/27/15 at 10:15 AM, during the initial tour, and throughout the survey week, Random Resident #12's room refrigerator was observed to have a July 2015 temperature log on the front door of her refrigerator which was blank. On 7/27/15 at 10:15 AM, during the initial tour, and throughout the survey week, Random Resident #14's room refrigerator was observed to have a July 2015 temperature log on the front door of his refrigerator which documented no temperatures had been taken for 7/1 through 7/12, 7/14 through 7/21, 7/25 or 7/26. <p>On 7/30/15 at 10:50 AM, the DCS stated the facility department heads were responsible for resident room refrigerators. When shown the temperature logs for Random Resident #s 12 & 14, the DCS stated the temperature logs were lacking and the plan was to document daily temperatures.</p>	F 253		
F 309 SS-D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p>	F 309	<ol style="list-style-type: none"> Resident # 5 was placed on comfort care August 17, 2015 related to terminal End Stage Renal Disease. Blood pressure medication and dialysis treatment were discontinued at this time. The resident was transferred to Hospice House on August 19, 2015 where he expired on August 23, 2015. 	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 309 Continued From page 15

This REQUIREMENT is not met as evidenced by:

Based on record review and staff interview, it was determined the facility failed to administer a blood pressure medication within parameters and to assess the dialysis access site per care plan for 1 of 15 sampled residents (Resident #5). This deficient practice created the potential for the resident to have complications with hypertension or delayed identification of complications with the dialysis access site. Findings included:

1. Resident #5 was re-admitted to the facility 7/14/15 with multiple diagnoses including End Stage Renal Disease, congestive heart failure, hypertension, and cardiomyopathy.

a. The 8/1/15 Physician Recapitulation Orders documented "Fludrocortisone tablet 0.1 mg. take one tablet by mouth everyday for hypertension. Hold for SBP [systolic blood pressure] > 120."

The June 2015 MAR documented 20 of 23 instances where the SBP was above 120 and Fludrocortisone was administered. Similar findings were found in July 2015 with 8 of 22 instances.

On 7/30/15 at 9:45 a.m., the DCS confirmed the medication was administered when it should have been held in these instances.

b. Resident #5's 7/14/15 MDS Admission Assessment documented he received dialysis.

The 6/8/15 Dialysis Care Plan documented interventions for the resident's dialysis site:

- F 309 2. An audit of current resident medication administration records (MAR) was conducted by the DCS and no other residents were found to have medications administered outside prescribed parameters. Additionally, there are no other residents on dialysis at this time. Residents requiring an outside (End Stage Renal Disease) ESRD facility will have services coordinated by the facility. There will be communication between the facility and the ESRD facility regarding the resident to include: location of access site; port status (capped or clamped); pain at site; sign and symptoms of infection three times a week. The Dialysis Communication form (Med-Pass Form CNS-021) will be utilized to document coordination of services.
3. Licensed nurses will be in-serviced and competency tested using Performance Tool PI 250 AJ to ensure residents are receiving medications per physician orders. Licensed nurse will be in-serviced on utilizing the Dialysis Communication form to ensure the

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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<p>F 309 Continued From page 16</p> <p>*Monitor access site each shift; *Observe site for infection, bleeding, edema; & *Notify MD/NP of any signs, symptoms and/or suspicion of infection.</p> <p>The access site was assessed 13 of 87 shifts in July 2015. However, the July 2015 Dialysis Communication Records documented 6 of 9 instances where the shunt site was not fully assessed before the resident was sent to dialysis. In these instances, various assessment items were lacking, including the location of the access site, if ports were capped or clamped, if pain was present at the site, or any problems with the site.</p> <p>On 7/30/15 at 9:45 a.m., the DCS confirmed the Dialysis Communication Record assessments were lacking. She said assessment of the site per shift are found in the nursing notes, however, no further assessments on the dialysis site could be found in the nursing notes.</p> <p>F 312 483.25(a)(3) ADL CARE PROVIDED FOR SS-E DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure showers and/or baths were consistently provided for 9 of 10 residents (#s 2-9 & 15) reviewed for ADL assistance. This deficient practice had the</p>	<p>F 309 resident's medical record reflects complete accurate information. The ED and DCS will meet with the Dialysis Center to improve the coordination of dialysis services.</p> <p>4. DCS / designee will audit MARs and Dialysis communication three time per week to ensure medications are administered according to prescribed parameters and coordination of dialysis services is documented to include: location of access site; port status (capped or clamped); pain at site; sign and symptoms of infection. Results of the audit will be reported to the monthly QAPI committee x 3 months to ensure substantial compliance.</p> <p>F 312 5. Date of compliance 10/9/15</p> <p style="text-align: right;"><i>10/9/15</i> <i>C. J. [Signature]</i></p>
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 312	<p>Continued From page 17</p> <p>potential for more than minimal harm If residents experienced dental caries, gingivitis, infections of the mouth and teeth from lack of oral care; and rashes, skin issues and/or unpleasant odors due to not being bathed regularly. Findings included:</p> <ol style="list-style-type: none"> 1. On 7/28/15 at 1:00 PM, a Group Interview with 9 residents was conducted. Four residents stated they were having problems with getting showered. One resident stated she hadn't had a shower in 2 weeks. Another resident stated she had gone 26 days without a shower. Another resident stated she only got three showers in 30 days and she asked and asked. 2. Resident #7 was admitted to the facility on 3/5/15 with multiple diagnoses including cerebrovascular accident (CVA), dementia, expressive aphasia, and apraxia. <p>The resident's quarterly MDS assessment, dated 3/11/15, documented extensive assist of 1 staff for dressing, personal hygiene, and bathing.</p> <p>The facility's bathing schedule documented Resident #7 was scheduled for baths/showers on Wednesdays and Saturdays.</p> <p>The bathing record for Resident #7 documented: *May 2015 - The resident had 1 shower the week of 5/1/15-5/7/15, 1 shower the week of 5/8/15-5/14/15, then the resident did not bathe for 14 days from 5/13/15 until 5/27/15. There was no evidence the resident was offered or had refused any showers in May. *June 2015 - The resident had 1 shower on 6/15/15. The resident did not bathe for 19 days from 5/27/15 until 6/15/15. There was no evidence the resident was offered or had refused</p>	F 312	<ol style="list-style-type: none"> 1. Resident #'s 2-9 & 15 were interviewed to determine baths / showers preferences. Their bath/shower schedules have been updated to reflect personal preference. 2. Current residents will be interviewed to determine bath/shower preferences and bath / shower schedules adjusted to reflect resident preference. Resident preference will be obtained on admission, quarterly and upon request. The C.N.A will document resident bath / shower on the SKIN CARE ALERT sheet and the residents ADL record. The SKIN ALERT SHEET is given to the licensed nurse for review and follow-up as indicated (i.e. skin conditions, refusals) Resident ADL sheets will be reviewed daily by the Mock Survey team members and reported at morning stand up meeting. Ongoing refusals will be further evaluated for appropriate action by the Interdisciplinary Team (IDT), which will include the consultant LSW.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/14/2015
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F 312

Continued From page 18
any showers in June.
*July 2015 - The resident refused a shower on 7/4/15 and 7/11/15. The resident did not bathe for 37 days from 6/15/15 until 7/22/15. There was no evidence the resident after the refusal of a shower had been reapproached and offered another one.

3. Resident #8 was readmitted to the facility on 9/8/09 with multiple diagnoses including dementtia, schizophrenia, dyskinesia, and macular degeneration.

The resident's annual MDS assessment, dated 7/15/15, documented extensive assist of 1 staff for bathing..

The facility's bathing schedule documented Resident #8 was scheduled for baths/showers on Mondays and Thursdays.

The bathing record for Resident #8 documented:
*May 2015 - The resident had 1 shower the week of 5/8/15-5/14/15, and then did not bathe for 42 days from 5/14/15 until 6/25/15. The resident had refused a shower on 5/18/15, but there was no evidence the resident was offered or had refused any showers from 5/18/15 through 6/25/15.
*June 2015 - The resident had only 1 shower on 6/25/15 for the month of June. There was no evidence the resident was offered or had refused any showers in June.
*July 2015 - The resident had 1 shower the week of 7/1/15-7/7/15.

On 7/28/15 at 3:20 PM, CNA #5 was interviewed about the care of the residents. The CNA said she was working a double shift today, since the facility was short staffed. CNA #5 stated the

F 312

3. Nursing staff will be in-serviced on obtaining resident preference for bath / showers on admission, quarterly, and upon request, accurate and complete documentation on ADL records as well as the use of the SKIN CARE ALERT sheets; and protocol when a resident declines to bathe as outlined above in #2.
4. DCS / designee will audit resident preference and ADL documentation weekly to ensure baths / showers are given per resident preference and documented. ED / designee will audit action taken by the IDT when documentation indicates on-going resident refusals. The ED / designee will complete Performance Improvement tool PI250 W Free Choice & Rights monthly x 3 months, then quarterly. Results of the audits will be reported to the monthly QAPI committee x 3 months to ensure substantial compliance.
5. Date of compliance 10/9/15

10/9/15

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F 312	<p>Continued From page 19</p> <p>shower schedule had 3 to 4 residents per day, on each of the day and evening shifts, and the floor CNAs were responsible for the baths/showers. The CNA said she had finished 2 showers today with 1 resident being a 2 person assist and felt at times "rushed" and "very busy." The CNA said she was dedicated to doing the best job possible, but "hard to do a good job when we don't have enough help."</p> <p>4. Resident #4 was admitted to the facility on 3/29/15 with multiple diagnoses including dementia, osteoarthritis, and generalized weakness.</p> <p>The resident's quarterly MDS assessment, dated 6/30/15, documented: the resident required total assist of 1 staff for bathing.</p> <p>The facility's bathing schedule documented Resident #4 was scheduled for baths/showers on Mondays and Thursdays.</p> <p>The bathing record for Resident #4 documented: *May 2015 - The resident did not bathe for 22 days from 5/21/15 until 6/12/15. There was no evidence the resident was offered or had refused any showers from 5/21/15 through 6/12/15. *June 2015 - The resident did not have a shower for 13 days from 6/12/15 until 6/25/15. There was no evidence the resident was offered any additional showers than 6/12/15, 6/25/15, and 6/29/15 or had refused any showers for the month of June. *July 2015 - The resident did not have a shower for 8 days from 7/20/15 through 7/29/15. There was no evidence the resident was offered or had refused any showers for July.</p>	F 312		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 312	<p>Continued From page 20</p> <p>On 7/30/15 at 4:08 PM, the DCS was interviewed along with the RDCS in regards to the lack of bathing of the residents. The DCS and RDCS acknowledged there was an issue of the consistent bathing of the residents. The DCS and RDCS said they had become aware of the bathing concerns in June and the QA committee was involved in working on the root cause and had developed a plan to address. The RDCS stated, the bathing issue was a "work in progress."</p> <p>5. Resident #3 was readmitted from the hospital on 4/10/15 with multiple diagnoses including bipolar disorder and the installation of a PEG tube.</p> <p>The resident's significant change MDS assessment, dated 5/11/15, documented total assist of 2 staff for and bathing.</p> <p>The facility's bathing schedule documented Resident #3 was scheduled for baths/showers on Wednesdays and Saturdays.</p> <p>The bathing record for Resident #3 documented: *May 2015 - The resident had a shower on 5/13/15. The resident had refused a shower on 5/6/15, 5/20/15 and 5/27/15. The resident did not bathe for 13 days from 5/1/15 until 5/13/15 and did not bathe for 48 days from 5/13/15 until 7/1/15. There was no evidence the resident was reapproached when she had refused on 5/6/15, 5/20/15, and 5/27/15 or offered to be bathed on another day during May. *June 2015 - The resident did not have a shower for the whole month of June. There was no evidence the resident had refused or offered any showers during June.</p>	F 312	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 312 Continued From page 21
*May 2015 - The resident had 1 shower on 7/23/15, the 4th week of July and there was no evidence of the resident being offered to bathe or a refusal for 6 days from 7/23/15 through 7/29/15.

On 7/30/15 at 9:45 AM, the DCS and RDCS were interviewed regarding the residents lack of bathing. The DCS and RDCS acknowledged there was a concern the residents were not being bathed and the facility had already identified there was a problem and had implemented steps to correct the problem.

There were similar findings for Resident #s 2, 5, 6, 9, and 15 in regards to the lack of bathing.

F 315 483.25(d) NO CATHETER, PREVENT UTI, SS=G RESTORE BLADDER

Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

This REQUIREMENT is not met as evidenced by:

Based on record review, and resident and staff interviews, it was determined the facility failed to ensure a resident with a suprapubic catheter received care and services to protect against catheter-related complications. This was true for 1 of 1 (#2) sampled resident reviewed for urinary

F 312

F-315

1. Resident #2 had her suprapubic catheter surgically replaced by urologist on 7/1/15. The nursing staff provides routine catheter care per physician orders

2. An audit of current residents was conducted and there are no other residents with a suprapubic catheter.

3. Nursing staff will be re-educated on care of suprapubic catheters. Resident #2's suprapubic catheter will be changed by the urologist per order. Performance Improvement tool PI 250 E Catheter Use Review and suprapubic competency tool will be utilized to evaluate staff knowledge and performance in caring for residents with a urinary catheter. Licensed nurses will report changes in function of the urinary catheter such as leakage, appearance of urine, complaints of pain to the physician as indicated. The attending physician will be notified of consultant physician appointment dates and any cancellation of scheduled appointments. Notification will be documented in the medical record.

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 315

Continued From page 22

catheters. Resident #2 was harmed when her suprapubic catheter was incorrectly inserted and she ultimately required surgical replacement. Findings included:

Resident #2 was admitted to the facility on 4/4/15 with diagnoses that included neurogenic bladder.

The resident's admission MDS Assessment, dated 4/10/15, and most recent quarterly MDS Assessment, dated 6/3/15, both documented the resident was cognitively intact with a BIMS Score of 15, had an indwelling catheter and required total assistance of 2 people for toileting.

Resident #2's Urinary Catheterization Care Plan, implemented 4/4/15, documented the resident had a suprapubic catheter.

The June 2015 recapitulated Physician's Orders documented:

- *4/4/15 - Suprapubic catheter care every shift, discontinued.
- *4/8/15 - Change suprapubic catheter on the 17th of each month on night shift, crossed out and "foley catheter" handwritten in place of "Suprapubic."
- *4/16/15 - Irrigate catheter as needed, discontinued.

The 4/8/15 order to change the resident's foley catheter on the 17th of each month during night shift was included on the recapitulated July 2015 Physician's Orders.

- *4/5 and 4/6 Progress Notes (PNs) - Suprapubic (SP) catheter was intact, patent and draining amber urine;
- *4/7 (PN) - SP catheter intact;
- *4/8 (PN) - Orders received to change SP

F 315

4. DCS / designee will assess residents with a urinary catheter weekly to ensure the catheter is functioning properly and staff is competent in the care of the catheter. Results of the audit will be reported to the monthly QAPI committee x 3 months to ensure substantial compliance.
5. Date of compliance 10/9/15

10/9/15

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F 315	<p>Continued From page 23</p> <p>catheter.</p> <p>*4/11 (PN) - SP catheter patent and draining amber urine;</p> <p>*No documentation for 4/12 to 4/15 regarding the resident's SP catheter;</p> <p>*4/16 N.O. (New Order) - Irrigate foley PRN;</p> <p>*4/17 (PN) - SP catheter changed due to resident report of leakage, monitor for leakage;</p> <p>*4/19 (PN) - Resident reported increased urinary leakage and voiding through urethra. No urine output noted in the catheter bag for two days; assess need for SP replacement;</p> <p>*4/20 (PN) - New order for nonemergent transport to ED for evaluation of SP catheter;</p> <p>*4/20 Emergency Department Note - Complaint of catheter investigated, found to irrigate easily, discharged back to the facility;</p> <p>*4/22 Physician's Progress Note - Requires follow-up with urology for poor SP drainage;</p> <p>*4/25 (PN) - Resident reported ongoing leakage of urine around SP insertion site, dressing was saturated. Continued to void intermittently from urethra and SP catheter insertion site. Resident reported frustration over continuing SP catheter concerns, scheduled for urologist appointment;</p> <p>*4/27 (PN) - SP site dressing wet with urine, continues to have urine through urethra, no urine noted in catheter bag, no redness around SP site, bladder non-distended;</p> <p>*4/29 (PN) - Appointment canceled and rescheduled for 5/7/15, no reason given;</p> <p>*5/3 (PN) - No noted urine output in foley bag. No drainage or redness noted at site. Urologist appointment rescheduled for 5/7. MD notified MD - wants resident urology appointment as soon as possible, phone call to office and message left to schedule appointment earlier in the week if possible;</p> <p>*5/7 (PN) - No urine noted in foley bag. SP</p>	F 315	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 315	<p>Continued From page 24</p> <p>catheter intact, appeared to be voiding via urethra. Adult brief changed every 2 hours, urology appointment at 11:00 AM;</p> <p>*5/7 (PN) - Returned from urology office at 11:15 AM, unable to examine resident as paperwork not completed. Facility RN completed paperwork to send back to the urology office with the resident. At 1:45 PM the resident was transported back to the urology office with completed paperwork;</p> <p>*5/7 Urology Report - "They changed her suprapubic tube a few days ago but it hasn't drained since. The suprapubic tube was first placed 2 months ago. She has been voiding per urethra and incontinence since then... The suprapubic tube was removed. It was not in far enough. I placed the flexible cystoscope down the tract, however, I was unable to negotiate this into the bladder. I could not pass a wire into the bladder either." The assessment documented, "Dislodged suprapubic tube, unfortunately the tract has healed up. She will need to have the suprapubic tube replaced in the operating room."</p> <p>*7/1 Operative Report - SP catheter placed under direction of cystoscopy by urologist;</p> <p>*7/2 (PN) - Resident returned from local hospital status post SP cath placement. Resident complained of pain at cath insertion site, medication given, SP cath draining bloody urine. The resident's urologist notified and new antibiotic order received.;</p> <p>On 7/30/15 at 2:15 PM, Resident #2 stated the physician told her the SP catheter had not been inserted all the way into the bladder, which caused urine elimination through the urethra.</p> <p>The resident was harmed when the facility failed to correctly insert a SP catheter, which led to leakage of urine around the SP insertion site and</p>	F 315	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 322	<p>Continued From page 26</p> <p>for complications with the PEG tube when multiple medications were administered without flushing in between each medication, and one oral-only medication was administered through the PEG tube. Findings included:</p> <p>Resident #3 was readmitted from the hospital on 4/10/15 with multiple diagnoses including bipolar disorder and the installation of a PEG tube.</p> <p>The July 2015 Physician Recapitulation Orders documented the instructions for tube feeding, "Flush PEG with 30 mL of water before and after each medication" and "may give meds oral or per tube."</p> <p>It also documented these morning medications: "Culturella, give 1 orally 3 times daily (supplement) do not put in tube; Amlodipine Besylate 5 mg tab...give 1 tablet via tube/orally once a day; Metoprolol Tartrate 50 mg tab, give 1 tablet via tube 2 times a day; Clonazepam 1 mg tablet...give 1 tablet orally every 12 hours...; ASA [aspirin] 81 mg, give per PEG tube or orally daily; Senna 8.8 mg/5 mL syrup, give 10 mL orally 2 times a day; Vitamin D2 2000 IU, give per PEG tube or orally every day; Multivitamin with mineral, give daily per PEG tube or orally; Cranberry concentrate, give 30 mL in 6-8 oz of fluid 2 times a day; and, Miralax powder, give 17 grams via tube once a day mixed in liquid."</p> <p>The July 2015 MAR documented the start of Bactrim suspension 20 mL per mouth or tube BID</p>	F 322	<p>4. DCS / designee will conduct weekly observation audits of nurses administering medication through a PEG tube. Results of the audit will be reported to the monthly QAPI committee x 3 months to ensure substantial compliance.</p> <p>5. Date of compliance 10/9/15</p> <p style="text-align: right;">10/9/15</p>

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F 322	<p>Continued From page 27</p> <p>(two times a day) for 7 days. It also documented the start of D-Mannose powder 1 tsp every 3 hours on 7/6/15. Note: The MAR did not document when the Bactrim order was initiated, and these orders did not appear on the July Physician Recapitulation Orders. See F514 for documentation issues.</p> <p>On 7/28/15 at 7:30 a.m., LN #1 was observed entering Resident #3's room to administer medications. After asking the resident if she wanted her medications by mouth or through the tube, the resident wanted her to administer them through the tube (medication was already crushed in the cup). The LN put the Bactrim suspension through the tube, flushed with water, added the small cup of crushed medication through the tube (LN stated this was "Probiotic and heart medicine") flushed the tube, and finally added "the cranberry" into the tube.</p> <p>On 7/28/15 at 10:20 a.m., LN #1 said after the antibiotic was administered, Culturelle, Amlodipine, Metoprolol, Clonazepam, Aspirin, Senna, Vitamin D, and Multivitamin with minerals were crushed and administered together (without flushing between medications) through the PEG tube during the morning medication administration. She also confirmed cranberry concentrate, D-Mannose powder, and Miralax was administered together without flushing in between.</p> <p>Ten medications were administered together, without flushing 30 mL of water in between each medication per order. The Culturelle was administered through the PEG tube when orders stated this medication should not be put in the tube.</p>	F 322		

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F 323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, it was determined the facility failed to ensure side rails were assessed as safe for resident use. This was true for 1 of 6 (#2) sampled residents. This had the potential for more than minimal harm should residents experience accidental hazards due to side rail entrapment. Findings included:</p> <p>Resident #2 was admitted to the facility on-4/4/15 with diagnoses of quadriplegic C5-C7, incomplete, depression, chronic pain and neurogenic bladder and bowel.</p> <p>The resident's admission MDS Assessment, dated 4/10/15, and most recent quarterly MDS Assessment, dated 6/3/15, both documented the resident was cognitively intact with a BIMS Score of 15, and needed total assistance with 2+ staff for bed mobility.</p> <p>The Self-Care Deficit Plan, dated 4/4/15, documented an intervention the resident needed extensive to total assist of one to two staff for bed mobility and positioning. The care plan documented an undated handwritten entry</p>	F 323	<ol style="list-style-type: none"> Resident #2 uses bilateral ½ side rails as enablers to assist with bed mobility. Her side rail / restraint assessments have been updated to include "safe for resident use" by the IDT, which includes therapy services. An audit of current resident's mobility status revealed no other side rails in use. Transfer mobility status is assessed on admission, quarterly, and with significant change in condition. When a side rail is indicated, the DCS / physical or occupational therapy in conjunction with the IDT will determine safe use and document such on the side rail / restraint assessments. The IDT will be in-serviced by the therapy department on how to assess side rail safety. DCS / designee will audit resident transfer mobility status weekly to ensure residents are safe when a side rail is indicated. Results of the audit will be reported to the monthly QAPI committee to ensure substantial compliance. Date of compliance 10/9/15 	10/9/15	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/14/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/31/2015
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F 323	Continued From page 29 indicating the resident could use a trapeze, and 1/2 side rails for positioning. On 7/2/15 at 2:15 PM, and throughout the survey week, Resident #2's air bed was observed to have bilateral 1/2 side rails in the up position. Record reviewed documented a 7/9/15 Physical Restraint Evaluation for side rails as enablers. There was no documentation the side rails had been assessed to be safe for Resident #2's use. On 7/31/15 at 08:00 AM, the DCS was asked for a side rail safety assessment. She stated she would check with PT [Physical Therapy] as they were involved in her assessment. However, no further documentation was provided by the facility.	F 323			
F 328 SS=D	433.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to	F 328	1. Resident # 13's oxygen tank was changed when observed to be empty and resulted in no adverse outcome to the resident. The orders for oxygen have been clarified to include the route of administration per "nasal cannula". 2. Current residents using oxygen tanks were assessed and no other tanks were found to be empty. An audit of oxygen orders will be completed and orders clarified to include route of administration as indicated. The Mock Survey team will observe residents using oxygen to ensure tanks are not empty and report their findings at the daily stand up / stand down meetings.		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 328	<p>Continued From page 30</p> <p>ensure residents who use oxygen were provided with oxygen therapy per physician's orders. This was true for Random Resident (#13), observed for oxygen during the dining experience. This deficient practice created the risk of respiratory distress due to empty oxygen tanks. Findings include:</p> <p>Resident #13 was admitted to the facility on 6/27/01, and readmitted on 1/20/13, with multiple diagnoses which include bacterial pneumonia and COPD (Chronic Obstructive Pulmonary Disorder.)</p> <p>The resident's July 2015 Physician's Orders (Recapitulation Orders) documented a 2/1/13 order, "Oxygen at 2 L [Liters] continuously." The order did not include the route of administration.</p> <p>The July 2015 Respiratory Flow Sheet documented the facility monitored oxygen at 2 L continuously for all shifts.</p> <p>On 7/30/15 at 12:25 PM, Resident #13 was observed in the dining room with a portable O2 (oxygen) tank set at 2 L. A nasal cannula was present. The tank was observed to be empty. The DCS observed the resident's empty O2 tank, and asked the MDS coordinator to replace the empty O2 tank.</p>	F 328	<ol style="list-style-type: none"> 3. Nursing staff will be in-serviced to check oxygen tanks at 2-hour intervals to ensure tanks are replaced prior to becoming empty for residents using oxygen. Physician orders will include route of administration. The Mock Survey team member assigned to the resident will check the oxygen tank during daily rounds to ensure tanks are replaced prior to becoming empty. 4. DCS / designee will conduct weekly audits of residents using oxygen to ensure orders contain route of administration and tanks are replaced prior to becoming empty. Results of the audit will be reported to the monthly QAPI committee x 3 months to ensure substantial compliance. 5. Date of compliance 10/9/15 	10/9/15
F 353 SS=F	<p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS</p> <p>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p>	F 353		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 353	<p>Continued From page 31</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>This REQUIREMENT is not met as evidenced by: Based on Resident Grievances, Resident Individual and Group interviews, Staff interviews, and facility staffing records, it was determined the facility failed to ensure there was adequate staffing to ensure call lights were answered timely and provide for the needs and well-being of most residents. This affected 9 out of 16 sampled residents (#s 2-9 & 15) and 7 of 9 residents who attended the group interview and any resident who lived in the facility and required staff assistance with their ADLs. This failure created the risk for residents in the facility to have unmet needs. Findings included:</p> <p>On 7/29/15 the MDS Coordinator provided a list of 8 residents who needed the assistance of 2 staff for ADL's (Activities of Daily Living).</p> <p>a. Grievance Concern Forms for April 2015 through June 2015 were reviewed and included</p>	F 353	<ol style="list-style-type: none"> The facility is actively recruiting qualified care givers to meet the needs of the residents. Positions are posted on Internet employment sites such as Indeed, Career Builder, Craig's list, and local news paper. The facility voluntarily elected to stop accepting admissions. The facility will continue to not admit until sufficient staff are hired, trained, and the facility is in substantial compliance. The facility is utilizing supplemental staffing agency and will continue to do so until sufficient staff are hired and trained to meet the needs of the residents. The facility administration will monitor staffing daily and resident concerns/grievances to ensure adequate staff available to meet the needs of the residents. Wages have been adjusted and are competitive with the current market. The licensed charge nurse will be in-serviced to notify the administration promptly when scheduled staff is not present. The facility administration will work to remedy the scheduling discrepancy. 	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 353	<p>Continued From page 32</p> <p>the following documentation:</p> <p>*4/26/15 Resident reported to staff, "...are you going to help the other girls so I can get a shower today." The staff member asked what the resident meant and the resident stated she had asked for a shower yesterday but was told she couldn't get any help, so she couldn't give the resident a shower. Action taken documented the shower was given and the resident would ask for showers when ready.</p> <p>*4/27/15 Resident reported to Administrator she was not getting showers and had long call light wait times. Action taken documented education was given to staff on call light response. No action was documented regarding the resident's shower concern.</p> <p>*5/19/15 Resident reported all personal cares were being omitted except when two CNA's were assigned to her. Action taken documented the SSD spoke with the resident who reported the staff only forgot once and the resident was happy with her care. Encouraged resident to report any further concerns.</p> <p>b. On 7/28/15 at 1:00 PM, a Group Interview with 9 residents was conducted. During that time, 8 residents stated they had problems with call light response times. Four residents stated staff will come in, turn off the light and say they will be right back but then don't come back. One resident stated she had waited for "1-1/2 hours" for assistance and another resident stated she had waited for "2 hours." One resident stated, "Sometimes the problem is understaffing, we need more staffing." Another resident stated, "We don't have enough aides here." Another resident stated, "The worse time is change of shift." Another resident stated, "One-half hour before change of shift, lights don't get answered. Staff</p>	F 353	<p>4. ED / designee will continue to audit the daily schedule and resident concerns/grievances to ensure there is adequate staff to meet the needs of the residents. The results of the audit will be reported weekly to the Regional team and monthly to the facility QAPI committee.</p> <p>5. Date of compliance 10/9/15</p>	10/9/15

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 353	<p>Continued From page 33</p> <p>will give excuses like they have paperwork to do, charting or they are short-handed. We don't want to get anyone in trouble, we just want to get the help we need. There are good aides here."</p> <p>c. The Three-Week Nursing Schedule was reviewed, and documented the following evening shift CNA hours, which indicated two CNA's worked:</p> <ul style="list-style-type: none"> *7/6, 15 hours of CNA coverage, Census of 32 Residents; *7/9, 15 hours, 30 Residents; *7/21, 19 hours, 28 Residents. <p>On 7/29/15 at 9:40 PM, CNA #9 stated there should be 3 CNA's on evening shift but typically they had 2 CNA's, however, tonight they had four CNA's. She stated the CNA's try to do the best they can. If day shift is unable to get showers done, then they will try to give showers, but if they are short staffed, they don't always get done.</p> <p>On 7/29/15 at 9:55 PM, CNA #10 stated evening shift was short staffed, with 2 CNA's, at least 50 percent of the time, and the facility needed to hire more CNA staff. She stated it was hard to get showers done, and call lights answered while both staff are doing two person transfers. CNA #10 stated it was nice when they had three CNA's working.</p> <p>d. The Three-Week Nursing Schedule was reviewed, and documented the following night shift CNA hours, which indicated 1 to 1-1/2 CNA's worked :</p> <ul style="list-style-type: none"> *7/5, 7.5 hours of CNA coverage, Census of 32 Residents *7/10, 11.5 hours, 20 Residents *7/11, 11.5 hours, 30 Residents 	F 353		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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F 353	Continued From page 34 *7/12, 7.5 hours, 30 Residents *7/15, 7.5 hours, 29 Residents *7/16, 11.25 hours, 29 Residents *7/17, 7.5 hours, 29 Residents *7/18, 11.25 hours, 29 Residents *7/23, 11.5 hours, 28 Residents *7/25, 11.5 hours, 28 Residents On 7/29/15 at 10:25 PM, CNA #11 stated she worked 1-2 times a week, as the only CNA on night shift, for the last three weeks. She stated they had been short staffed since July. She stated if showers didn't get done on the evening shift, then they don't get done. She stated the facility needed to hire a third aide for graveyard shift, and there needed to be three CNA's. Please refer to F-312 for details regarding showers. On 7/31/15 at 8:55 AM, the DCS was shown the Three-Week Nursing Schedule and stated adequate staffing was an area she was working on. She stated the facility had posted positions on multiple Internet employment sites such as Indeed and Career Builder. The RDCS stated the facility had strategically held admissions to zero since 7/18 and the facility had offered sign on and referral bonuses.	F 353			
F 490 SS=D	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	F 490		F - 490 1. The facility has maintained an interim Administrator in place while the Corporate Recruiter searched for qualified individuals to interview for the Administrator position. The Regional team then went through the interview process to choose the best individual to fill the administrator position. The traveling Regional Administrator will provide orientation for the new Administrator regarding policy and procedure that will include the comprehensive Quality Assurance Performance Improvement Program as well as ongoing support and mentorship.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 490 Continued From page 35

This REQUIREMENT is not met as evidenced by:
Based on resident interviews, group interview, staff interviews, review of grievances, and medical record review, it was determined the management team failed to administer resources effectively and efficiently to prevent systematic problems for 11 of 12 sampled residents (#s 1-10 & 12) and 4 random residents (#s 13-16), with the potential to affect all residents in the facility. This failure resulted in the management team providing insufficient direction and control necessary to ensure residents' Quality of Life and Quality of Care needs were being met. Findings included:

The facility failed to provide sufficient implementation, monitoring, evaluation and continued oversight to maintain regulatory compliance in the following areas:

A. Refer to F241 - The facility failed to ensure residents were treated with dignity and respect when a resident was observed during a meal in the dining room with nasal discharge and copious amounts of mucus discharge from his mouth.

B. Refer to F250 - The facility failed to ensure a licensed social worker was involved with residents who needed counseling, instrumental with discharge planning for residents, and provided the Social Service oversight.

C. Refer to F309 - The facility failed to ensure administration of a blood pressure medication was within the defined parameters and the assessment of a dialysis access site was performed.

F 490

2. Current residents have the potential to be affected when management team members change. The District Team will assign Regional staff as interim, in open positions, to sustain systems until permanent management members are recruited, hired, trained, and follow up on a continuous basis. Facility administration will be available to meet with the resident council president to ensure resident concerns are addressed promptly and residents are satisfied with resolutions.
3. Facility will conduct bi-weekly resident council meetings to discuss care and service issues, and treatment of residents that will enhance dignity and respect. Facility staff will receive continuing education based on resident comments and suggestions.
4. The facility has developed a plan of correction that has systemic changes as well as audits and monitoring by various departments to ensure compliance. These findings will be reviewed by the monthly QAPI committee. The Regional Team will provide monitoring and oversight to ensure compliance is maintained and findings will be reported to the District Team.
5. Date of compliance 10/9/15 *CAF 10/16/15*

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 490 Continued From page 36

D. Refer to F312 - The facility failed to ensure residents were bathed consistently and provided oral care.

E. Refer to F315 - The facility failed to ensure a resident had a urinary catheter inserted correctly which resulted in the resident having surgery.

F. Refer to F322 - The facility failed to ensure a resident with a PEG tube received the care and services to protect against complications of medications improperly administered via the PEG tube.

G. Refer to F328 - This facility failed to provide residents oxygen needs when a resident's oxygen canister was found to be empty.

H. Refer to F353 - The facility failed to provide sufficient staff to provide for the quality of care and quality of life needs of the residents.

F 514 483.75(l)(1) RES
SS-E RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

F 490

F-514 1. Resident # 1 no longer resides at the facility. The Licensed Nurse who failed to correctly document the administration of prn narcotic medication was re-educated. No adverse outcome occurred as a result of this documentation error. The Licensed Nurse who completed the July recapitulation orders for residents # 4 and #8 is no longer employed by the facility. The nursing assistant staff responsible for ADL documentation for residents # 4, #7, and #8 were re-educated on the acceptable practice for record correction that will include date, initial, and reason for correction. Licensed Nurses responsible for incomplete documentation for residents #2, 3, 5, and 6 were re-educated on record completion to include signature, date, time on physician orders, MARs, and record corrections.

F 514

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 514	<p>Continued From page 37</p> <p>This REQUIREMENT Is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to maintain clinical records for each resident in accordance with accepted professional standards and practices to ensure the records were complete and accurate. This was true for 8 of 9 sample residents (#s 1, 2, 3, 4, 5, 6, 7, & 8). This deficient practice created the potential for medical decisions to be based on incomplete or inaccurate information which increased the risk for complications due to inappropriate care or interventions. Findings included:</p> <p>The facility's Policies and Procedures on Physician Orders, dated 11/30/14, documented: "...A Clinical Nurse shall transcribe and review all physician orders in order to effect their implementation...attending physician shall review and confirm the orders. The nurse shall document the date, time, physician's name and that the orders were confirmed on the order form: I.e. [example] 12/01/98 11:00 AM [Physician];[LN]...Routine Orders: A Clinical Nurse may accept a telephone order...order sheet shall be signed T.O.: [telephone order]...The order must then be transcribed to all appropriate areas (MAR, TAR, etc.) The nurse shall sign off the orders upon completion or verification of transcription as follows: Noted [LN], 12/01/98 11:45 AM..."</p> <p>1. Resident #1 was admitted to the facility on 6/9/15 with multiple diagnoses including metastatic lung cancer, opiate abuse disorder, Schizophrenia and psychosis.</p>	F 514	<p>2. An audit of current resident physician orders including transcription to MAR and TAR will be conducted to verify a complete and accurate medical record. Physician orders will be reviewed at the daily clinical meeting to ensure proper transcription. ADL flow records will be audited daily to ensure documentation is accurate and error correction meets professional standards of practice.</p> <p>3. The nursing staff will be in-serviced and competency tested on proper documentation in the medical record that will meet professional standards of practice: error correction will include signature, date, time and reason for correction; physician orders and transcription MAR / TAR will include signature, date, and time; orders discontinued will include signature, date, and time.</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 514	<p>Continued From page 38</p> <p>The resident's July 2015 MAR documented 2 orders for Oxycodone 5 mg. One Physician's Order was scheduled for every 4 hours and the other Physician's Order was a PRN order for every 4 hours. The orders were documented: "Oxycodone 5 mg tab [tablet] 1 PO [by mouth] Q [every] 4 PRN Breakthrough Pain...7-10-15." "Oxycodone 5 mg 1 tab every 4 hours X [times] 30 days." The date of the Physician's order was not documented on the MAR.</p> <p>The LN's initials were documented on the Oxycodone 5 mg 1 tab every 4 hours on 7/30/15 for the scheduled times of 6:00 AM, 10:00 AM, 2:00 PM, and 6:00 PM. The LN's initials were documented to signify the administration of 1 tablet of Oxycodone 5 mg at those times. The resident's Oxycodone 5 mg tab 1 PO Q 4 PRN did not contain any LN initials to signify the PRN dose had been administered on 7/30/15.</p> <p>Resident #1's Narcotic Sign Out Sheet for the Oxycodone 5 mg with the directions of 1 tab Q 4 hours X 30 days documented the date of 7/30/15 at 10 AM, 2 PM, and 6 PM with the LN's initials, but the dose of 2 tablets being administered instead of just the 1 tablet as ordered by the physician.</p> <p>On 7/30/15 at 7:10 PM, the DCS was interviewed regarding the discrepancy on Resident #1's 7/2015 MAR for the scheduled Oxycodone and the resident's Narcotic Sign Out Sheet. The DCS said it appeared the LN had failed to chart the Oxycodone PRN dose had been administered at 10 AM, 2 PM, and 6 PM.</p> <p>2. Resident #4 was admitted to the facility on 3/29/15 with multiple diagnoses including</p>	F 514	<p>4. DCS / designee will audit physician orders including transcription to MAR/TAR at daily clinical meetings and ADL documentation weekly to ensure documentation meets professional standards of practice. Staff will be re-educated and competency tested if documentation does not meet professional standards of practice. Results of the audit will be reported to the monthly QAPI committee x 3 months to ensure substantial compliance.</p> <p>5. Date of compliance 10/9/15</p>	10/9/15

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/14/2015
FORM APPROVED
OMB NO. 0938-0391

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F 514	<p>Continued From page 39</p> <p>dementia, osteoarthritis, and generalized weakness.</p> <p>The resident's July 2015 recapitulation Physician's Orders documented: **5/22/15...Zinc Oxide 20% Ointment: Apply (BID/ [Twice a day] 2 X [times] day) topically to right buttock as needed until resolved..." The handwritten words of "BID/2Xday" were added but there were no staff initials or a date to reflect when the correction was made. **5/22/15...Zinc Oxide 20% Ointment apply topically to right buttock 2 times a day." The order had been lined out with a pen and the words "Repeat" are handwritten at the end of the order. The lined out order does not have a date nor the LN's initials to document who made the correction and the date of the correction.</p> <p>Resident #4's ADL Bathing Record documented: 7/2015 - The bathing section has the 3 shifts (night, day & evening) for the staff to document a "SH" to signify the resident had a shower and they document with a "8/8" to signify the ADL support and the activity of bathing did not occur or family and/or non-facility staff provided care 100% of the time. On 7/2/15, 7/6/15, and 7/9/15 the record documented heavier handwritten letters of "SH" over the top of the underlying "8/8". There are no initials and dates to verify who, why, and when the changes had been made. This is not consistent with acceptable clinical practice for record correction.</p> <p>3. Resident #8 was readmitted to the facility on 9/8/09 with multiple diagnoses including dementia, schizophrenia, dyskinesia, and macular degeneration.</p>	F 514	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 514	<p>Continued From page 40</p> <p>The resident's July 2015 recapitulation Physician's Orders documented: "Wanderguard for safety-check placement every shift. Wanderguard check function daily." There was no date nor a nurse's initials to document who made the correction or the date of implementation.</p> <p>Resident #8's ADL Bathing Record documented: 7/2015 - The bathing section has the 3 shifts (night, day & evening) for the staff to document a "SH" to signify the resident had a shower and they document with a "8/8" to signify the ADL support and the activity of bathing did not occur or family and/or non-facility staff provided care 100% of the time. On 7/6/15, 7/9/15, 7/13/15, 7/16/15, 7/20/15, and 7/26/15 the record documented heavier handwritten letters of "SH" over the top of the underlying "8/8". There are no initials and dates to verify who, why, and when the change had been made.</p> <p>4. Resident #7 was admitted to the facility on 3/5/15 with multiple diagnoses including cerebrovascular accident (CVA), dementia, expressive aphasia, and apraxia.</p> <p>Resident #7's ADL Bathing Record documented: 7/2015 - The bathing section has the 3 shifts (night, day & evening) for the staff to document a "SH" to signify the resident had a shower and they document with a "8/8" to signify the ADL support and the activity of bathing did not occur or family and/or non-facility staff provided care 100% of the time. On 7/11/15, 7/22/15, and 7/25/15 the record documented heavier handwritten letters of "SH"</p>	F 514		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
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F 514	<p>Continued From page 41</p> <p>over the top of the underlying "8/8". There are no initials and dates to verify who, why, and when the changes had been made.</p> <p>On 7/29/15 at 10:25 PM, CNA #11 stated she had noticed that someone went through the ADL Bathing Records and had written "SH" over the top of the "8/8."</p> <p>5. Resident #5 was readmitted to the facility in June 2015. The orders for this admission included 29 medications. In one instance, an order was crossed out with "error" by it but no documented signature, date, or time for the error. Another instance documented "D/C" next to a medication order with no signature, date, or time. The resident was readmitted 6/8/15, but the date of the readmission orders documented 6/1/15.</p> <p>The June 2015 Physician Recapitulation Orders documented 16 medication orders with no order date for each individual order.</p> <p>The June 2015 MAR documented 19 medication, intervention, and treatment orders with no date. In addition, 2 medications were discontinued on the MAR without a signature, date, or time of discontinuance.</p> <p>6. Resident #3 was admitted to the facility on 4/10/15 with multiple diagnoses including catatonia and bipolar disorder.</p> <p>The July 2015 Physician Recapitulation Orders documented 7 medication and treatment orders that were crossed out, but did not indicate if they were discontinued and did not have a date or signature. In addition, none of these orders</p>	F 514		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 514	Continued From page 42 indicated which physician ordered the medication, interventions, or treatments and there was no physician signature linked to the orders. There were 12 instances where "PO or PT (PEG tube)," or something similar, was written on the orders with no signature, time, or date. The June 2015 Physician Recapitulation Orders documented 13 instances of written changes or additions to the orders without a signature, date, or time of the change. The July 2015 MAR documented 5 instances where a medication or treatment was crossed out or discontinued, with no corresponding signature, date, or time. There were similar findings for residents #2 & #6.	F 514			
F 518-SS=E	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility, periodically review the procedures with existing staff, and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to provide staff training on the procedure for a power outage. This was true for 3 of 4 staff interviewed during the environmental task. This failure created the potential for adverse outcomes for any resident during a power outage that might need access to electricity for oxygen concentrators, ventilators, tube feeding pumps, etc. Findings included:	F 518	1. LN #2 and C.N.A's #3 and 4 have been re-educated on the power outage procedure to include the location and purpose of red outlets during a power outage. 2. The facility staff was interviewed to ascertain understanding of the power outage procedure including the purpose of red outlets. Staff members were immediately re-educated if unable to verbalize sufficient understanding. 3. Facility staff will be competency tested weekly using the question and answer method to explain what to do in the event of a power outage. Staff will be immediately re-educated if unable to verbalize sufficient understanding.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 518	<p>Continued From page 43</p> <p>The facility's "Electrical Outage" Policy & Procedure documented staff is to call Maintenance if power supply fails to function, but is automatic if the power goes out. It also documented the alternate power system supplied power to every other light in the hallways, exit lights, one light in the kitchen, red colored outlets, and all 100 wing rooms.</p> <p>On 7/29/15 at 3:15 p.m., LN #2 was asked about what to do in the event of a power outage. She said, "I would keep the residents safe and make sure they were okay." The LN did not speak to red outlets or power to 100 hall rooms, and could not say if she had been trained on this.</p> <p>On 7/30/15 at 10:15 a.m., CNA #3 and #4 were asked about the procedure during a power outage and said they did not know what they would do, and were not sure if the facility had a generator. They said they received training at orientation on emergency preparedness but were unsure of power outage training specifically.</p> <p>On 8/4/15 at 3:00 p.m., surveyors recieved the Orientation Checklist that covered emergency procedures. This documentation was reviewed but did not alleviate concerns that staff members were not knowledgeable about what to do during the event of a power outage.</p>	F 518	<p>4. ED / designee will conduct weekly staff interviews using Performance Improvement too PI 250 J Disaster & Emergency Preparedness to ensure staff understanding of emergency procedures including power outage (location and purpose of the red outlets). Results of the audit will be reported to the monthly QAPI committee x 3 months to ensure substantial compliance.</p> <p>5. Date of compliance 10/9/15</p> <p style="text-align: right;">10/9/15</p>
F 520 SS=D	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of</p>	F 520	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 520	<p>Continued From page 44</p> <p>nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and a review of the facility's compliance history, it was determined the facility's Quality Assessment and Assurance (QAA) committee failed to take actions that identified and resolved systematic problems for 11 of 12 sampled residents (#s 1-10 & 12) and 4 random residents (#s 13-16), with the potential to affect all residents in the facility. This failure resulted in the QAA committee providing insufficient and necessary direction and control over the facility to ensure residents' quality of life, assessments, and quality of care needs were met. Findings included:</p> <p>The QAA committee failed to provide sufficient</p>	F 520	<ol style="list-style-type: none"> The facility has hired an Executive Director to stabilize the leadership and to solidify the QAPI processes at the facility. The permanent Executive Director will be responsible to ensure the QAPI processes identify issues appropriately and timely according to standards of practice and facility policy and procedure. The facility's regional and corporate staff has reviewed current QAPI practices in the facility to identify areas for improvement. QAPI policies and practices that were not implemented as per policy have been addressed and implementation has begun for those processes. Root cause analysis of the systems breakdown and correction of those processes have been completed. The new facility leadership team will be in-serviced by the Corporate VP of Performance Improvement on a comprehensive approach to QAPI that will promptly identify areas for improvement through on-going monitoring; root cause analysis; resident and staff interviews; and staff performance that will improve resident satisfaction and standards of care outcomes. 	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 520	Continued From page 45 monitoring and oversight and the ability to sustain regulatory compliance, as evidenced by the recitation of the following citations for the recertification and complaint survey, dated 7/31/15. a. Refer to F309 as it related to the QAA committee's failure to ensure the facility provided the necessary care and services to attain or maintain the residents' highest practicable physical, mental, and psychosocial well-being. The facility was previously cited at F309 during the 2/27/15 recertification survey, as well as for the current recertification survey, dated 7/31/15. b. Refer to F322 as it related to the QAA committee's failure to ensure medications were correctly administered through a PEG tube. The facility was previously cited at F322 during the 2/27/15 recertification survey, as well as for the current recertification survey, dated 7/31/15. On 7/31/15 at 8:05 AM, the Administrator was interviewed regarding the facility's QAA process, as well as concerns with Quality of Care, as evidenced by the lack of bathing for residents. The Administrator stated the facility had become aware they had skin prevention and bathing issues sometime in July. The QAA had then implemented a "4 Point Plan". The plan had included audits, base line head to toe skin assessments, schedules updated for weekly skin assessments and showers to reflect the room changes, licensed nurses and CNAs in-services, and DCS/designee audits of the weekly skin assessments and shower documentation daily to ensure system compliance. The plan was implemented in July by the QAA committee and they were still currently reviewing their process.	F 520	3. The facility's implementation of QAPI processes and practices will be based on continuous quality assurance through various acceptable standards of practice measures that include but are not limited to auditing of high risk problem prone areas; root cause analysis of incident / accidents; quality measures; daily mock survey environmental rounds; morning stand up meeting; Clinical Risk Meetings; and staff and resident interviews to self identify process improvements. If a deficient practice is identified a 4 point plan will be implemented to correct the practice. The 4 point plan includes: a.) correcting the immediate problem identified to ensure resident safety; b.) root cause analysis to identify the system breakdown and process improvement necessary to correct the deficient practice c.) Staff education and training on process improvements initiated; d.) On-going monitoring to sustain the gain.		

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|--|--|--|---|---------|
| | | | <p>4. A Regional Team member will conduct monthly visits to audit the facility's QAPI program to ensure deficient practices are identified promptly and a sustainable process improvement plan is implemented. Results of the visit will be reported the District Team to ensure sustainable correction is maintained.</p> <p>5. Date of compliance 10/9/15</p> | 10/9/15 |
|--|--|--|---|---------|

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F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the annual federal recertification and complaint survey of your facility.</p> <p>The surveyors conducting the survey were: Linda Hukill-Nell, RN, Team Coordinator Rebecca Thomas, RN Kendra Delnes, RN, BSN Angela Morgan, RN, BSN</p> <p>The survey team entered the facility on 7/27/15 and exited on 7/31/15.</p> <p>Survey Definitions: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status cm = Centimeters CNA = Certified Nurse Aide DCS = Director of Clinical Services E = Employee LN = Licensed Nurse LSW=Licensed Social Worker MAR = Medication Administration Record MCO=Manager of Clinical Operations MDS = Minimum Data Set assessment MG=Milligrams NS=Director of Nursing Services PRN = As Needed RDSCS = Regional Director of Clinical Services TAR = Treatment Administration Record</p> <p>F 166 SS=D 483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</p> <p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p>	F 000	<p>Disclaimer Statement for POC's</p> <p>Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or correctness of the conclusions set forth on the statement of deficiencies, the plan of correction is prepared and submitted solely because of the requirements under State and Federal law.</p> <p>This Plan of Correction will serve as the Facility's allegation of substantial compliance</p> <p style="text-align: right;">RECEIVED AUG 27 2015 FACILITY STANDARDS</p>		
F 166 SS=D	<p>483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</p> <p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p>	F 166	<p>F - 166</p> <p>1. On 4/23/15 residents #14 reported a missing brown wallet which included credit cards. The Social Service Director (SSD) offered to have cards</p>		

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

Sathy Anand Jenkins

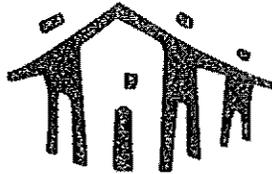
TITLE

Executive Director

(X6) DATE

8/26/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. 'BUTCH' OTTÉR – Governor
RICHARD M. ARMSTRONG – Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
OEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

November 6, 2015

Warren Taylor, Administrator
Coeur d'Alene Health Care & Rehabilitation Center
2514 North Seventh Street
Coeur d'Alene, ID 83814-3720

Provider #: 135052

Dear Mr. Taylor:

On July 31, 2015, an unannounced on-site complaint survey was conducted at Coeur d'Alene Health Care & Rehabilitation Center.

The complaint was investigated in conjunction with the facility's on-site Recertification and State Licensure survey conducted on July 27, 2015 through July 31, 2015.

The following observations were made:

Direct care staff interactions with the identified resident for the provision of care;
Management staff interactions with the identified resident for the provision of care; and,
Nine other residents for the provision of care.

The following documents were reviewed:

The entire medical record of the identified resident;
Nine other residents' medical records were reviewed for Quality of Care concerns;
The facility's grievance file from February to July 2015;
The facility's Incident and Accident reports from February to July 2015;
The facility's Allegation of Abuse reports from February to July 2015; and,
Resident Council meeting minutes from May to July 2015.

The following interviews were completed:

The Administrator and the Interim Director of Clinical Services were interviewed regarding various quality of care concerns;

The Director of Rehabilitation was interviewed regarding the resident's physical therapy and occupational therapy programs;

The Minimum Data Set (MDS) Coordinator and the Restorative Nurse were interviewed regarding positioning and range of motion concerns;

The identified resident, two individual residents and two resident family members were interviewed regarding quality of care concerns;

Seven Certified Nursing Aides (CNAs) and three Licensed Nurses (LNs) were interviewed regarding quality of care concerns; and,

A group of 10 residents were interviewed regarding various quality of care concerns.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007016

ALLEGATION #1:

The complainant stated the identified resident was not adequately repositioned to alleviate bed sores.

FINDINGS #1:

Based on observation, the identified resident did not have abraded skin over a bony prominence. Multiple interviews with staff, along with review of the resident's medical record, documented the resident was verbally abusive, rude to staff, kicked staff out of her room, and refused to allow staff into her room. This allegation could not be substantiated due to lack of evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant alleged the facility was falsifying the identified resident's chart and was not given therapy treatment toward regaining mobility to go home or to an assisted living facility.

Warren Taylor, Administrator
November 6, 2015
Page 3 of 3

FINDINGS #2:

Based on observation, therapy staff interviews and record review, it was determined the facility provided the required therapy, however, the identified resident frequently refused services. Review of the identified resident's medical record, along with review of seven other resident records determined the facility failed to maintain complete and accurate clinical records. This allegation was substantiated and the facility was cited at F-514. Please refer to Federal 2567 report.

Based on interviews with the identified resident, several other resident interviews, the resident group interview, staff interviews, as well as record review, it was determined the allegation was substantiated and the facility was cited at F-312 and F-353. Please refer to Federal 2567 report.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #3:

The complainant stated the identified resident was not bathed regularly and was not given ample time for personal hygiene activities.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

If you have questions, comments or concerns regarding our investigation, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,



David Scott, R.N., Supervisor
Long Term Care

DS/lj



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
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August 26, 2015

Robert D. Nahmensen, Administrator
Coeur d'Alene Health Care & Rehabilitation Center
2514 North Seventh Street
Coeur d'Alene, ID 83814-3720

Provider #: 135052

Dear Mr. Nahmensen:

On July 31, 2015, an unannounced on-site complaint survey was conducted at Coeur d'Alene Health Care & Rehabilitation Center. The complaint allegations, findings and conclusions are as follows:

Complaint #6979

ALLEGATION #1:

The complainant reported the facility was understaffed.

FINDINGS #1:

Facility staffing was investigated as part of the Recertification survey from July 27, 2015 to July 31, 2015. Based on observations of resident cares, interviews with staff, interviews with residents and review of grievances and staffing records, this concern was cited at F353.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

Robert D. Nahmensen, Administrator
August 26, 2015
Page 2

ALLEGATION #2:

The complainant reported the facility did not answer call lights.

FINDINGS #2:

This allegation was investigated as part of the Recertification survey July 27, 2015 to July 31, 2015. Based on observation of call light responses, interviews with residents about wait times and interviews with staff, this allegation was not substantiated based on a lack of evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant reported the facility left the resident soiled and unchanged.

FINDINGS #3:

ADL (activities of daily living) cares were investigated as part of the Recertification survey July 27, 2015 to July 31, 2015. Based on observation of staff providing cares, interviews with staff, interviews with residents and review of ADL care records, this allegation was substantiated based on the lack of showers provided to residents and was cited at F312.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #4:

The complainant reported the resident's wheelchair was unclean.

FINDINGS #4:

This allegation was investigated as part of the Recertification survey July 27, 2015 to July 31, 2015. Based on observations of residents' wheelchairs and interviews with residents, this concern was not substantiated based on lack of evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

The complainant reported the resident did not have access to a cup for drinking fluids.

FINDINGS #5:

Hydration was investigated as part of the Recertification survey July 27, 2015 to July 31, 2015. Based on observation of residents' access to fluids (and cups), observations of residents' hydration status, interviews with residents, interviews with staff, review of hydration policy & procedure, review of fluid intakes and review of care plans, this allegation was not substantiated based on lack of evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

The complainant reported the resident was taken to a hospital without facility staff.

FINDINGS #6:

There is no regulatory requirement for this allegation; therefore, an investigation was not completed.

CONCLUSIONS:

No regulatory requirement for the allegation.

ALLEGATION #7:

The complainant reported the facility refused to send medications to a receiving facility.

FINDINGS #7:

Transferring of medications upon discharge from the facility was investigated as part of the Recertification survey July 27, 2015 to July 31, 2015. Based on staff interviews, review of transfer records and review of policy & procedures, this concern was substantiated and was cited at F250.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

Robert D. Nahmensen, Administrator

August 26, 2015

Page 4

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

If you have questions, comments or concerns regarding our investigation, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

DAVID SCOTT, R.N., Supervisor

Long Term Care

DS/dinj

A handwritten signature in black ink that reads "David Scott". The signature is written in a cursive style with a large, prominent "S".



IDAHO DEPARTMENT OF
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FILE COPY

August 26, 2015

Robert D. Nahmensen, Administrator
Coeur d'Alene Health Care & Rehabilitation Center
2514 North Seventh Street,
Coeur d'Alene, ID 83814-3720

Provider #: 135052

Dear Mr. Nahmensen:

On July 31, 2015, an unannounced on-site complaint survey was conducted at Coeur d'Alene Health Care & Rehabilitation Center. The complaint allegations, findings and conclusions are as follows:

Complaint #6986

ALLEGATION #1:

The complainant reported a CNA did not provide cares for a resident for a day.

FINDINGS #1:

The allegation was investigated as part of the Recertification survey July 27, 2015 to July 31, 2015. Based on staff interviews about the CNA's performance, review of the personnel file, review of ADL care records and the care plan, this concern was not substantiated based on lack of evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Robert D. Nahmensen, Administrator
August 26, 2015
Page 2

ALLEGATION #2:

The complainant reported there was no outcome to two reports of neglect to the DoN.

FINDINGS #2:

Abuse and neglect of residents (including the reporting and investigation of these events) were investigated as part of the Recertification survey July 27, 2015 to July 31, 2015. Based on review of Incident & Accident reports (with investigation) and interviews with staff regarding the response of the DoN to allegations of neglect, this concern was not substantiated based on lack of evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant reported a CNA did not provide cares for another resident for a day.

FINDINGS #3:

The allegation was investigated as part of the Recertification survey July 27, 2015 to July 31, 2015. Based on staff interviews about the CNA's performance, review of the personnel file, review of ADL care records and the care plan, this concern was not substantiated based on lack of evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The complainant reported the facility was not allowing overtime hours for staff.

FINDINGS #4:

This is an issue for the Department of Labor; therefore, the allegation was not investigated.

CONCLUSIONS:

No regulatory authority for the allegation.

Robert D. Nahmensen, Administrator
August 26, 2015
Page 3

ALLEGATION #5:

The complainant reported restorative care records were being falsified.

FINDINGS #5:

Restorative care was investigated as part of the Recertification survey July 27, 2015 to July 31, 2015. Based on observations of restorative cares, interviews with residents and staff about current and past restorative care, and review of restorative care records, this concern was not substantiated based on a lack of evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

The complainant reported the DoN did not report two incidents of abuse and neglect to the state agency.

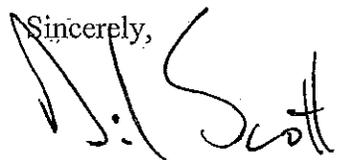
FINDINGS #6:

Abuse and neglect of residents (including the reporting and investigation of these events) were investigated as part of the Recertification survey July 27, 2015 to July 31, 2015. Based on review of Incident & Accident reports (with investigation), review of self-reported events to the state agency and interviews with staff regarding the response of the DoN to allegations of neglect, this concern was not substantiated based on lack of evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,


DAVID SCOTT, R.N., Supervisor
Long Term Care

DS/dmj



IDAHO DEPARTMENT OF
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August 21, 2015

Robert Nahmensen, Administrator
Coeur d'Alene Health Care & Rehabilitation Center
2514 North Seventh Street
Coeur d'Alene, ID 83814-3720

Provider #: 135052

Dear Mr. Nahmensen:

On July 31, 2015, an unannounced on-site complaint survey was conducted at Coeur d'Alene Health Care & Rehabilitation Center. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007111

ALLEGATION #1:

The complainant stated there was not enough staff on all shifts to take care of the residents' needs:

- a. Three identified residents developed pressure ulcers.
- b. Pericare is not performed consistently and incontinent residents are not changed often enough due to lack of staff.
- c. Residents' teeth are not being brushed due to lack of staff.
- d. Showers are not provided regularly due to lack of staff.
- e. An identified resident's behaviors of hitting, grabbing, and yelling at other residents and staff are out of control due to lack of staff.

FINDINGS:

Facility staffing was investigated as part the of recertification survey from July 27, 2015, to July 31, 2015. Based on observation, staff and resident interviews, review of grievances, record

Robert Nahmensen, Administrator
August 21, 2015
Page 2 of 3

review and staffing records, the facility was cited at F-353 for inadequate staffing and at F-312 for insufficient grooming and bathing.

Based on observation, record review and staff interviews regarding the development of pressure ulcers, this was not substantiated due to lack of evidence.

Based on observation, staff interviews and record review, insufficient staffing related to resident behaviors could not be substantiated due to lack of evidence.

CONCLUSION:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #2:

The complaint stated the corporate nurse had been providing nursing care with an out-of-state license.

FINDINGS:

Based on an interview with the corporate nurse, this allegation could not be substantiated due to lack of evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

Residents who have geri-sleeves ordered are provided gauze on their arms instead.

FINDINGS:

Based on observation and staff interview, this allegation was not substantiated since resident's were observed to have tubi-grip stockinette for geri-sleeves, and not gauze.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Robert Nahmensen, Administrator
August 21, 2015
Page 3 of 3

ALLEGATION #4:

The complainant stated the facility repeatedly did not have a sufficient number of adult briefs for residents.

FINDINGS:

Based on observation and staff interviews, this allegation was not substantiated due to lack of evidence. It was determined there was ample supply of briefs for residents in the supply room.

ALLEGATION #5:

The complainant stated there was not a human resource person on staff.

FINDINGS:

This allegation could not be investigated since there is not a regulation which pertains to human resource staff.

CONCLUSIONS:

Unsubstantiated. Allegation did not occur.

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

If you have questions, comments or concerns regarding our investigation, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626; option 2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

A handwritten signature in black ink that reads "David Scott". The signature is written in a cursive style with a large, stylized "D" and "S".

DAVID SCOTT, R.N., Supervisor
Long Term Care

DS/lj



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November 13, 2015

Warren Taylor, Administrator
Coeur d'Alene Health Care & Rehabilitation Center
2514 North Seventh Street,
Coeur d'Alene, ID 83814-3720

Provider #: 135052

Dear Mr. Taylor:

On **July 31, 2015**, an unannounced on-site complaint survey was conducted at Coeur d'Alene Health Care & Rehabilitation Center. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007094

The complaint was investigated in conjunction with the facility's on-site Recertification and State Licensure survey conducted on July 27 to July 31, 2015.

The following observations were made:

Call lights;

Dining room meals;

Infection Control Task and practices;

Medication Pass Administration;

The identified resident and staff interactions with daily cares;

Nine other residents and staff interactions with daily cares and at meals; and,

Management staff interactions with the identified resident for the resolution of concerns.

The following documents were reviewed:

The entire medical record of the identified resident;

Nine other residents' medical records were reviewed for Quality of Care and Quality of Life concerns;

The facility's policies and procedures for Resident Rights;

The facility's grievance file from February to July 2015;
The facility's Incident and Accident reports from February to July 2015;
The facility's Allegation of Abuse reports from February to July 2015; and,
Resident Council meeting minutes from May to July 2015.

The following interviews were completed:

The Administrator and the Interim Director of Clinical Services regarding various Quality of Care concerns;

The identified resident;

Two individual residents, and two resident family members regarding Quality of Care concerns;

Seven CNAs and three LNs were interviewed regarding quality of care concerns; and,

Ten residents in the Resident Group meeting.

Allegation #1: The complainant reported residents were not bathed regularly and those who are independent and able to bathe themselves are locked out of the shower room.

Findings #1: The residents and staff interviews revealed that bathing was not provided on a consistent schedule. The review of residents' bathing documentation revealed residents were not given or offered bathing on a regular basis. The facility failed to ensure residents were bathed on a consistent basis. The identified resident was observed to be independent, but still required set up assistance for safety reasons, which was appropriate.

This complaint was substantiated and the facility was cited at F312. Refer to Federal Form 2567 for additional information.

Conclusion #1: Substantiated. Federal deficiencies related to the allegation are cited.

Allegation #2: The complainant reported a resident liked to sit outside the front door, but had difficulty doing this independently because the threshold is too high to navigate with his/her wheelchair. The resident had almost fallen out of his/her wheelchair on a number of occasions trying to cross it.

Findings #2: On numerous occasions during the survey, the identified resident, other residents and visitors ambulating independently, ambulating with walkers, in non-motorized wheelchairs, pushing their wheelchairs, and motorized wheelchairs were observed going out the front door of the facility without any difficulty in maneuvering the threshold.

Three residents were interviewed and stated the threshold was not too high and there was no difficulty in maneuvering over it.

The facility's Incident and Accident reports did not document any concerns regarding the front door threshold.

The facility's grievances file did not document any concerns about the front door threshold.

The concern of the threshold being too high was not substantiated based on the lack of sufficient evidence.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: The complainant reported a resident was consistently given medications late. The resident had to ask a nurse for medications; pain medications and an antibiotic were late when given as needed and on the resident's routine-ordered schedule.

Findings #3: Medication pass observations were completed with no concerns; Medication pass observation to the identified resident was performed with no identified concerns; Interviews with residents, families, and staff revealed no areas of concern related to medications; Nine residents' medication administration records, including the identified resident's, were reviewed with no identified areas of concern; The facility's grievances file did not document any concerns with medication administration; and, The facility's Incident and Accident Reports did not document any issues with medication administration.

Based on observation, staff and resident interview, review of grievances, and record review, this allegation was not substantiated due to lack of evidence.

Conclusion #3: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: The complainant stated she overheard nurses in the hall and at the nurses' station talking about a resident's medical condition within earshot of others. The complainant feels this violates the resident's privacy.

Findings #4: During the recertification survey and complaint investigation, nurses were observed in the hallways, at the nurses' station, facility common areas, and while providing cares in residents' rooms, to determine whether residents' private health information was discussed where others could hear, or whether residents' written private health or personal information.

Residents were interviewed and stated there had been no concerns of their private information being discussed and overheard in a public area.

Based on observations, staff interviews and resident interviews, the facility did not exhibit any deficient practices related to confidential health information. This allegation could not be substantiated due to a lack of evidence.

Conclusion #4: Unsubstantiated. Lack of sufficient evidence.

Allegation #5: The complainant stated a resident provided his/her medical records to the facility, which did not return those records. The complainant also stated the facility would not allow the resident to look at his/her current medical records or make copies of those records.

Findings #5: The identified resident's medical record was reviewed and the resident's request for the records had been appropriately dealt with in terms of regulatory requirements.

Based on observation, record review, staff and resident interviews, and review of the facility's policies and procedures for Resident Rights, this allegation could not be substantiated due to lack of evidence.

Conclusion #5: Unsubstantiated. Lack of sufficient evidence.

Allegation #6: The complainant stated the facility has a resident with poor hygiene who sets dining room tables with napkins and silverware. The resident wears gloves that are not provided by the facility. The complainant stated the resident does not wash his/her hands, nor does staff cue or assist the resident in washing. The resident carries the napkins and silverware in her/his lap.

Findings #6: Dining room observations and the Infection Control task were performed as part of the recertification and complaint investigation survey with no identified deficient practices. There was no resident observed setting tables during the survey week. Resident and staff were interviewed about residents assisting in the dining room and no concerns were expressed with this area. The facility has residents who like to assist in the dining room. The facility ensures residents wash their hands or use hand sanitizer every time prior to assisting. The facility has a resident who has assisted in the dining room at times. The resident wears gloves that are not supplied by the facility, but are new and approved patient-care gloves. This resident was observed using a barrier between her/his body and the silverware tray and napkins.

Based on observations and interviews, this allegation could not be substantiated due to a lack of evidence.

Conclusion #6: Unsubstantiated. Lack of sufficient evidence.

Allegation #7: The complainant stated there is a resident who wanders intrusively throughout the facility. The complainant stated the resident has wandered into another resident's room numerous times and there was a concern of theft.

Findings #7: Review of grievances and the facility's response to those grievances, Incident & Accident reports with the applicable investigation, staff interviews, and individual and group resident interviews were completed as part of the recertification and complaint investigation survey. The facility determined methods to secure the identified resident's personal belongings, and addressed concerns with individual residents wandering obtrusively into other residents' personal space.

Based on observations, record review, and staff and resident interview, this allegation could not be substantiated due to a lack of evidence.

Conclusion #7: Unsubstantiated. Lack of sufficient evidence.

Allegation #8: The complainant said a resident called the Ombudsman numerous times about concerns and now felt the facility was treating him/her differently because of these calls. The complainant said the resident feels staff are "rude" and "yell" when the resident brings concerns to their attention.

Findings #8: During the recertification survey, facility staff were observed while interacting with residents, staff and residents were interviewed and grievances were reviewed with no concerns.

The facility's Allegation of Abuse reports did not document any evidence of staff mistreatment towards the residents.

Based on the observations and interviews, this allegation of being treated differently because of calls to the Ombudsman, and staff being rude and yelling, could not be substantiated due to lack of evidence.

Conclusion #8: Unsubstantiated. Lack of sufficient evidence.

Allegation #9: The complainant stated the facility served raw pork for dinner on July 8, 2015.

Findings #9: Review of the facility's kitchen and its adherence to the Idaho Food Code and infection control were performed as part of the recertification and complaint investigation survey of July 27, 2015 to July 31, 2015. Observations, as well as family and resident interviews were conducted, and record reviews were completed with no identified concerns of raw pork being served. The facility's infection control log did not reflect any food-bourne illnesses occurring from the serving of raw pork.

This allegation could not be substantiated due to a lack of evidence.

Conclusion #9: Unsubstantiated. Lack of sufficient evidence.

Allegation #10: The complainant stated a resident reported tiny burn marks on his/her left hand. The resident smokes but uses his/her right hand to smoke. The resident does not know how the burns to his/her left hand occurred but the burns hurt.

Findings #10: Review of the Incidents & Accidents reports and related investigations, as well as staff and resident interviews, and the identified resident's record, did not reflect the burn marks were documented or reported and, thus, were never investigated. The identified resident's record documented he/she smoked, was assessed for safety, and allowed to smoke independently.

This allegation could not be substantiated due to a lack of evidence.

Conclusion #10: Unsubstantiated. Lack of sufficient evidence.

Allegation #11: The complainant stated the facility issued a resident a 30-day discharge notice and then rescinded the discharge. The complainant stated the facility took medical records along with the discharge letter from the drawer of the resident. The complainant stated the resident wanted to appeal the discharge notice.

Findings #11: The identified resident's medical record was reviewed and the resident received a 30-day discharge notice which the facility rescinded.

The identified resident was still residing at the facility during the survey and complaint investigation process and had not been discharged nor received a second discharge notice. The facility identified concerns with information in the resident's original discharge notice and was in the process of obtaining additional information regarding the resident. The resident was interviewed regarding the discharge and his/her alternative placement options. The Administrator and the Director of Clinical Services were interviewed regarding the identified resident's discharge status and both staff members were involved in seeking alternative placement for the resident.

Based on observation, record review, resident and staff interview, this allegation for the resident was not substantiated, however the facility was cited at F250. Refer to the 2567 survey report for additional information.

Conclusion #11: Substantiated. Federal deficiencies related to the allegation are cited.

Allegation #12: The resident's primary care provider sent a certified letter notifying the resident he/she would no longer be his/her doctor. The facility's Director of Clinical Services signed for the resident. The resident was concerned about the length of time the letter took to get to him/her and felt the facility signing for the letter deprived him/her of his/her right to see who sent the letter and refuse to sign for it.

Findings #12: The identified resident's medical record was reviewed for physician care with no identified concerns;

The identified resident was interviewed regarding the facility's mail delivery and said the certified letter was presented to him/her unopened;

The Administrator and the Director of Clinical Services were interviewed regarding the facility's mail delivery system. The facility's mail carrier leaves all mail at the front desk to be distributed to residents. Certified mail requiring a signature could- and was signed by staff at the front desk instead of locating each individual resident to sign for his/her mail. The mail is then delivered to each resident, unopened, that same day.

Warren Taylor, Administrator
November 13, 2015
Page 7 of 7

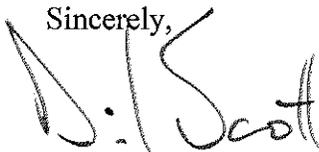
Based on record review, resident and staff interview, it was determined this allegation could not be substantiated.

Conclusion #12: Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

If you have questions, comments or concerns regarding our investigation, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

A handwritten signature in black ink that reads "D. Scott". The signature is written in a cursive style with a large initial "D" and a clear "Scott".

DAVID SCOTT, RN, Supervisor
Long Term Care

DS/pmt