IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

CORRECTED COPY

November 16, 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 November 5, 2015, an on-site revisit of your facility was conducted to verify correction of deficiencies noted during the survey of **July 31, 2015**. In addition, a Complaint Investigation was conducted in conjunction with the on-site revisit. Coeur d'Alene Health Care & Rehabilitation Center was found to be in substantial compliance with federal health care requirements regulations as of October 9, 2015.

The findings to the Complaint Investigation are being processed and will be sent to your facility under separate cover.

Your copy of the Form CMS-2567B, Post-Certification Revisit Report listing the deficiencies that have been corrected is enclosed.

Thank you for the courtesies extended to us during our on-site revisit. 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,

Nina Sanderson

Nina Sanderson, L.S.W., Supervisor
Long Term Care

NS/lj
Enclosures

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November 27, 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 **November 5, 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 Follow-Up Recertification and State Licensure survey conducted on November 3 to November 5, 2015.

The following observations were made:

- Call lights were observed;
- Dining room observations;
- Infection Control observations;
- The identified resident and staff interactions observed with daily cares and at meals; and,
- Five other residents and staff interactions observed with daily cares, meals, and oxygen delivery.

The following documents were reviewed:

- The medical record of the identified resident was reviewed;
- Four other residents' medical records were reviewed for Quality of Care and Quality of Life concerns;

- The facility's policies and procedures for Infection Control Prevention; and,
- The facility's October 2015 infection log and resident room mapping.

The following interviews were completed:

- The Consultant Director of Clinical Services and Director of Nursing Services were interviewed regarding the facility's infection control practices and oxygen therapy;
- Three residents were interviewed regarding Quality of Care issues; and,
- Four Certified Nurse Aides and one licensed nurse were interviewed regarding Quality of Care issues, Infection Control practices, and oxygen therapy.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007184

Allegation #1:

The complainant reported an identified resident was diagnosed with an infectious disease around the beginning of October. The resident was not confined to his/her room, allowed to roam around the facility, and touch surfaces in common areas, including the dining room and activity room. The identified resident had an incident in the dining room, which had increased the risk of infection control concerns.

Findings #1:

An initial tour of the facility was completed during the Follow-up Recertification and Complaint Investigation survey on November 3 to November 5, 2015. There were no residents and/or residents' rooms observed to have any infectious disease precautions posted on the doors or isolation carts set up.

The identified resident was observed and he/she was no longer on contact precautions after antibiotic treatment and clearance of signs/symptoms of the infectious disease. The identified resident was incontinent of bowel and bladder and totally dependent on staff for his/her personal care and hygiene.

The identified resident's medical record was reviewed. When the identified resident had signs and symptoms of an infectious disease the beginning of October, the facility followed their Infection Control Policies and Procedures protocol. The identified resident was placed in contact isolation, his/her roommate was moved to another room and observed for signs/symptoms of any infectious diseases, staff were made aware of the correct isolation precautions and care needed for the resident, and appropriate laboratory testing was completed.

The facility's policies and procedures for preventing spread of the identified infectious disease were followed, by allowing the identified resident to ambulate and participate in social and therapeutic activities so long as moist body substances (urine, feces, wound drainage, etc.) were contained, and the resident washed his/her hands before leaving his/her room.

The facility's October and November 2015 infection logs were reviewed and the identified resident was the only resident with the identified infectious disease.

The nursing care and assistance at meal times for five residents were performed appropriately and no infection control issues were observed during the survey.

The three residents interviewed had no care area concerns.

The interview with the Consultant Director of Clinical Services, Director of Nursing Services, and the nursing staff did not reveal any concerns regarding infection control protocol.

Based on observation, record review, resident and staff interview, and review of the facility's policies and procedures, this complaint was determined to be unsubstantiated due to the lack of supporting evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Allegation #2:

The complainant stated there are residents who are on continuous oxygen. The residents are taken to the shower rooms without having oxygen on and the oxygen was not placed back on, until the resident was returned to his/her room.

Findings #2:

During the Follow-Up Recertification and Complaint Investigation survey, there were three residents observed who received continuous oxygen. The three residents were observed in their rooms, dining room, activity room, and other common areas of the facility, and had portable full oxygen tanks with oxygen being delivered via nasal cannula at all times.

One resident was observed, while two nursing staff assisted him/her with transferring from a wheelchair with portable oxygen over to his/her bed and immediately placed on oxygen delivered by the room concentrator with no concerns.

Two residents who received oxygen therapy were interviewed and both stated there had never been any care concerns with oxygen delivery.

Three Certified Nurse Aides (CNAs) were interviewed regarding the residents who received continuous oxygen. All three of the CNAs stated the residents were taken to the shower rooms on portable oxygen and the oxygen tubing was removed only briefly, while clothing was removed and then the oxygen was immediately placed back on.

Based on observations, resident and staff interviews, this complaint could not be substantiated due to the 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,

Nina Sanderson, L.S.W., Supervisor
Long Term Care

NS/lj

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December 15, 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 **November 5, 2015**, an unannounced on-site complaint survey was conducted at Coeur D'Alene Health Care & Rehabilitation Center. The complaint allegations, incidents, findings and conclusions are as follows:

Complaint #ID00007143

The complaint was investigated in conjunction with the facility's follow-up Recertification and Complaint Investigation survey conducted from November 3, 2015 to November 5, 2015.

The following observations were completed: Call lights; staff on the floor; breakfast and lunch meal services; residents receiving showers or baths; care of residents; the use of gloves during perineal care for three residents; range of motion exercise and restorative care for three residents; and the daily care and staff interaction for five other residents.

The following documents were reviewed: The medical record of the identified resident; the medical records of four other residents for quality of life and quality of care concerns; the facility's Infection Control Policy and Procedure; the facility's October 2015 infection log and mapping; staffing numbers and actual hours worked for licensed nurses and CNAs from October 11, 2015 to October 31, 2105; grievances from October 2015; and ADL care sheets documenting showers for nineteen residents.

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The following interviews were completed: the Director of Nursing, MDS (Minimum Data Set) nurse, and Director of Social Work regarding showers, staffing, infection control, quality of care concerns for the resident, and care of the resident's belongings after discharge; six residents regarding accommodation of needs, showers, and the facility's food; the physical therapy assistant regarding therapy for the identified resident; three CNAs and one licensed nurse regarding staffing across shifts; and the administrator regarding food taste.

Allegation #1: The complainant reported the facility was understaffed and had constant staff turnover.

Findings #1: There were observations of adequate staffing to care for residents each shift and residents' call lights were answered in a timely manner. Review of nurses' and CNAs' (Certified Nursing Assistant) actual hours worked documented adequate staffing. Interviews with CNAs and a licensed nurse revealed no concerns with care for residents. Interviews with six residents revealed no concerns with getting help when needed, and grievances did not document any concerns with staffing.

Based on findings from the Federal Recertification and State Licensure survey conducted July 27, 2015 to July 31, 2015, the allegation was substantiated at F-353.

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

Allegation #2: The complainant reported the resident went weeks without a shower.

Findings #2: Review of activities of daily living forms for nineteen residents documented residents were bathed when scheduled; interviews with six residents revealed no concerns with bathing. Upon observation, residents' appearance was well kept and clean. Residents were provided showers when scheduled and grievances documented no concerns with bathing.

Based on findings from the Recertification and State Licensure survey conducted July 27, 2015 to July 31, 2015, the allegation was substantiated at F-312.

Conclusion #2: Substantiated. Federal deficiencies related to the allegation are cited.

Allegation #3: The complainant reported the food served at the facility was tasteless, specifically the fish.

Findings #3: Interviews with six residents revealed no concerns with the food served in the facility; the Administrator described daily monitors in place with daily resident interviews about meals served to them and concerns then resulted in a test tray by staff. Grievances did not document any concerns with the taste of food.

Based on staff and resident interviews, the allegation was unsubstantiated due to lack of evidence.

Conclusion #3: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: The complainant reported a staff member changed the resident's dressing without wearing gloves.

Findings #4: Gloves were properly worn and changed during observations of resident cares (four observations) and meal services per the infection control policy. The infection control log and mapping documented control of infections with no outbreaks.

Based on staff and resident interviews, the allegation was unsubstantiated due to lack of evidence.

Conclusion #4: Unsubstantiated. Lack of sufficient evidence.

Allegation #5: The complainant reported the resident's oxygen levels were critically low and staff was not monitoring the resident; when staff realized something was wrong, the resident was sent to the emergency room.

Findings #5: Review of the identified resident's medical record documented vital signs monitored when the resident began exhibiting symptoms. Nurse's notes documented frequent assessments and communication with the physician about the resident's condition. Labs were ordered. The resident was sent to the emergency room immediately when blood oxygen saturation levels became critically low.

Based on record review, the allegation was unsubstantiated due to lack of evidence.

Conclusion #5: Unsubstantiated. Lack of sufficient evidence.

Allegation #6: The complainant reported the resident did not qualify for therapy, but required a Hoyer lift.

Findings #6: Interview with the Physical Therapy Assistant revealed the resident had a goal of being able to stand and transfer him/herself; physical therapy records documented the resident participated in therapy often, but frequent pain and infection made it difficult and the resident sometimes refused therapy due to illness.

Based on record review and staff interview, the allegation was unsubstantiated due to lack of evidence.

Conclusion #6: Unsubstantiated. Lack of sufficient evidence.

Allegation #7: The complainant reported the resident was sent to the hospital for PICC (percutaneous indwelling central catheter) placement, was admitted to the hospital, and the facility did not notify the family or complainant about the hospitalization.

Findings #7: The resident's medical record documented notification of the identified resident's family on July 19, 2015 when the resident was sent to the hospital.

Based on record review, the allegation was unsubstantiated due to lack of evidence.

Conclusion #7: Unsubstantiated. Lack of sufficient evidence.

Allegation #8: The complainant reported the facility refused to accept the resident back into the facility after hospitalization.

Findings #8: Interview with the Director of Nursing revealed the facility stopped admitting new residents July 18, 2015.

Based on staff interview, the allegation was unsubstantiated due to lack of evidence.

Conclusion #8: Unsubstantiated. Lack of sufficient evidence.

Allegation #9: The complainant reported the resident was discharged from the facility, but his/her belongings were left at the first facility. The facility would not aid the resident in retrieving the belongings, and the belongings were left in the parking lot of the second facility (including an expensive tablet device).

Findings #9: Interview with the Director of Nursing, MDS (Minimum Data Set) nurse, and Director of Social Work revealed the resident's belongings were locked at the first facility. When staff learned the resident was not coming back to the facility they boxed up the resident's belongings and took them to the second facility, directly to the resident; the resident's belongings list did not document a tablet device.

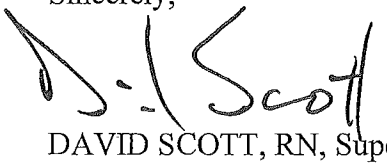
Based on record review and staff interview, it was determined the allegation was unsubstantiated due to lack of evidence.

Conclusion #9: 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,



DAVID SCOTT, RN, Supervisor
Long Term Care

DS/pmt