



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

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

DEBRA RANSOM, R.N., R.H.I.T., Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0009  
PHONE 208-334-6626  
FAX 208-364-1888

**CERTIFIED MAIL: 7012 1010 0002 0836 1901**

February 6, 2014

Bryan K. Lindsay, Administrator  
Life Care Center of Coeur d'Alene  
500 West Aqua Avenue  
Coeur d'Alene, ID 83815-7764

Provider #: 135122

Dear Mr. Lindsay:

On **January 23, 2014**, a Complaint Investigation survey was conducted at Life Care Center of Coeur d'Alene by the Department of Health & Welfare, 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, and a similar State Form 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) and on or before the "Opportunity to Correct" (listed on page 3). **Please provide ONLY ONE completion date for each federal and state tag 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. After each deficiency has been answered and dated, the administrator should sign both Form CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in the spaces provided and return the originals to this office.

Bryan K. Lindsay, Administrator  
February 6, 2014  
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Your Plan of Correction (PoC) for the deficiencies must be submitted by **February 19, 2014**. Failure to submit an acceptable PoC by **February 19, 2014**, may result in the imposition of civil monetary penalties by **March 11, 2014**.

The components of a Plan of Correction, as required by CMS include:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put in place or what systemic change will you make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. This monitoring will be reviewed at the follow-up survey, as part of the process to verify that the facility has corrected the deficient practice. Monitoring must be documented and retained for the follow-up survey. In your Plan of Correction, please be sure to include:
  - a. Specify by job title, who will do the monitoring. It is important that the individual doing the monitoring have the appropriate experience and qualifications for the task. The monitoring cannot be completed by the individual(s) whose work is under review.
  - b. Frequency of the monitoring; i.e., weekly x 4, then q 2 weeks x 4, then monthly x 3. A plan for 'random' audits will not be accepted. Initial audits must be more frequent than monthly to meet the requirement for the follow-up.
  - c. Start date of the audits;
- Include dates when corrective action will be completed in column 5.

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 both the federal survey report, Form CMS-2567 and the state licensure survey report, State Form.

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **February 27, 2014 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **February 27, 2014**. A change in the seriousness of the deficiencies on **February 27, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **February 27, 2014** includes the following:

Denial of payment for new admissions effective **April 23, 2014**. [42 CFR §488.417(a)]

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **July 23, 2014**, 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, it will provide you with a separate formal notification of that determination.**

If you believe these deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0036; phone number: (208) 334-6626; 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.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **January 23, 2014** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State

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Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the noncompliance at the time of the revisit, 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:

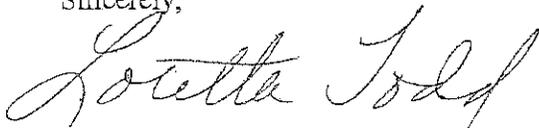
- BFS Letters (06/30/11)

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

This request must be received by **February 19, 2014**. If your request for informal dispute resolution is received after **February 19, 2014**, 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, please contact us at (208) 334-6626.

Sincerely,



LORETTA TODD, R.N., Supervisor  
Long Term Care

LT/dmj  
Enclosures

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

PRINTED: 02/06/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135122	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 01/23/2014
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NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF COEUR D'ALENE	STREET ADDRESS, CITY, STATE, ZIP CODE 500 WEST AQUA AVENUE COEUR D ALENE, ID 83815
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(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
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiency was cited during a complaint investigation survey of your facility.</p> <p>The surveyors conducting the survey were: Amy Barkley RN, BSN, Team Coordinator Rebecca Thomas, RN</p> <p>The survey team entered the facility on 1/22/14, and exited the facility on 1/23/14.</p> <p>Survey Definitions: ADLs = Activities of Daily Living CNA = Certified Nurse Aide CVA = Cerebrovascular Accident or stroke DNS/DON = Director Nursing Services/Director of Nursing ED = Emergency Department ER = Emergency Room LN = Licensed Nurse Pt = Patient Q = Every w/c = Wheelchair</p>	F 000	<p>This plan of correction is submitted as required under Federal and State regulations and statutes applicable to long term care providers. This plan of correction does not constitute an admission of liability on the part of the facility and, such liability is hereby specifically denied. The submission of the plan does not constitute agreement by the facility that the surveyor's findings and/or conclusions are accurate, that the findings constitute a deficiency or that the scope and severity regarding any of the deficiencies cited are correctly applied.</p> <p style="text-align: right;"><b>RECEIVED</b> <b>FEB 21 2014</b> <b>FACILITY STANDARDS</b></p>	
F 323 SS=G	<p><b>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</b></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 record review, staff interview, and</p>	F 323	<p><b>F 323</b> <b>Free of Accident/Hazards/Supervision /Devices</b></p> <p><b>SPECIFIC RESIDENTS</b> Resident affected by alleged deficient practice was discharged on 1/13/2014.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Bryan Lindsay TITLE: Executive Director (X6) DATE: 2/18/14

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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STATE IDENTIFICATION OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135122	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 01/23/2014
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF COEUR D'ALENE		STREET ADDRESS, CITY, STATE, ZIP CODE 500 WEST AQUA AVENUE COEUR D ALENE, ID 83815	
(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)
F323	<p>Continued From page 1</p> <p>review of the facility's Incident/Accident Reports, it was determined the facility failed to keep a resident from rolling out-of-bed when staff performed care. This was true for 1 of 4 (#1) sampled residents reviewed for falls. This failed practice caused the resident to fracture his nose when he fell on the floor, causing excessive bleeding, and was sent to the Emergency Room for treatment. Findings include:</p> <p>Resident #1 was admitted with multiple diagnoses to include, macular degeneration (legally blind), Cerebrovascular accident (CVA), and falls.</p> <p>The Resident's 7 day MDS, dated 12/28/13, documented the resident was an extensive assist of two staff for bed mobility, transfers, and toileting.</p> <p>The resident's 14 day MDS, dated 1/4/14, documented the resident was an extensive assist of one staff for bed mobility, transfers, and toileting.</p> <p>The Fall Risk Evaluation, dated 1/8/14 and 1/9/14, documented the following: * Page 1, the resident is at high risk for falls. Page 2 listed an intervention, #2, "Pt slipped out of w/c [wheel chair] and fell forward and hit his back on the dresser. Pt [patient] educated to lock w/c brakes and not reach out too far." * Page 1, the resident is at high risk for falls. Page 2, listed an intervention, #3, "Education for CNAs to turn patients body facing CNA while doing brief changes and patient care needs while in bed so CNA's body blocks pt [patient] from falling..."</p> <p>The resident's Activities of Daily Living (ADL)</p>	F 323	<p><b>OTHER RESIDENTS</b> The DNS and/or designee completed an audit on bed mobility on 3/7/14. Updates to care plans were made as necessary.</p> <p><b>SYSTEMIC CHANGES</b> Residents who require extensive assistance of 1 person for bed mobility are assessed upon admission and quarterly for safety with bed mobility.</p> <p>Certified Nursing Assistants were in-serviced on: 1. Proper body positioning when rolling someone on their side while in bed and to communicate to residents prior to rolling them to not to lift their leg while on their side, which could cause a fall.</p> <p><b>MONITOR</b> The Director of Nursing or his/her designee will observe and assess via audit that residents are repositioned in bed safely with cares: Three times weekly for two weeks, then twice weekly for two weeks, then weekly for four weeks and then monthly for one month with review by Quality Assurance Committee for further needs</p> <p><b>DATE OF COMPLIANCE:</b> 03/07/2014</p>

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NAME OF PROVIDER OR SUPPLIER  <b>LIFE CARE CENTER OF COEUR D'ALENE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 WEST AQUA AVENUE COEUR D ALENE, ID 83815</b>		
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F 323	<p>Continued From page 2</p> <p>Care Plan, dated 1/2/14, documented the following:</p> <ul style="list-style-type: none"> <li>- Needs extensive assist with grooming and hygiene tasks,</li> <li>- Extensive assist of one with transfers, toileting...,</li> <li>- Extensive assist with dressing/undressing/donning footwear.</li> </ul> <p>The resident's Fall Care Plan documented the following:</p> <ul style="list-style-type: none"> <li>* 1/2/14 - Problems, "[Resident's name] is at risk for falls r/t [related to] weakness with decline in mobility, from poss[ible] CVA, [and] poor vision.</li> <li>* 1/2/14 - Approaches, "Assist [Resident's name] to keep call light within reach at all times when in his room. Assist with toileting, transfers, and bed mobility. At nurses discretion, may start 1:1, Q (every) 30 min[ute] checks, and direct line of site."</li> <li>* 1/8/14 - Problems, "Fell out of w/c."</li> <li>* 1/9/14 - Approach (for the fall out of w/c), "Self locking breaks to w/c."</li> <li>* 1/8/14 - Problems, "Fell out of bed."</li> <li>* 1/9/14 - Approach (for fall out of bed), "Bed against wall to [increase] living space."</li> </ul> <p>The resident's Care Directive (date unknown), documented the resident was assist of one person for transfers, bed mobility, dressing, bathing, and toileting.</p> <p>Note: The Care Directive also documented the resident used siderails, however that information was not found on the Fall or ADL Care Plan, nor was it documented anywhere else in the resident's medical record.</p> <p>An Incident Report dated 1/8/14, Summary of Investigative Facts documented, "Resident fell off</p>	F 323			

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F 323	<p>Continued From page 3</p> <p>side of bed onto abdomen and face while CNA performed peri-care."</p> <p>The "Re-Creation of the Last 3 Hours Before [the] Fall," documented the following statement from CNA #1. "I had just changed [Resident's name] bed sheets which were soiled [with] urine. Resident was lying on right side. I had just picked up brief to put on [Resident's name]; when he lifted his left leg slightly and put it over his right leg and fell out of bed. I had both hands one on residents hip and one on shoulder but I could not pull his weight back so he fell on the floor. "</p> <p>The Incident/Accident Data Entry Questionnaire, dated 1/8/14 documented the following, "[Resident's name] nose was bleeding continuously but he was able to breathe through his mouth...He had a hematoma on the right side of the bridge of his nose, bruising to both eyes at inner canthus and a contusion between his eyebrows."</p> <p>Note: The resident was transferred to [Hospital's Name] Emergency Room for evaluation and treatment.</p> <p>The Incident Summary, "Description of Incident," completed by the DNS and faxed to the Bureau on 1/28/14, documented the following related to the resident's fall out of bed on 1/8/14. "On 1/8/14, at 23:30 [11:30] p.m. C.N.A. #1 [CNA's name] was providing incontinence care to [Resident #1's name]. She [CNA #1] changed his soiled bedding and was also changing his brief. When she rolled him onto his right side, resident lifted his left leg and flipped it over the edge of bed, which caused him to start to fall onto floor. The C.N.A. had her hands on his left hip and left</p>	F 323			

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F 323	<p>Continued From page 4</p> <p>shoulder but was unable to stop resident from continuing his decent to the floor." The "Corrective Action" documented, "After re-enactment of fall with staff member involved, it was felt that fall had 2 extenuating circumstances, (1) that resident lifted his leg and flung it with such force that caused the entire body to follow. (2) that staff members should have had resident more towards middle of mattress at end of roll, although this may have not prevented him from falling. Staff were educated that when rolling someone to their side to ensure that they are in middle of mattress at end of roll, and that the leg placement must remain on mattress during roll."</p> <p>Note: The Corrective Action did not document the CNA was to, "Body block patient..." as identified under the Fall Risk Evaluation Intervention #3 related to CNA education.</p> <p>A Progress Note, dated 1/9/14, at 7:45 AM, documented, "...At 3:00 a.m. phone call was rec'd [received] from [Hospital's name] ED LN stating that [Resident's name] was returning to this facility...She [LN from hospital] he [resident] has a broken nose and a 'rhino rocket' [A rhino rocket is nasal packing placed in the nose to stop excessive and prolonged bleeding] had been placed to his right nostril to stop his nose bleed which is to be removed in three days at [Hospital's name] ER."</p> <p>A Progress Note, dated 1/13/14, at 11:23 PM, documented, "Resident is alert and oriented to self and family. Went to hospital today to have nasal balloon removed. CNA went into his room tonight and resident was covered in blood, blood pooled under head. Blood with clots on sheet, [and] in urinal with clots. Called [Physician's</p>	F 323			

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F 323	<p>Continued From page 5</p> <p>name] and tried to get bleeding to stop. Never stopped and sent [resident] to ER for evaluation..."</p> <p>Note: The resident returned to the hospital during the day of 1/13/14 to have the rhino rocket removed and then returned to the facility. The resident was transported back to the ED at approximately 11:29 PM and was admitted to the hospital due to excessive bleeding from his nose.</p> <p>On 1/22/14, at 2:00 PM, the DNS was interviewed about facility's policy related to residents that have been identified as high fall risk and the proper way to turn a resident in bed while providing cares. The DNS stated "A" hall and "D" hall (the front halls) have been identified by the facility for placement of residents that are at a high risk for falls. The DNS stated these two halls have higher staff monitoring, which provides increased awareness of the residents. The residents are reviewed periodically to determine if need for continued placement on these halls is necessary. The DNS stated the facility's policy documents to turn the resident away from you, however, staff must ensure the resident is in the middle of the mattress at the end of the roll before providing cares.</p> <p>On 1/23/14, at 12:30 PM, CNA #2 was interviewed by the surveyor and asked how she performs care on a resident who is in bed. CNA #2 stated it is best to have 2 CNA's, one on each side of the bed because it is safer. In addition, she stated if she (CNA #2) is changing the resident herself, she rolls the resident towards her (CNA #2) and then goes to the opposite side of the bed and rolls the resident towards her on that side. The CNA stated, "You never roll the</p>	F 323			

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F 323	<p>Continued From page 6</p> <p>resident away from you." On 1/23/14, at 12:15 PM, CNA #3 was interviewed and asked the same question by the surveyor. CNA #3 stated, "I roll the resident towards me, usually tuck the soiled material under the resident, then I go to the other side and I roll the resident towards me. I always work with the resident towards me, it makes them feel more secure."</p> <p>On 1/23/14 at 1:00 PM, additional nurses notes, physician's orders, and ADL flow sheets, were provided by the Administrator for the survey team to review.</p> <p>The facility failed to ensure the safety of Resident #1 was safe from rolling out-of-bed when staff performed cares. The resident experienced harm when he fell on the floor, fractured his nose, suffered a hematoma on the bridge of his nose, bruising to both eyes and a contusion between his eyebrows. Additionally, the resident was admitted to the hospital on 1/13/14 due to the inability to stop his nose bleed.</p>	F 323			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001390</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C <b>01/23/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>LIFE CARE CENTER OF COEUR D'ALENE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 WEST AQUA AVENUE COEUR D ALENE, ID 83815</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2.</p> <p>The following deficiency was cited during a complaint survey for your facility.</p> <p>The surveyors conducting the survey were: Amy Barkley, RN, BSN, Team Coordinator Rebecca Thomas, RN</p>	C 000		
C 790	<p>02.200,03,b,vi Protection from Injury/Accidents</p> <p>vi. Protection from accident or injury; This Rule is not met as evidenced by: Please refer to F 323 as it relates to fall prevention.</p>	C 790	Please see POC for F323	<p><b>RECEIVED</b> <b>FEB 21 2014</b> <b>FACILITY STANDARDS</b></p>

Bureau of Facility Standards  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

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

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February 11, 2014

Bryan K. Lindsay, Administrator  
Life Care Center of Coeur d'Alene  
500 West Aqua Avenue  
Coeur d'Alene, ID 83815-7764

Provider #: 135122

Dear Mr. Lindsay:

On **January 23, 2014**, a Complaint Investigation survey was conducted at Life Care Center of Coeur d'Alene. Amy Barkley, R.N. and Becky Thomas, R.N. conducted the complaint investigation.

The following documents were reviewed:

- The identified resident's closed record along with the records of three other sampled residents;
- Grievances from August 2013 to January 2014;
- Incident/Accident Reports from August 2013 to January 2014;
- Resident Council Meeting minutes from August 2013 to January 2014; and
- Staffing records from October 27, 2013 to January 9, 2014.

This complaint covered the admission date of December 21, 2013 to January 13, 2014.

The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00006319**

**ALLEGATION #1:**

The complainant reported that while staff was performing cares on the resident, he rolled out of

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bed, onto the floor and fractured his nose.

#### FINDINGS:

The Incident Report dated January 8, 2014, was reviewed and documented the resident fell off the side of his bed and onto the floor, landing on his abdomen and face, when a certified nurse aide (CNA) was performing peri-care. As a result, the resident was transported to the Emergency Room and treated for a nasal fracture.

Four CNAs were interviewed related to proper turning and positioning for a resident in bed when providing cares. The CNAs stated the proper technique is to roll the resident toward staff and never away from staff. Additionally, they indicated the resident should be positioned in the middle of the bed after being turned.

This allegation was substantiated, and the facility was cited at F323 for failure to prevent accidents.

#### CONCLUSIONS:

Substantiated. Federal and State deficiencies related to the allegation are cited.

#### ALLEGATION #2:

The complainant had a concern related to bed linens being changed routinely during the night shift.

#### FINDINGS:

Grievances were reviewed and did not document concerns related to bed linens being changed in the middle of the night.

Resident Council Meeting minutes were reviewed and did not document concerns related to bed linens.

Four CNAs and one LN were interviewed and asked when the linens are changed on resident's beds. The four CNAs stated that linens are changed on the residents shower days and as needed if the linens become soiled. The nurse stated the linens are changed on shower days, when they become soiled and upon resident or family request.

The DNS was asked if it was the facility's standard of practice to change bed linens in the middle of the night. The DNS stated absolutely not, and the linens are only changed in the middle of the

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night if they become soiled.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant had a concern related to inadequate staffing on the night shift.

FINDINGS:

The facility's staffing schedule was reviewed for a total of 12 weeks, from October 27, 2013 through January 12, 2014, which included the time of the complaint.

Grievances were reviewed from August 2013 to January 2014 and did not document concerns related to staffing.

Resident Council Meeting minutes were reviewed from August 2013 to January 2014 and no staffing concerns were identified.

The administrator was interviewed and stated he had not had any family members verbalize complaints related to staffing.

Review of the facility's staffing documented the facility had adequate staffing levels.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The complainant had a concern related to waiting for ten minutes outside at 2:45 a.m. before being let into the building.

FINDINGS:

The Facility provided the survey team with a facility document titled "Guest Services," which included the following information:

Visiting Hours: "...While there are no restrictions on visiting hours, it is preferred that visitors come between 8 a.m. and 9 p.m., while the front entryway is open. If visiting outside of those

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hours, you must ring the entry phone and an associate will let you into the building."

The facility was observed to have a phone on the wall outside the main door of the facility with directions for after hour entry into the facility.

The Nurse Progress Notes dated January 9, 2014, identified the resident returned to the facility at 3:00 a.m. and the resident's son entered the building at the same time as the resident.

The facility's staffing was reviewed for January 8, 2014 and January 9, 2014, and documented adequate staffing levels.

There is not a Federal Regulatory requirement that identifies what is an acceptable or unacceptable wait time to gain after hour access to a facility. Therefore, this complaint is considered a customer service concern.

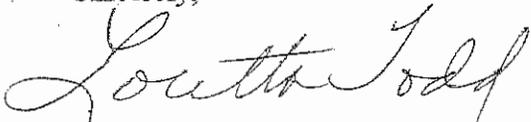
CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,



LORETTA TODD, R.N., Supervisor  
Long Term Care

LT/dmj