



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER -- Governor
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CERTIFIED MAIL: 7012 1010 0002 0836 4131

July 29, 2014

Bryan 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 **July 15, 2014**, a Complaint Investigation survey was conducted at Life Care Center of Coeur d'Alene 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 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.) 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.**

FILE COPY

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After each deficiency has been answered and dated, the administrator should sign both the Form CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **August 11, 2014**. Failure to submit an acceptable PoC by **August 11, 2014**, may result in the imposition of civil monetary penalties by **August 31, 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 does 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 (X5).

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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.

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

This agency is required to notify CMS Region X of the results of this survey. We are recommending that CMS impose the following remedy:

Denial of payment for new admissions effective as soon as notice requirements can be met. [42 CFR §488.417(a)]

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **January 15, 2015**, 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 Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

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>

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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 **August 11, 2014**. If your request for informal dispute resolution is received after **August 11, 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, comments or concerns, please contact Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care at (208) 334-6626.

Sincerely,

A handwritten signature in black ink that reads "Lorene Kayser". The signature is written in a cursive, slightly slanted style.

LORENE KAYSER, L.S.W., Q.M.R.P., Supervisor
Long Term Care

LK/lj
Enclosures

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

PRINTED: 09/04/2014
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 07/15/2014
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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>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the complaint investigation conducted at your facility. This report reflects changes resulting from the Informal Dispute Resolution (IDR) process.</p> <p>The surveyors conducting the survey were: Lorraine Hutton, RN, Team Leader Nina Sanderson, BSW, LSW</p> <p>The survey team entered the facility on Monday, July 14, 2014 and exited the facility on Tuesday, July 15, 2014.</p> <p>Survey Definitions:</p> <p>ADL = Activities of Daily Living CNA = Certified Nurse Aide DON = Director of Nursing ER = Emergency Room H&P = History & Physical MAR = Medication Administration Record OT = Occupational Therapy PT = Physical Therapy RN= Registered Nurse ST = Speech Therapy TIA = Transient Ischemic Attack</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>	
F 323 SS=G	<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>	F 323	<p>F 323 Fall and Accidents:</p> <p>SPECIFIC RESIDENTS Resident #3 and #4 no longer reside in the facility.</p> <p>Resident #1 was assessed for appropriateness of outdoor activity and care plan was updated accordingly. A new fall assessment was also completed.</p>	8/8/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Brian Johnson</i>	TITLE Executive Director	(X6) DATE 9-10-14
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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.

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F 323	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, review of facility policy and review of accident reports, it was determined the facility failed to provide supervision and assistive devices, identify and evaluate potential environmental hazards and/or develop and implement plans to prevent falls with fractures for 3 of 4 (#s 1, 3 & 4) residents reviewed for falls. Resident #4 was harmed when she fell and fractured her pubic bone and right hip. Resident #3 was harmed when he fractured his left leg while being assisted to the bathroom. Resident #1 was harmed when he fell and sustained a left hip fracture. The findings include:</p> <p>1. Resident #4 was admitted to the facility on 5/22/14 for, "Aftercare for healing traumatic fracture of the left arm." The resident's diagnoses included, a recent history of a fall resulting in a left arm fracture, recent history of TIA, osteoporosis, thoracic/lumbosacral neuritis/radiculitis, atherosclerosis, and essential hypertension, and diabetes.</p> <p>Review of the resident's medical record for the hospital stay of 5/19/14 to 5/22/14 revealed the resident fell while with friends at a restaurant. Prior to falling the resident's speech was incoherent and she leaned to her left side. During her hospital stay, Physician Notes documented her speech and physical symptoms improved and it was determined she had a TIA versus a stroke. Intervention and Assessment notes documented the resident was intermittently confused, required a bed alarm due to a high fall risk score, was forgetful, had short term memory deficits and occasional long term memory deficits, had a foley</p>	F 323	<p>OTHER RESIDENTS</p> <ol style="list-style-type: none"> Residents admitted to facility will be assessed for cognitive deficits and prior fall history and will have a fall risk assessment completed, and appropriate fall interventions noted on their initial care plan. Residents with cognitive deficits, independence wheelchair mobility and high risk for falls were reviewed to ensure care plans are updated with appropriate interventions. Fall assessments were reviewed and updated for these residents. Residents with a change in condition will be discussed by the IDT in rounds. New fall assessments will be completed when indicated with care plan and care directives updated as needed. 	

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F 323	<p>Continued From page 2</p> <p>catheter due to urinary retention problems which was discontinued on 5/22/14, experienced significant pain in her left arm and required frequent reminders to keep the arm immobilized.</p> <p>The facility Inquiry and Pre-Admission Information Form for Resident #4, dated 5/21/14, documented the resident was pleasantly confused, had memory issues, and required a bed alarm at the hospital.</p> <p>The facility's Initial Data Collection Tool/Nursing Service for Resident #4, dated 5/22/14 at 4:15 PM, documented the resident:</p> <ul style="list-style-type: none"> * Had short and long term memory loss. The data collection form did not indicate the resident had intermittent confusion. * Was occasionally incontinent of urine. The data collection form failed to document, in the space provided, the resident had a foley catheter in the hospital which was discontinued on 5/22/14. * Required the assistance of 1-2 people with transfers. The form documented that the resident "Understands need to wait for assistance to transfer." * Required the assistance of 1-2 with ambulation, had an unsteady gait and decreased endurance and strength. The form documented the resident, "Understands need to wait for assistance to ambulate." <p>The Initial Data Collection Tool/Nursing Service form did not document how the resident's understanding of the need to wait for assistance with transferring and/or walking was determined in light of her intermittent confusion and short term/long term memory issues.</p> <p>A Fall Risk Evaluation dated 5/22/14 documented</p>	F 323	<p>5. Residents who enjoy going outside to sit in the front of the building will have a fall assessment completed to ensure safe ability to be in the area. Education will be provided on courtyard options for those wanting to spend time outside.</p> <p>SYSTEMIC CHANGES</p> <ol style="list-style-type: none"> 1. A letter was added to the admission packets to include education on areas of safety in the front entrance as well as other sitting areas that are wheelchair appropriate. 2. A sign was placed in the front entrance area reading "Slope! Use Caution" 3. Education on the slope and courtyards will be provided during next resident council meeting. 4. Training was completed with Nursing Assistants on reporting changes in residents to Licensed Nurse, reviewing and following care directives and gait belt use. 		

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F 323	<p>Continued From page 3</p> <p>the resident scored 22 out of a possible 38. The form documented, "A resident who scores a 10 or higher is at risk.... If a score is 10 or higher interventions should promptly be put in place." The back of the form listed only one intervention, "Call light in reach."</p> <p>The Fall Risk form did not document if the resident could use the call light and how that was determined in light of her intermittent confusion and short term/long term memory issues.</p> <p>Resident #4's Interim Care Plan, dated 5/22/14, listed the resident need, "At risk for physical injury from falls," relating to, "Fall risk score of 24 [sic], Unsteady Ambulation, Recent fall(s), History of fall(s) with injury, Use of high risk medications (Norco)."</p> <p>Interventions were generic in nature and included: <ul style="list-style-type: none"> * Educate the resident/family on fall precautions * Assist of 2 for transferring and ambulation * Monitor and encourage use of proper foot wear, * Glasses/hearing aides prior to getting out of bed * Assist of [blank] for toileting Individualized interventions included: <ul style="list-style-type: none"> * NWB LUE [No weight bearing left upper extremity] for 2 months, and * One hour round for 3 Ps [Pain, Positioning, Potty] </p> <p>Intermittent confusion and short term/ long term memory issues were not addressed on this care plan area or anywhere else in the resident's Interim Care Plan.</p> <p>Progress Notes (PNs) <ul style="list-style-type: none"> * 5/22/14 at 6:12 pm - An LN documented, "New admit, oriented to room, staff, and call bell. Demonstrated call bell use. Alert but confused </p>	F 323	<p>5. Training was completing with Licensed Nurses on documentation on new admissions to include pain, fall risk, cognition and gait belt use.</p> <p>MONIITOR</p> <p>The Director of Nursing or designee will audit new admissions for cognitive deficits, and are high risk for falls and that fall assessment and appropriate interventions are in place to prevent falls beginning 7/30/14. Five times weekly for four weeks, then twice weekly for four weeks, then weekly for four weeks and then review by Quality Assurance Committee for three months and until a lesser frequency is deemed necessary.</p>	

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F 323	<p>Continued From page 4 and forgetful, cooperative with care, up to 2 person moderate assist. * 5/23/14 at 3:20 am - An LN documented, "Alert with some confusion. Calling out and when I went to her room she had forgotten where she was at..... Removes her arm out of sling. Staff attempts to keep [left] arm stabilized with pillow and sling... Compliant with use of call light, and waiting for assistance." * 5/23/14 at 10:47 am- LN #1 documented, "Resident Calling out, found on floor [in her room], resident stated she was trying to get up and go to her room, and chair went out from under her, resident was lying on floor on right side [complained of] pain in right lower extremity.</p> <p>An Incident Follow-up & Recommendation Form (Incident Report), dated 5/23/14, documented the resident was in her room, stood up without calling for assistance and fell to the floor. The resident was found at 10:45 am, seen by a physician, and then was sent to the emergency room of a local hospital and found to have a fractured hip. The incident form documented the resident: * Was "seen" 3 minutes prior to the fall. * Was alone in her room at the time of the fall * Was alert but confused * Attempted to transfer herself * The call light was in place but not used * The resident had last been assisted to toilet at 8:30 am</p> <p>The 5/23/14 Incident form documented the root cause of the incident as, "Resident confused, attempting to self transfer, poor safety awareness."</p> <p>The 5/23/14 incident form also documented the resident used the bedpan and ate breakfast that</p>	F 323	<p>The Director of Nursing or designee will observe and assess via audit that staff are using appropriate gait belt usage beginning 7/30/14. Five times weekly for four weeks, then twice weekly for four weeks, then weekly for four weeks and then review by Quality Assurance Committee for three months and until a lesser frequency is deemed necessary.</p> <p>The Director of Nursing or designee will observe and assess via audit residents who sit outside in the front entrance area for safety needs beginning 7/30/14. Five times weekly for four weeks, then twice weekly for four weeks, then weekly for four weeks and then review by Quality Assurance Committee for three months and until a lesser frequency is deemed necessary.</p> <p>DATE OF COMPLIANCE:</p>	8/8/14

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F 323	<p>Continued From page 5</p> <p>morning and then was evaluated by, "therapy." The report documented, "Therapy got patient up and dressed," before the fall.</p> <p>OT, PT, and ST Therapy Plan of Care (TPOC) and Treatment Notes (TN) notes for the morning of 5/23/14 (no specific times were provided) documented the resident:</p> <ul style="list-style-type: none"> * Had fallen when out with a group and fractured her left arm. The resident's speech was incoherent and she leaned to the left before suddenly falling. (OT, ST, PT) * Was alert and oriented to self only. (OT, PT, ST) * Had severe deficits in orientation and memory and mild deficits in comprehension and attention. (ST) * Able to follow clear, concise, one step commands. (OT, PT) * Was educated to call light and able to demonstrate use. (OT, PT) * Was unable to recall educated on situation with her fractured arm and unable to put her immobilize on. (PT) * Was experiencing a high level of pain in her left arm. (OT, PT, ST) <p>Note: Based on the resident's MAR, the resident had not been medicated for pain since the night before leaving the hospital.</p> <ul style="list-style-type: none"> * Required increased supervision (OT) and a CNA was notified of the need for increased supervision. <p>A Physician's handwritten Progress Note, dated 5/23/14 at 11:15 am, documented, "Pt [resident] was sitting in her chair [with] a fractured humerus. She attempted to transfer self and fell injuring her right hip... right hip pain, ... probable hip fracture... To [hospital] ER for evaluation and</p>	F 323		

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F 323	<p>Continued From page 6 treatment.</p> <p>A hospital Admission Physician Note, dated 5/23/14, documented, "The patient... is well known to me as I discharged her from my service yesterday... She went to a TCU... and apparently during a transfer, she fell... Unfortunately, during the fall she fractured her right hip as well as fractured her pelvic rami... On my evaluation the resident is confused, although pleasantly. She does not believe she broke her hip. She complains of no pain... she denies any symptoms posed to her... I discussed the complexity of [the resident's] medical condition with her [family] and also discussed the 2-month mortality of this type of injury in the orthopedic literature is extremely high and certainly greater than 50 %... and I suspect it will even be larger given the fact she has multiple fractures as well as recent [TIA]... "</p> <p>During an interview on 7/14/14 at 2:00 pm, LN #1 stated he was the medication cart nurse on the day of the incident and was the nurse notified by the CNA that the resident had fallen. LN #1 stated he assessed the resident, notified the physician (who was in house) and later completed the incident report. When asked if he was aware that morning that the resident was a high fall risk and had short term memory issues as well as confusion, LN #1 stated he had not been informed during shift change of the resident's fall history, high risk for falls, or short term memory issues. He stated he was informed that the resident used the call light appropriately during the night and not informed of any concerns. In addition, LN #1 stated he was not made aware of the therapists' recommendations for increased supervision.</p>	F 323			

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F 323	<p>Continued From page 7</p> <p>On 7/14/14 at 2:15 pm, the DON was interviewed regarding the resident's fall risk status, cognitive and memory issues, and Interim Care Plan. During the interview, the DON stated she was aware the resident was a high fall risk and had some cognitive issues. The DON stated:</p> <p>* The resident was assessed upon admission for her fall risk and her ability to use the call light. The DON stated that the admission nurse, as well as the subsequent shifts stated the resident had no problems using the call light. When the DON was asked about the LN documentation on 5/23/14, about the resident calling out, rather than using the call light, and then not remembering what she had called out for, the DON had no comment.</p> <p>* Information regarding a newly admitted resident's high fall risk, confusion, and memory loss, would be shared generally shared with staff during the shift to shift report. The information would also be placed on the interim care plan. The Interim Care Plan, which did not address the resident's confusion, short and long term memory problems, was shared with the DON who stated she would look for other documentation indicating this information was shared with staff caring for the resident. No additional information was provided.</p> <p>* Regarding the generic nature of Resident # 4's fall care plan, the facility has standard procedures for each resident at risk for falls which are indicated on the care plan but the care plan should also be individualized to the resident. When asked about the 1 hour checks, the DON stated that the 1 hour checks is a new program they are testing for all new admits and people requiring increased supervision. When asked if there was documentation of Resident #4's 1 hour checks, the DON stated, "No." When asked if the</p>	F 323			

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F 323	<p>Continued From page 8</p> <p>resident's plan for falls had been otherwise individualized, the DON indicated that nothing, in addition to the interim care plan, was documented to address the resident's fall history, confusion, short term memory problems. She felt the resident was safe because she had demonstrated the use of the call light.</p> <p>* The facility was still in the process of evaluating the resident and had not considered using a chair alarm. The DON stated they found alarms very intrusive for the residents and attempted to avoid them when ever possible. At the point of the resident's first 24 hours no other safety measures had been considered (i.e.. line of site supervision, increased frequency of checks, self release belt ...).</p> <p>On 7/15/14 at 10:50 am, CNA #1, who was assigned to Resident #4 on the morning of 5/23/14, stated she had she had seen the resident frequently between 6:00 am and 8:30 am. She had provided the resident fresh ice water, assisted her to use the bedpan, and placed the resident's breakfast tray at the resident's bedside and picked it up when the resident was finished. When asked if she assisted the resident to get up, the CNA stated, "No, Therapy got her up and dressed her." CNA #1 stated the night shift had told her the resident used the call light appropriately during the night and did not mention her high fall risk status or her confusion and memory issues. When asked if any of the therapists had talked to about the need to increase the resident's supervision, CNA #1 stated, "No, but they could have talked to another CNA that day."</p> <p>2. Resident #3 was re-admitted to the facility on 3/24/14 after hospitalization for pneumonia and a</p>	F 323		

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F 323	<p>Continued From page 9</p> <p>urinary tract infection. The resident's chronic diagnoses included congestive heart failure, hypertension, renal failure, chronic obstructive pulmonary disease, diabetes mellitus, anxiety and depression.</p> <p>The most recent MDS, dated 2/14/14, assessed the resident as requiring extensive assistance (including physical assistance) of two people with transfers, extensive assistance (staff providing weight bearing support) with locomotion, and extensive 2 person, physical assist with toilet use.</p> <p>Resident #3's readmission Initial Data Collection Tool/Nursing, dated 3/24/14, documented the resident required 1-2 person assistance with ambulation. Nurse's Notes, dated 3/26/14 at 6:45 pm, documented the resident, "Requires[s] extensive assist of 1-2 aides to transfer..."</p> <p>A 3/24/14 Care Plan for falls documented, "[Resident] is at risk for falls r/t [related to] weakness, pain with decline in mobility..." Interventions included, "Ext [extensive] assist of (2 was handwritten in) transfers/toileting/gait with use of walker." The use of a gait belt or other safety devices, other than the walker, were not listed on the Care Plan.</p> <p>A Fall Risk Evaluation was not completed for the 3/24/14 re-admission. The last Fall Risk Evaluation documented in the resident's chart was completed on 3/21/14 (3 days prior to the resident's hospitalization for pneumonia and urinary tract infection). This evaluation scored the resident as an 18 (high risk for falls) documenting the resident ambulated with problems and devices (gait is unsteady, slow, lurching) and the resident did not have adequate balance to stand,</p>	F 323		

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F 323	<p>Continued From page 10 sit, or transfer without physical help.</p> <p>The only Fall Risk Evaluation documented after the resident's readmission was completed on 4/13/14, the same date the resident fell and fractured his left hip. This evaluation scored the resident at 16, and documented the resident still ambulated with problems and devices, his balance was not steady and he was only able to stabilize with physical assistance.</p> <p>On 3/25/14 Resident #3 was assessed by physical therapy (PT) for a treatment diagnoses of general muscle weakness. The assessment documented, "Patient and caregiver ed[ucation] regarding transfers with use of walker and mod A [moderate assist] of 1 vs caregiver's lifting patient under arms... Transfers bed [to/from] chair with walker... with mod A of 1 with max [maximum] cues with patient needing tactile cues for forward lean. Max cues for pivoting walker fully vs falling into chair diagonally. Max A for all dressing except shirt." The PT documented, "60 - 79 % impaired mobility, walking and moving around functional limitation..."</p> <p>On 3/26/14 the PT documented, "Patient previously requiring min [minimum] assist with ambulating to and from bathroom and recliner with FWW [front wheel walker]. Is now demonstrating deficits in bed mobility, transfers, and gait that limit mobility..."</p> <p>On 3/31/14 the PT documented, " [Resident] required total assist for [lower body] clothing and pericare... pericare was completed with seated rest break due to increased shortness of breath and low endurance.</p>	F 323		

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F 323	<p>Continued From page 11</p> <p>The resident's fall prevention care plan did not reflect that the resident would experience shortness of breath or decreased endurance with exertion</p> <p>On 4/9/14 the PT documented, [Resident] performed gait x 20 feet x 2 with report of left knee pain... [Resident] requires CGA (Contact Guard Assistance) to min A with w/c follow due to fatigue/shortness of breath, and pain."</p> <p>The resident's fall prevention care plan did not reflect that the resident required CGA and/or w/c follow. It also did not address how staff should ensure a wheel chair was behind the resident during ambulation and still maintain CGA. Contact guard assistance is a protective safeguard and a variation of minimal assistance where the resident requires hand or physical contact to maintain balance or dynamic stability.</p> <p>On 4/10/14 the PT documented, "Gait training with fww... requiring frequent rest breaks due to shortness of breath..."</p> <p>The last PT note was dated 4/14/14 at 1:19 pm. This note was a Functional Level (End of billing period) Progress Report for service dates 3/25/14 through 4/13/14. Under #3, "Gait Tasks: Distance - Surfaces," the report documented, " Patient is able to demo[nstrate] gait for up to 20 feet with fww and CGA with w/c [wheel chair] follow." Under, "Caregiver Education," the report documented, "Patient and CNAs educated with need for continued CGA for all transfers and gait to/from bathroom with fww and CGA for safety."</p> <p>An Incident Follow-up & Recommendation Form, dated 4/13/14, documented the resident</p>	F 323		

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F 323	<p>Continued From page 12</p> <p>experienced a fall with injury. The Incident report documented, "The CNA was walking resident to the br [bathroom] [with] his fww; he fell to the floor to buttocks without any indication that he was about to fall. CNA tried to catch him but could not prevent fall. Had non-skid slipper socks on at the time of incident. Was gotten up with Hoyer lift; body check completed, [resident complaining of] [left] hip pain - sent to ER [emergency room] for eval[uation]."</p> <p>The "Factors observed at the time of the fall," portion of the 4/13/14 incident report documented the resident, "Lost strength/appeared to get weak?" The FSI (Fall Scene Investigation Report) documented, "Appears accidental in cause walking [with] staff to restroom, either was weak of hip gave out when ambulating."</p> <p>The 4/13/14 incident report did not document that, other than his walker, an assistive device, such as a safety device or w/c follow, or other protective safeguards (CGA), was used when ambulating the resident to the bathroom.</p> <p>A 4/13/14 Witness Interview/Statement Form completed by the CNA who was ambulating the resident [alone] when he fell, documented, " I was assisting the resident... to the restroom... using his walker and [was] by his side to assist him. He was walking to the restroom and was turning to go into the restroom when his foot slipped and he fell onto his back. I tried to grab him to slide him to the floor, but it happened too fast. [The resident] tried to get off the floor, but I told him to lay there while I went to get another aide to assist me. I also got the nurse... so she could check him...."</p>	F 323		

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F 323	<p>Continued From page 13</p> <p>The Incident report documented the facility notified the resident's physician and called for a portable x-ray because the resident was complaining of pain. The x-ray report, dated 4/13/14, documented the resident had an, "Acute comminuted left intertrochanteric fracture with mild displacement."</p> <p>A 4/13/14 telephone order instructed staff to transfer the resident, per ambulance, to the hospital for evaluation and treatment of a left hip fracture.</p> <p>Resident #3 also had an incident report, dated 3/13/14, which documented a CNA was transferring the resident from a recliner to his wheel chair. The resident's legs, "slid out from under him," and the CNA lowered him to the floor without injury. The incident report documented the CNA was transferring the resident alone and the resident was wearing, "no skid socks" on his feet at the time of the incident. The incident report did not mention if the staff was using an assistive device (such as a gait belt) during the transfer. The recommendations on the incident report included non-slip sock/slippers on at all times, 2 person transfers. The follow-up section on the incident report documented, "2 [two] person transfer at all times x (times) 24 hrs. Non-slip socks/slippers at all times. The Resident's Care Plan was updated on 3/13/14 with a hand written note, in the prevent falls section, that documented,"NIF [non injury fall], slid to floor [with] assist from CNA. Will have 2 CNAs for transfers."</p> <p>The resident's medical records documented the resident was discharged to the hospital on 4/13/14, had hip surgery, and did not return to the</p>	F 323		

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F 323	Continued From page 14 facility. The discharge MDS indicated the facility anticipated the residents return but a PT note, dated 4/25/14, noted the patient, had "expired." On 7/14/14 at 2:20 pm, the DON was interviewed regarding Resident #3, his fall history, the incident reports and care plan, and the facility's policy/practice regarding the use of gait belts. During the interview the DON stated: * The facility did not really consider the resident's slip to the floor on 3/13/14 as a fall. He just slid off the recliner. * The use of gait belts was the facility's standard of practice for all residents who needed assistance with ambulating and/or transfers and the use of gait belts would not necessarily be listed on the resident's care plan because it was a common practice. * The non-use of a gait belt would be placed on the care plan if an individual resident did not want the gait belt used and/or there was a medical reason for not using the gait belt. When told that the use/or non-use of a gait belt could not be found on the resident's 3/13/14 and 4/13/14 incident reports, the DON stated she would review the reports to check if they were listed. The DON later returned stating the gait belt use was not addressed on either incident report. * The resident's care plan was wrong and had not been updated to omit the 2 persons needed for transfers. The PT had been working with the resident and he needed less assistance. The DON provided the PT notes listed above to indicate the resident did not require 2 person assistance any longer. * The CNA listed on the 4/13/14 incident report had been counseled regarding not using the gait belt during the transfer.	F 323			

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F 323	<p>Continued From page 15</p> <p>3. Resident #1 was admitted to the facility on 6/4/12. His multiple diagnoses included Parkinson's disease, hypotension, urinary obstruction, transient awareness alteration, acute kidney failure, and weakness with gait instability.</p> <p>Resident #1's annual MDS assessment, dated 5/2/14, coded: *BIMS of 9, indicating moderately impaired cognitive skills; *Extensive assistance of 2 for bed mobility; *Did not ambulate; *Extensive assistance of 1 for wheelchair mobility, on and off the unit; and *Needed physical assistance to move from a seated to standing position, and for surface to surface transfers.</p> <p>Information for this deficiency was obtained from physician's progress notes (MDPN), Fall Risk Evaluations (FRE), resident care plan (CP), ADL Monthly Flow Reports (ADL MFR), care area assessments (CAA), nurse's progress notes (PN), Fall Scene Investigation (FSI), and Incident Follow-Up and Recommendation Forms (I/A).</p> <p>On 4/29/14, an MDPN documented the resident had ongoing symptoms from hypotension, complained to the physician about his level of forgetfulness and fatigue, and used a wheelchair due to ongoing muscle weakness.</p> <p>On 4/29/14, a FRE for Resident #1 documented a score of 14, indicating the resident was at risk for falls. The instructions on the form documented, "A resident who scores 10 or higher is at risk. Consider environmental factors in resident's interventions."</p>	F 323		

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F 323	<p>Continued From page 16</p> <p>Resident #1's CP for falls, initiated on 6/24/12 and reviewed on 4/29/14, documented the resident was at risk for falls due to a history of falls, cognitive deficits, a diagnosis of Parkinson's disease, and the use of high risk medications. Approaches included: **Motion alarms to bed and chair...anti roll back bars on [wheelchair]." **At nurse's discretion, may implement [every] 15-30 minute checks, 1:1, line of sight."</p> <p>Resident #1's CP for ADL assistance, initiated 6/23/12 with an updated target date of May 2014, documented the resident had an alteration in ADL's related to kidney disease, catheter use, Parkinson's disease with muscle weakness and decline in mobility, diabetes, and the use of high risk medications. Approaches documented, "Uses [wheelchair] for assisted mobility on/off unit. Able to propel self for short distances."</p> <p>Resident #1's ADL MFRs for locomotion off the unit on day shift documented: *April 2014. Extensive assistance of one person 14 of 30 days, did not occur 7 of 30 days, and the resident was independent with the activity 9 of 30 days. *May 2014. Extensive assistance of one person 14 of 31 days, did not occur 6 of 31 days, supervision after set-up 3 of 31 days, and the resident was independent with the activity 8 of 31 days.</p> <p>Resident #1's CAAs for the annual MDS dated 5/2/14 documented: *Falls analysis of findings, "[Resident #1] hasn't had any [sic] recent falls but he is at risk for falls and injury - fall assessment with a score of 14, [diagnosis] of Parkinson's, impaired mobility and</p>	F 323			

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F 323	<p>Continued From page 17</p> <p>balance, needs staff assist with transfers and mobility. Able to propel [sic] [wheelchair] but staff usually assist. Has antiroll back brakes [sic] on [wheelchair]. Alarms as he has a [history] of attempting to self-transfer. Proceed to care plan." *Cognitive Loss supporting documentation, "BIMS score is 9 showing moderate cognitive issues. Resident has confusion and is very forgetful." *Activities of Daily Living supporting documentation and analysis of findings, "[Resident #1] needs staff assist with his needs daily, has impaired mobility, Parkinson's...poor balance and needs staff assist or sit to stand lift depending on how he is feeling...has had some decline in his care needs, he needs assist with all ADLs and is now needing sit to stand at times...recent addition of pain patch...will proceed to care plan to assist with cares as he is at risk for needs not being met."</p> <p>Resident #1's ADL MFR for locomotion off the unit on day shift between 6/1/14 and 6/15/14 documented the resident required: *Extensive assistance of 1 for 9 of 15 days, including 6/15/14; *The acitivity did not occur 1 of 15 days; and *The resident was independent 5 of 15 days.</p> <p>On 6/15/14 at 12:00 noon, a facility I/A documented, "Resident went out front doors into parking lot, rolled down drive way in his wheelchair hitting curb at flagpole that flipped wheelchair over throwing [sic] resident to the ground. Left hip struck curb while upper torso landed in the rocks..." The resident's mental status both before and after the incident was documented as, "Alert/confused." An attached FSI, under the area, "What did the resident say they were trying to do just prior to they fell?"</p>	F 323			

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F 323	<p>Continued From page 18</p> <p>documented, "They were talking to another resident's family member."</p> <p>On 6/15/14 at 3:54 PM, Resident #1's PNs documented, "At approximately 12 noon, overhead page for assistance to front was sounded. When this nurse arrived at front doors I noted this resident laying in the middle of the parking lot with his left hip on the cement curb and upper torso in the rocks of the flower bed. Multiple staff were at resident's side. We did not move this resident [due to] increase in pain of left hip and possible fracture. Resident was [complaining of] left hip pain at this time. CNA called 911..."</p> <p>On 6/15/14, Resident #1's H&P from the acute care hospital documented he was diagnosed with a left hip fracture, and admitted for surgical repair of that injury.</p> <p>On 6/17/14, unknown time, a handwritten statement from a facility LN, included as a witness statement in the facility's investigation of the incident, documented, "In regard to [Resident #1] a little over 3 [weeks] ago after supper, I asked the CNA where [Resident #1] was because at times they had been leaving him in the dining room alone after meals (and at times when he move [sic] about in wandering fashion [with] his hand on his head for a very long time and often went to A wing.) After a few minutes I came back down that portion of the wing [and Resident #1] was sitting in the middle of the hall [no] other issues noted. He was in good humor. The next day [staff] said you know [Resident #1] was outside yesterday we saw him and brought him back. Was almost down near the flag. No further issues noted when he was brought back to wing.</p>	F 323			

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

PRINTED: 09/04/2014
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 07/15/2014
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)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 19</p> <p>[After] meals he liked to go right to bed. I thought mistakenly that this was an isolated issue."</p> <p>On 6/20/14, the facility faxed investigation results from the incident to the Bureau of Facility Standards. The report documented, in part, "... [Resident #1] went outside to enjoy the sunshine and when he attempted to find his room, he started to propel down the slight slope at the entrance and could not stop...[Resident #1] does enjoy going outside but does not do it very often. The last time was approximately 3 weeks ago and he sat out in front of the building visiting with families...[Resident #1] told the Executive director when he went to see him at the hospital, that he went outside in the sun and then decided to go back to his room, and at that point exactly what occurred is unsure. [Resident #1] said he pulled out to turn around and go back to his room and the next thing he knew he was going down the slope...he stated, "I started to roll and was not able to stop the chair..."</p> <p>On 7/15/14 at 8:55 AM, the DNS was asked about Resident #1's fall. The DNS stated: *The resident had a history of going outside the front door with a visitor to look at the flowers, particularly in the warm summer months. Because the resident had been able to find his way about the facility, i.e., his room, the dining room, etc., and had stated at the time of the fall he was trying to turn his wheelchair around to come back into the building when the wheel caught on the slope of the driveway, the facility had not considered his exit from the building an elopement. *The resident had been observed just minutes prior to the event in the lobby of the building, but was not observed to exit the building.</p>	F 323			

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

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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 07/15/2014
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)	(X5) COMPLETION DATE	
F 323	Continued From page 20 *The DNS was asked, considering the risk factors for this resident, including weakness, variable confusion, and high fall risk, if it was acceptable for the resident to be outside unsupervised. The DNS stated since there had never been a problem with the resident going outside that she was aware of, the facility did not feel the need to address this issue in the resident's care plan. *When asked about the statement from the nurse indicating the resident had been outside the facility and retrieved by staff approximately 3 weeks prior to the fall, the DNS stated, "A nurse who did not normally work with the resident saw him outside and didn't know if it was OK, so she sent a CNA out to get him. The CNA went out, asked him if he was ready to come in, and he said yes. The nurse just saw a resident outside and didn't know if it was OK. He was perfectly fine." "He never goes anywhere. He just sits out there and looks at the flowers then comes back in. The fact that he got carried down that slope is a fluke. It was completely unforeseen," and "We recognize [the risk] now. There had never been an incident before. I think he was trying to turn around and the wheel of the chair just dropped off the edge, and he was gone. There is no way we could have foreseen the slope would be a problem." NOTE: The LN's statement from 6/17/14 documented the resident had been found outside near the flags. See description of the fall scene below. *When asked whether the resident had ever been educated as to the presence of the slope at the end of the drive way, or evaluated for his ability to recognize or recover from the slope safely, the DNS stated, "No. There was never any need. He had been out many times, and had gotten back into the facility." However, the DNS was unable to describe how often the resident had been in that	F 323			

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

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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 07/15/2014
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		
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F 323	<p>Continued From page 21</p> <p>area unsupervised, versus with a visitor, and whether or not the facility had re-evaluated this situation after the resident had been found outside near the flags.</p> <p>*The DNS was asked if the driveway contained any visual cues, such as a sign or contrasting paint on the slopes from the driveway, to alert residents to the presence and severity of the slope. The DNS stated, "No."</p> <p>*The DNS was asked if the slope from the driveway on the side the resident lost control of his wheelchair was more pronounced than the other side, the DNS stated, "Yes, much. Significantly."</p> <p>*The DNS stated the facility would not necessarily have incorporated the resident's preference or tendency to go outside unsupervised into his record, or into his care plan. The DNS was unable to explain why this information would not be included.</p> <p>*The DNS stated after the resident's fall, hospitalization, and subsequent return to the facility, they were able to direct the resident to enjoy the flowerbeds in one of the facility's enclosed, level patio areas. The DNS stated this had not previously been offered or encouraged for the resident.</p> <p>Resident #1 was harmed when he fell and sustained a left hip fracture requiring surgical repair.</p>	F 323			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001390	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/15/2014
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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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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 deficiencies were cited during the complaint investigation conducted at your facility.</p> <p>The surveyors conducting the survey were: Lorraine Hutton, RN, Team Leader Nina Sanderson, BSW, LSW</p> <p>The survey team entered the facility on Monday, July 14, 2014 and exited the facility on Tuesday, July 15, 2014.</p>	C 000	<p style="text-align: center;">RECEIVED SEP 15 2014 FACILITY STANDARDS</p> <p>For the Plan of Correction for C790, please refer to the Federal 2567 form.</p>	
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 accident prevention.</p>	C 790	<p>DATE OF COMPLIANCE:</p>	8/8/14

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

[Signature]

Executive Director

9-10-14



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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BUREAU OF FACILITY STANDARDS
3232 Elder Street
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Boise, ID 83720-0009
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September 10, 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 **July 15, 2014**, a Complaint Investigation survey was conducted at Life Care Center of Coeur d'Alene. Nina Sanderson, L.S.W. and Lorraine Hutton, 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 May 11, 2014 to July 14, 2014;
- Incident/Accident Reports from May 11, 2014 to July 14, 2014;
- Policies and Procedures on Falls/Fall prevention and Gait Belt use; and
- Admission Packet.

The following facility employees were interviewed:

- The Administrator;
- The Director of Nursing;
- The Physical, Occupational and Speech therapists;
- Licensed Nursing staff; and
- Certified Nurse Aides.

The complaint allegations, findings and conclusions are as follows:

Complaint #6531

ALLEGATION #1:

The complainant stated the identified resident's family received a telephone call from a caregiver, identified by first name only, at 11:09 a.m. on May 23, 2014, the day after the resident was admitted. The caregiver told the family that the identified resident, who had been assessed as "high risk for fall," had been left unattended in a "chair" without alarms. The resident attempted to stand up but fell to floor. The resident was transported to the emergency room at a local hospital where she was x-rayed and diagnosed with two fractures to the left pelvis.

The complainant also stated the accident report was incomplete. It did not mention that the resident was a high fall risk and left unattended in a chair without an alarm immediately prior to a fall with injury.

FINDINGS #1:

The identified resident had a known history of falls with fractures, intermittent confusion and short-term memory issues when she was admitted to the facility. The facility did not adequately supervise the resident and put interventions in place to ensure the resident's safety. As a result, the resident attempted to get out of her wheelchair while alone in her room and fell. The resident was transported to the emergency room, where she was operated on for a right hip fracture. The resident also sustained fractures of the pelvis during the fall.

The allegations that the identified resident was left unsupervised, without a safety alarm and that the incident report was not complete were substantiated. The facility was cited at F323 on the CMS-2567 survey report.

CONCLUSIONS:

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

ALLEGATION #2:

The complainant stated the identified resident's family requested a copy of the resident's records "Just prior to June 2, 2014." The facility informed the resident's family that copies of the resident's medical record would cost \$25 for first 25 pages and 25 cents for each additional page. The facility told the resident's family "there would be hundreds and hundreds of pages." The resident's family asked how that could be when the identified resident was only at their facility

Bryan K. Lindsay, Administrator
September 10, 2014
Page 3 of 3

from 5:00 p.m. Thursday until 11:00 a.m. Friday. The facility medical records staff could not answer the question. The facility's Administrator sent a record request form to the resident's family for signature. The form was mailed back to facility (no date given). The family received an accident report two weeks later but received no additional records since.

FINDINGS #2:

Due to a lack of evidence, it could not be determined that the facility charged the resident's family \$25 for a copy of the first 25 pages of the medical records and \$0.25 per page thereafter, nor could it be determined that it took the facility two weeks to provide the resident's family with a copy of the medical record. During the investigation, the Administrator stated that on the same day he received a request for the resident's medical record a copy was left at the front desk of the facility for the family to pick up. When asked for a copy of the receipt for the cost of the copies, the Administrator stated the facility did not charge them.

CONCLUSIONS:

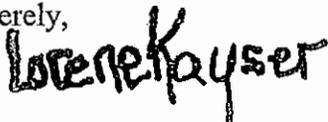
Unsubstantiated. Lack of sufficient evidence.

In addition, the complainant expressed a concern that the facility was attempting to extend resident's stay at facility from two weeks to two months "for more money." This allegation does not fall within the regulatory authority of the Bureau of Facility Standards and was not investigated.

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, comments or concerns regarding our investigation, please contact Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care 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,



LORENE KAYSER, L.S.W., Q.M.R.P., Supervisor
Long Term Care

LKK/dmj