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 3050 0001 2128 3443

July 29, 2014

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

FILE COPY

Provider #: 135052

Dear Mr. Clarke:

On **July 16, 2014**, a Complaint Investigation survey was conducted at Coeur d'Alene Health Care & Rehabilitation Center by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes no actual harm with potential for more than minimal 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 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).

  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*.

Due to the continued noncompliance from the Recertification Survey that was conducted at the facility on June 13, 2014, the recommendations for remedies by Centers for Medicare and Medicaid Services (CMS) from the survey will continue. The recommended remedies were set forth in the letter that was issued to the facility by this office on June 24, 2014.

The remedy, which will be recommended if substantial compliance has not been achieved by **July 18, 2014** includes the following:

Denial of payment for new admissions effective **September 13, 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 **December 13, 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, they 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, Post Office Box 83720, Boise, Idaho, 83720-0009; 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 **July 16, 2014** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State 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 **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,

Lorene Kayser

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

LK/lj
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135052		C 07/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COEUR D'ALENE HEALTH CARE & REHABILITATION CENTER	2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
	The following deficiencies were cited during a complaint investigation at Coeur D'Alene Care and Rehabilitation. The complaint investigation was conducted on July 16, 2014.			
	The survey team was: Nina Sanderson, BSW LSW, Team Leader Lorraine Hutton, RN			
	Survey definitions are: ADL = Activities of Daily Living CNA = Certified Nursing Assistant DNS = Director of Nursing MDS = Minimum Data Set POA = Power of Attorney			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		
	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.			
	This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff and resident interviews, and information received from the Ombudsman's office regarding the facility's incontinence management at night, it was determined the facility failed to ensure resident care policies reflected the facility's overall approach to the care for residents with			

RECEIVED
AUG 13 2014
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
C.L. Clarke	Executive Director	8/11/14

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135052		C 07/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COEUR D'ALENE HEALTH CARE & REHABILITATION CENTER	2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 1 dementia, including a clearly outlined process for their care. This was true for 1 of 2 residents (R # 6) sampled for dementia care. The deficient practice had the potential to cause more than minimal psychosocial harm when an incontinent resident who was unable to speak for themselves was not given incontinence products at night. Additionally, the facility did not consult the resident's responsible party to explore the resident's preferred method for managing incontinence. Findings included: Federal guidance at F 309 pertaining to care and services for a resident with dementia: *"Person-centered care...is care that is individualized by being tailored to all relevant considerations for that individual, including physical, functional, and psychosocial aspects..." *"Identifying, to the extent possible, factors that may underlie the resident's expressions of distress, as well as applying knowledge of lifelong patterns, preferences, and interests..." *"The facility should document attempts made to include the family/representative, to the extent possible, in the decision-making process...of the care planning..." *"...It is important for the facility to have systems and procedures in place to assure that assessments are timely and accurate, interventions are described, consistently implemented, monitored, and revised as appropriate in accordance with current standards of practice." *"...In addition, determine...Whether resident care policies reflect the facility's overall approach to the care of residents with dementia, including a clearly outlined process for their care...How the facility monitors whether staff follow related policies and procedures in choosing and	F 309	F 309 1.) Resident #6 no longer resides at the facility. The practice of not using briefs at night was stopped on 7/16/14. 2.) DON and MDS coordinator re-assessed current incontinent residents to identify their potential for retraining and/or pattern of elimination. Residents that score 0-6 are not candidates for retraining. These residents will utilize incontinent products unless the physician orders not to use , and/or the family or resident choose not to use an incontinent product. Restorative toileting programs will be implemented as indicated. 3.) DON in-serviced nursing staff on providing residents with incontinent products, including checking incontinent residents every two hours. 4.) DON/designee will conduct audits weekly x 4 weeks then monthly x2 months to ensure residents are provided incontinent products per plan of care. The results of the audit will be reported to monthly QA/PI x3 months to ensure substantial compliance. 5.) The facility will be in substantial compliance on August 20, 2014. 0-6 on Bowel & Bladder training score per telephone conversation with Cole Clarke Administrator 8/15/14 @ 10:57 AM Mountain Time	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	135052		C 07/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COEUR D'ALENE HEALTH CARE & REHABILITATION CENTER	2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 2 implementing interventions for the care of each resident with dementia..." Resident # 6 was admitted to the facility on 5/31/14 with diagnoses which included left femoral neck fracture, Alzheimer's dementia, hypertension, and atrial fibrillation. On 5/31/14, Resident # 6's Admission Care Plan for bowel and bladder incontinence documented the pre-printed goal of, "Resident will establish bowel/bladder routine." The only intervention documented was a check mark next to the statement, "Start continence tracking program." The goal for Psychosocial Well-Being was documented as, "Resident will express/exhibit satisfaction." The checked interventions included, "Allow participation in decision/goal making." On 5/31/14, Resident # 6's Admission/Readmission Data Collection form documented the resident was incontinent of bowel and bladder with pads or briefs used. Resident #6's physician orders, dated 5/31/14, documented the resident was to receive Questran (cholestryramine) 4 milligrams (mg) twice daily for diarrhea, as well as 1 packet (no milligram amount documented) every 6 hours as needed for diarrhea. The physician's orders did not document the resident should be "left open to air" when in bed at night. Resident # 6's Admission MDS assessment, dated 6/7/14, coded: *Long and short term memory deficits, with severely impaired decision making skills; *Physical behaviors directed towards others which occurred 1 to 3 days out of the past 7 days;	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135052		C 07/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COEUR D'ALENE HEALTH CARE & REHABILITATION CENTER	2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 3 *Total dependence on two persons for toileting; *Always incontinent of bowel and bladder; and *Preferences for customary routine either blank or marked as, "unchecked," with the exception of, "Discuss care with family/other," which was marked as, "checked." Resident #6's Care Area Triggers (CATs), dated 6/7/14, repeatedly documented the resident was at risk of not having her needs met, including her psychosocial needs, due to her Alzheimer's disease. For example: *Under the problem area of Cognitive Loss, "She is incontinent of [bowel and bladder.] Never makes decisions...She only understands very simple direct communication in a slow stim[ulus] environment. She is unable to answer open ended questions. Her speech is unclear, she will often babble...Because of her severe dementia [Resident #6] is at risk of not having her needs met." *Under the problem area of Communication, "...She has inattention and disorganized thinking...she is unable to make her needs known. She is at risk of not having her needs met." *Under the problem area of ADL Function [NOTE: The heading for this area on the printed reports was cut off. However, the associated information begins on page 17 of 31 on the printed report.], "She has recurrent UTIs and is [treated] daily with nitrofurantoin...is unaware of her toileting needs. She is completely dependent upon staff for toileting. She is at risk for skin breakdown." *Under the problem area of Psychosocial Well-Being, "...has Alzheimer's and us unable to make her needs known. Her daughter usually visits daily. [Resident #6] is at risk of not having her psychosocial needs met."	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135052		C 07/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COEUR D'ALENE HEALTH CARE & REHABILITATION CENTER	2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 4 *Under the problem are of Behavioral Symptoms, "Her behaviors are usually on [night] shift...has swung at and been combative with cares. This has only happened on [night] shift. Maybe she was startled. Maybe she had been woken up. Staff will reapproach if necessary...She is at risk of not having her needs met." *Under the problem area of Pressure Ulcer, "...at risk of developing pressure ulcers...Braden scale score is a 15...she is incontinent of [bowel and bladder]. She has a pressure reducing mattress and [wheelchair] cushion." Resident # 6's Initial Social Service History, dated 6/6/14, documented the resident was unable to provide any information regarding significant life experiences, medical, or psychiatric history due to her advanced dementia. There was no documentation the resident's family or responsible party had been contacted to provide this information. Resident #6's bowel and bladder tracking form (ADL flow sheets) for 6/1/14 through 6/18/14 documented the resident was incontinent of bladder 2-3 times daily on night shift, and incontinent of bowel three times on night shift. Resident # 6's care plan for self-care deficit, initiated 6/10/14, documented an intervention of, "Toilet use: Total [assistance of 2], is incontinent of [bowel and bladder]. Wears briefs. Check and change [every 2 hours]. Apply protective barrier with each brief change." Resident #6's behavior management care plan, dated 6/10/14, documented a goal of, "Resident will have reduced episodes of being combative with staff by next review." Interventions included,	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135052		C 07/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COEUR D'ALENE HEALTH CARE & REHABILITATION CENTER	2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 5 "Redirect when behaviors arise," "Psych[iatric] consult[ation] as indicated," "Positive feedback when resident is compliant and appropriate," and, "Be slow, quiet and gentle when awakening on [night] shift, as this seems to be when she is combative." It was not stipulated in the care plan that the resident was not to have an incontinence brief at night. It was not documented as to whether or not the resident waking to find herself nude from the waist down, soiled with urine and/or feces, had been considered and ruled out as a contributing cause to her combativeness at night. Please see documented interviews below for further details. On 6/14/14 at 12:55 PM, a Daily Skilled Nurse's Note documented, "...family in and insists that res[ident] is allowed to wear briefs in bed. Will have resi[ident] placed in briefs while in bed..." On 6/14/14, a hand-written addition to the resident's care plan documented, "[No] open to air [nights], briefs 24/7 [at all times]." On 7/16/14 at 9:45 AM, the Administrator produced a typed document entitled, "Brief Usage." The document was not dated or signed. The Administrator identified the document as the facility's plan of correction from a survey conducted in September 2013, and stated it served as the facility's policy for residents being left open to air. The "Brief Usage" sheet documented the number of briefs needed daily for residents depending on whether or not they were left open to air at night, where to obtain briefs when needed, and which supplies would be needed for a brief to be changed. It did not document:	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135052		C 07/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COEUR D'ALENE HEALTH CARE & REHABILITATION CENTER	2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 6 *Clinical data supporting the rationale for leaving residents exposed, criteria for implementing the open to air practice, alternatives to be attempted before leaving a resident exposed, how the practice was to be monitored for effectiveness, and at what juncture a resident would again be offered an incontinence brief. *Physician involvement in determining if the practice was indicated for a specific individual's clinical condition.	F 309		
	*How residents and/or resident representatives would be notified this practice was being implemented as part of their plan of care, or offered the opportunity for input as to whether or not they agreed with the facility's decision to leave them exposed. *How psychosocial considerations for potential resident reaction to being left exposed or in their own uncontained waste would be addressed. On 7/16/14 at 4:20 AM, CNA #1 was interviewed regarding resident incontinence management at night, including Resident #6. CNA #1 reported the following: *At night, it was customary to use incontinence briefs for some, but not all, of the incontinent residents. The residents not using briefs were left, "open to air"; that is, nude from the waist down, with a cloth pad underneath them to protect the bed from bodily fluids. *In order to receive incontinence products at night, a resident had to request them. If a resident did not request, or was unable to request, an incontinence product, they were left open to air. *At the time of the interview, CNA #1 stated of the 14 residents in his/her care, 5 were currently open to air. Of those 5 residents, 1 resident was capable of asking for an incontinence brief. The other 4 were unable to make their needs and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135052		C 07/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COEUR D'ALENE HEALTH CARE & REHABILITATION CENTER	2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 7 preferences known. *The facility had been "informally" leaving residents open to air for approximately 4-5 months. "It started slowly at first, with just a few aides doing it. Then, after the survey exit (on 6/13/14) we had the first formal in-service on it." *When asked the reason given by the facility for leaving residents open to air, the CNA stated, "We were told it was to prevent skin breakdown. But I don't agree with it." The CNA stated the in-service contained no data to support the claim of reduced skin breakdown that s/he could recall. *The CNA expressed concern for the residents whose dementia had advanced to the point they were unable to request an incontinence brief. The CNA stated, "I don't agree with it. I was told their families had been told and were in agreement with it, but when I asked for specific information, I was given only one example of someone who had been told. I think it would be very upsetting for some of them if they knew." *The CNA stated one resident's family had become very upset after discovering their loved one was being left open to air. The CNA identified the family of Resident #6. The CNA stated the family removed the resident from the facility, citing the open to air policy, and that they had not been informed or offered the opportunity to interact with the facility on the resident's behalf. On 7/16/14 at 9:25 AM, the surveyors spoke to the facility's Medical Director (MD) via conference call. The MD stated he recalled some conversations in the facility, "some time ago," but did not recall a formal policy change regarding that subject. The MD stated he had seen some residents benefit from this practice, if they had enough continual moisture on their skin to cause the potential for skin breakdown. However, the	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135052		C 07/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COEUR D'ALENE HEALTH CARE & REHABILITATION CENTER	2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 8 MD stated such a practice should be individualized and based on the clinical needs of the resident, rather than a blanket policy. The MD stated when considering this practice for any resident, the individual's wants and needs regarding being left exposed should be taken into account. On 7/16/14 at 9:45 AM, the Administrator also provided the content from an in-service conducted with facility staff on 7/11/14. The in-service documented, "Open to air policy was implemented to help prevent skin breakdown in incontinent residents. This practice is widely used in long term care facilities...Residents and POAs have agreed to the open to air policy since it was implemented in 2013..." On 7/16/14 at 10:30 AM, the Administrator stated it was the DNS who talked to the residents and their families about the open to air policy, but he did not believe it would be documented anywhere. On 7/16/14 at 10:50 AM, the surveyors spoke with the DNS via conference call regarding the facility's open to air practice. The DNS stated: *The facility had implemented the open to air "policy" at night to prevent "skin issues." The DNS stated being left open to air meant the resident would not have an incontinence brief, but instead laid on a standard cloth incontinence pad, nude from the waist down. *Even when lying on the pads, the staff were to check on the residents every 2 hours, and change the pad as needed. *Any resident who requested a brief could have one, as well as any time the staff felt a brief was necessary (i.e., loose stools, excessive urination,	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135052		C 07/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COEUR D'ALENE HEALTH CARE & REHABILITATION CENTER	2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 9	F 309		

etc.)
*Not every incontinent resident was left open to air, but there was no clear process for identifying which residents were to be left open to air, or when that practice would start. Information regarding whether or not a resident would be left open to air was not necessarily incorporated into the resident's care plan.
*The family of any resident not able to speak for themselves could also request a brief on behalf of their loved one.
*If a resident was unable to speak for themselves due to advanced dementia, it was presumed they consented to the practice and the facility would proceed with implementing open to air for that resident.
*The DNS stated when the "policy" was originally implemented in September 2013, she called all of the resident family members and let them know. However, the DNS stated there was no documentation of these conversations. The DNS stated she would talk to the families of residents admitted since that time if the facility was leaving the resident open to air. The DNS stated she did not document those conversations anywhere.
*When asked if the facility had an actual written policy for open to air, above and beyond what the surveyors had already seen, the DNS stated, "No."
Regarding Resident #6, the DNS stated:
*When the resident was initially admitted to the facility at the end May 2014, she used incontinence products at all times.
*At some point, the facility began to leave the resident open to air. The DNS stated she was not sure when that point was.
*The DNS was not sure why this particular resident had been left open to air, but thought maybe the resident had become resistive or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135052		C 07/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COEUR D'ALENE HEALTH CARE & REHABILITATION CENTER	2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 10 combative with staff. NOTE: The only documentation of the resident being resistive to care at night was in the Daily Skilled Nurse's Notes on 6/1/14 when the resident was experiencing pain, and on 6/3/14 when staff were taking her vital signs. *The DNS stated the resident would have been unable to consent to being left open to air due to her advanced dementia. The DNS did not recall having a conversation with the resident's family informing them of this practice being implemented for their loved one. The DNS stated it was not her practice to document those conversations when they did occur. *The DNS stated she was aware, at some point, the resident's family came to the facility to ask the resident not be left open to air any longer, and the facility attempted to educate the family as to the potential benefits of the program. Even so, the DNS stated, the family insisted the resident wear a brief at all times, so the resident's care plan was updated to reflect this request. *The DNS could not state when or how the resident's psychosocial response to being left open to air had been considered or assessed in response to this aspect of her treatment. *The DNS was not sure, and it was not documented, how the resident's incontinence had previously been managed, and whether or not being left open to air could be established as the resident's preference. The facility implemented an open to air practice, which per staff interview was disproportionately used on residents who had a diagnosis of dementia, and whose dementia had progressed to the point where they were unable to speak for themselves. The facility did not develop a clearly outlined policy, including when and how the open	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135052		C 07/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COEUR D'ALENE HEALTH CARE & REHABILITATION CENTER	2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 11 to air practice should be implemented and monitored, or the potential for negative psychosocial outcomes of residents being left exposed and without their waste contained. The care plans of the effected residents were not individualized, nor were resident families consulted for their input when their loved ones had advanced dementia. On 7/16/14 at approximately 1:45 PM, the Administrator and Regional Vice President were informed of the surveyor's concerns. The surveyors requested the facility provide additional information regarding clinical rationale for an open to air practice, and the corporate policy for incontinence management at night. However, the facility provided no additional information.	F 309		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	MDS001600		07/16/2014

NAME OF PROVIDER OR SUPPLIER: COEUR D'ALENE HEALTH CARE & REHABILIT

STREET ADDRESS, CITY, STATE, ZIP CODE: 2514 NORTH SEVENTH STREET, COEUR D'ALENE, ID 83814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	16.03.02 INITIAL COMMENTS 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. The following deficiencies were cited during a complaint investigation at Coeur D'Alene Care and Rehabilitation. The complaint investigation was conducted on July 16, 2014. The survey team was: Nina Sanderson, BSW LSW, Team Leader Lorraine Hutton, RN	C 000	RECEIVED AUG 13 2014 FACILITY STANDARDS	
C 400	02.120,05,c,v Window Provided With Screen v. It shall have screening. This Rule is not met as evidenced by: Based on observation, staff interview, and a complaint from the public, it was determined the facility failed to provide screens for all windows in the dining room. This had the potential to effect all resident's dining in the room and wanting fresh air through the windows without the influx of flies or bugs. Findings include: During a tour of the building at 8:45 am on 7/16/14, all windows in resident rooms and common access rooms were observed. Although all resident rooms were observed to have screens on their windows, two windows in the dining room did not have screens. Both windows were located near a large table with the capability of seating 10 to 12 residents. One of the windows was directly in front and to the right of the long side of the table. The second window was to the right of the end of the table. Each window was approximately 5 feet from the table and could be opened to permit the entrance of fresh air.	C 400	1. No residents were harmed by this practice. Screens were replaced in the two windows 2. Maintenance completed an audit of windows to ensure screens are in place. 3. Maintenance will make weekly rounds to ensure windows have screens in place. 4. ED/designee will conduct audits weekly x 4 weeks then monthly x 2 months to ensure screens are in place	08/20/2014

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: C.C. Clark | TITLE: Executive Director | (X6) DATE: 8/11/14

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	MDS001600		07/16/2014

NAME OF PROVIDER OR SUPPLIER: COEUR D'ALENE HEALTH CARE & REHABILIT

STREET ADDRESS, CITY, STATE, ZIP CODE: 2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 400	Continued From page 1 At 9:00 am the facility administrator and the corporate regional vice president (RVP) toured the dining room with the surveyor. The missing screens were pointed out to the administrator who indicated they would place screens in the window. Prior to leaving the facility at 2:00 pm on 7/16/14, the RVP handed the survey team a receipt for the purchase and future placement of two large window screens.	C 400		

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

August 11, 2014

FILE COPY

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

Provider #: 135052

Dear Mr. Clarke:

On **July 16, 2014**, a Complaint Investigation survey was conducted at Coeur d'Alene Health Care & Rehabilitation Center. Nina Sanderson, L.S.W. and Lorraine Hutton, R.N. conducted the complaint investigation.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006543

ALLEGATION #1:

The complainant reported windows in the facility did not have screens in them.

FINDINGS:

During a tour of the facility on July 16, 2014, two large windows in the dining room were observed to be without screens as required by the State Life Safety Code. The complaint was substantiated and the facility was cited at C400 on the State Survey Report.

CONCLUSIONS:
Substantiated. State deficiencies related to the allegation are cited.

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

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

LKK/dmj