



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – GOVERNOR
RICHARD M. ARMSTRONG – DIRECTOR

TAMARA PRISOCK – ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
JAMIE SIMPSON – PROGRAM SUPERVISOR
RESIDENTIAL ASSISTED LIVING FACILITY PROGRAM
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: 208-334-6626
FAX: 208-364-1888

November 6, 2013

Bonita Powers, Administrator
Pacifica Senior Living Coeur d'Alene
Managed by Encore Senior Living, LLC
840 E. Dalton Ave.
Coeur d'Alene, ID 83815

License #: RC-1049

Dear Ms. Powers:

On September 10, 2013, a complaint investigation survey was conducted at Pacifica Senior Living Coeur d'Alene - Managed by Encore Senior Living, LLC. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level:

- Non-core issues, which are described on the Punch List, and for which you have submitted evidence of resolution.

Your submitted evidence of resolution is being accepted by this office. Please ensure the corrections you identified are implemented for all residents and situations, and implement a monitoring system to make certain the deficient practices do not recur.

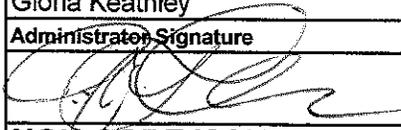
Thank you for your work to correct these deficiencies. Should you have questions, please contact Gloria Keathley, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 364-1962.

Sincerely,

Gloria Keathley, LSW
Team Leader
Health Facility Surveyor

GK/ftp

cc: Jamie Simpson, MBA, QMRP Supervisor, Residential Assisted Living Facility Program

Facility Pacifica Senior Living CDA	License # RC-1049	Physical Address 840 EAST DALTON AVENUE	Phone Number (208) 665-2100
Administrator Jeffery Hill	City COEUR D'ALENE	ZIP Code 83815	Survey Date September 10, 2013
Survey Team Leader Gloria Keathley	Survey Type Complaint Investigation	RESPONSE DUE: October 10, 2013	
Administrator Signature 	Date Signed 9/14/13	22	

NON-CORE ISSUES

Item #	IDAPA Rule # 16.03.22.	Description	Department Use Only	
			EOR Accepted	Initials
1	225.02.c	Interventions used to manage Resident #'s 1 3 & 4's behaviors were not evaluated when they were not effective.	10/30/13	JK
2	300.01	The facility RN did not assess residents for changes of conditions such: Resident #1's lethargy and abdominal pain, Resident #2's weight loss and Resident #6's physical decline.	10/30/13	JK
3	305.04	The facility RN did not make recommendations when changes of conditions were reported to her.	10/30/13	JK
4	305.7	The facility RN did not evaluate the side effects of psychotropic medications and report concerns to the physician.	10/30/13	JK
5	335.03	Staff were observed using a shared cloth towels in the kitchen to dry their hands. Staff were not observed to wash hands or change gloves between tasks.	10/15/13	JK
6	350.02	The administrator did not complete an investigation of incidents and accidents.	10/3/13	JK
7	451.01	The menu was not signed by a dietician.	10/13/13	JK
8	600.06	The facility did not schedule sufficient staff: For example, 1 caregiver had to feed 4 residents simultaneously, and residents were left unsupervised while a caregiver provided care in another room. Additionally, the facility did not follow their admission agreement regarding staffing patterns.	10/20/13	JK
9	711.01.a	Behavior tracking did not include the specific time the behavior occurred.	10/31/13	JK
10	711.08.e	Caregivers did not document notification of the nurse prior to giving PRN medications to residents who were unable to request them.	10/30/13	JK
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September 20, 2013

Jeffery FM Hill, Administrator
Pacifica Senior Living Cd'A
Mngd By Encore Senior Living
840 E Dalton Ave
Coeur d'Alene, ID 83815

Dear Mr. Hill:

An unannounced, on-site complaint investigation survey was conducted at Pacifica Senior Living Cd'A - Managed By Encore Senior Living, LLC between September 9 and September 10, 2013. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00005894

Allegation #1: The facility did not follow a dietician approved menu.

Findings #1: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.451.01 for not following an approved dietician menu. The facility was required to submit evidence of resolution within 30 days.

Allegation #2: Residents were not assisted with eating when the caregivers would spend time talking on their cell phones.

Findings #2: Substantiated. However, the facility was not cited as they acted appropriately by identifying the problem prior to the complaint investigation and terminating the caregivers that were involved in this practice.

Allegation #3: Residents were not receiving medications as ordered.

Findings #3: Nine residents' records and medication assistance records (MARs) were reviewed. All nine records contained documentation that medications were given as ordered.

On 9/9/13, seven caregivers stated they gave medications as directed on the MAR. Additionally, the caregivers stated they checked the MAR with the medication packaging prior to assisting the resident with medications. They further stated, if a resident received a new medication, the facility LPN was called to confirm dosage and times. If PRNs (as needed) were requested, the facility LPN was called and caregivers were directed on giving the medication.

On 9/10/13 at 8:18 AM, the facility wellness director (LPN) stated caregivers called her with new medication changes and if a resident needed a PRN.

Unsubstantiated. This does not mean the incident did not take place; it only means that the allegation could not be proven.

Allegation #4: Tab alarms and call lights were not responded to in a timely manner.

Findings #4: Between 9/9/13 and 9/10/13, during the complaint investigation, call lights and tab alarms were observed to be answered in a timely manner in all three buildings. Eight residents that were interviewable stated call lights were answered in a timely manner. Seven staff interviewed stated they were able to answer call lights timely. They additionally stated, tab alarms were answered quickly to prevent a resident from falling.

Unsubstantiated. This does not mean the incident did not take place; it only means that the allegation could not be proven

Allegation #5: The facility staff did not practice good infection control.

Findings #5: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.335.03 for staff sharing a common use cloth towel in the kitchen and not washing their hands appropriately or changing gloves between tasks. The facility was required to submit evidence of resolution within 30 days.

Allegation #6: The facility did not have appropriate nursing oversight.

Findings #6: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.300.01 for the facility RN not assessing residents with changes of condition. The facility also received a deficiency at IDAPA 16.03.305.07 for the facility RN not evaluating the side effects of psychotropic medications and reporting concerns to the physician. The facility was required to submit evidence of resolution within 30 days.

Allegation #7: Residents were not treated with dignity and respect.

Findings #7: Substantiated. However, the facility was not cited as they acted appropriately by investigating the allegations of mistreatment and terminating the staff prior to the investigation.

Allegation #8: Facility staff were not properly trained.

Findings #8: On 9/10/13, seven employee records were reviewed. All seven records contained signed documentation of orientation training. The records also included specialized training in dementia and ongoing monthly training sessions.

Between 9/9/13 and 9/10/13, seven caregivers interviewed stated they received 16 hours of orientation training, which included general care of residents and training on behavior management. They further stated, the facility nurse would watch them perform duties before delegating medication assistance and other tasks.

On 9/10/13 at 8:18 AM, the facility LPN stated she provided a 16 hour orientation class and then she would watch caregivers perform care and medication passes before signing off on delegation. She further stated, a new behavior management training was being conducted the week of the complaint investigation.

On 9/10/13 at 11:05 AM, the executive director stated caregivers received at least 16 hours of orientation. She stated the caregiver then "shadowed" another caregiver for a few days. The caregivers also had additional training usually on a monthly basis.

Unsubstantiated.

Please bear in mind that non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference, on **September 10, 2013**. The completed punch list form and accompanying evidence of resolution (e.g., receipts, pictures, policy updates, etc) are to be submitted to this office within thirty (30) days from the exit date.

If you have questions or concerns regarding our visit, please call us at (208) 364-1962. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,



Gloria Keathley, LSW
Health Facility Surveyor
Residential Assisted Living Facility Program

GK/TFP

cc: Jamie Simpson, MBA, QMRP, Supervisor, Residential Assisted Living Facility Program



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September 20, 2013

Jeffery FM Hill, Administrator
Pacifica Senior Living Cd'A
Mngd by Encore Senior Living
840 E Dalton Ave
Coeur d'Alene, ID 83815

Dear Mr. Hill:

An unannounced, on-site complaint investigation survey was conducted at Pacifica Senior Living Cd'A - Managed by Encore Senior Living, LLC between September 9 and September 10, 2013. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00005929

Allegation #1: The facility did not provide residents with an appropriate discharge.

Findings #1: Unsubstantiated. According to rule 16.03.22.220.01.c, the facility was authorized to issue an immediate discharge to protect the residents from potential danger. It could not be determined based on the facility documentation, that the discharge notice was not given in accordance to the rule. Additionally, at the time of the complaint investigation, a change of ownership had occurred. Therefore, only current facility practices could be addressed. It was not determined during the investigation that the facility was currently giving innappropriate discharges.

Allegation #2: The facility did not have enough staff to adequately supervise residents.

Findings #2: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.600.06 for the facility not scheduling sufficient staff to adequately supervise the residents. The facility was required to submit evidence of resolution within 30 days.

Allegation #3: The facility did not provide residents with a partial month refund after being discharged immediately from the facility.

Jeffery FM Hill
September 20, 2013
Page 2 of 2

Findings #3: Insufficient Evidence was available at the time of the investigation and in the records reviewed to substantiate this allegation.

Unsubstantiated.

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If you have questions or concerns regarding our visit, please call us at (208) 364-1962. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,

A handwritten signature in black ink, appearing to read 'GK', with a long horizontal flourish extending to the right.

Gloria Keathley, LSW
Health Facility Surveyor
Residential Assisted Living Facility Program

GK/ftp

cc: Jamie Simpson, MBA, QMRP, Supervisor, Residential Assisted Living Facility Program



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Dear Mr. Hill:

An unannounced, on-site complaint investigation survey was conducted at Pacifica Senior Living Cd'A - Managed By Encore Senior Living, LLC between September 9 and September 10, 2013. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00006098

Allegation #1: The facility did not have sufficient staff to supervise residents' behaviors.

Finding #1: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.600.06 for the facility not scheduling sufficient staff to adequately supervise the residents' behaviors. The facility was required to submit evidence of resolution

Allegation #2: Residents' behavior management plans were not effective.

Findings #2: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.225.02.c for the facility not evaluating whether or not interventions used were effective in managing residents' behaviors. The facility was required to submit evidence of resolution within 30 days.

Allegation #3: The facility nurse did not respond to residents' changes of condition.

Findings #3: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22. 300.01 for the facility RN not assessing residents with changes of condition. The facility was required to submit evidence of resolution within 30 days.

Allegation #4: Unlicensed staff did not call the facility nurse to assist with as needed (PRN) medications.

Findings #4: On 9/9/13 through 9/10/13, record reviews and interviews were conducted concerning PRN medications.

On 9/9/13 through 9/10/13, seven caregivers stated they called the facility nurse (LPN) prior to giving a PRN medication. They additionally stated the facility nurse instructed them on the appropriate PRN to give.

Unsubstantiated. However, the facility was issued a deficiency at IDAPA 16.03.22.711.08.e for not having documentation that the facility nurse was called when PRN medications were given. The facility was required to submit evidence of resolution within 30 days.

Please bear in mind that non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference, on **September 10, 2013**. The completed punch list form and accompanying evidence of resolution (e.g., receipts, pictures, policy updates, etc) are to be submitted to this office within thirty (30) days from the exit date.

If you have questions or concerns regarding our visit, please call us at (208) 364-1962. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

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