



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

Scott Doughton, Administrator  
Emeritus at Coeur d'Alene  
205 E. Anton Avenue  
Coeur d'Alene, ID 83815

License #: RC-771

Dear Mr. Doughton:

On September 13, 2013, a complaint investigation survey was conducted at Emeritus at Coeur d'Alene. 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 Karen Anderson, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 364-1962.

Sincerely,

Karen Anderson, RN  
Team Leader  
Health Facility Surveyor

KA/ftp

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



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P.O. Box 83720  
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PHONE: 208-334-6626  
FAX: 208-364-1888

September 24, 2013

**CERTIFIED MAIL #: 7012 1010 0002 0836 0232**

Bridget Kosinski, Administrator  
Emeritus at Coeur d'Alene  
205 E. Anton Ave.  
Coeur d'Alene, ID 83815

Dear Ms. Kosinski:

A complaint investigation survey was conducted at Emeritus at Coeur d'Alene between September 11 and September 13, 2013. Eight (8) non-core issue deficiencies were identified on the punch list and two (2) were identified as repeat punches. As explained during the exit conference, the completed punch list form and accompanying evidence of resolution (e.g., receipts, photographs, policy updates, etc.) needs to be submitted to our office no later than October 13, 2013.

Two (2) of the repeat deficiencies have been cited on three (3) consecutive surveys, as follows:

- 10/21/2009
- 6/27/2012
- 9/13/2013

These deficiencies are direct violations of the following administrative rules for Residential Care or Assisted Living Facilities in Idaho:

**IDAPA 16.03.22.320. REQUIREMENTS FOR THE NEGOTIATED SERVICE AGREEMENT.**

**01. Use of Negotiated Service Agreement.** Each resident, regardless of the source of funding, must enter into a Negotiated Service Agreement. The Negotiated Service Agreement provides for coordination of services and instruction to the facility staff. Upon completion, the agreement must clearly identify the resident; describe services to be provided, the frequency of such services, and how such services are to be delivered. The Negotiated Service Agreement must be implemented.

**IDAPA 16.03.22.350. REQUIREMENTS FOR HANDLING ACCIDENTS, INCIDENTS, OR COMPLAINTS.**

**02. Administrator or Designee Investigation within Thirty Days.** The administrator or designee must complete an investigation and written report of the finding within thirty (30) calendar days for each accident, incident, complaint, or allegation of abuse, neglect or exploitation.

The following administrative rules for Residential Care or Assisted Living Facilities in Idaho give the Department the authority to impose a monetary penalty for these violations:

**IDAPA 925. ENFORCEMENT REMEDY OF CIVIL MONETARY PENALTIES.**

**01. Civil Monetary Penalties.** Civil monetary penalties are based upon one (1) or more deficiencies of noncompliance. Nothing will prevent the Department from imposing this remedy for deficiencies which existed prior to survey or complaint investigation through which they are identified. Actual harm to a resident or residents does not need to be shown. A single act, omission or incident will not give rise to imposition of multiple penalties, even though such act, omission or incident may violate more than one (1) rule.

**02. Assessment Amount for Civil Monetary Penalty.** When civil monetary penalties are imposed, such penalties are assessed for each day the facility is or was out of compliance. The amounts below are multiplied by the total number of occupied licensed beds according to the records of the Department at the time noncompliance is established.

b. Repeat deficiency is ten dollars (\$10).

Based on findings that you have repeatedly failed to correct these deficiencies, the Department is imposing the following penalties:

For the dates of June 15, 2013, through September 13, 2013:

Penalty	Number of Deficiencies	Times number of Occupied Beds	Times Number of days of non-compliance	Amount of Penalty
\$10.00	2	65	90	\$ 117,000

Maximum penalties allowed in any ninety day period per IDAPA 16.03.22.925.02.c:

# of Occupied Beds in Facility	Initial Deficiency	Repeat Deficiency
3-4 Beds	\$1,440	\$2,880
5-50 Beds	\$3,200	\$6,400
51-100 Beds	\$5,400	\$10,800
101-150 Beds	\$8,800	\$17,600
151 or More Beds	\$14,600	\$29,200

Your facility had 65 occupied beds at the time of the survey. Therefore, your maximum penalty is: \$10,800.

Send payment of \$10,800 by check or money order, made payable to:

**Licensing and Certification**

Mail your payment to:

**Licensing and Certification - RALF**  
**PO Box 83720**  
**Boise, ID 83720-0009**

Payment must be received in full within 30 calendar days from the date this notice is received. Interest accrues on all unpaid penalties at the legal rate of interest for judgments. Failure of a facility to pay the entire penalty, together with any interest, is cause for revocation of the license or the amount may be withheld from Medicaid payments to the facility.

Bridget Kosinski  
September 24, 2013  
Page 3 of 3

Please be advised that you may contest this decision by filing a written request for administrative review pursuant to IDAPA 16.05.03.300, **no later than twenty-eight (28) days after this notice was mailed.** Any such request should be addressed to:

**Tamara Prisock, Administrator  
Division of Licensing and Certification  
Department of Health and Welfare  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0009**

If you fail to file a request for administrative review within the time allowed, this decision shall become final.

Should you have any questions, or if we may be of assistance, please call our office at (208) 364-1962.

Sincerely,



JAMIE SIMPSON, MBA, QMRP  
Program Supervisor  
Residential Assisted Living Facility Program

KA/TFP

cc: Steve Millward, Licensing & Certification



Facility Emeritus at Coeur d' Alene	License # RC-771	Physical Address 205 EAST ANTON AVENUE	Phone Number (208) 667-6490
Administrator Bridget Kosinski <i>Bridget Kosinski</i>	City COEUR D'ALENE	ZIP Code 83815	Survey Date September 13, 2013
Survey Team Leader Karen Anderson	Survey Type Complaint Investigation	RESPONSE DUE: October 13, 2013	
Administrator Signature	Date Signed		

**NON-CORE ISSUES**

Item #	IDAPA Rule # 16.03.22.	Description	Department Use Only	
			EOR Accepted	Initials
1	220.10.c	Resident #6 was charged more than 15 days after an emergency discharge.	10/13/13	KA
2	300.02	Resident #3's oxygen was not implemented as ordered, as the caregivers and facility nurse were not aware of the current physician's orders. Previously cited on 3/2/12 & 6/20/12	10/13/13	KA
3	305.02	Physician orders were not signed for Resident #3 and there was no current oxygen order.	10/13/13	KA
4	305.03	The facility RN did not assess residents' changes of condition such as: Resident #2's skin tears, Resident #3's decline in health status and Resident #6's falls.	10/13/13	KA
5	310.01.f	Resident #3 was not observed to completely swallow her medications before the medication aide left her room. The resident was observed choking on the pill and then spitting it out on a napkin.	10/13/13	KA
6	320.01	Staff did not follow the NSA for Resident #3 & #6 such as: toileting and ambulation, and Resident #2's NSA did not reflect the required assistance she needed for eating. Resident #3's NSA was not followed regarding laundry services. Previously cited on 10/21/09 & 6/27/12.	10/13/13	KA
7	350.02	The administrator did not investigate all incidents and accidents. Previously cited on 10/21/09 & 6/27/12.	10/13/13	KA
8	711.08.c	Documentation was not maintained when the NSA was not followed, such as, showers not being given.	10/13/13	KA
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September 23, 2013

Bridget Kosinski, Administrator  
Emeritus at Coeur d'Alene  
205 E. Anton Ave  
Coeur d'Alene, ID 83815

Dear Ms. Kosinski:

An unannounced, on-site complaint investigation survey was conducted at Emeritus at Coeur d'Alene between September 11 and September 13, 2013. During that time, observations, interviews or record reviews were conducted with the following results:

**Complaint # ID00006206**

**Allegation #1:** The facility did not assist residents with oxygen as ordered.

**Findings #1:** Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.300.02 for not implementing oxygen as ordered. The facility was also issued a deficiency at 16.03.22.305.03, for not having current physician orders for oxygen. The facility was required to submit evidence of resolution within 30 days.

**Allegation #2:** The facility was not maintained in a clean and orderly manner.

**Findings #2:** On 9/11/13, a tour of the facility was conducted. The facility was observed to be maintained in a clean and sanitary manner. Thirty-six residents were interviewed during the tour. Each stated they were satisfied with the cleaning services provided at the facility. Additionally, three family members were interviewed and stated the facility was observed clean during their visits, but if they noticed that something needed attention, housekeeping handled the issue in a timely manner. On 9/12/13, further observations were conducted on sampled rooms and the rooms were observed to be clean.

Between 9/11 and 9/12/13, the housekeeper was observed cleaning the facility and caregivers were observed taking trash from residents' rooms. The housekeeper and seven caregivers were interviewed. Each stated that deep cleaning was provided to

residents' rooms weekly by the housekeepers, and residents' rooms were cleaned as-needed by the caregivers.

On 9/12/13, the complaint log was reviewed. It did not contain complaints regarding the cleanliness of the facility.

Unsubstantiated. However, the facility was given technical assistance that one room had an odor, which required the facility's attention.

Allegation #3: Facility staff did not answer call lights in a timely manner.

Findings #3: On 9/11/13, thirty-six residents were interviewed. Thirty-three stated call lights were answered promptly. Three stated, they occasionally had to wait up to thirty minutes before staff came to assist them.

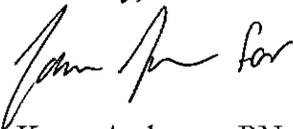
On 9/11/13 and 9/12/13, call light response times were tested at different periods during the day on four occasions. Staff were observed to respond in less than five minutes. During this time, seven caregivers were interviewed and stated they felt there was sufficient staff to answer call lights in a timely manner, unless there was an emergency situation. They further stated, the administrator and nurse were good about responding to call lights if they were busy.

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

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 13, 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,



Karen Anderson, RN  
Health Facility Surveyor  
Residential Assisted Living Facility Program

KA/TFP

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



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September 23, 2013

Bridget Kosinski, Administrator  
Emeritus at Coeur d'Alene  
205 E. Anton Ave  
Coeur d'Alene, ID 83815

Dear Ms. Kosinski:

An unannounced, on-site complaint investigation survey was conducted at Emeritus at Coeur d'Alene between September 11 and September 13, 2013. During that time, observations, interviews or record reviews were conducted with the following results:

**Complaint # ID00006130**

**Allegation #1:** Residents did not receive cares according to their Negotiated Service Agreements (NSAs).

**Findings #1:** Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.3201 for not implementing residents' NSAs. The facility was required to submit evidence of resolution within 30 days.

**Allegation #2:** The facility was not maintained in a clean and sanitary manner.

**Findings #2:** On 9/11/13, a tour of the facility was conducted. The facility was observed to be maintained in a clean and sanitary manner. Thirty-six residents were interviewed during the tour. Each stated they were satisfied with the cleaning services provided at the facility. Additionally, three family members were interviewed and stated the facility was observed clean during their visits, but if they noticed that something needed attention, housekeeping handled the issue in a timely manner. On 9/12/13, further observations were conducted on sampled rooms and the rooms were observed to be clean.

Between 9/11/13 and 9/12/13, the housekeeper was observed cleaning the facility and caregivers were observed taking trash from residents' rooms. The housekeeper and seven caregivers were interviewed. Each stated that deep cleaning was provided to residents' rooms weekly by the housekeepers, and residents' rooms were cleaned as needed by the caregivers.

On 9/12/13, the complaint log was reviewed. It did not contain complaints regarding the cleanliness of the facility.

Unsubstantiated. However, the facility was given technical assistance that one room had an odor, which required the facility's attention.

Allegation #3: Laundry services were not provided according to the NSA.

Findings #3: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.320.01 for not implementing laundry services according to residents' NSAs. The facility was required to submit evidence of resolution within 30 days.

Allegation #4: The facility charged for more than 15 days after a resident was given an immediate discharge.

Findings #4: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.220.10.c for charging for more than 15 days after an emergency discharge. The facility was required to submit evidence of resolution within 30 days.

Allegation #5: The facility did not have an insect control program, which resulted in an infestation of spiders.

Findings #5: On 9/11/13, an inspection of the facility was conducted. Spiders or insects were not observed. Thirty-six residents denied excessive spiders or insects. Seven caregivers stated the facility had a pest control program, which they observed to be effective. One caregiver stated at one time, it was thought a resident had been bitten by a spider, but it turned out to be a bacterial infection.

On 9/12/13, the pest control records were reviewed and documented services were provided on a routine basis.

Unsubstantiated. Although the allegation may have occurred, it could not be determined during the complaint investigation.

Allegation #6: Residents were not observed taking their medications.

Findings #6: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.310.01.f for not observing residents take their medications. The facility was required to submit evidence of resolution within 30 days.

Allegation #7: The administrator did not respond in writing to complainants.

Findings #7: On 9/11/13, the complaint log was reviewed. It contained copies of letters that were provided regarding complaint findings to various complainants.

On 9/12/13 at 11:30 AM, the administrator stated, she responded in writing to all complainants whether complaints were received verbally or in writing.

On 9/11/13, during a tour of the facility, thirty-six residents were interviewed. Two expressed minor complaints, but stated they had not spoken to the administrator. Three family members interviewed, stated they had no complaints regarding the facility and felt the administrator would be responsive if they did have complaints.

Bridget Kosinski, Administrator  
September 23, 2013  
Page 3 of 3

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

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 13, 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,



Karen Anderson, RN  
Health Facility Surveyor  
Residential Assisted Living Facility Program

KA/tp

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



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Bridget Kosinski, Administrator  
Emeritus at Coeur d'Alene  
205 E. Anton Ave  
Coeur d'Alene, ID 83815

Dear Ms. Kosinski:

An unannounced, on-site complaint investigation survey was conducted at Emeritus at Coeur d'Alene between September 11 and September 13, 2013. During that time, observations, interviews or record reviews were conducted with the following results:

**Complaint # ID00006105**

Allegation #1: Residents were not assisted with showers.

Findings #1: Insufficient evidence was available at the time of the investigation and in the records reviewed to substantiate this allegation.

Unsubstantiated. However, the facility received a deficiency at 16.03.22.711.08.c for not maintaining documentation of when the Negotiated service agreement was not followed, such as missed showers.

Allegation #2: Residents were not receiving assistance with all cares according to their Negotiated Service Agreements (NSAs).

Findings #2: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.320.1 for not implementing residents' NSAs. The facility was required to submit evidence of resolution within 30 days.

Allegation #3: The facility did not have RN coverage at all times.

Findings #3: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.305.03 for not ensuring the facility RN was available to address changes of condition. The facility was required to submit evidence of resolution within 30 days.

Allegation #4: Caregivers worked alone prior to having completed orientation.

Findings #4: On 9/11/13 and 9/12/13, seven caregivers were interviewed alone and in private. They all stated they received at least three days of supervised training prior to working alone. They further stated, they received monthly training on various topics and felt they had received enough training to complete their required tasks.

Six employee records were reviewed. All contained the necessary signed evidence of orientation training.

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

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 13, 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,



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