



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 2125 6089

October 9, 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 **September 23, 2014**, we conducted an on-site follow-up revisit to verify that your facility had achieved and maintained compliance. We had presumed, based on your allegation of compliance, that your facility was in substantial compliance as of **August 8, 2014**. However, based on our on-site follow-up revisit conducted **September 23, 2014**, we found that your facility is not in substantial compliance with the following participation requirements:

F281 -- S/S: D -- 42 CFR §483.20(k)(3)(i) -- Services Provided Meet Professional Standards
F323 -- S/S: D -- 42 CFR §483.25(h) -- Free of Accident Hazards/Supervision/Devices
F353 -- S/S: F -- 42 CFR §483.30(a) -- Sufficient 24-Hr Nursing Staff Per Care Plans
F364 -- S/S: E -- 42 CFR §483.35(d)(1)-(2) -- Nutritive Value/Appear, Palatable/Prefer Temp

In addition, a Complaint Investigation survey was conducted in conjunction with the on-site follow-up.

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

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state the date when each will be completed. **Please provide ONLY ONE completion date for each federal and state tag in column X5 Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

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

The findings to the Complaint Investigation is being processed and will be sent to your facility under separate cover.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **October 22, 2014**.

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

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained.
- 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*.

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As noted in the letter of **July 29, 2014**, following the **Complaint Investigation** survey of **July 15, 2014**, we have already made the recommendation to the Centers for Medicare and Medicaid Services (CMS) for Denial of Payment for New Admissions and termination of the provider agreement 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.

STATE ACTIONS effective with the date of this letter (**October 9, 2014**):

If you believe the 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, option #2; 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.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. 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)

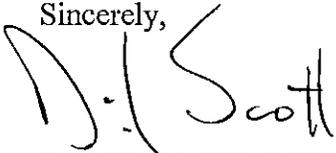
[2001-10 Long Term Care Informal Dispute Resolution Process](#)
[2001-10 IDR Request Form](#)

This request must be received by **October 22, 2014**. If your request for informal dispute resolution is received after **October 22, 2014**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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Thank you for the courtesies extended to us during the on-site follow-up revisit. 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 "D. Scott". The signature is written in a cursive style with a large, stylized "D" and "S".

DAVID SCOTT, R.N., Supervisor
Long Term Care

DS/dmj
Enclosures

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

PRINTED: 10/08/2014
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 R-C 09/23/2014
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF COEUR D'ALENE			STREET ADDRESS, CITY, STATE, ZIP CODE 500 WEST AQUA AVENUE COEUR D ALENE, ID 83815		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 281	Continued From page 1 with diagnoses which included respiratory failure, anxiety, and diabetes mellitus. On 9/22/14 at 12:05 p.m., Resident #6 stated two insulin syringes had been left by a nurse in her room. The resident opened the drawer in her overbed table and took out two items wrapped in paper. The resident opened the first item, wrapped in paper, showed the surveyor a syringe and stated it was left on her overbed table on 8/9/14 and was the "last shot of the day." The resident opened the second item wrapped in paper which was another syringe and stated she had found the syringe on the floor in her room on 8/2/14. On 9/23/14 at 3:15 p.m., the DON stated the syringes should have been disposed by the nurse who administered the medication. She stated there was a sharps container in the resident's room and a sharps container on the side of the medication cart for syringe disposal.	F 281	Other staff were inserviced on notifying LN, DON, ED if needles were observed in residents room. MONITOR Unit managers and/or designee are performing room rounds to ensure safe sharps disposal. DON or designee will monitor for compliance of safe sharp disposal through review of daily rounds and incident reports. The results of the room rounds and incident reports will be taken to the monthly Quality Assurance meetings for review and action taken as necessary.		
{F 323} SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, it was determined the facility failed to	{F 323}	F-323 SPECIFIC RESIDENT Resident # 9 receives adequate supervision to prevent falls as she allows. She has requested no 1:1 observations as it makes her feel like a baby. She has agreed to allow the use of alarms. Her care plan has been reviewed and updated as indicated. She has had no further falls.	10-9-14	

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{F 323}	<p>Continued From page 2.</p> <p>ensure residents received the appropriate care and services, including adequate supervision, to prevent both injury- and non-injury falls. This was true for 2 of 4 sampled residents (#s 8 and 9) reviewed for falls. Resident #8 was lowered to the floor when a CNA failed to lock the resident's wheelchair brakes prior to transferring the resident. Resident #9 was injured when she fell on her newly acquired leg stump and the incision site dehiscd. This failed practice had the potential for harm if either resident sustained an injury requiring surgical intervention.</p> <p>1. Resident #8 was admitted to the facility on 6/18/14 with multiple diagnoses, including above the knee amputation, generalized pain, Peripheral Vascular Disease (PVD), and Coronary Atherosclerosis.</p> <p>The resident's most recent MDS, dated 7/16/14, documented the resident required extensive assist of two people for bed mobility, transfers, and toileting.</p> <p>The resident's Fall care plan documented the following interventions: * 6/27/14 - Hi/Lo bed in lowest position when in use with mats on floor at bedside. At nurses discretion, may start 1:1, Q [every] 15-30 minute checks, direct line of sight, etc. * 7/21/14 - One assist with wheelchair mobility. * 8/2/14 - q [every] 30 minute checks. * 8/4/14 - Alarm to BR [bathroom door]. * 8/27/14 - Offer to toilet before or after meals, [and] HS [hour of sleep] * 9/10/14 - Brakes must be engaged (locked) with all transfers."</p> <p>An Incident/Accident Data Entry Questionnaire</p>	{F 323}	<p>Resident # 8 is transferred in a manner that maintains safety including ensuring the w/c brakes are locked. Her care plan has been reviewed and updated as indicated. She has had no further falls.</p> <p>OTHER RESIDENTS</p> <p>Residents who are at risk for falls are provided adequate supervision and transfers in a manner that prevent injuries and falls.</p> <p>SYSTEMIC CHANGES</p> <p>The IDT reviewed the current residents who have had repeat falls since January 2014. Care plans were up-dated and adjusted as indicated.</p> <p>The IDT also reviewed the current residents who have had falls in the past 2 months. Care plans were up-dated and adjusted as indicated.</p> <p>The IDT team will continue to review all falls during the daily stand-up meeting to ensure appropriate preventive measures are implemented.</p> <p>Staff were inserviced on fall prevention and safe transfers. This included ensuring brakes are locked and supervision.</p>		

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{F 323}	<p>Continued From page 3 dated 9/10/14 documented: * "When new CNA was assisting resident to the toilet she put the gait belt on and was going to lock the brakes and resident said she didn't have to and when she [CNA] started to transfer her [resident] the w/c [wheelchair] moved and she [CNA] had to lower her [resident] to the floor." * Witness Interview/Statement Form: "Resident told me [CNA] that the wheels did not need to be locked [on the wheelchair] and so I did as she requested. I helped her stand up and she sat in the chair, but was sitting on the corner so we tried to lift her up. The chair came out from underneath her and I didn't know what to do so I slowly lowered her to the floor." * "CNA educated the brakes are always to be locked when transferring a resident." * "Remind resident that with all transfers the w/c breaks must be locked before any transfer can be done, cna also educated."</p> <p>On 9/23/14, the DNS stated the CNA was doing what the resident wanted per the resident's rights. The DNS agreed the facility is responsible to keep residents safe and wheelchair brakes should be locked prior to any transfer.</p> <p>2. Resident #9 had multiple admissions to the facility. The two most recent admission occurred on 8/18/14 and 8/28/14. The resident was admitted with multiple diagnoses, including below the knee amputation, encephalopathy, and mononeuritis.</p> <p>The resident's Quarterly MDS, dated 7/17/14, coded the resident required set-up supervision for bed mobility, transfers, and toileting. The resident had no impairment to her upper or lower extremities.</p>	{F 323}	<p>The facility will continue to provide fall prevention training, and transfer training, on hire and PRN as indicated.</p> <p>ED was inserviced to ensure all incident reports were reviewed within 5 days of the occurrence.</p> <p>MONITOR</p> <p>DON, Unit Managers and/or designee will monitor through observation of transfers.</p> <p>DON, ED and/or designee will monitor through participation in the daily stand-up meeting and review of the daily staffing patterns.</p> <p>Medical Records will audit incident reports to ensure all incidents are reviewed within 5 days.</p> <p>The results of the transfer observations and incident reports will be taken to the monthly Quality Assurance meetings for review and action taken as necessary.</p>	

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{F 323}	<p>Continued From page 4</p> <p>The resident's Fall care plan, dated 7/21/14, documented the following interventions: * Bed against wall to increase living space. * Bedside commode next to bed at night.</p> <p>On 7/25/14, "hourly checks for safety" was handwritten on the care plan.</p> <p>The resident's Progress Notes, dated 8/11/14, documented the following: "I entered res' [sic] room and found res. lying on back with head about 1 ft. under the bed and rest of body facing out toward tv [television]. Res. was unable to explain what caused her to be on the floor. Res. was involuntary [sic] shaking and I asked res if she was cold and she shook her head yes...Res eyes not focusing. Res. not able to answer simple questions and body continued to experience involuntary coarse tremors... Resident was transported to the hospital and admitted with possible sepsis.</p> <p>The Idaho Department of Health & Welfare, Bureau of Facility Standards Informational letter #2014-04, dated 5/23/14, documented the following: "All investigations must be signed by the Administrator within five (5) working days of the allegation/incident. This signature indicates the administrator has reviewed the investigation, approves it as complete, and has ensured that appropriated measures have been taken. If the Administrator is out of the facility, his/her designee may sign the investigations."</p> <p>The Incident Follow-up and Recommendation form, dated 8/11/14, was not signed by the Administrator until 8/29/14 or 14 working days</p>	{F 323}		

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{F 323}	<p>Continued From page 5 after the incident occurred.</p> <p>An Incident form, dated 8/11/14, documented the following: * "Resident attempted to self transfer to bathroom [and] was found on floor, upon assessment res[ident] was noted [with] increased confusion and abnormal [vital signs]. Seen 30 min[utes] prior [and] denied need to toilet. * Interventions in place at the time of incident, "blue gripper socks, call don't fall reminder, and bed alarm." * Interventions in place after the fall, "bed alarm."</p> <p>NOTE: The Nurse's Progress Note and the Summary of Investigative Facts documented two different statements for the cause of the resident's fall. Additionally, the interventions listed on the Incident Follow-up form did not correspond with the current interventions listed on the resident's Fall care plan.</p> <p>The resident's Fall care plan documented the following: * "8/18/14 - D/C [Discontinue] Bedside commode next to bed at night. D/C bed alarm while in bed. * 8/19/14 - W/C (wheelchair) at bedside at night. Encourage call light use at night, wait for help with transfers. Wear blue gripper socks. Wake x 1 at night to toilet. Q [every] hour checks for safety."</p> <p>On 8/25/14, Resident #9 was admitted to the hospital for a below the knee amputation of her right leg and was re-admitted to the facility on 8/28/14.</p> <p>The resident's Fall care plan, dated 8/28/14, documented the following:</p>	{F 323}		

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{F 323}	<p>Continued From page 6</p> <ul style="list-style-type: none"> * D/C Q hr [every hour] checks for safety. * Mobillity alarms to bed and wheelchair. <p>The resident's Significant Change MDS, dated 9/3/14, documented the resident was a two person extensive assist with bed mobility, transfers, and toileting. The resident had impairment to a lower extremity.</p> <p>The resident's Progress Notes, dated 9/2/14, documented, "...CNA reports went to resident's room and found her sitting on the floor leaning against bed. Bed was in low position, non skin [sic] sock worn to L[eft] foot, stump brace (protector) worn to RLE. When asked what happened stated, 'I was trying to reach something on my night stand and I slowly slid off the side of the bed.' She also added that she did not hit her buttocks hard on the floor because she gradually slid off. Call bell was in reach and was not on during the fall."</p> <p>Similar findings were documented in the resident's Incident Follow-Up form dated 9/2/14. Additionally, the Incident Follow-Up form documented the following:</p> <ul style="list-style-type: none"> * Has Hi/Low bed [with] mats. * Bed not in low position. * Has bolsters that were not in place. * Bed alarm not sounding. Bed alarm changed out. * Will initiate lipped mattress to bed. D/C bolsters when available. <p>NOTE: The hourly checks were discontinued on 8/28/14 after the resident was re-admitted to the facility with a right below the knee amputation. On 9/2/14, four days after the hourly checks were discontinued Resident #9 fell.</p>	{F 323}			

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{F 323}	<p>Continued From page 7</p> <p>The Fall care plan was updated on 9/3/14 to include: * Lipped mattress to bed DC bolsters when mattress available. * OT to assess environment and set up for improved functioning.</p> <p>NOTE: The resident's Fall care plan did not document the facility had considered or implemented increased supervision, before or after this fall.</p> <p>The Incident Follow-up and Recommendation form, dated 9/17/14, was required to have been signed by the Administrator or designee on or by 9/23/14. The area for signatures on the form was blank.</p> <p>The resident's Incident Follow-Up & Recommendation Form, dated 9/17/14, documented the following: * "Resident found sitting on floor, leaning against recliner. blood [sic] on stump dressing - [sic] states she was trying to get more [incontinent briefs] from closet shelf [and] slid out of wc - [sic] pulled [herself and], crawled to recliner... Assessed for injuries - [sic] noted dehiscence of Rt [right] stump incision and abrasion to mid[dle] spine. First aide [sic] provided."</p> <p>The resident's Progress Note, dated 9/18/14, documented: * "5:15 PM, LE [Late Entry] for 9/17/14 eve[ning]. LN came to resident's room at 5:15 PM to ask resident's consent for Bathroom [sic] alarm due to her multiple self transfers, explained the purpose, the risk and benefits, resident did not give consent stating that, 'it's getting so restrictive</p>	{F 323}		

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{F 323}	<p>Continued From page 8 now.'</p> <p>* 5:30 PM, I saw the resident's call light on, head [sic] to her room to response, [sic] found resident sitting on the floor leading [sic] against the recliner opposite to the close. [sic]... R[ight] stump was bleeding, pressured [sic] and found a 3 x 1 x 0.1 cm skin tear to mid spine area. Resident stated she could not remember if he [sic] hit his [sic] head of [sic] not. Incision to RBKA was dehiscence [sic] 3 x 0.2, pressure applied."</p> <p>The resident's Progress Notes documented the following: * On 9/20/14 at 1:06 AM, the resident was on 15 minute checks for fall precautions. * On 9/20/14 at 3:43 AM, the resident was on 1 hour checks.</p> <p>NOTE: It could not be determined which intervention was implemented after the fall. The resident's Fall care plan did not document fifteen minute checks or hourly checks as an intervention.</p> <p>On 9/23/14 at 5:45 PM, the DNS and Regional Nurse Consultant (RNC) were interviewed. The DNS was asked how the facility determined that adding more alarms to a resident who already had alarms would decrease the resident's risk of falls. The DNS stated, "When an alarm goes off it alerts staff that a resident is trying to transfer himself/herself and the staff goes to the resident's room and assists the resident." The RNC stated alarms did not always prevent falls, but alarms could alert the resident to wait for assistance. When the surveyor asked whether the alarms helped prevent Resident #9 from falling. The DNS stated the facility had implemented every intervention they had to decrease the resident's</p>	{F 323}			

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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	
{F 323} F 353 SS=F	Continued From page 9 risk for falls and the resident was placed on fifteen minute checks on 9/17/14 after her fall with injury. No additional information was provided to resolve this concern. 483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on a resident group interview, observations, review of grievances, and resident, family and staff interviews, it was determined the facility failed to ensure there was adequate staffing to provide for the needs and well-being of all residents. This affected 2 of 6 sampled	{F 323} F 353	F-353 SPECIFIC RESIDENT Resident #5 and #6, residents that attended the resident group interview and other facility residents have adequate nursing staff to meet their individual care needs including showering, toileting, assistance with ADLs and timely answering of lights. OTHER RESIDENTS Resident residing in the facility have adequate nursing staff to meet their individual care needs and timely answering of lights. SYSTEMIC CHANGES Staff were inserviced on ensuring resident individual care needs are met daily. Staffing patterns have been evaluated and adjustments made as indicated to ensure adequate staffing throughout the facility to provide showers, timely toileting assistance, ADL assistance and timely answering of call lights. The facility has increased the average daily PPD for floor staff.	10-9-14	

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

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F 353	<p>Continued From page 10 residents (#s 5 and 6), and 8 of 10 residents who attended the group interview. This failure had the potential to affect all other residents who lived in the facility who required staff assistance with their ADLs. This created the potential for psychosocial and physical harm to the residents in the facility. Findings included:</p> <p>1. On 9/22/14 at 2:00 p.m., 10 residents attended a group interview with the surveyors. Eight residents attending the interview stated there were not enough staff and voiced the following concerns:</p> <ul style="list-style-type: none"> * Four residents attending the interview stated they transfer themselves, because they can't wait to use the toilet, even though they know they are to be assisted with transfers. Note: The facility was cited at F 323 related to falls, which included residents attempting to transfer themselves to the toilet. * When asked if there had been problems with call lights not being answered timely in the current month (September), 5 of 10 residents stated it had been a problem. * One resident stated he/she has not had a shower for 1 month and on evening or night shift it takes up to 45 minutes to have the call light answered. * One resident stated he/she put his/her call light on early after breakfast or he/she waits up to 2 hours for the light to be answered. * Another resident stated he/she puts the call light on as soon as he/she is in this/her room so he/she "[doesn't] have to wait as long." * One resident stated it took staff 45 minutes to respond to the call light. * A resident reported the mechanical lift was in front of the bathroom door and his/her roommate 	F 353	<p>The facility has increased the average daily hours (PPD) for floor staff by using current and additional staff. Open positions will be aggressively advertised moving forward to include offering sign on and referral bonuses as needed.</p> <p>ED will conduct resident group interviews twice a month to address any care or food concerns.</p> <p>MONITOR</p> <p>Management staff will perform call light audits to monitor call light response time.</p> <p>Social Services and/or designee will perform resident satisfaction interviews to monitor resident perception of their needs being met in to provide showers, toileting assistance, ADL assistance and timely answering of call lights.</p> <p>The results of call light and resident interviews will be taken to the monthly Quality Assurance meetings for review and action taken as necessary.</p>		

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F 353	<p>Continued From page 11</p> <p>had experienced an episode of incontinence waiting for staff to move the lift.</p> <p>* All ten residents stated staff will come into their rooms, turn the call light off, say they will come back, and then do not return. All 10 residents reported this happens on all shifts at least twice a day.</p> <p>* There are not enough staff to serve food in a timely manner. The staff will serve one person and not others at the table. It is uncomfortable to eat when others at the same table must wait a "long time" for their food.</p> <p>* The food served during meals is cold due to not enough staff to serve the food.</p> <p>On 9/23/14 at 12:09 p.m., during an observation of the mid-day meal, Resident #11's tablemate was served his meal and began to eat. Resident #11 sat without his food for 17 minutes while his tablemate finished eating his meal.</p> <p>Three family members, who wished to remain anonymous, were observed eating a meal with their loved ones. When asked if the food was warm enough, one of the family members stated the facility did not have enough staff to ensure the food was warm enough when served. A different family member stated the food tasted good but was not hot enough. A third family member stated the food could be warmer and thought the facility needed more staff to serve the food. After the meal, the first family member stated the facility had "done better" while the surveyors were observing the meal.</p> <p>Note: The facility was cited at F364 related to food temperatures.</p> <p>:</p>	F 353			

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F 353	<p>Continued From page 12</p> <p>2. A Concern/Comment form for Resident #6, dated 8/13/14, documented in the Concern section, "Has issue with staffing and the wait for assistance on and off the commode."</p> <p>On 9/22/14 at 12:05 p.m., Resident #6 stated that morning she had turned on the call light to ask for help to get off of the commode. Staff responded within 10 minutes, turned off the light and said they would come back. The staff came back 15-20 minutes later and stated they were still busy. Resident #6 stated she was on the commode and waited for assistance off the commode and waited to be assisted off the commode from 10:00 a.m. until 11:45 a.m. Additionally the resident stated she was to get 2 showers a week but had missed a shower on 9/20/14 as there were not enough staff. The resident stated the CNA did not always have time to shower residents and had even came in on her day off to make sure Resident #6 had a shower. The resident stated the facility often would document she had refused, which she did sometimes, but on those occasions was not always offered a bed bath.</p> <p>On 9/23/14, CNA #1 stated the bath aide gets reassigned frequently (at least 3 times in past 2 weeks) and there is no time on the following day for the missed baths to be "made up."</p> <p>On 9/23/14, at 12:55 p.m., the Staffing Coordinator (SC) stated the Restorative Aide (RA) frequently got "pulled" on the weekends to work on the floor. The SC was asked for the days the RA was pulled to work on the floor and provided the following documentation:</p> <p>7/4/14 and 7/5/14 from 9:00 a.m. to 2:00 p.m.</p>	F 353			

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F 353	<p>Continued From page 13</p> <p>7/25/14 and 7/26/14 from 2:00 to 5:00 p.m. and 3:30 to 5:00 p.m.</p> <p>8/16/14 and 8/31 (no time documented)</p> <p>9/1/14 from 2:00 p.m. to 4:30 p.m.</p> <p>9/2/14 from 8:00 a.m. to 12:30 p.m.</p> <p>9/14/14 from 7:30 a.m. to 3:00 p.m.</p> <p>9/21/14 from 7:30 a.m. to 2:00 p.m.</p> <p>The Concern/Comments forms were requested from 8/8/14 through 9/22/14 and documented the following:</p> <p>* 8/15/14 - a family member documented a resident's evening meal was delivered 30 minutes after other meal trays for "2 days."</p> <p>* 9/10/14 - documented 2 residents stated "more staff are needed around lunch, dinner and bedtime."</p> <p>* 9/10/14 - Resident Council documented a resident reported CNA's start "helping him and then leave and don't come back." Another resident reported staff were slow at answering call lights.</p> <p>* 9/16/14 - "[Resident #6]" reports had call light on yesterday morning, no one answered, so she had to urinate herself. She said it feels like she's a baby."</p> <p>*A Concern/Comment form, undated, documented a resident reported "has had her call light on 4 x (times) today for toileting. She reports she was only taken to the restroom 1 x and that her call light keeps getting shut off."</p> <p>On 9/23/14 at 6:05 p.m. the DON and the Regional Consultant were informed the facility had failed to ensure adequate staffing. The Consultant stated staffing met the required minimal staffing. The surveyor explained residents' ADL needs were not met as evidenced</p>	F 353			

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F 353	Continued From page 14 by grievances, and interview with family, staff and residents.	F 353	F-364 SPECIFIC RESIDENT		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on Resident Group Interview, Family Interview, test tray evaluation and staff interview, it was determined the facility failed to prepare palatable food. This affected 7 of 10 residents who attended the Resident Group Interview and had the potential to affect other residents who dined in the facility. This failed practice created the potential to negatively affect the resident's nutritional status and psychosocial well-being related to unpalatable food. Findings included: On 9/22/14 at 2:00 p.m., 10 residents attended a group interview with the surveyors. 7 of the 10 residents stated the food served at meals was cold. On 9/23/14 at 12:09 p.m. during an observation of the mid-day meal, three family members, who wished to remain anonymous, were eating a meal with their loved ones. When asked if the food was warm enough, one of the family members stated the facility did not have enough staff to ensure the food was warm enough when served. A different family	F 364	Resident #5 and #6, residents that attended the resident group interview and other facility residents are served meals timely enough to maintain temperature and palatability. OTHER RESIDENTS Residents eating their meals in the facility are served timely enough to maintain temperature and palatability SYSTEMIC CHANGES Staff were inserviced on ensuring timely delivery of meals. Staffing patterns have been evaluated and adjustments made as indicated to ensure adequate staffing throughout the facility. The facility has increased the average daily PPD for floor staff. ED will conduct resident group interviews twice a month to address any food concerns. MONITORS ED, DON, and/or designee will perform resident satisfaction interviews for food palatability.	10-9-14	

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F 364	<p>Continued From page 15</p> <p>member stated the food tasted good but was not hot enough. A third family member stated the food could be warmer. The first family member stated, after the meal, the facility had "done better" while the surveyors were observing the meal.</p> <p>On 9/23/14 at 12:40 p.m. a lunch meal test tray was evaluated by the survey team, the DM, and the RD. The test tray included a pork chop with gravy with a temperature of 105 Fahrenheit (F), mashed potatoes with gravy with a temperature of 122 F, and cooked carrots with a temperature of 120 F. At that time the dietitian stated the potatoes were a good temperature. The surveyor stated the pork chop with gravy was barely warm. The dietary manager stated the pork chop was "right on the edge."</p> <p>On 9/23/14 at 6:05 p.m. the DON and Regional Consultant were informed of the above concern. The Consultant stated the temperatures were taken and were acceptable. The surveyor stated the food was not palatable as it was not warm enough.</p> <p>On 9/24/14, the facility faxed information which did not resolve the issue. The faxed information stated the facility was cited during its' annual recertification survey on, "palatability not temperature." The regulation at F 364 documents in Probes: §483.35(d)(1)(2) "Food temperature": Is food served at preferable temperature (hot foods are served hot) as discerned by the resident and customary practice? Not to be confused with the proper holding temperature." Additionally the fax included a statement by the Dietary Manager that the food was warm enough to eat, "But not hot."</p>	F 364	The results of the food palatability interviews will be taken to the monthly Quality Assurance meetings for review and action taken as necessary.		

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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 R-C 09/23/2014
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF COEUR D'ALENE	STREET ADDRESS, CITY, STATE, ZIP CODE 500 WEST AQUA AVENUE COEUR D ALENE, ID 83816
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{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 the State Licensure complaint/complaint follow up survey in your facility. The survey team was: Sherri Case BSW LSW, QIPD, Team Coordinator Amy Barkley RN, BSN The survey team entered the facility on 9/22/14 and exited the facility on 9/23/14.	{C 000}		10-9-14
C 111	02.100,02,f Provide for Sufficient/Qualified Staff f. The administrator shall be responsible for providing sufficient and qualified staff to carry out all of the basic services offered by the facility, i.e., food services, housekeeping, maintenance, nursing, laundry, etc. This REQUIREMENT Is not met as evidenced by: Please refer F353 as it pertains to adequate nursing staff in the facility.	C 111	Please see Plan of correction for citation of F 353	10-9-14
C 311	02.107,07 FOOD PREPARATION AND SERVICE 07. Food Preparation and Service. Foods shall be prepared by methods that conserve nutritive value, flavor and appearance, and shall be attractively served at proper temperatures.	C 311	Please see plan of correction for citation of F364	10-9-14

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OCT 14 2014
FACILITY STANDARDS

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Byan Lindsy</i>	TITLE Executive Director	(X6) DATE 10-10-14
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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 R-C 09/23/2014
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C 311	Continued From page 1 This Rule is not met as evidenced by: Please refer to F364 as it related to the palatability of the food.	C 311		
(C 790)	02.200,03,b,vi Protection from Injury/Accidents vi. Protection from accident or injury; This Rule is not met as evidenced by: Please refer to F323 as it relates to hazards, accidents and supervision.	(C 790)	Please see plan of correction for citation of F323	10 9-9-14 dy



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

November 3, 2014

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

FILE COPY

Provider #: 135122

Dear Mr. Lindsay:

On **September 23, 2014**, a Complaint Investigation survey was conducted at Life Care Center of Coeur d'Alene. Amy Barkley, R.N., Lorraine Hutton, R.N. and Sherri Case, L.S.W., Q.I.D.P. conducted the complaint investigation.

The complaint allegations, findings and conclusions are as follows:

Complaint #6569

ALLEGATION #1:

The complainant stated a resident was left unsupervised, as there is not enough staff.

FINDINGS #1:

The survey team entered the facility on September 22, 2014, and exited on September 23, 2014.

Based on a resident group interview, observations, review of grievances and interviews with residents, families and staff the complaint was substantiated.

The facility was cited at F353 for lack of sufficient staffing to meet the needs of the residents.

Bryan K. Lindsay, Administrator
November 3, 2014
Page 2 of 2

CONCLUSIONS:

Substantiated. Federal and 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.I.D.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,

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.I.D.P., Supervisor
Long Term Care

LKK/dmj