



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
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FILE COPY

CERTIFIED MAIL: 7012 3050 0001 2125 6096

October 8, 2014

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 **September 26, 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 20, 2014**. However, based on our on-site follow-up revisit conducted **September 26, 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
F441 -- S/S: D -- 42 CFR §483.65 -- Infection Control, Prevent Spread, Linens
F490 -- S/S: D -- 42 CFR §483.75 -- Administration

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

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. **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.

Your copy of the Post-Certification Revisit Report, Form CMS-2567B, listing deficiencies that have been corrected is enclosed. The findings to the complaint investigation is being processed and will be sent to your facility under a cover

Your Plan of Correction (PoC) for the deficiencies must be submitted by **October 21, 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*.

As noted in the letter of **June 24, 2014**, following the **Recertification, Complaint Investigation and State Licensure** survey of **June 13, 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 **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

Cole Clarke, Administrator
October 8, 2014
Page 3 of 3

or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

If you believe 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, 83720-0036; 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.

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)

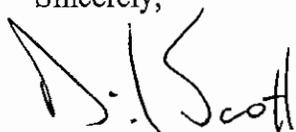
2001-10 Long Term Care Informal Dispute Resolution Process

2001-10 IDR Request Form

This request must be received by **October 21, 2014**. If your request for informal dispute resolution is received after **October 21, 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 on-site follow-up revisit 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,



David Scott, R.N., Supervisor
Long Term Care

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

PRINTED: 10/29/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/26/2014
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NAME OF PROVIDER OR SUPPLIER COEUR D'ALENE HEALTH CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2614 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814
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{F 000}	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during a Follow- Up Re-visit and Complaint Survey at your facility.</p> <p>The survey team included: Amy Barkley, RN, BSN, Team Coordinator Sherri Case, LSW, QMRP</p> <p>The survey team entered the facility on 9/24/14 and exited the facility on 9/26/14.</p> <p>Survey definitions: cm = centimeters DC or D/C = Discontinued ft = feet RBKA = Right below the knee amputation RLE = Right lower extremity</p>	{F 000}	<p>Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or correctness of the conclusions set forth on the statement of deficiencies, the plan of correction is prepared and submitted solely because of the requirements under State and Federal law.</p>	
{F 281} SS=E	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and review of purchase orders, it was determined the facility failed to ensure necessary supplies were readily available at all times. This was true for 4 of 4 direct care staff interviewed regarding the availability of medications and supplies. This failure created the potential for residents not to have their medical or ADL needs met when needed supplies/medications were not available. Findings included:</p>	{F 281}		10/25/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Cole Cloche* TITLE *Executive Director* (X6) DATE *10/30/14* ~~10/20/2014~~ cc

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{F 281}	<p>Continued From page 1</p> <p>On 9/24/14 at 4:30 p.m. the Central Supply cabinet was observed not to have denture cleaning tablets. The staffing coordinator was informed and stated denture tablets had been ordered but because none were available she would run to the local drug store to purchase some.</p> <p>On 9/25/14 LNs across shifts were interviewed and stated the following:</p> <p>LN #1 stated lancets needed to puncture skin for blood glucose checks were not always available and nurses would use "what they got." The nurse stated in the past 6 months the facility had run out of lancets 3 times. LN #1 stated she had purchased supplies for the facility at the local drug store.</p> <p>LN #2 stated the facility would run out of "things" such as insulin syringes and over the counter medications every month. LN #2 stated she had purchased supplies for the facility at the local drug store.</p> <p>LN #3 stated the facility had run out of lancets and had to use insulin syringes to puncture residents' skin to check blood glucose levels. LN #3 stated the facility had been running out of supplies "for at least 6 months."</p> <p>The 7/22/14 and 8/17/14 PO (Purchase Order) Detail forms did not include orders for lancets or denture cleaning tablets. The 7/22/14 PO included an order for syringes, however syringes were not ordered on the 8/17/14 Purchase Order.</p> <p>On 9/25/14 at 5:20 p.m. the DON stated the facility had "gotten low at times, but never run out</p>	{F 281}	<p>This Plan of Correction will serve as the Facility's allegation of substantial compliance</p> <p>F 281</p> <ol style="list-style-type: none"> 1.) Insulin syringes, lancets, and denture tabs are available to meet the needs of current residents requiring these supplies. 2.) The Director of Clinical Services (DCS) and Administrator completed an inventory of central supply to ensure there are adequate supplies to meet the needs of current residents. Various supply storage areas were identified. Supplies have been moved to the designated central supply room to sustain inventory control. Minimum inventory levels (PAR level, example attached) were established for each item based on current resident census and needs. PAR levels will be reviewed and adjusted weekly to reflect changes in census and resident needs. 3.) DCS in-serviced direct care staff on the established location of supplies, inventory supply levels and the procedure for reordering timely to maintain established PAR levels. Direct care staff will review supply needs at the start of the shift and alert DCS/designee of any concerns. 	
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{F 281}	Continued From page 2 of things." The DON added if the facility was low on items she would pick them up at the local drug store. On 9/26/14 at 10:45 a.m. the Administrator stated staff should not have to purchase supplies and it was not acceptable for the facility to run out of supplies. On 9/26/14 at 11:00 a.m., the Administrator, DON, and the Regional Consultant were notified of the above concern. The facility provided no further information.	{F 281}	4.) ED/designee will conduct on-going weekly audits to ensure PAR levels are maintained to meet the needs of the residents. The results of these audits will be reported to QAPI monthly x3 to ensure substantial compliance. 5.) Facility will be in substantial compliance on 10/25/2014.	
{F 441} SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a	{F 441}	F 441 1.) C.N.A's #4, 5, 6, 7 were immediately re-educated and competency tested on hand hygiene practices including washing hands after glove removal. 2.) The DCS / designee completed hand hygiene observations and competency tested current staff (direct care & non-direct care) to ensure hand hygiene is performed according to current CDC guidelines.	10/25/14

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{F 441}	<p>Continued From page 3</p> <p>communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of the facility's policy and procedure on handwashing, it was determined the facility failed to ensure infection control measures were consistently implemented. This was true for 1 of 10 (#4) sampled residents and 3 of 3 (#'s 5, 14, & 20) random residents sampled during cares. Failure to follow hand hygiene procedures placed residents at risk for infections. Findings included:</p> <p>The current CDC (Centers for Disease Control and Prevention) website (<Http://www.cdc.gov>), documented an accepted professional standard, and listed indications for handwashing that included but were not limited to:</p> <ul style="list-style-type: none"> * Before having direct contact with residents. * After contact with a resident's intact skin (when taking blood pressure or lifting a resident). * After contact with body fluids. * If moving from a contaminated-body site to a clean-body site during patient care. * After contact with inanimate objects including 	{F 441}	<p>3.) The nurse management team was educated by the Corporate Nurse Educator (see attached Bio for Karlene Greenleaf) on infection control practices to include hand hygiene, dressing change techniques, isolation precautions, and peri-care. DCS/designee in-serviced facility staff on proper hand hygiene practices including washing hands before and after glove removal. Each nurse manager (DCS, MDS and Unit Manager) was assigned 1/3 of the direct care staff to complete a minimum of two weekly observations related to infection control practices (hand hygiene, peri-care & isolation precautions). Facility staff not following proper procedure will be immediately re-educated. Continued non-compliance will result in disciplinary action, up to termination.</p>		

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{F 441}	<p>Continued From page 4</p> <p>medical equipment in the immediate vicinity of the resident.</p> <p>* After removing gloves.</p> <p>* After any direct contact with the resident.</p> <p>NOTE: Resident #4 and Random Resident #5 were roommates. CNA #4 and CNA #5 were observed at the same time while providing cares for the identified residents.</p> <p>On 9/25/14 at 6:30 AM, CNA #4 washed her hands, applied clean gloves, removed a garbage bag from the garbage can, opened a dresser drawer and removed clean washcloths, and placed those items on the end of the resident's bed.</p> <p>* CNA #4 provided peri-care to the resident and, without first removing the soiled gloves, removed the resident's gown and applied a clean incontinent brief, pants, and shirt. With the same soiled gloves, the CNA then opened the drawer of the resident's dresser, touched several items and removed a pair of socks.</p> <p>* CNA #4 discarded the soiled gloves, washed her hands, and put the socks on the resident.</p> <p>On 9/25/14 at 6:50 AM, CNA #4 was interviewed about the observation. The CNA stated, "I should have washed my hands after the peri-care before dressing the resident and getting into the dresser."</p> <p>On 9/25/14 at 6:30 AM, CNA #5 washed her hands and applied clean gloves. The CNA then removed Resident #4's incontinent brief, opened the second and third dresser drawer, removed clean washcloths, wet the washcloths in the sink, and provide peri-care on the resident. The CNA then assisted the resident to pull her pants up</p>	{F 441}	<p>4.) The Regional Director of Clinical Services (RD/CS) and the Corporate Nurse Educator (bio attached) will conduct observation audits of resident care weekly x4 weeks, then monthly x 2 months to ensure direct care staff practice hand hygiene, including proper glove use in accordance with CDC guidelines. The results of these audits will be reported to the monthly QA/PI x3 months to ensure substantial compliance</p> <p>5.) Facility will be in substantial compliance on 10/25/2014.</p>		

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{F 441}	<p>Continued From page 5 without first removing the soiled gloves or washing her hands.</p> <p>On 9/25/14 at 6:50 AM, CNA #5 was interviewed about the observation. The CNA stated, "I should have gotten the washcloths first and washed my hands after peri-care before pulling the resident's pants up."</p> <p>On 9/25/14 at 2:00 PM, the DNS and Nurse Consultant were informed about the observations. The DNS and Nurse Consultant stated the facility had just provided In-service training for staff on proper handwashing that included: washing hands before applying gloves, after providing peri-care, and before dressing residents after providing peri-care.</p> <p>NOTE: Random Resident #14 and Random Resident #20 were roommates. CNA #6 and CNA #7 were observed at the same time while providing cares for the identified residents.</p> <p>On 9/25/14 at 4:20 PM, CNA #6 and CNA #7 washed their hands, applied gloves, and removed RR #14's soiled incontinent brief. The CNAs provided peri-care and without washing hands or changing gloves placed a clean incontinent brief on the resident. The CNAs, with soiled gloves, then pulled the resident's pants up. CNA #6 removed the gait belt from the resident's waist and placed it on the resident's bed. CNA #7 picked up the gait belt and placed the gait belt on the resident. CNA #6 then spread the resident's blanket over her bed and repositioned her pillow, without first removing the soiled gloves or washing his hands.</p> <p>* 4:25 PM, RR #20 entered the room in her wheelchair and requested to be laid down. CNA #</p>	{F 441}		
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{F 441}	Continued From page 6 7, with solled gloves (from assisting RR #14), walked over to RR #20 and placed her hands on the resident's shoulders. CNA #7 assisted RR #20 onto her bed, lifted the resident's legs and feet onto the bed, and covered the resident with her blanket. * 4:40 PM, CNA #7 removed her gloves and without washing her hands removed a hair brush from RR #14's dresser drawer and brushed the resident's hair.	{F 441}		
F 490 SS=E	On 9/25/14 at 4:50 PM, the DNS and Nurse consultant were informed about the observation. Additional information provided by the facility did not resolve the concern. 483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and review of the facility's compliance history, it was determined the Administrator and management team failed to take actions that identified and resolved systematic problems for 1 of 10 (#4) sampled residents and 3 random residents (#s 5, 14, and 20). This failure resulted in the management team providing insufficient direction and control over the facility to ensure the potential prevention and spread of infection for all residents in the facility.	F 490	F 490 1.) The facility administration will utilize the Performance Improvement (P.I.) program to systematically monitor and evaluate the quality and appropriateness of Resident care, pursue opportunities to improve resident care, resolve identified problems, and identify opportunities for improvement through daily Stand-up and Stand-down meetings, use of the comprehensive 24 hour report, daily Mock Survey rounds by the P.I. members and staff engagement initiatives. Facility administration will provide sufficient direction and control through use of these systems to ensure sustained compliance. In addition, the ED and DCS maintain an "open door" policy to encourage facility staff to report concerns.	10/25/14

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F 490	<p>Continued From page 7</p> <p>Refer to F441 as it relates to the management team's failure to ensure sufficient monitoring and staff training related to proper hand hygiene. The facility has a history of noncompliance and was previously cited at F441 during the annual recertification surveys on 2/18/11, 3/1/12, 5/23/14 and 6/13/14.</p> <p>The management team failed to take actions that identified and resolved systematic problems and sustained compliance which resulted in residents' being placed at risk for spread of infection.</p>	F 490	<ol style="list-style-type: none"> 2.) The Medical Director reviewed the current Infection Control policies related to hand hygiene and infection surveillance data for the past 3 months to ensure the facility is acting in accordance with CDC guidelines. 3.) The RDCS in-serviced the facility management team on the QAPI policy, specifically on identifying high risk/high volume problem prone indicators that will address and reduce the potential for adverse outcomes. 4.) RDCS/designee and Regional Vice President of Operations will provide oversight to ensure the facility administration identifies systematic problems and provides sufficient direction and control to ensure sustained compliance. The results of this oversight will be incorporated into the facilities 'P.I. process. 5.) The facility will be in substantial compliance on 10/25/2014. 	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001600	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 09/26/2014
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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
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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) COMPLETE DATE
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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 a Follow-Up Re-visit and Complaint Survey at your facility. The survey team included: Amy Barkley, RN, BSN, Team Coordinator Sherrl Case, LSW, QMRP The survey team entered the facility on 9/24/14 and exited the facility on 9/26/14.	{C 000}		
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C 107	02.100.02,b Written Policies/Procedures b. The administrator shall be responsible for establishing and assuring the implementation of written policies and procedures for each service offered by the facility, or through arrangements with an outside service and of the operation of its physical plant. The policies and procedures shall further clearly set out any instructions or conditions imposed as a result of religious beliefs of the owner or administrator. The administrator shall see that these policies and procedures are adhered to and shall make them available to authorized representatives of the Department. If a service is provided through arrangements with an outside agency or consultant, a written contract or agreement shall be established outlining the expectations	C 107		
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NOV 10 2014
FACILITY STANDARDS

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Col O'Leary</i>	TITLE Executive Director	(X6) DATE 10/30/14
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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001600	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 09/26/2014
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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
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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) COMPLETE DATE
C 107	Continued From page 1 of both parties. This Rule is not met as evidenced by: Please see F 490 as it pertains to facility administration.	C 107	See POC for F490	10/25/2014.
{C 672}	02.150,03,c Staff Knowledge of Infection Control c. Exhibited knowledge by staff in controlling transmission of disease. This Rule is not met as evidenced by: Please refer to F441 as it relates to infection control.	{C 672}	See POC for F441	10/25/2014.
{C 788}	02.200,03,b,iv Medications, Diet, Treatments as Ordered iv. Delivery of medications, diet and treatments as ordered by the attending physician, dentist or nurse practitioner; This Rule is not met as evidenced by: Please refer to F281 as it relates to accepted standards of practice.	{C 788}	See POC for F281	10/25/2014.



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 7, 2014

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 **September 26, 2014**, a Complaint Investigation survey was conducted at Coeur d'Alene Health Care & Rehabilitation Center. Amy Barkley, R.N. and Sherri Case, L.S.W., Q.I.D.P. conducted the complaint investigation.

The survey team entered the facility on September 24, 2014, and exited the facility on September 26, 2014.

The following documentation were reviewed:

- Resident Council Minutes from March 2014 through August 2014;
- Grievances from March 2014 through August 2014;
- Incident reports and Investigations from August 2014 through September 25, 2014;
- Physicians' Notes;
- Physicians' telephone orders;
- Physician Orders for Scope of Treatment; and
- Policy for Change in Resident Condition

Family members and the Director of Nursing were interviewed.

The complaint allegations, findings and conclusions are as follows:

Complaint #6600

ALLEGATION:

The complainant stated the facility failed to notify her when the resident required suctioning due to an inability to swallow and prior to the resident passing away.

FINDINGS:

Family members for two residents were interviewed and stated the facility notified them in a timely manner of any changes in the resident.

Physicians' telephone orders documented family members were informed of a change in treatment for the residents.

There were no concerns regarding the notification of physician or family for changes in residents' condition documented in the Council minutes or grievances.

Incident/Accident reports reviewed documented family members and the physicians were notified of resident significant changes.

The identified resident's record included a Physician's Progress note, which documented the resident was seen by the physician the day before she passed away. The physician's progress note documented an overall decline for the resident and death was anticipated. The physician's note documented the family was notified. The physician's notes did not document that the resident required suctioning.

A nursing note a day prior to the physician's visit documented the resident was having difficulty swallowing but did not document the resident required suctioning. A nursing note the same day as the physician's note, documented the power of attorney was notified that the resident's temperature was normal and the resident's oxygen level was 93 percent. A late entry documented on the previous day (day of physician's visit) the Director of Nursing called the Power of Attorney informing her of the resident's health decline.

The identified resident's medical record documented the Power of Attorney was notified when the resident passed away at 1:30 a.m. On the day the resident passed away, the Minimum Data Set Coordinator was in the facility and spoke to the nurse. The nurse informed her that the resident had been sick for the past day and the Power of Attorney had been notified.

The Director of Nursing stated she assessed the resident the night before the resident saw the

Cole Clarke, Administrator
November 7, 2014
Page 3 of 3

physician and called the Power of Attorney. The Director of Nursing stated the physician contacted the Power of Attorney the day he examined the resident. The Director of Nursing stated the evening after the physician's visit she had called the Power of Attorney. The Director of Nursing stated the facility assessed the resident frequently for pain and placed the resident on an airbed and oxygen for comfort. The Director of Nursing stated the Power of Attorney was informed of the comfort measures at approximately 10:00 a.m. the day the resident saw the physician.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

As none of the complaint's allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

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



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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November 7, 2014

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 **September 26, 2014**, a Complaint Investigation survey was conducted at Coeur d'Alene Health Care & Rehabilitation Center. Amy Barkley, R.N. and Sherri Case, L.S.W., Q.I.D.P. conducted the complaint investigation.

A total of 23.25 hours were required to complete this complaint.

During the investigation, the Administrator, Director of Nursing (DNS), Regional Nurse Consultant (RNC), Licensed Nurses (LNs), Certified Nurse Aides (CNAs), Dietary Staff and Maintenance Director were interviewed.

The following documents were reviewed:

- The facility's pest control service logs for June, July and August 2014;
- Resident Council Meeting minutes from March 2014 to August 2014;
- Grievances from March 2014 to August 2014;
- Staffing for August and September 2014;
- Supply invoices for July 2014 and August 2014; and
- The facility's policy on hand washing and infection control.

The complaint allegations, findings and conclusions are as follows:

Complaint #6652

ALLEGATION #1:

The complainant stated there were ants seen in two residents' rooms and "everywhere," except the dining room and kitchen. The complainant stated ants were identified in a resident's wound when the bandage was removed and nursing staff was informed. Additionally, the Administrator, Director of Nursing Services, and Maintenance Supervisor were aware. The complainant stated he/she had "heard" an exterminator was recently in the facility.

FINDINGS #1:

On September 24, 2014, fifty residents' rooms and bathrooms were observed to be rodent and insect free. The Maintenance Supervisor provided copies and invoices of the scheduled service visits.

On September 25, 2014, at 4:15 p.m., the Maintenance Supervisor stated that in July 2014 the pest control company identified ants were present on the outside of the building from the main dining room down the two hundred hall. The pest control company sprayed those areas identified and sprinkled granulated ant bait. The Nonattendance Supervisor stated the facility received routine and as needed services.

The identified resident's wound was observed to be free from ants.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant stated he/she and three other staff had "anonymously" submitted a list of items the facility was out of to the Administrator. The facility was out of the following items:

- The facility only had small and bariatric brief sizes, and staff has to run around and try to find briefs in other residents' rooms. The complainant stated an identified resident complained his/her brief was digging into his/her skin.
- On an identified date, an identified nurse had to purchase insulin syringes with her own money because the facility was out.
- Lancets for blood glucose checks were out; therefore, nursing staff was using insulin syringes to lance residents' fingers for blood glucose checks.
- Measuring containers for emptying urinary drainage bags.

- Denture tabs for soaking dentures.

FINDINGS #2:

On September 24, 2014, the following items were observed in the Central Supply:

- Sixteen bags of extra-large briefs, nineteen bags of bariatric briefs, fifteen bags of large briefs, thirteen bags of regular briefs, and fourteen bags of incontinent briefs.
- Four boxes of one hundred count insulin syringes.
- Five boxes of lancets.

On September 24, 2014, at 4:30 p.m., the Central Supply cabinet was observed not to have denture-cleaning tablets. The staffing coordinator was informed and stated denture tablets had been ordered but because none were available, she would run to the local drug store to purchase some.

The rooms of twenty-two incontinent residents were observed to have incontinent briefs in their rooms.

The July 22, 2014 and August 17, 2014, PO (Purchase Order) Detail forms were reviewed and did not include orders for lancets or denture-cleaning tablets. The July 22, 2014, PO included an order for syringes; however, syringes were not ordered on the August 17, 2014, Purchase Order.

On September 24, 2014, the identified resident, when asked how her incontinent briefs fit, stated she just asked the CNAs not to fasten the top tabs.

On September 24, 2014, when asked how staff determined the size of an incontinent brief for a resident, the DNS stated she and the CNA measure the resident's hips for the appropriate size. When asked what it meant if a resident's incontinent brief could not have the top tabs fastened, the DNS stated she would ask the resident why he/she did not want the top tabs fastened. When asked if not fastening the top tabs indicated the brief was too small the DNS stated it was a possibility.

The facility was cited at F281, Professional Standards related to the identified concerns.

CONCLUSIONS:

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

ALLEGATION #3:

The complainant stated on August 29, 2014 or August 30, 2014, all of the individual milk cartons had a "sell by" or "used by" date of August 8, 2014. Two identified residents and an "un-named" resident complained of sour milk that day.

FINDINGS #3:

On September 24, 2014, the following was observed in the walk-in refrigerator:

- Forty fat free individual skim milks, thirty-nine individual vitamin D milks and thirty-two individual two percent milks were observed within expiration dates.
- Thirty-six containers of individual raspberry and vanilla yogurts were within expiration dates.
- Six chicken base and four beef base containers were within expiration dates.
- Two five-pound containers of cottage cheese were within expiration dates.

On September 24, 2014, the dietary staff stated when a new shipment of milk, orange juice, yogurt, etc. comes in the stock is rotated. The new stock is placed in the back and the existing stock is pulled forward. This ensures that the existing stock is used first. The dietary staff stated the milk is not generally rotated because it is used before it is even close to the expiration date.

On September 25, 2014, when asked if they had ever received expired cartons of milk, juice, yogurt, etc., the resident group stated they had not.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The complainant stated the facility was inadequately staffed and had only one CNA in the dining room during the evening shift, and the CNA had to feed four residents and cue eight more.

FINDINGS #4:

The following was observed during a dinner observation on September 24, 2014, and a lunch observation on September 25, 2014; all residents were being attended to, and the facility had only three residents that required total assistance with their meals.

During the dinner observation, the three dependent residents were provided one-to-one staffing to assist with the resident's meals. During the lunch observation, two dependent residents were

Cole Clarke, Administrator
November 7, 2014
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assisted by a licensed nurse, and the other resident received one-to-one assistance.

Grievances were reviewed and did not include any concerns related to staffing during meals.

Resident council meeting minutes were reviewed and did not include any concerns related to staffing during meals.

The group interview was attended by ten residents and no one expressed concerns related to not receiving the help they needed at meals.

The facility implemented a Customer Care Liaison position, and the position is staffed seven days a week by a department head, the DNS or the Administrator. The position is staffed Monday through Friday from 5:00 p.m. to 8:00 p.m. and on Saturday and Sunday from 12:00 p.m. to 8:00 p.m. The liaison is identified by a purple shirt and their picture is placed by the front desk. The liaison is responsible for addressing grievances, concerns related to the dining experience and assisting in the dining room during meals.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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,



LORENE KAYSER, L.S.W., Q.I.D.P., Supervisor
Long Term Care

LKK/dmj