IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

March 18, 2016

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

Provider #: 135052

Dear Ms. Martellucci:

On **March 4, 2016**, a survey was conducted at Coeur d'Alene Health Care & Rehabilitation Center by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE**: The alleged compliance date must be after the "Date Survey Completed" (located in field X3.) **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance.

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **March 28, 2016**. Failure to submit an acceptable PoC by **March 28, 2016**, may result in the imposition of civil monetary penalties by **April 20, 2016**.

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; and
- 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 the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

This agency is required to notify CMS Region X of the results of this survey. We are recommending that CMS impose the following remedy(ies):

- **Civil Monetary Penalty**
- **Denial of payment for new admissions effective as soon as notice requirements can be met. [42 CFR §488.417(a)]**

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **September 4, 2016**, 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, CMS will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact David Scott, R.N. or Nina Sanderson, L.S.W., 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. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx

go to the middle of the page to **Information Letters** section and click on **State** and select the following:

- BFS Letters (06/30/11)

  2001-10 Long Term Care Informal Dispute Resolution Process
  2001-10 IDR Request Form

This request must be received by **March 28, 2016**. If your request for informal dispute resolution is received after **March 28, 2016**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2.

Sincerely,

David Scott, R.N. Supervisor
Long Term Care

DS/lj

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

PRINTED: 03/18/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135052	A. BUILDING _____ B. WING _____	03/04/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following deficiencies were cited during the federal recertification survey conducted at the facility February 29, 2016 to March 4, 2016. The surveyors conducting the survey were: Amy Barkley, RN, BSN, Team Coordinator Presie Billington, RN Abbreviations included: CHF- Congestive Heart Failure cm - centimeters CP - Care Plan CVA - Cerebrovascular Accident DNS- Director of Nursing ER - Emergency Room IDT - Interdisciplinary Team LN-License Nurse MDS - Minimum Data Set MD - Medical Doctor NS- Normal Saline PRN - As needed PT - Physical Therapy PTA - Physical Therapy Assistant SBAR - Situation Background Assessment Request UM- Unit Manager UTI - Urinary Tract Infection w/c - Wheelchair WNL - Within Normal Limits	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	F 241		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Joan B Mackenzie NHA Executive Director 3/25/2016

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.

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

PRINTED: 03/18/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135052	A. BUILDING _____ B. WING _____	03/04/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain residents' dignity when toenails were not kept cleaned and trimmed. This was true for 1 of 9 sampled residents (#2) and created the potential for a negative effect on the resident's self-esteem and possible skin injury. Findings included: Resident #2 was admitted to the facility on 5/22/15 with multiple diagnoses, including dementia and breast cancer. The resident's most recent Quarterly MDS assessment, dated 2/20/16, documented moderately impaired cognition, independent with eating and required one person physical assist for bed mobility, toilet use, personal hygiene, transfers and bathing. On 3/1/16 at 2:50 pm, Resident #2's toenails were observed to be long and thickened. On 3/1/16 at 3:35 pm, the DNS and surveyor went to Resident #2's room. The DNS removed the resident's socks after asking permission and looked at the resident's toenails. The DNS said the resident should have a podiatrist consult. On 3/2/16 at 8:50 am, the DNS said she trimmed Resident #2's toenails and requested a podiatry consult for the resident.	F 241	F 241 Resident #2's toenails were trimmed on 3/2/16 by the Director of Clinical Services. A podiatry appointment was made on 3/3/16 for the resident on 3/8/2106. As of 3/7/16 the resident continues to decline going to the podiatry appointment. Director of Clinical Services /designee have examined current residents for possible need of toenail trimming. Nails were trimmed and/or podiatry appointments were made as appropriate. Social Services will maintain log for toenail/podiatry services and assure podiatry appointments are made. Director of Clinical Services/Designee will assure that nursing services provides toenail care on a regular basis. Current Nursing staff trained on resident dignity/grooming with special attention to toenail care. Social Services Designee and The Director of Clinical Services will submit a Toenail/Podiatry report monthly, for 12 months, with recommendations, to QA/PI committee for ongoing compliance.	4/4/2016
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social	F 250		

PRINTED: 03/18/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	136052	A. BUILDING _____ B. WING _____	03/04/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	Continued From page 2 services 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 staff interview and record review it was determined the facility failed to recognize signs of on-going depression; provide sufficient hours to address social service needs; and complete a thorough and on-going assessment for a resident related to recurrent thoughts of wanting to die. This was true for 1 of 1 sampled resident (Resident #5). Resident #5 had the potential for harm when the RCC did not follow-up on the resident's expressed thoughts and actions related to wanting to die. Findings included: Resident #5 was admitted to the facility on 3/5/15 with multiple diagnoses including dementia, depression, impaired vision, and aphasia. Quarterly MDS assessments, dated 11/27/15 and 2/16/16, coded the resident was tired, had little energy, and a poor appetite. The current Behavior Management care plan, dated 12/14/15, documented, "Risk to self, has a history of pulling plastic bags over her head, suicidal ideations." Interventions included redirect when behavior arises; approach resident calmly and speak with a calming tone; spend one-to-one time with her; offer snacks; offer activities, 15 minute checks, and limit environmental changes. "[RCC] is her favorite person." Nurses Notes from 12/9/16 to 12/30/15	F 250		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	136052	A. BUILDING _____ B. WING _____	03/04/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	Continued From page 3 documented: a. 12/9/15 - "Resident having suicidal ideation. MD called awaiting callback placed on 15 minute checks, adopt-a-resident, and alert charting..." The nurses notes did not include how the suicidal ideation was expressed and/or whether the resident had formulated a plan. b. 12/12/15 - "Continue on 15 minute checks and [there were] no trash bags in the room." c. 12/30/15 - "Resident calling out over and over again 'I want to die.'" Staff were unable to redirect the resident and after several attempts the resident was placed with a 1:1 and calmed down after approximately 1 hour. There was no documentation the MD had been notified of the resident's expressed desire to die. RCC notes contained one entry from 12/9/15 to 1/8/16 related to the resident's expressed suicidal ideations. The 12/9/15 note documented, "Resident verbalized, 'I don't want to live.' Resident unable to explain why or what was wrong. Resident also reported wanting a pill to die and was trying to get into DON's desk drawer. MD was notified. Resident put on 15 minute checks." RCC notes did not document the facility's contracted LMSW had been contacted to follow-up on the resident's expressed desire to die, actions observed on 12/9/15, or the resident's expressed desire to die on 12/30/15. RCC progress review, dated 2/25/16, documented the resident was restless, a danger to herself, and cried. The review did not include what verbal and non-verbal signs the staff should watch for related to self-danger. The progress review did not document the facility's contracted LMSW had been contacted to assess and/or address the resident's social service needs.	F 250	F250 Resident #5 has had no new suicidal ideations. LCSW visited with patient on 3/4/2016 and continues weekly visits. The Interdisciplinary Team reviewed careplan and updated with new interventions to address Resident #5's depression. Facility reviewed current inhouse residents for anyone else with suicidal ideations. None were identified. Director of Clinical Services educated the nursing staff, Clinical Care Coordinator and Consultant Social Worker on suicide policy and procedures. Director of Clinical Services will direct weekly Behavior Management Meeting with the Interdisciplinary Team including the Consultant Social Worker and review current residents for any new suicidal ideations/behavior issues. Clinical Care Coordinator will report monthly x 3 months to QA/PI committee, those patients reviewed by the Behavior Management Committee and any recommendations for improvement in services on an ongoing basis.	4/4/2016

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

PRINTED: 03/18/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135052	A. BUILDING _____ B. WING _____	03/04/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	Continued From page 4 On 3/1/16 at 12:00 pm, the LMSW stated while at the facility she attended morning meetings with staff, spent time discussing resident concerns with the RCC, and followed up with 3 residents she routinely visited every month. She stated those activities took up most of her time. The LMSW stated she attempted to visit with the resident on 2/5/16, but Resident #5 was too tired to meet. On 3/3/16 at 3:30 pm, the Administrator and DNS stated they were not in the building prior to January 2016 and were not aware the resident had expressed suicidal ideations. Social Services stated she was not aware the resident had expressed suicidal ideations on 12/9/15 and again on 12/30/15. When asked why the trash bags had been removed from the resident's room, social services stated the resident had previously placed a trash bag and the trash can over her head. The Administrator stated he was aware the resident did not have trash bags in her room, but did not realize it was related to the resident placing them over her head. On 3/4/16 at 8:00 am, the MD stated that on 12/9/15 nursing staff notified him they had concerns related to possible expressed suicidal thoughts by Resident #5. The MD stated he felt it was a single episode of possible suicidal ideations associated with recurrent mental status changes with behaviors related to UTI. He stated labs were ordered, including a UA. The MD stated he reviewed the "WNL" results on 12/10/15 with the nurse and was told the behaviors had resolved and the resident was back at baseline. The MD stated he considered ordering an antidepressant for the resident but decided it was	F 250		

PRINTED: 03/18/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135052	A. BUILDING _____ B. WING _____	03/04/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	Continued From page 5 not necessary. The MD stated he had not been notified of the 12/30/15 incident.	F 250		
F 323 SS=G	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 record review and staff interview, it was determined the facility failed to ensure residents at risk for falls were adequately assessed and interventions were implemented and monitored for efficacy to prevent repeated falls. This was true for 1 of 3 residents sampled for safety and supervision and resulted in harm to Resident #5 when over the course of two months she experienced four falls, one of which resulted in a facial laceration that required sutures. Findings included: Resident #5 was admitted to the facility on 3/5/15 with multiple diagnoses, including dementia, history of CVA with aphasia, history of bilateral hip replacement, and chronic pain syndrome. The most recent Physical Therapy summary, dated 10/7/15, documented the resident had met the following goals: Improved lower extremity muscle performance and completing transfers independently with tactile cues and contact guard assistance. The Summary documented Resident #5 had reached the optimal functional level for	F 323		

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

PRINTED: 03/18/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135052	A. BUILDING _____ B. WING _____	03/04/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 6 her age and therapy treatments would be discontinued, however the document also noted the resident would continue to be at risk for falls without assistance in the facility. A Quarterly MDS assessments, dated 11/27/15, documented the resident required extensive assistance of one staff for transfers, toileting, hygiene, when moving from a seated to standing position, and when transferring between a bed, chair, and/or wheelchair. From November 2015 to January 2016, the facility documented Resident #5 fell on four occasions. Fall Investigation Reports, Nurses Notes, SBAR, Therapy Screens, Therapy Notes, IDT/Fall Committee Notes, and an ER Report documented the following: 1. 11/26/15 - 2:20 pm: Resident #5 did not wait for assistance and fell while self-transferring from a wheelchair to his/her bed. The resident's right leg was noted to be externally rotated and, when found, the resident was holding his/her right hip and "yell[ing] out" in pain. The MD was notified and Resident #5 was transported to the ER, where x-rays documented he/she sustained a "contusion of the right hip or thigh." a. Fall prevention interventions in place prior to the fall included placing the resident's call light within reach and keeping the bed in its lowest position. b. Post-fall interventions included reminding the resident to ask for assistance with all transfers, 15-minute checks, and a Physical Therapy assessment. This assessment, dated 11/26/15 and performed by a Physical Therapy Aide rather than a licensed Physical Therapist, documented no current problems, changes in status, or potential risks related to transfers, bed mobility, and balance/postural stability. The PTA documented the resident was "recently on PT	F 323	F 323 Resident# 5's fall prevention careplan was reviewed by the Interdisciplinary Team for efficacy and resident was evaluated by a licensed Physical Therapist. Current residents identified as high risk for falls (score of 10 or above on fall risk assessment) fall prevention careplans were reviewed for efficacy and screened by a Licensed Physical Therapist. Director of Clinical Services/designee will conduct random daily rounds of 100% of the high fall risk patients to assure care plan interventions are in place and Interdisciplinary Team will conduct daily/weekly Fall Prevention Meeting to assure careplans are reviewed for efficacy and any time a fall occurs. Screening by a Licensed Physical Therapist will be conducted when requested. Director of Clinical Services or RN Designee will conduct monthly audits x 12 months of newly identified high risk residents or any resident experiencing a fall and report findings to the QAPI Committee for ongoing Compliance.	4/4/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135052	A. BUILDING _____ B. WING _____	03/04/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 7 caseload for similar issue with little improvement. " 2. 12/23/15 - 1:00 pm: Resident #5 was found sitting on the floor next to and " still hanging onto the sink with both hands. It appears she pulled herself up to stand at her sink and then either missed her w/c while sitting down or her legs gave out. " a. In addition to interventions already in place following the 11/26/15 fall, post fall interventions included encouraging the resident to rest after meals and on 12/28/15 the Fall Committee put into place additional interventions, which included staff staying with the resident when she was at her sink, adding the resident to the facility ' s " Adopt-a-Resident " program, initiating alert charting, and performing a therapy screening to address balance and transfers. b. A 12/28/15 therapy screen conducted by the Physical Therapy Aide rather than a licensed Physical Therapist documented the resident had no current problems, changes in status, or potential risks related to transfers, bed mobility, and balance/postural stability. 3. 12/31/15 - 2:00 pm: Staff heard yelling and found Resident #5 lying on her left side on the floor by her sink/bathroom door. The wheelchair with its brakes in the unlocked position was next to the resident, who had sustained a hematoma to her forehead measuring 8.5 cm X 7.5 cm X 1.0 cm; a skin tear to the left elbow measuring 1.9 cm X 1.0 cm; and a " small " [no measurement provided] abrasion to the left ankle. a. In addition to interventions already in place following the 11/26/15 and 12/23/15 falls, post fall interventions included a Physical Therapy evaluation and anti-rollback brakes to the resident ' s wheelchair. b. A 12/31/15 PT screen conducted by a	F 323		

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

PRINTED: 03/18/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	136052	A. BUILDING _____ B. WING _____	03/04/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 8 Physical Therapy Aide rather than a licensed Physical Therapist documented the resident had no current problems, changes in status, or potential risks related to transfers, bed mobility, and balance/postural stability. The PTA documented, " Resident fell while standing at [the] skink. IDT recommendations include self-locking wheelchair. " 4. 1/27/16 - 9:00 am: Resident #5 was found lying on the floor behind her bedroom door. The resident pulled herself to a standing position while hanging onto her sink, lost her balance, and fell onto her left side. Resident #5 sustained a 3.0 cm X 1.5 cm laceration to the left side of her head and was transferred to the ER for evaluation and treatment. The ER report documented a 3.5 cm linear laceration to the left side of the resident ' s forehead to her skull and surrounding bruising; the laceration required 3 sutures. a. In addition to interventions already in place following the 11/26/15, 12/23/15, and 12/31/15 falls, post fall interventions included evaluating the resident for an alarmed Velcro seatbelt and a Physical Therapy screening. b. A 1/28/16 PT screen conducted by a Physical Therapy Aide rather than a licensed Physical Therapist documented no current problems, changes in status, or potential risks related to transfers, bed mobility, and balance/postural stability. The PTA documented, " Resident has fallen several times recently. Discussed rehabilitation potential with PT staff, with the concerns being that patient has not benefitted from previous attempts ... " NOTE: A " Physical Therapist Job Description " provided by the facility documented, " The Physical Therapist assesses the need for, develops, and delivers physical therapy programs to facilitate rehabilitation. "	F 323		

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

PRINTED: 03/18/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135052	A. BUILDING _____ B. WING _____	03/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COEUR D'ALENE HEALTH CARE & REHABILITATION CENTER	2614 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 9 Nursing Notes, dated 2/2/16, documented, " PT soreen and evaluation no treatment indicated. Resident placed on Restorative for [seatbelt] release while in w/c, mobility, and lower extremity ROM to maintain current level of mobility. " A Physician Progress Note, dated 2/9/16, documented that on 2/6/16 Resident #5 " began working with Physical Therapy on standing again. " There was no order in the clinical record directing Resident #5 to begin Physical Therapy. On 3/3/16 at 3:30 pm, the Administrator and DNS stated they were not employed at the facility prior to January 2016 and could not, therefore, provide information related to the resident ' s falls prior to the 1/27/16 injury-accident.	F 323		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure a physician was informed of a pharmacist's recommendation to monitor the Magnesium serum concentration for 1 of 9 residents (#1) sampled for quality of care. Failure to inform the physician of the	F 428		

PRINTED: 03/18/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135052	A. BUILDING _____ B. WING _____	03/04/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 10 recommended laboratory test placed Resident #1 at risk for undetected abnormal Magnesium serum concentration and resulting complications. Findings included: Resident #1 was admitted to the facility on 3/24/15, and was readmitted on 10/16/15, with multiple diagnoses which included essential hypertension and impaired renal function. The resident's recapitulated February 2016 physician's orders documented a 10/16/15 order of Magnesium Oxide 400 mg tablet orally two times a day (supplement). Resident #1's Consultation Summary Report dated 1/1/16 through 2/29/16 documented two recommendations from the pharmacist dated 1/27/16 and 2/24/16 to monitor Resident #1's Magnesium serum concentration. There were no laboratory results of Magnesium serum concentration found in the resident's clinical record. On 3/3/16 at 5:15 pm, the DNS said the doctor would visit at the end of the week and the laboratory request for resident's theMagnesium serum level was placed in his folder for him to review at that time. When asked if the pharmacist recommendation for January was relayed to the physician, the DNS said the UM responsible for informing the doctor of the January recommendation was no longer working in the facility.	F 428	F 428 Serum magnesium level for Resident #1 was obtained and was within normal limits. Director of Clinical Services/designated staff have reviewed all pharmacy recommendations from 1/2016 to present to assure all recommendations have been addressed. Director of Clinical Services/designee will complete pharmacy recommendations within 7 day time frame on an ongoing basis. Medical Records designee will conduct monthly audit for 3 months then quarterly x 1 year to assure recommendations were addressed and report findings to QA/PI for ongoing compliance.	4/4/2016