



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
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April 10, 2017

Jacob Moore, Administrator
Coeur d'Alene Of Cascadia
2514 North Seventh Street
Coeur d'Alene, ID 83814-3720

Provider #: 135052

Dear Mr. Moore:

On **March 23, 2017**, a survey was conducted at Coeur d'Alene of Cascadia 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. **This survey found the most serious deficiency to be an isolated deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided 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. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct." **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. Waiver renewals may be requested on the Plan of Correction.

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After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567 and State Form (if applicable), 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 **April 20, 2017**. Failure to submit an acceptable PoC by **April 20, 2017**, may result in the imposition of penalties by **May 15, 2017**.

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*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **April 27, 2017 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **June 21, 2017**. A change in the seriousness of the deficiencies on **May 7, 2017**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **June 21, 2017** includes the following:

Denial of payment for new admissions effective **June 21, 2017**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying non-compliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **September 19, 2017**, 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.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **June 21, 2017** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, 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>

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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 **April 20, 2017**. If your request for informal dispute resolution is received after **April 20, 2017**, 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,

A handwritten signature in black ink, appearing to read "David Scott for". The signature is written in a cursive, flowing style.

David Scott, RN, Supervisor
Long Term Care

ds/lj
Enclosures

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

PRINTED: 05/01/2017
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 03/23/2017
NAME OF PROVIDER OR SUPPLIER COEUR D'ALENE OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 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 from March 20, 2017 through March 23, 2017. The surveyors conducting the survey were: Presie C. Billington, RN, Team Coordinator Marci L. Clare, RN Survey Abbreviations: DNR = Do Not Resuscitate DON = Director of Nursing LN = Licensed Nurse MDS = Minimum Data Set	F 000			
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered	F 309		4/26/17	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

04/17/2017

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 309	<p>Continued From page 1 care plan, and the residents' choices, including but not limited to the following:</p> <p>(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.</p> <p>(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure residents receiving dialysis had related physician orders and care plans addressing potential emergencies. This was true for 1 of 1 resident (#7) sampled for dialysis. This deficient practice placed Resident #7 at risk of more than minimal harm should staff not know how to respond to emergencies involving his dialysis healthcare needs or if Resident #7 developed medical complications due to lack of monitoring of his dialysis access site. Findings include:</p> <p>Resident #7 was admitted to the facility on 12/21/15, and readmitted on 3/10/17, with multiple diagnoses, including kidney failure and dialysis.</p> <p>Resident #7's quarterly MDS assessment, dated</p>	F 309	<p>For resident #7, the dialysis four (4) times a week order was placed on the April, 2017 orders recapitulation. If additional sessions are done a physician's order will be obtained for the additional session. Additionally, an order to assess the right A-V shunt for bruit/thrill every shift was added to the April 2017 orders recapitulation and to notify the physician if he misses a dialysis session. These directions (orders) were also added to the treatment administration record (TAR). Additional documentation related to checking the AV shunt for Bruit/thrill and bleeding/clotting is found on the Dialysis Communication Record. When the resident returns from dialysis the assessment includes blood pressure, pulse, respirations, a pain assessment,</p>		

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F 309	<p>Continued From page 2 11/16/16, documented he received dialysis.</p> <p>Resident #7's recapitulated January, February, and March 2017, physician's orders did not include an order for dialysis.</p> <p>Resident #7's current care plan documented dialysis for end stage renal disease was provided every Monday, Wednesday and Friday. Other interventions included on the care plan directed staff to:</p> <ul style="list-style-type: none"> * Review and complete dialysis communication forms * Note PRN medications given during dialysis for potential effects upon return to the facility * Monitor vital signs for hypotension [low blood pressure]/volume depletion [a result of the loss of total body salt] effects * Monitor [dialysis] access site each shift * Observe for infection, bleeding, and/or edema * Report any signs or symptoms of redness, drainage, and/or increased pain [at the access site] * Palpate for thrill and bruit [sound and feel of blood flow through a dialysis access site] each shift <p>Resident #7's care plan did not describe how staff were to address emergencies or complications, such as bleeding from the access site. Additionally, Resident #7's clinical record did not include documentation that his dialysis access site was monitored for bleeding, bruit, or thrill.</p> <p>On 3/20/17 at 10:15 am, LN #1 said Resident #7 received dialysis each Monday, Tuesday,</p>	F 309	<p>and the AV shunt assessment including checking for the bruit and the presence of bleeding. This is documented on the Dialysis Communication Record.</p> <p>For resident #7, a care plan was written specifically related to the AV Shunt Management. This care plan included interventions related to assessing the shunt for bruit and Thrill and how to manage bleeding from the shunt or possible clotting in the shunt. Licensed nursing staff were inserviced related to the need to ensure dialysis care needs are addressed during the care planning process.</p> <p>Resident #7 is the only resident at the facility receiving dialysis services.</p> <p>The Dialysis Communication Record, monthly recapitulation physician orders and subsequent physician orders, and TARs will be audited two (2) times monthly. Any variances will be immediately remediated and the specific nurse responsible for the variance will receive 1:1 remediation. The audits will be completed for two (2) months. The results of the audits will be reported to the QA committee for review and further recommendation as indicated and/or appropriate.</p> <p>Care plans are reviewed at least quarterly with the MDS process. All dialysis care needs will be specifically audited during the quarterly care planning process for</p>		

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F 309	Continued From page 3 Wednesday and Friday. On 3/22/17 at 11:35 am, when shown Resident #7's care plan documenting dialysis was provided only on Mondays, Wednesdays and Fridays, LN #1 said the dialysis center scheduled an additional dialysis session when the resident refused a weekly treatment. LN #1 was unable to provide a physician's order addressing the Tuesday dialysis sessions. On 3/22/17 at 1:50 pm, the Interim DON said Resident #7's physician orders and care plan would be revised to reflect the four-day per week dialysis schedule. The Interim DON also stated Resident #7's dialysis care plan did not provide direction to staff for addressing dialysis-related emergencies, such as bleeding from the dialysis access site. When asked how often the resident's dialysis site was monitored, the Interim DON said nurses monitored the site each shift. The Interim DON stated Resident #7's clinical record did not include documentation that his dialysis access site was monitored by staff.	F 309	two (2) quarters. The results of these care plan audits will be reported to the QA committee for review and further recommendations as indicated and/or appropriate. Responsible: Director Clinical Services (DCS), all licensed nursing staff		
F 371 SS=D	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable	F 371		4/26/17	

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F 371	<p>Continued From page 4 safe growing and food-handling practices.</p> <p>(iii) This provision does not preclude residents from consuming foods not procured by the facility.</p> <p>(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.</p> <p>(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure food was stored under sanitary conditions. This was true for 2 of 2 residents residing in the facility who consumed thickened food or liquids prepared in the facility's kitchen. The deficient practice resulted in the storage of a food scoop in a bin of thickener powder, which created the potential for contamination and potential exposure of the 2 residents to disease causing pathogens. Findings include: During the initial kitchen tour on 3/20/17 at 10:15 am, with the Dietary Manager, a scoop used for scooping thickener powder out of a storage bin was observed unattended in the bin and in contact with the powdered thickener. The Dietary Manager stated the scoop should not have been stored inside the bin. On 3/22/15 at 11:50 am, the Dietary Manager stated she had started to in-service kitchen staff</p>	F 371	<p>For the 2 Of 2 residents (not specifically identified in the 2567L with resident identifier numbers) and for all residents that eat food prepared in the facility kitchen, the facility shall ensure food is stored under sanitary conditions.</p> <p>Dietary staff were inserviced related to the proper management of bulk food storage bins and most specifically that scoops are not to be stored in the bins at any time.</p> <p>Daily inspection/audits are conducted in the kitchen. Inspection of the bulk food storage bins will be included in this inspection/audit. Unsatisfactory findings will be immediately corrected and staff will be inserviced/remediated on a 1:1 basis The audit sheets will be turned into the facility Administrator daily. The audits will also be presented to the QA Committee</p>		

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F 371	Continued From page 5 on the proper storage of dry powders and scoops.	F 371	<p>for review and further comments or recommendations as indicated.</p> <p>The facility Administrator will conduct a random weekly walk through audit of the kitchen. The results of these random weekly audits will be reported to the QA Committee for review and further comments or recommendations as indicated.</p> <p>Responsible: Certified Dietary Manager, dietary staff, Administrator</p>		