

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

PRINTED: 01/10/2019
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 C 08/22/2018
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	<p>INITIAL COMMENTS</p> <p>On August 20, 2018 through August 23, 2018, an onsite complaint survey of your facility was conducted. Coeur A'lene of Cascadia was found to be in substantial compliance with federal health care regulations.</p> <p>The surveyors conducting the survey were: Brad Perry, LSW, Team Coordinator Kathi Davis, RN</p>	F 000			

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

TITLE

(X6) DATE

Electronically Signed

09/25/2018

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.



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSSELL S. BARRON – Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
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PHONE: (208) 334-6626
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October 19, 2018

Lowell Smith, Administrator
Coeur d'Alene of Cascadia
2514 North Seventh Street
Coeur d'Alene, ID 83814-3720

Provider #: 135052

Dear Mr. Smith:

On **August 22, 2018**, an unannounced on-site complaint survey was completed at Coeur d'Alene of Cascadia. The investigation took place from August 20, 2018 to August 22, 2018.

There were 41 current residents in the facility. Observations were conducted throughout the facility, in two of two resident hallways, resident rooms, and the common areas shared by the residents including: shower rooms, dining rooms and activities room. Multiple interviews were conducted with residents, family members and staff members. Three closed records were reviewed.

The complaint, findings and conclusions are as follows:

Complaint #ID00007615

ALLEGATION #1:

Facility failed to ensure residents were provided with routine bathing and personal cares, which resulted in residents developing skin infections.

FINDINGS:

All of the current residents sampled were reviewed for quality of care and assistance with Activities of Daily Living (ADLs), specifically bathing and hygiene assistance, as well as

appropriate nail care. The facility Ombudsman was contacted by phone on 8/20/18 and stated the facility has had issues in the past, but things are getting better, and she currently has no open cases for this facility.

One resident was admitted to the facility on 5/13/17, with diagnoses including: congestive heart failure (CHF), chronic obstructive pulmonary disease, dementia, and chronic kidney disease. The resident was admitted to hospice care on 06/30/17, and expired in the facility on 08/28/17.

The resident's ADL flowsheets for May 2017 to August 2017 documented the resident received staff assistance with showers twice weekly. During this timeframe there were only three incidents of the resident refusing a shower and receiving a bed bath instead, and two incidents of the resident refusing a shower or bath.

Review of the resident's "Hospice Care Plan," dated 06/30/17, documented the resident also received visits from a hospice CNA, three times weekly, to provide additional hygiene and bathing assistance, that was not documented in the facility's records.

A "Hospice Comprehensive Assessment and Plan of Care Update Report" dated 08/10/17, stated "(###) is on service for CHF and is weakening rapidly. He has cognitive impairment as well and that seems to be progressing rapidly. He has been interacting less ...and has declined care and bathing ..."

The medical record review did not include documentation there was a fungus on the resident's perineal area. Records related to urinary catheter care were reviewed and no evidence of a fungus was noted.

Observations were made during the survey, and the facility was found to be clean and free of foul odors. The residents were observed both in their rooms, in the common areas, and dining rooms. The residents clothes were observed to be clean and the residents were groomed and no concerns related to poor hand hygiene and nail care were identified. Several residents were observed for hygiene, staff assistance with showers, ADLs and nail care, with no concerns identified.

Resident interviews were conducted regarding their care. The residents did not state they were not being showered regularly. A resident stated, "Yes I get a shower twice a week, whether I want one or not." He stated he could alter his shower schedule if he "just didn't feel up to it", but he gets two showers a week.

Two residents who were confused and not interviewable, had observations related to their hygiene, and both ladies had clean, combed hair, nails trimmed and polished, and their clothes were clean during the complaint investigation.

Random staff interviews were conducted throughout the complaint investigations regarding showers and ADL care. The interviews included four CNAs and three Licensed Practical Nurses (LPNs). The staff stated residents received their showers twice weekly and some showers are scheduled on day shift and some for evening shift. One of the CNAs working the evening shift stated "If they are scheduled for an evening shift shower, and refuse then it probably won't happen until the next day." None of the staff interviewed were aware of instances when residents went without showering for an extended period of time. When asked about nail care the staff stated that nails are trimmed as needed by staff and not documented separately from the shower task on the ADL flow sheets.

The allegation was unsubstantiated due to lack of evidence residents were not provided with routine bathing and personal care..

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

Facility failed to ensure residents were protected from a scabies outbreak.

FINDINGS:

Review of an NP (Nurse Practitioner) progress note dated 08/07/17, regarding one resident stated, "The patient is seen in his room with nurses present. He is very tired after his shower and communicates very little. He remains on hospice ...LN (Licensed Nurse) reports POA (Power of Attorney) has expressed concern about a general rash. This reportedly appeared spontaneously. He states the lesions 'itch awful' ...+ (###) rash to arms, wrists, folds, no growths or bruises ...scabies ...may use OTC (###) tea tree and clove oils for itching 4X(times)/day PRN (as needed)."

A subsequent progress note by the NP, dated 08/21/17, stated "The patient is seen in his room. He is confused and speaks unintelligibly. He remains on hospice ...Derm (###): resolving rash ...healing rash to wrists, arms, folds ...scabies improved."

An interview with a Licensed Practical Nurse (LPN), who was employed at the facility during the outbreak, stated a named resident was identified as the source of the outbreak. The LPN had cared for both the resident above, and the resident identified as the carrier. The LPN stated "At first we weren't sure what it was, then when it was identified we treated everyone in the facility, residents and staff. Some residents required multiple treatments with the cream and with PO (###) meds (###) for itching."

Lowell Smith, Administrator
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During an interview with a Registered Nurse (###), who was the current Infection Control (###) nurse for the facility, she stated she was in the facility at the time of the reported scabies outbreak. She stated there was no IC nurse at the time, and "The Director of Nursing (###) denied the outbreak rather than acknowledge it and try to fix it, that was how she handled everything ...sweep it under the rug."

The facility's policy titled, "Infection Prevention and Control Program," dated 10/31/17, was reviewed and no current concerns were identified. The IC nurse was tracking and trending antibiotic use, and potentially contagious illnesses, "such as the flu this spring" since she assumed the position in January 2018. The former DON is no longer at the facility and was not interviewed.

An interview was conducted with the Housekeeping Supervisor provided current housekeeping cleaning, and "deep cleaning" schedules for the resident rooms and common areas for review and no concerns were identified. The Housekeeping Supervisor was aware of the policy regarding infection control and containing potentially contagious illnesses.

The allegation was substantiated but no deficiencies were cited related to the allegation because it was determined the facility had several processes in place which identified, monitored, tracked, and worked to prevent infectious disease.

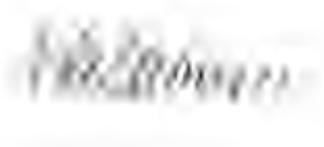
CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

One of the allegations was substantiated, but not cited. Therefore, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,



Laura Thompson, RN, Supervisor
Long Term Care Program

LT/lj

Lowell Smith, Administrator
October 19, 2018
Page 5 of 4



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February 20, 2019

Lowell Smith, Administrator
Coeur d'Alene of Cascadia
2514 North Seventh Street
Coeur d'Alene, ID 83814-3720

Provider #: 135052

Dear Mr. Smith:

On **August 22, 2018**, an unannounced on-site complaint survey was conducted at Coeur d'Alene of Cascadia. An unannounced complaint survey was conducted from August 20, 2018 to August 23, 2018. During the investigation surveyors performed observations, resident and staff interview, record review, and policy review.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007682

ALLEGATION #1:

Facility failed to ensure reports of resident falls were appropriately reported and documented.

FINDINGS #1:

A resident was admitted to the facility in 2017 with diagnoses which included stroke, encephalopathy (disease that affects the structure of function of the brain), and major depression. The resident's record included a quarterly assessment which documented the resident had significant cognitive deficits.

It was reported the resident was dropped by staff during an improper transfer. An assessment was completed at the time of the fall, and no deficient practice was identified related to the fall assessments or reporting of the fall.

Another resident was admitted to the facility in 2017 with diagnoses which included polyneuropathy (damage to multiple nerves), schizoaffective disorder, fainting, and difficulty walking. Review of the resident's care plan included fall interventions such as: encourage to call for assistance, keep frequently used items within reach, and reorient resident PRN (as needed). The plan also included the use of a bed alarm.

The resident's record documented there were two non-injury falls. The first fall was the result of the resident attempting to self-transfer during an incident when he was delusional and experiencing Post Traumatic Stress Disorder (PTSD) symptoms. The resident stated, "it was 1973, he was in the military and in danger, and he was trying to escape through the window." The resident was found uninjured, on his knees, on the floor of his room, by staff. The resident was assessed and an investigation was completed in to the cause of the fall with interventions and care panning updates.

The second fall reported the resident stated he "rolled out of bed reaching for the bed/tv control." The staff was alerted to the resident's room by the bed alarm and found the resident on the floor. Documentation of the facility's investigation, interventions and care plan updates were reviewed, with no concerns identified.

The resident was interviewed on 8/21/18 at 9:10 AM. The resident was reluctant, and offered little additional information, but denied having any concerns related to his safety in the facility.

Another resident was admitted to the facility in 2016 with diagnoses which included falls with traumatic left hip fracture, Dementia and Alzheimer's Disease. The residents record included an assessment which documented the resident has severe cognitive deficits and was placed on hospice/end of life care.

The resident's care plan included interventions in place for falls related to impaired cognition and poor safety awareness. The interventions included: fall mats at bedside when in bed; bed and chair alarms, low bed, and resident in room near nurses station for frequent monitoring.

The resident did have a history of frequent falls due to impaired cognition and "poor impulse control/poor safety awareness." The resident's record included documentation they were assessed with each fall, and new interventions were added. The resident's care plans were updated as needed, and the family was notified when the resident fell.

Lowell Smith, Administrator
February 20, 2019
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The Director of Nursing was interviewed on 8/22/18 at 2:30 PM, stated she was employed at the facility for less than 90 days.

Based on the investigative findings the allegation was unsubstantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

Facility failed to ensure there was adequate staffing to assist residents during meals.

FINDINGS #2:

Dining observations were conducted both in the dining room and in resident rooms. On 8/20/18 at 12:07 PM, staff were assisting the residents with their meals in both areas. Residents and families were interviewed during the survey and no concerns about lack of assistance with meals were verbalized.

The Resident Council minutes and grievance logs were reviewed from July 2017 through present, with no concerns identified related to the allegation.

Six resident records were reviewed for assistance with Activities of Daily Living (ADL) including eating, and weight loss with no concerns identified. Staffing was reviewed, as were Certified Nurse Aide (CNA) competencies. No deficient practice was identified.

One resident, who was observed, needed extensive assistance with all ADLs, due to his debility and blindness. The resident stated he preferred time in his room and ate his meals there at his request. He stated a preference for small, familiar surroundings since becoming totally blind. Observations of his meals being served and set up for him were made during the lunch service on 8/20/18 and on 8/21/18 during breakfast service, with no concerns. The resident denied concerns with assistance by staff with his meals. Another resident ate his meals in the dining room. When asked on 8/21/18, at 8:10 AM, the resident stated there was adequate staff to assist the residents during meal times.

Two residents, who were non-interviewable, were observed eating their meals in the dining room, with staff sitting at their table assisting residents throughout the three meals observed. There were 15-20 residents who ate in the dining room regularly and during the complaint survey there was adequate staff circulating in the dining room to assist the residents with their meals.

Based on the investigative findings the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

Facility failed to ensure residents choice was addressed as relates to bathing and dining options.

FINDINGS #3:

Staff were interviewed and none of the staff had witnessed the behaviors of forcing residents to shower and/or go to the dining room.

Resident observations were made through out the three-day complaint investigations and no concerns about placing residents in locations for staff convenience were identified.

Residents, family members and staff were interviewed and no concerns were identified.

Based on the investigative findings the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

Facility failed to ensure resident grievances were addressed.

FINDINGS #4:

A resident was admitted to the facility in 2017, with diagnoses including: bipolar disorder, malignant neoplasm of the bladder requiring urostomy, blindness due to glaucoma. The resident's record included an assessment documenting they had mild cognitive deficits. The resident was observed on several occasions throughout the survey and was interviewed on 8/21/18 at 8:10 AM. The resident denied any current concerns with facility staff or Social Services.

In an interview with the Social Services Manager (SSM), on 8/22/18 at 3:30 PM, the SSM stated she had only been at the facility for "a couple of months." The SSM did document and investigate resident concerns about staff "when & where it comes up." The SSM stated she had no current issues with residents.

A resident's record, who requested assistance from the SSM, included documentation of the interactions between the resident and SSM. The SSM assisted the resident with contacting and resolving an issue at his bank. The proper contacts and notifications were made and the resident was kept updated, and the documentation of inquiries and contacts was present. Processes for handling resident concerns and/or grievances were in place and no concerns were identified.

Based on the investigative findings the allegation was not substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

Facility failed to ensure staff did not administer medications that may have been dropped on the floor.

FINDINGS #5:

Medication administration was observed during the complaint survey. These observations were on two of two resident halls, and on two different shifts. There were 28 medication administration observations and no concerns were identified. None of the medications were dropped, the medications administered by the Licensed Practical Nurses (LPNs) were identified and explained to the residents as they were administered. The observations included multiple routes of administration: oral administration, pills crushed, and/or liquid medications instilled via G-tube (feeding tube), and subcutaneous administrations. No concerns were identified. The nurses were interviewed at the time of the observations and stated if a medication was dropped or unsuitable for any reason, it should be discarded and replaced.

During the 28 medication administration opportunities no deficient practice was identified, and no deficiencies were cited related to this allegation.

Based on the investigative findings the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

Facility failed to ensure residents were not improperly restrained during care at the facility.

FINDINGS #6:

There were two residents residing in the facility that used a reclining type specialty chair. No observations were made of these residents being reclined to prevent their exit from the chair. No restraints were observed during the complaint survey, with visits to the facility on all shifts for resident observations.

Residents and families were interviewed with no concerns about restraint use in the facility, nor about forcing residents to congregate for staff convenience.

The Administrator and Director of Nursing were interviewed on 8/21/18 at 7:40 AM, and both stated the facility did not use restraints of any kind. The Resident Council minutes and grievance logs were reviewed from July 2017 through the present and no complaints related to restraints were identified.

Based on investigative findings the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #7:

Facility failed to ensure appropriate measures were taken to manage behaviors relating to potential elopement.

FINDINGS#7:

There were two residents in the facility identified as elopement risks. Observations were made of these residents during the complaint survey. The facility doors were not found to be locked to prevent residents from exiting the building. The facility used a "Wander Guard" system to sound an alarm if an exit seeking resident was in proximity of the exits. The outer doors to the facility were unlocked from 6:00 AM to 8:00 PM. After 8:00 PM an inner door to the facility was locked with a doorbell to alert staff of visitors. The surveyors entered the facility at 10:20 PM on 8/21/18 with no difficulty. No concerns were identified with the residents identified as elopement risks, nor were there concerns with entry and/or exiting the facility.

Based on investigative findings the allegation could not be substantiated.

Lowell Smith, Administrator
February 20, 2019
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CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,

A handwritten signature in black ink, appearing to read "Laura Thompson".

Laura Thompson, RN, Supervisor
Long Term Care Program

LT/lj



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

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April 5, 2019

Eric Miller, Administrator
Coeur d'Alene of Cascadia
2514 North Seventh Street
Coeur d'Alene, ID 83814-3720

Provider #: 135052

Dear Mr. Miller:

On **August 20, 2018** through **August 22, 2018**, an unannounced on-site complaint survey was conducted at Coeur d'Alene of Cascadia. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007607

ALLEGATION #1:

Residents were discharged from the facility without proper notification or explanation.

FINDINGS #1:

During the investigation six residents were observed and nine resident records were reviewed, which included three closed records, for Quality of Care, abuse, and discharge planning. Multiple interviews were conducted with residents and family members. Multiple staff members were interviewed.

All three closed records were reviewed for discharge planning and notifications, including a resident admitted to the facility in 3/2017 and discharged in 7/2017.

Eric Miller, Administrator
April 5, 2019
Page 2 of 3

During the review of the records, two out of three records did document a concern regarding discharge planning. Resident Council minutes and Grievances from 6/1/17 through 8/20/18, were reviewed and did not document concerns with discharge planning.

During the record review of one resident, admitted 3/2017, progress notes documented the resident's family member and facility staff were in the process of transferring the resident to a different facility. Discharge orders were documented in the record. Progress notes documented a family member was with the resident when they were discharged from the facility. A discharge summary documented the resident was to be transferred to another facility.

On 8/21/18 at 1:10 PM, a family member of the discharged resident said they were working with the facility's social worker for several weeks before the resident was discharged. The family member said they had picked a facility that was going to accept the resident, and were waiting for a bed to open up. The family member said the resident did much better at the new facility.

The allegation was unsubstantiated due to lack of evidence of involuntary discharge or lack of proper notification.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2: A resident was abused by night shift staff

FINDINGS #2:

Seven resident records were reviewed for restraints and abuse, including a resident admitted to the facility in 3/2017. The facility's abuse policy, abuse allegations, and five employee files were reviewed. Staff were interviewed and observed.

The facility abuse policy, dated 11/28/17, documented allegations of abuse were to be reported immediately to the administrator and the state agency and were to be investigated.

During the review of the records for one resident, admitted in 3/2017, an abuse allegation report documented the resident was tied to his/her wheelchair by a CNA, and a nurse who had knowledge of the incident told other staff members to "mind their own business." The report documented the abuse was substantiated and the State Agency was informed of the incident. The CNA and nurse involved with the abuse were both terminated and their professional licensing and certification agencies were informed of the abuse. Background checks for abuse and employee personal files for three CNAs and two nurses were reviewed and each had current background checks without abuse findings.

Eric Miller, Administrator
April 5, 2019
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Several CNAs and nurses, including night shift staff, were observed throughout the survey for abuse or restraints. Staff interactions with residents were observed and their interactions with residents were in a respectful manner. During the night shift on 8/21/18 most of the residents in the facility were observed and none were restrained in bed or in their wheelchairs.

Several CNAs and nurses said if a resident was observed to be restrained or abused, they would protect the resident and immediately report the restraint and/or abuse allegation to the Administrator or the Director of Nursing. The Director of Nursing said residents were not restrained and incidents of restraint or abuse were reported to the State Agency and staff who were involved in any such incidents were suspended until a full investigation could be conducted. The Administrator said the abuse of the resident in the above report had occurred before he was there and said the investigation showed the resident was restrained and the staff involved were terminated.

The allegation was substantiated. However, no deficiencies were cited related to the allegation because it was determined the facility had taken appropriate action at the time of the incident and there were no further incidents identified.

CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

One of the allegations was substantiated, but not cited. Therefore, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,



Laura Thompson, RN, Supervisor
Long Term Care Program

LT/lj



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April 8, 2019

Eric Miller, Administrator
Coeur d'Alene of Cascadia
2514 North Seventh Street
Coeur d'Alene, ID 83814-3720

Provider #: 135052

Dear Mr. Miller:

On **August 20, 2018** through **August 22, 2018**, an unannounced on-site complaint survey was conducted at Coeur d'Alene of Cascadia. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007684

ALLEGATION #1:

Residents were dropped by staff during transfers and then did not assess residents before attempting to help them off the floor.

FINDINGS #1:

During the investigation six residents were observed for Quality of Care and medication administration, and their records were reviewed, including a resident admitted to the facility in 9/2017. Multiple interviews were conducted with residents and family members. Multiple staff members were interviewed and observed regarding transfers and medication administration. Facility incident and accidents, grievances, and Resident Council minutes were reviewed.

Eric Miller, Administrator
April 8, 2019
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Several staff were observed to transfer residents in a safe and appropriate manner, including two-person assistance transfers.

During the review of the records for one resident, admitted in 9/2017, an incident report, dated 11/2017, documented two CNAs had attempted to transfer the resident without a gait belt, the resident's legs became weak and fell to the floor. A nurse documented he/she witnessed the two CNAs attempting to help the resident off the floor prior to being assessed by a nurse or another licensed professional. The investigation concluded the CNAs used improper technique and lacked understanding of the facility's fall procedures.

A resident said he/she was dropped by two CNAs and then they attempted to help him/her off of the floor prior to being evaluated for injuries by a nurse. The resident said since the incident he/she had been transferred safely.

Several CNAs and nurses said they had received training on proper transferring and said if a resident fell, they would make sure the resident was properly assessed. The Director of Nursing said the two CNAs did not follow a resident's care plan which resulted in a fall when the resident became weak and fell. The Director of Nursing said the two CNAs also attempted to help the resident up off the floor before a nurse could assess the resident for injuries and said the CNAs were re-educated.

The allegation was substantiated. However, no deficiencies were cited related to the allegation because it was determined the facility had taken appropriate action at the time of the incident and there were no other incidents at the time of the survey.

CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

ALLEGATION #2:

The facility did not appropriately handle a complaint when a wrong medication was almost administered to a resident.

FINDINGS #2:

Several nurses were observed to administer residents' medication as ordered by the physician.

The grievance files from 6/1/17 to 8/20/18, were reviewed and documented grievances were followed through with. Resident Council minutes from 6/1/17 to 8/20/18, documented the facility followed through with complaints and concerns.

Eric Miller, Administrator
April 8, 2019
Page 3 of 3

The records of six residents were reviewed and identified concerns had been addressed.

During the review of the record for one resident, admitted in 9/2017, a nurse progress note documented a nurse almost gave the wrong medication to a resident but did not administer it. The nurse reported the incident to the Director of Nursing.

Several residents and family members said grievances and concerns were followed up with. Several CNAs and nurses said if residents had concerns, they would address them immediately if they could or file a grievance on behalf of the resident if it could not be fixed immediately. The Administrator said residents' grievances and concerns were followed up with and handled appropriately.

Based on investigative findings the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,



Laura Thompson, RN, Supervisor
Long Term Care Program

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June 12, 2019

Eric Miller, Administrator
Coeur d'Alene of Cascadia
2514 North Seventh Street
Coeur d'Alene, ID 83814-3720

Provider #: 135052

Dear Mr. Miller:

On **August 20, 2018** through **August 23, 2018**, an unannounced on-site complaint survey was conducted at Coeur d'Alene of Cascadia. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007767

ALLEGATION #1:

Residents appeared to be malnourished.

FINDINGS #1:

During the investigation, nine records were reviewed, six residents were observed and multiple interviews with staff, residents and family members were conducted.

Residents were observed during two different mealtimes in the dining room and in their rooms and no concerns regarding weight loss were identified. Staff were observed providing appropriate meals, assisting residents to eat as needed, and offering snacks to residents. No observed residents exhibited signs of malnutrition.

Seven of seven residents' records reviewed for weight loss, including a resident admitted on 11/2017, documented appropriate monitoring and interventions regarding their weight.

The resident's record documented they were admitted with a feeding tube and a physician had modified their nutrition orders due to the dietician's concerns of gradual weight loss.

The resident also worked with a speech therapist to include oral nutrition to help reduce the resident's dependence on the feeding tube. Several residents said they had no concerns with nutrition and/or weight loss. Several family members said the residents received the correct diet to maintain weight. The dietician said the resident received adequate nutrition and their diet was modified appropriately and their weight stabilized.

The allegation was unsubstantiated of malnutrition due to lack of evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

Family members and other visitors were not allowed access to residents.

FINDINGS #2:

Observations of residents were conducted, three resident records were reviewed, Resident Council minutes were reviewed, grievances were reviewed, and residents and family members were interviewed.

During the investigation several residents were observed visiting with friends and family in the facility without staff interference.

Three of three residents' records reviewed for visitor contact, including a resident admitted on 11/2017, did not include documentation of concerns regarding access to residents. Resident Council minutes and Grievances from 11/1/17 to 3/31/18, did not document concerns with access to residents by family members or other visitors.

Several residents and family members said they were able to visit with residents whenever they wanted. Several nurses and CNAs said family members and visitors were allowed to visit residents whenever they wanted. One nurse said the family members of a resident admitted on 11/2017, used a video chat function on the resident's phone.

The allegation was unsubstantiated regarding denial of access to residents.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

Residents had urinary catheters for long periods of time, without justification of use, and developed urinary tract infections (UTI).

FINDINGS #3:

Three of three residents' records were reviewed for urinary catheters and staff were interviewed.

One resident admitted on 11/2017, was admitted with a urinary catheter without a clinical diagnosis or rationale. The resident's bladder evaluation documented they had a foley catheter. The resident's treatment administration record documented they received care for the catheter. The resident's physician's progress note documented the resident had a history of neurogenic bladder (neurological damage) without recent UTIs. The resident's physician's orders, for a three month period, did not include a physician's order for a catheter. The facility's physician order request, dated 1/2018, documented a nurse had requested a justification for the resident's urinary catheter. The resident's physician ordered the catheter with a justification of urinary retention after the request was sent.

The Director of Nursing said the facility had not identified a reason for the catheter for nearly two months, for the above resident, and the facility staff asked the physician to justify its use.

The allegation was substantiated. However, no deficiencies were cited related to the allegation because it was determined the facility had recognized the need for the clinical justification and had obtained the rationale from the physician.

CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

ALLEGATION #4:

Residents' representatives were not notified when behaviors increased and medication changes were implemented.

FINDINGS #4:

Four of four residents' records were reviewed for behaviors, psychotropic medications, and notifications. Staff were also interviewed.

One resident's record, admitted on 11/2017 for encephalopathy (brain disease), documented they had a POA (Power of Attorney) for healthcare. The resident's progress notes from November 2017 through March 2018, documented multiple times they were confused, experienced delusions, and had aggressive behaviors towards others. A psychoactive medication consent documented the POA was not informed of a new psychotropic medication (Seroquel) which was ordered for encephalopathy with behaviors.

A nurse said the resident came into the facility with behaviors including delusions, delirium, verbal and physical aggression towards others, and was not able to make her own needs known.

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She said the POA and other family members were not always notified of the resident's medication changes and changes in condition, until near the end of their stay when there was better communication with the POA and family. The Director of Nursing said the facility did not obtain a consent from the POA for the Seroquel and did not always clearly communicate changes in the resident's condition.

The allegation was substantiated. However, no deficiencies were cited related to the allegation because it was determined the facility had recognized the need to notify the POA, as well as notification to three other residents' representatives who were reviewed for notification.

CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

Two of the allegations were substantiated, but not cited. Therefore, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,



Laura Thompson, RN, Supervisor
Long Term Care Program

LT/lj