



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  
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](mailto:fsb@dhw.idaho.gov)

October 4, 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 **September 14, 2018**, 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 actual 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.) **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.

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 **October 15, 2018**. Failure to submit an acceptable PoC by **October 15, 2018**, may result in the imposition of civil monetary penalties by **November 6, 2018**.

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*.

We are recommending that Centers for Medicare & Medicaid Services (CMS) Region X impose the following remedy(ies):

- Civil Monetary Penalty

Denial of payment for new admissions effective **December 14, 2018**

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **March 14, 2019**, 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.**

Lowell Smith, Administrator  
October 4, 2018  
Page 3 of 3

If you believe these deficiencies have been corrected, you may contact Debby Ransom, RN, RHIT, Bureau Chief, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 5; 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 **October 15, 2018**. If your request for informal dispute resolution is received after **October 15, 2018**, 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 Debby Ransom, RN, RHIT, Bureau Chief at (208) 334-6626, option 5.

Sincerely,



Debby Ransom, RN, RHIT, Chief  
Bureau of Facility Standards

DR/lj

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135052</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/14/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COEUR D'ALENE OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814</b>		
(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 and complaint survey conducted September 10, 2018 to September 14, 2018.  The surveyors conducting the survey were:  Jenny Walker, RN, Team Coordinator Cecilia Stockdill, RN  ABBREVIATIONS:  ADL = Activity of Daily Living BWAT = Bates-Jensen Wound Assessment Tool cm = centimeter CNA = Certified Nursing Assistant DNR = Do Not Resuscitate DNS = Director of Nursing ER = Emergency Room IDT = Interdisciplinary Team LPN = Licensed Practical Nurse MDS = Minimum Data Set OT = Occupational Therapy PICC = Peripherally Inserted Central Catheter POST = Physician Orders For Scope of Treatment prn = as necessary RN = Registered Nurse SW = Social Worker TAR = Treatment Administration Record	F 000			
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii)  §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to	F 622		10/30/18	

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

TITLE

(X6) DATE

Electronically Signed

10/15/2018

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135052</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/14/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COEUR D'ALENE OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814</b>		
(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 622	Continued From page 1 remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.	F 622			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135052</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/14/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COEUR D'ALENE OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814</b>		
(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 622	Continued From page 2 §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c) (1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c) (2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary,	F 622			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135052</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/14/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COEUR D'ALENE OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814</b>		
(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 622	<p>Continued From page 3</p> <p>consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, facility policy and procedure review, and staff interview, it was determined the facility failed to ensure discharge information was provided to the receiving care agency for 1 of 1 resident (Resident #40) reviewed for discharge planning. This deficient practice had the potential to cause harm should the resident not receive treatment from the receiving care agency in a timely manner due to lack of information provided upon discharge. Findings include:</p> <p>The facility's policy and procedure for Transfer and Discharge, dated 11/28/17, documented the following:</p> <p>Information to be provided to the receiving provider should include the following:</p> <ul style="list-style-type: none"> <li>* Contact information of the provider who was responsible for the resident's care.</li> <li>* The resident's representative information, including contact information.</li> <li>* Advance Directive information.</li> <li>* Special orders and/or precautions for ongoing care.</li> <li>* Comprehensive care plan goals.</li> <li>* All necessary information to meet the resident's needs.</li> </ul> <p>Resident #40 was admitted to the facility on 5/21/18, with multiple diagnoses including sepsis and autistic disorder. Sepsis is a potentially</p>	F 622	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Coeur d'Alene Health of Cascadia does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.</p> <p>F 622 Transfer and Discharge requirements:</p> <p>Resident Specific Resident #40 has discharged from the facility.</p> <p>Other Residents The ID team reviewed residents with planned discharges occurring in the past 30 days for evidence of appropriate communication to the receiving facility/agency. No additional communication was indicated.</p> <p>Facility Systems Social Services, medical records, nursing</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135052</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/14/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COEUR D'ALENE OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814</b>		
(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 622	<p>Continued From page 4</p> <p>life-threatening complication of an infection.</p> <p>Resident #40's discharge MDS assessment, dated 6/12/18, documented severe cognitive impairment.</p> <p>A Physician Order Request, dated 6/8/18 at 10:15 AM, documented it was planned for Resident #40 to discharge home on 6/11/18. The form was faxed to the physician on 6/8/18.</p> <p>A Discharge Planning Communication/Orders form, dated 6/11/18, documented the physician was notified via fax on 6/12/18, Resident #40 was being discharged to home and a Home Health Agency was named.</p> <p>A Progress Note, dated 6/11/18 at 11:09 AM, documented Resident #40 was planned for discharge home the next day, and an order was received from the physician to discontinue the PICC line (an intravenous catheter used for long-term medications and blood draws) as the intravenous antibiotics were completed.</p> <p>A physician order documented Resident #40 was to discharge home on 6/12/18.</p> <p>A Progress Note, dated 6/12/18 at 10:51 AM, documented Resident #40 would be discharged from the facility with a Home Health Agency to provide in-home services. Resident #40 was taking antibiotics by mouth.</p> <p>A Progress Note, dated 6/12/18 at 2:15 PM, documented Resident #40 was discharged home with his mother who was very confused, very scattered, and did not understand instructions for</p>	F 622	<p>staff and the ID team have been educated on appropriate documentation for transfer and discharges. Re-education was provided by Director of nursing and/or designee to include but not limited to documentation of the communication and information provided to the receiving facility/agency for planned discharges and the facility's policy and procedure for transfer and discharge. The system is amended to include oversight by the Director of Nursing with review in Clinical meeting upon day of discharge.</p> <p>Monitor Resident Support Services Manager and/or designee will audit 1 resident weekly for appropriate transfer and discharge documentation until deficiency is no longer identified. Starting the week of October 22nd, 2018 the review will be documented on the audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135052</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/14/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COEUR D'ALENE OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814</b>		
(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 622	Continued From page 5 Resident #40's Keflex (antibiotic).  There was no documentation in Resident #40's clinical record the facility communicated with the Home Health Agency or provided information to the Home Health Agency regarding Resident #40's discharge.  On 9/14/18 at 11:00 AM, the SW said Resident #40's mother refused to have the facility contact the Home Health Agency. Resident #40's mother said she would contact the Home Health Agency herself.  On 9/14/18 at 11:08 AM, RN #1 said there was no documentation of coordination with the Home Health Agency regarding Resident #40's discharge.  On 9/14/18 at 11:35 AM, the DNS said the 6/12/18 Progress Note documented the SW was in contact with the Home Health Agency.	F 622			
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3)  §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident	F 655		10/30/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135052</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/14/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COEUR D'ALENE OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814</b>		
(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 655	<p>Continued From page 6 including, but not limited to-</p> <p>(A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable.</p> <p>§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-</p> <p>(i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).</p> <p>§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:</p> <p>(i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure baseline care plans included the resuscitation code status (Resuscitate or Do Not Resuscitate). This was true for 1 of 1 resident (Resident #37) whose baseline care plan was reviewed. This created the potential for residents' resuscitation</p>	F 655	<p>F655 Baseline Care plan</p> <p>Resident Specific The ID team reviewed resident # 37's care plan and her resuscitation code status has been included.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135052</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/14/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COEUR D'ALENE OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814</b>		
(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 655	Continued From page 7 measures to be initiated, or not initiated, contrary to the residents' wishes. Findings include:  Resident #37 was admitted to the facility on 8/6/18, with multiple diagnoses including dementia and hypertension.  Resident #37's baseline care plan, dated 8/6/18, did not include Resident #37's resuscitation code status. The section in the care plan to document code status was blank.  On 9/11/18 at 4:13 PM, the DNS and the Resident Support Services Manager were unaware the code status should have been documented on the baseline care plan.	F 655	Other Residents The ID team reviewed other new admission residents for completion of baseline care plans to include resuscitation code status. Adjustments have been made as indicated.  Facility Systems Social Services, medical records, and nursing staff were educated on baseline care plans. Re-education was provided by Director of Nursing and/or designee to include but not limited to, clarification/accuracy between advanced directive and physician order, PCC code status order entry, accurate code status included on resident's baseline/comprehensive care plan, and facility's policy on advanced directives/health care decisions. The system is amended to include oversight by the Director of Nursing with review in the 72- hour care conference.  Monitor The Medical Records clerk and/or designee will audit 2 newly admitted residents weekly until the deficiency is no longer identified. Starting the week of October 22nd, 2018 the review will be documented on the audit tool. Any concerns will be addressed immediately and discussed with the IDT Team. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.		
F 656 SS=F	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)	F 656		10/30/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135052</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/14/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COEUR D'ALENE OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814</b>		
(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 656	Continued From page 8 §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the	F 656			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135052</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/14/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COEUR D'ALENE OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814</b>		
(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 656	<p>Continued From page 9</p> <p>requirements set forth in paragraph (c) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, facility policy and procedure review, and resident family and staff interview, it was determined the facility failed to ensure comprehensive resident-centered care plans included residents' code status (Resuscitate or Do Not Resuscitate) and the care plan and physician order matched the POST (a document that indicates the resident's wishes for life sustaining measures). This was true for 5 of 5 residents (#22, #24, #25, #28, and #34) whose comprehensive care plans were reviewed for code status and all other residents residing in the facility. This failure created the potential for harm should residents be resuscitated, or not resuscitated, contrary to their wishes. Findings include:</p> <p>The facility's policy and procedure for Care Plans, dated 11/28/17, documented the following:</p> <p>The care plan described services to be provided to reach or maintain the resident's highest practicable, physical, mental, and psychosocial well-being. Services under normal circumstances would be required, but not provided because of resident's exercise of rights, including the right to decline treatment.</p> <p>This policy was not followed. Examples include:</p> <p>a. Resident #34 was admitted to the facility on 11/10/17, with multiple diagnoses including unspecified dementia with behavioral disturbance, obstructive sleep apnea, and</p>	F 656	<p>F 656 Develop/Implement comprehensive care plan.</p> <p>Resident Specific The ID team reviewed resident # 22, 24, 25, 28, and 34's record. The comprehensive resident center care plan was updated after validation of the code status.</p> <p>Other Residents The ID team reviewed other residents for validation that the physician order, resident advanced directive/POST, and the comprehensive care plan include the accurate code status. Adjustments have been made as indicated.</p> <p>Facility Systems Social Services, medical records, and nursing staff were educated on comprehensive care plans. Re-education was provided by Director of Nursing and/or designee to include but not limited to, clarification/ accuracy between advanced directive and physician order, PCC code status order entry, accurate code status included on resident's baseline/ comprehensive care plan, and facility's policy on advanced directives/health care decisions. The system is amended to include oversight by the Director of Nursing in the clinical meeting for new admission or order</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135052</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/14/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COEUR D'ALENE OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814</b>		
(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 656	<p>Continued From page 10 chronic obstructive pulmonary disease.</p> <p>Resident #34's quarterly MDS assessment, dated 8/17/18, documented he had severe cognitive impairment.</p> <p>Resident #34's current physician orders included an order dated 6/27/18, which documented his code status was Full Code (Resuscitate).</p> <p>Resident #34's POST documented his code status was DNR and was signed by his family member on 11/10/17.</p> <p>A Social Service Note, dated 8/20/18 at 11:16 AM, documented Resident #34's code status was DNR.</p> <p>On 9/10/18 at 2:57 PM, Resident #34's care plan did not include documentation of his code status.</p> <p>On 9/13/18 at 11:41 AM, Resident #34's care plan documented his code status was Full Code and was initiated on 9/11/18. The Resident Support Services Manager, also present, said the order for Resident #34's code status was wrong he was DNR, and she needed to fix it right away.</p> <p>On 9/13/18 at 3:15 PM, Resident #34's family member said Resident #34's code status was DNR since he came to the facility, and his code status had not changed.</p> <p>b. Resident #22 was admitted to the facility on 9/13/17, with multiple diagnoses including atrial fibrillation (irregular heart beat), hypertension, and encephalopathy (a disease affecting the function of the brain).</p>	F 656	<p>changes in code status. In addition, the code state will be validated with documentation reviewed as part of the quarterly care conference.</p> <p><b>Monitor</b> The Medical Records clerk and/or designee will audit 3 resident records weekly for comprehensive care plan inclusion of accurate code status that matches physician orders and resident advanced directives until no deficiency is identified. Starting the week of October 22nd, 2018 the review will be documented on the audit tool. Any concerns will be addressed immediately and discussed with the IDT team. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135052</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/14/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COEUR D'ALENE OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814</b>		
(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 656	<p>Continued From page 11</p> <p>Resident #22's Living Will and Durable Power of Attorney for Health Care, dated 2/8/18, documented, "...all medical treatment, care, and procedures necessary to restore my health and sustain my life be provided to me."</p> <p>Resident #22's POST documented his code status was Full Code (Resuscitate) and it was signed by Resident #22.</p> <p>Resident #22's record included a Cardiopulmonary Resuscitation Consent (CPR) from another facility, dated 10/13/15, which documented Resident #22's code status was DNR.</p> <p>The September 2018 physician's orders did not include Resident #22's code status.</p> <p>Resident #22's care plan did not include his code status.</p> <p>On 9/11/18 at 11:21 AM, RN #2 stated the code status for Resident #22 was in the hard chart under Advance Directives. RN #2 stated Resident #22's codes status was Full Code per the POST in his clinical record.</p> <p>On 9/11/18 at 4:13 PM, the DNS stated the code status for Resident #22 should have been in the physician's orders. The Resident Support Services Manager, also present, was unaware Resident #22's CPR consent documented his code status as DNR. The Resident Support Services Manager stated the facility was following Resident #22's Living Will and POST as a Full Code.</p>	F 656			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135052</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/14/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COEUR D'ALENE OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814</b>		
(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 656	<p>Continued From page 12</p> <p>On 9/12/18 at 11:30 AM, Resident #22 stated his code status was Full Code.</p> <p>c. Resident #24 was admitted to the facility on 7/26/18, with multiple diagnoses including cerebral infarction (stroke), paroxysmal atrial fibrillation (irregular heart rhythm), and a cardiac pacemaker.</p> <p>Resident #24's admission MDS assessment, dated 8/2/18, documented she had moderate cognitive impairment.</p> <p>Resident #24's September 2018 physician orders, on 7/26/18, documented her code status was DNR.</p> <p>Resident #24's POST documented her code status was DNR and it was signed by her representative on 7/26/18.</p> <p>On 9/10/18 at 3:16 PM, Resident #24's care plan did not include documentation of her code status.</p> <p>d. Resident #25 was admitted to the facility on 11/8/17, with multiple diagnoses including abnormal weight loss and dementia.</p> <p>Resident #25's quarterly MDS assessment, dated 8/17/18, documented she had severe cognitive impairment.</p> <p>Resident #25's current physician orders included an order dated 6/19/18, stating her code status was DNR.</p> <p>Resident #25's POST documented her code</p>	F 656			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135052</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/14/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COEUR D'ALENE OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814</b>		
(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 656	Continued From page 13 status was DNR and it was signed by her representative.  On 9/11/18 at 10:21 AM, Resident #25's care plan did not include documentation of her code status.  e. Resident #28 was readmitted to the facility on 8/31/18, with multiple diagnoses including chronic atrial fibrillation (irregular heart rhythm) and congestive heart failure.  Resident 28's Significant Change MDS assessment, dated 9/6/18, documented she was cognitively intact.  Resident #28's September 2018 physician orders documented a code status of DNR was ordered on 9/6/18.  Resident #28's POST documented her code status was DNR and it was signed by Resident #28.  On 9/10/18 at 9:29 AM, Resident #28's current care plan did not document her code status.  On 9/11/18 at 4:23 PM, the DNS and the Resident Support Services Manager stated the care plans of all residents currently residing in the facility did not include documentation of their code status.	F 656			
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)  §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be-	F 657		10/30/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135052</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/14/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COEUR D'ALENE OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814</b>		
(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 657	<p>Continued From page 14</p> <p>(i) Developed within 7 days after completion of the comprehensive assessment.</p> <p>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--</p> <p>(A) The attending physician.</p> <p>(B) A registered nurse with responsibility for the resident.</p> <p>(C) A nurse aide with responsibility for the resident.</p> <p>(D) A member of food and nutrition services staff.</p> <p>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.</p> <p>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</p> <p>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview and record review, it was determined the facility failed to ensure residents' care plans were regularly reviewed and revised as warranted. This was true for 2 of 13 residents (#1 and #33) reviewed for care plan revisions and created the potential for harm if care was not provided or decisions made based on inaccurate or outdated information. Findings include:</p> <p>1. Resident #33 was admitted to the facility on 11/3/17, with multiple diagnoses including mild</p>	F 657	<p>F657 Care plan timing and revision</p> <p>Resident Specific The Clinical management team reviewed resident # 33, care plan has been revised to include assessment, monitoring of the sling, and current fall interventions.</p> <p>The Clinical management team reviewed resident #1, care plan has been revised to include current pressure ulcer status and interventions.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135052</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/14/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COEUR D'ALENE OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814</b>		
(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 657	<p>Continued From page 15 intellectual disability and difficulty walking.</p> <p>A quarterly MDS assessment, dated 8/13/18, documented Resident #33 had moderate cognitive impairment, required supervision with ambulation, had limited ROM (range of motion), impairment to her lower extremities, and she experienced 2 or more non-injury falls.</p> <p>An incident report, dated 8/23/18, documented Resident #33 fell and injured her right wrist. An x-ray was performed and Resident #33 had sustained a fracture of the wrist. She was seen in the ER at a local hospital and returned with a splint and a sling on her right arm.</p> <p>Resident #33's skin impairment care plan, revised 9/12/18, documented staff were to assist Resident #33 with positioning the sling over her clothing. The care plan did not include assessment and monitoring of the splint and Resident #33's skin integrity under the splint.</p> <p>On 9/13/18 at 6:50 PM, the DNS stated Resident #33's care plan should have been revised to include assessment and monitoring the splint to her right forearm.</p> <p>b. Resident #33's care plan included her risk for falls, revised on 9/12/18. The interventions included to assist or steady her as needed due to an impaired balance with the sling on her right arm.</p> <p>In addition to her fall on 8/23/18, Resident #33 experienced 3 subsequent falls. They include:</p> <p>* An Incident Report, dated 8/24/18 at 3:00 PM,</p>	F 657	<p><b>Other Residents</b> The ID team reviewed other residents for interventions related to impaired skin integrity, pressure ulcer management, and skin prevention with use of slings/braces.</p> <p>Residents with falls in the past 30 days have been reviewed for missing care plan interventions/revisions. Adjustments have been made as indicated.</p> <p><b>Facility Systems</b> Nursing staff and ID team have been educated on timely care plan revision process. Re-education was provided by Clinical Resource consultant nurse to include but not limited to, update of care plan with use of slings/braces to include prevention of skin impairment, pressure ulcer management/healing, interventions to address root cause of each fall, and the facility's policy and procedure for Care planning, prevention and treatment of pressure ulcers and other skin alterations, and Falls management. The system is amended to include oversight by the Director of Nursing in clinical meeting with review of new orders for splint/brace, new pressure ulcers, and fall interventions to validate care plan updates, assessments and monitoring have occurred.</p> <p><b>Monitor</b> The Director of Nursing and/or designee will audit 3 residents weekly with splints/ braces, pressure ulcers, or falls, for</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135052</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/14/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COEUR D'ALENE OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814</b>		
(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 657	<p>Continued From page 16</p> <p>documented Resident #33 had a witnessed non-injury fall in the activity room.</p> <p>* An Incident Report, dated 8/25/18 at 3:50 PM, documented Resident #33 was found sitting on the floor in the dining room.</p> <p>* An Incident Report, dated 8/25/18 at 5:20 PM, documented Resident #33 was walking to dinner and was found on the ground near the entryway of the dining room.</p> <p>On 9/13/18 at 6:55 PM, the DNS stated Resident #33's care plan should have been revised after each fall on 8/23/18, 8/24/18, and 2 falls on 8/25/18.</p> <p>2. Resident #1 was readmitted to the facility on 6/4/18, with multiple diagnoses including a stroke and muscle weakness.</p> <p>Resident #1's quarterly MDS assessment, dated 8/9/18, documented Resident #1 was moderately cognitively impaired and required two-person extensive assistance with bed mobility and transfers. The MDS assessment documented Resident #1 was at risk for pressure ulcers and had no unhealed pressure ulcers.</p> <p>Resident #1's care plan, revised 8/8/18, documented she was at risk for skin impairment/pressure ulcer and she had a history of breakdown at the coccyx.</p> <p>An Incident Report, dated as a late entry on 8/27/18 for an incident on 8/25/18 at 11:30 AM, documented during cares the CNAs found an open area to Resident #1's coccyx. The care plan</p>	F 657	<p>accurate assessments, monitoring and care plan intervention updates until no deficiency is identified. Starting the week of October 22nd, 2018 the review will be documented on the audit tool. Any concerns will be addressed immediately and discussed with the IDT team. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135052</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/14/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COEUR D'ALENE OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814</b>		
(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 657	Continued From page 17 did not address Resident #1's pressure ulcer on her coccyx that was identified on 8/25/18.	F 657			
F 661 SS=D	On 9/13/18 at 9:25 AM, the DNS stated the care plan should have been revised to reflect the pressure ulcer on Resident #1's coccyx. Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv)  §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced	F 661		10/30/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135052</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/14/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COEUR D'ALENE OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814</b>		
(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 661	<p>Continued From page 18</p> <p>by: Based on staff interview, resident record review, and facility policy and procedure review, it was determined the facility failed to ensure appropriate information was documented in the resident's record and provided to the receiving health care provider upon discharge. This was true for 1 of 1 resident (Resident #40) reviewed for discharge from the facility. This failure created the potential for harm and inappropriate care due to incomplete documentation concerning the resident's discharge. Findings include:</p> <p>The facility's policy and procedure for Transfer and Discharge, dated 11/28/17, stated for an anticipated discharge, a discharge summary was to be prepared which included a recapitulation of the resident's stay, a final summary of the resident's status for all MDS items at the time of discharge, and a post-discharge plan of care developed with the resident and the resident's family.</p> <p>This policy was not followed.</p> <p>Resident #40 was admitted to the facility on 5/21/18, with multiple diagnoses including sepsis and autistic disorder. Sepsis is a potentially life-threatening complication of an infection.</p> <p>Resident #40's discharge MDS assessment, dated 6/12/18, documented severe cognitive impairment.</p> <p>A Discharge Planning Communication/Orders form, dated 6/11/18, documented the physician was notified Resident #40 was being discharged home and a Home Health Agency was named.</p>	F 661	<p>F661 Discharge summary</p> <p>Resident Specific Resident #40 has discharged from the facility.</p> <p>Other Residents The ID team reviewed residents with planned discharges occurring in the past 30 days for evidence of appropriate communication to the receiving facility/agency. No additional communication was indicated.</p> <p>Facility Systems Social Services, medical records, nursing staff and the ID team have been educated on appropriate documentation for transfer and discharges. Re-education was provided by Director of nursing and/or designee to include but not limited to final summary of resident status at discharge, post discharge plan of care, written discharge instruction, documentation of the communication and information provided to the receiving facility/agency for planned discharges and the facility's policy and procedure for transfer and discharge. The system is amended to include oversight by the Director of Nursing with review in Clinical meeting upon day of discharge.</p> <p>Monitor Resident Support Services Manager and/or designee will audit 1 resident</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135052</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/14/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COEUR D'ALENE OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814</b>		
(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 661	Continued From page 19  A Progress Note, dated 6/11/18 at 1:09 AM, documented Resident #40 was to be discharged to home the next day, and an order was received from the physician to discontinue the PICC line (an intravenous catheter used for long-term medications and blood draws) as the intravenous antibiotics were completed.  A Physician Order documented Resident #40 was to discharge home on 6/12/18.  A Progress Note, dated 6/12/18 at 10:51 AM, documented Resident #40 would be discharged from the facility with a Home Health Agency to provide in-home services. Resident #40 was taking antibiotics by mouth.  A Progress Note, dated 6/12/18 at 2:15 PM, documented Resident #40 was discharged home with his mother who was very confused, very scattered, and did not understand instructions for Resident #40's Keflex (antibiotic).  There was no documentation in Resident #40's clinical record of a final summary of his status at the time of discharge, a post-discharge plan of care, or written discharge instructions being provided to Resident #40's representative.  On 9/14/18 at 11:35 AM, the DNS was unable to provide a discharge summary for Resident #40.	F 661	weekly for appropriate transfer and discharge documentation until deficiency is no longer identified. Starting the week of October 22nd, 2018 the review will be documented on the audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.		
F 684 SS=D	Quality of Care CFR(s): 483.25  § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to	F 684		10/30/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135052</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/14/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COEUR D'ALENE OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814</b>		
(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 684	<p>Continued From page 20</p> <p>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 care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, resident and staff interview, and review of incident reports and facility policy, it was determined the facility failed to ensure professional standards of practice related to neurological checks and assessing, evaluating, and monitoring under a forearm splint and wrap were followed for 1 of 13 residents (Resident #33) reviewed for standards of practice. These failures created the potential for harm if changes in Resident #33's neurological status went undetected and untreated after four falls, one of which resulted in a goose-egg size bump to the forehead and if the forearm splint and wrap caused skin breakdown. Findings include:</p> <p>The facility's Neurological Evaluation policy and procedure, dated 11/28/17, documented:</p> <p>*Neurological vital signs supplement the routine measurement of temperature, pulse rate, and respirations when a resident is suspected to have hit his/her head or had hit his/her head.</p> <p>*The physician's order dictates the frequency of neurological evaluations.</p> <p>*The neurological evaluation consists of assessing the resident's level of consciousness, pupils and eye movement, and motor function</p>	F 684	<p>F684 Quality of care</p> <p>Resident Specific The ID team reviewed resident #33, skin has been assessed and appropriate monitoring has been implemented with care plan revision done. Neuro assessment completed with no adverse concerns identified.</p> <p>Other Residents The clinical management team reviewed other residents with splints/ braces for appropriate monitors and assessments.</p> <p>Residents with a fall within the last 7 days have had a neuro assessment completed. No adverse resident outcomes were identified.</p> <p>Facility Systems The nursing staff have been educated on professional standards post fall and with splints/brace use. Re-education was provided by the Director of Nursing and/or designee to include but not limited to, neurological assessment post unwitnessed fall and falls with known impact to resident head, the facility neurological assessment policy, post fall</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135052</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/14/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COEUR D'ALENE OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814</b>		
(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 684	<p>Continued From page 21 response.</p> <p>*Neurological evaluations should be assessed every 15 minutes for an hour, then; every 30 minutes for an hour, then; every hour for 2 hours, then every 4 hours until the physician stated it was no longer necessary or in the 72 hours if the resident's condition is stable and showing no signs and symptoms of neurological injury.</p> <p>This policy was not followed.</p> <p>Resident #33 was admitted to the facility on 11/3/17, with multiple diagnoses including mild intellectual disabilities and difficulty walking.</p> <p>a. An Incident Report, dated 8/23/18 at 9:00 AM, documented while walking at a fast pace, Resident #33 fell and hit her forehead and her right wrist was swollen and bruised. Neurological evaluations were initiated and an x-ray was completed which identified a right wrist fracture. A fax to the physician, dated 8/23/18 at 8:20 PM, documented Resident #33 was sent to the ER for medical treatment on 8/23/18 at 7:00 PM.</p> <p>A Nurse's progress note, dated 8/23/18 at 10:43 PM, documented Resident #33 returned from the ER with a splint on her right forearm and she was wearing a sling.</p> <p>The Neurological Assessment Flow Sheet documented Resident #33's neurological status was not consistently evaluated after the fall on 8/23/18. On 8/23/18 neurological evaluations were not completed at 10:15 AM, 10:30 AM, 11:00 AM, 12:00 PM, 1:00 AM, and 5:00 PM. On 8/24/18 neurological evaluations were not</p>	F 684	<p>neuro assessment completion, and appropriate assessments of circulation/sensation/movement (CSM) and monitoring for residents risk for skin impairment secondary to splints/braces. The system is amended to include clinical management team review in clinical meeting for completion of neurological assessments for 72 hours or per physician orders and for skin prevention program/monitor of CSM with fractures/sling use.</p> <p>Monitor The Director of Nursing and/or designee will audit 3 residents for completing of post fall neurological assessments, CSM assessments, and monitoring of skin under resident splints/braces. Starting the week of October 22nd, 2018 the review will be documented on the audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135052</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/14/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COEUR D'ALENE OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814</b>		
(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 684	<p>Continued From page 22</p> <p>completed at 4:00 AM, 8:00 AM, 12:00 PM, and 4:00 PM. There were no neurological evaluations completed on 8/25/18 or 8/26/18. Per the facility's policy Resident #33's neurological status was to be assessed for 72 hours, through 8/26/18 at 9:00 AM.</p> <p>An Incident Report, dated 8/25/18 at 3:50 PM, documented Resident #33 had an unwitnessed fall, while trying to pick up candy off the floor. There were no neurological evaluations initiated or completed.</p> <p>On 9/13/18 6:45 PM, the DNS stated she expected the nurses to follow the neurological evaluation protocol. The DNS reviewed Resident #33's neurological assessment related to the fall on 8/23/18 and stated the documentation was incomplete. The DNS reviewed Resident #33's clinical record related to the fall on 8/25/18 at 3:50 PM and stated the nurses should have initiated and completed a neurological assessment.</p> <p>b. Resident #33 returned from the ER on 8/23/18 with a diagnosis of a right wrist fracture and had a splint that was secured with a wrap. There were no physician orders indicating if the splint could be removed.</p> <p>The facility's Removable or Preformed Splint policy and procedure, dated 11/28/17, documented:</p> <p>* Splinting is used primarily to immobilize broken bones.</p> <p>* Nursing and therapy personnel may reapply</p>	F 684			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135052</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/14/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COEUR D'ALENE OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814</b>		
(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 684	<p>Continued From page 23</p> <p>splints for continuous wear situations and should assess the extremity and apply a splint according to a physician's order.</p> <p>* The removable or preformed splint includes assessing the resident's skin under the splint, neurovascular status, manufacturer's instructions, and circulation, movement, and sensation status.</p> <p>* Document in the resident's medical record splint application and evaluation results and notify the physician of complications and implement new orders.</p> <p>* If physician orders do not indicate the splint may be removed to check skin integrity at least daily, call and clarify orders with the physician.</p> <p>* Establish monitoring for the splint to include: Condition of the resident's skin and neurovascular status of the area distal to the splint during splint application, at least each shift.</p> <p>Resident #33's August 2018 and September 2018 TARs did not document assessments or monitoring under the splint.</p> <p>On 9/10/18 at 2:13 PM, Resident #33 was observed with a splint wrapped loosely and secured in a sling. Resident #33 stated she broke her arm.</p> <p>On 9/13/18 at 6:34 PM, the DNS obtained a verbal order to remove the wrap and splint to assess the skin for Resident #33. The DNS and the Clinical Resource Nurse removed the wrap and splint to Resident #33's right forearm. No</p>	F 684			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135052</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/14/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COEUR D'ALENE OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814</b>		
(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 684	Continued From page 24 redness was noted and bruising was resolving. The DNS reapplied the splint, while the Clinical Resource Nurse was holding Resident #33's right arm securely. The DNS then applied an ace wrap to secure the splint in place. Resident #33 denied pain or discomfort.  On 9/13/18 at 6:50 PM, the DNS stated the nurses should have clarified the physician's order to assess the skin under the splint from the fall on 8/23/18 and should assessed under the splint daily to assure there was no skin breakdown. The DNS stated the TAR should have had documentation the licensed nurses assessed and monitored to assure Resident #33's wrap was secure and her circulation, movement, and sensation status was checked every shift.	F 684			
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)  §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident and family interview, review of facility policies,	F 686	F686 Treatment/Svcs to prevent/ heal pressure ulcer	10/30/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135052</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/14/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COEUR D'ALENE OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814</b>		
(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 686	<p>Continued From page 25</p> <p>record review, and review of facility incident reports, it was determined the facility failed to prevent the development and worsening of pressure ulcers. This was true for 2 of 5 residents (#1 and #24) reviewed for pressure ulcers. These failures resulted in harm when Resident #24 developed a blister on her heel that deteriorated and became an unstageable pressure ulcer and when Resident #1 developed a pressure ulcer on her coccyx. Findings include:</p> <p>The facility's policy Prevention and Treatment of Pressure Ulcers, dated 11/28/17, documented the following:</p> <ul style="list-style-type: none"> <li>* Residents at risk for developing pressure ulcers were identified using the Braden Scale (an assessment tool widely adopted to assess a person's risk for development of a pressure ulcer).</li> <li>* Pressure ulcer and other wound/skin interventions were created in cooperation with the interdisciplinary team and were implemented to identify, avoid, or decrease the risk of pressure ulcers.</li> <li>* Based on the resident's assessment, clinical status, preferences and needs, routine care may include but is not limited to: redistributing pressure (e.g. repositioning, protecting/offloading heels), minimizing contact with moisture, providing appropriate pressure-redistributing surfaces that are non-irritating, and maintaining/improving nutrition and hydration.</li> <li>* New or existing pressure ulcers and non-pressure related wounds were treated</li> </ul>	F 686	<p>Resident Specific Resident #1 &amp; 24 physician orders were implemented and Wound Nurse practitioner has assessed and formed plan of care. Resident care plan was updated to reflect current plan of care and implemented at the bedside to promote healing and prevent further skin integrity issues.</p> <p>Other Residents The clinical management team reviewed other residents for new or worsening pressure wounds. Adjustments have been made as indicated.</p> <p>Facility Systems Nursing staff, ID team and clinical management team are educated to pressure prevention and treatment policy. Re-education was provided by the Director of Nursing and/or designee to include but not limited to, assessment and prevention of wounds, accurate staging of new wounds, identification of root cause, weekly skin checks, RD communication, timely implementation of treatment after identification, clarification of orders as needed, monitoring for healing, and the facility's policy prevention and treatment of pressure ulcers. The system is amended to include oversight by the Director of Nursing for proper pressure prevention intervention implementation and accuracy of nursing wound assessment with new issues in clinical meeting, then review of other wounds in</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135052</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/14/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COEUR D'ALENE OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814</b>		
(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 686	<p>Continued From page 26 according to the principles of wound healing.</p> <p>* The interdisciplinary team and resident/family cooperated to create goals and interventions to improve wound healing and/or prevent further skin breakdown.</p> <p>1. Resident #24 was admitted to the facility on 7/26/18, with multiple diagnoses including unsteadiness on feet, unspecified dementia with behavioral disturbance, hemiplegia (paralysis) affecting the left nondominant side, cerebral infarction (stroke), and muscle weakness.</p> <p>A Weekly Skin Integrity Review, dated 7/26/18, documented Resident #24's skin was intact. Resident #24's Braden Scale for Predicting Pressure Sore Risk, dated 7/30/18 at 9:00 AM, documented Resident #24 was at moderate risk for pressure ulcers.</p> <p>Resident #24's admission MDS assessment, dated 8/2/18, documented the following:</p> <ul style="list-style-type: none"> <li>* Moderate cognitive impairment.</li> <li>* Extensive assistance of 2 persons required for bed mobility and dressing.</li> <li>* Extensive assistance of 1 person with transfers and personal hygiene.</li> <li>* A wheelchair was in use.</li> <li>* Risk for developing pressure ulcers.</li> <li>* One unhealed Stage I pressure ulcer.</li> <li>* Pressure reducing device for chair and bed.</li> </ul> <p>According to the Hopkins Medicine website, accessed 10/2/18, pressure ulcers are classified by stages as defined by the National Pressure Ulcer Advisory Panel. A Stage I pressure ulcer is</p>	F 686	<p>routine weights and skin meeting.</p> <p>Monitor The Director of Nursing and/or designee will audit 3 residents weekly for prevention of pressure ulcers or worsening pressure ulcers, weekly skin checks, and accuracy of wound assessment documentation until no deficiency is identified. Starting the week of October 22nd, 2018, the review will be documented on the audit tool. Any concerns will be addressed immediately and discussed with the IDT Team. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135052</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/14/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COEUR D'ALENE OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814</b>		
(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 686	<p>Continued From page 27</p> <p>intact skin with non-blanchable redness of a localized area, usually over a bony prominence.</p> <p>Resident #24's September 2018 physician orders, dated 8/8/18, included Opti-foam (a type of dressing) to the right heel every day, a wound nurse consult, and Prevalon boots (pressure reducing) to be in place when in bed every shift.</p> <p>A Physician Order Request, dated 8/8/18 at 10:04 AM, documented a request was faxed to Resident #24's physician. The form documented Resident #24 had a 7 cm by 3 cm bruised, non-blanchable blister on the bottom of her right heel. An order was requested for Skin Prep (a protective film or barrier) to be applied to both heels every day, and application of Opti-foam to the right heel each day. The request also included Prevalon boots for Resident #24 and a wound nurse consult. A Nurse Practitioner signed the document on 8/8/18 at 5:52 PM.</p> <p>Resident #24's current care plan documented the following:</p> <ul style="list-style-type: none"> <li>* A new skin event of Stage II right heel pressure ulcer on 8/8/18. A Stage II pressure ulcer, defined by the Hopkins Medicine website accessed on 10/2/18, is partial thickness loss of the skin presenting as a shallow open ulcer with a red/pink wound bed, without dead tissue, or may present as a blister.</li> <li>* Pressure reduction in place to bed and chair, initiated on 8/8/18.</li> <li>* Follow facility protocol for wound care, initiated on 8/8/18.</li> <li>* Treatment per physician's order, initiated on 8/8/18.</li> </ul>	F 686			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135052</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/14/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COEUR D'ALENE OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814</b>		
(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 686	<p>Continued From page 28</p> <ul style="list-style-type: none"> <li>* Notify charge nurse of skin impairment, initiated on 8/8/18.</li> <li>* Heel boots on when up in chair, initiated on 8/27/18.</li> <li>* Heel lift when in bed, initiated on 8/27/18.</li> <li>* Refer to wound nurse as needed, initiated on 8/27/18.</li> </ul> <p>An Incident Report, dated 8/8/18, documented a 7 cm by 3 cm bruised, non-blanchable blister on Resident #24's right heel was reported by the CNA to the nurse. Skin Prep and an Opti-foam dressing were applied, and a fax was sent to the physician.</p> <p>Resident #24's record included Weekly Pressure Ulcer BWAT Reports. The weekly reports included inconsistent documentation of the Stage II pressure ulcer identified on Resident #24's right heel. The reports also documented how the ulcer worsened from a Stage II to an Unstageable pressure ulcer during a 30 day period from 8/8/18 to 9/7/18. Examples include:</p> <ul style="list-style-type: none"> <li>- On 8/8/18 at 10:59 AM, the report documented the Stage II pressure ulcer on the right heel measured 7 cm by 3 cm. A foam dressing was in place and the right heel was elevated off the bed.</li> <li>- On 8/16/18 at 11:25 AM, the report documented the Stage II pressure ulcer on the right heel measured 0.5 cm by 0.5 cm. The nurse documented the wound appeared unchanged and daily dressing changes continued. The wound size had changed and decreased by 6.5 cm and 2.5 cm from the previous measurements, 8 days before.</li> </ul>	F 686			

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:  <b>135052</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/14/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COEUR D'ALENE OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814</b>		
(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 686	<p>Continued From page 29</p> <p>- On 8/23/18 at 4:27 PM, the report documented the Stage II pressure ulcer on the right heel measured 0.5 cm by 0.5 cm. The nurse documented the wound was slightly improved, a foam dressing was in place, and Prevalon boots were in place to both feet. However, the measurements were unchanged from the report 7 days earlier on 8/16/18.</p> <p>- On 8/31/18 at 10:19 AM, the report documented the Stage II pressure ulcer on the right heel measured 7 cm by 3 cm. The blister was flat and dark tissue was present and a foam pad was in place. The wound had increased in size by 6.5 cm and 2.5 cm in 8 days.</p> <p>- On 9/6/18 at 1:29 PM, the report documented the Stage II pressure ulcer on the right heel measured 7 cm by 5 cm. The nurse documented the wound appeared the same as the previous week, a dark scab was present, and a foam dressing was in place. However, the wound had increased in length by 2 cm and a scab was present.</p> <p>- On 9/7/18 at 10:39 AM, the report documented a suspected deep tissue injury pressure area on the right heel that measured 4.1 cm by 6.1 cm. Resident #24 experienced pain during wound treatment. A foam dressing was applied and the heels were floated on a pad. A deep tissue injury according to the Hopkins Medicine website, accessed on 10/2/18, was a localized skin or blister area purple or maroon in color due to the damaged underlying soft tissue from pressure or shear. The area may be painful, mushy, or boggy.</p>	F 686			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135052</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/14/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COEUR D'ALENE OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814</b>		
(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 686	<p>Continued From page 30</p> <p>- On 9/12/18 at 4:44 PM, the report documented an unstageable pressure ulcer on the right heel that measured 5 cm by 5 cm. The nurse documented the wound was smaller in size with eschar (black dead tissue). A foam dressing was in place and Skin Prep was applied to both heels.</p> <p>On 9/10/18 at 2:24 PM, Resident #24's family member said Resident #24 had really dry skin on her feet, the skin was turning black during the past couple of weeks, and she had an infection on her heel. Resident #24's family member said her feet were not that way when she was in the hospital prior to coming to the facility.</p> <p>On 9/10/18 at 2:39 PM, Resident #24's family member said the facility told her there was a sore on Resident #24's heel and did not say why the sore appeared. Resident #24's family member said the sore on her heel was not present in the hospital.</p> <p>On 9/12/18 at 3:40 PM, a large purple/black area was observed on Resident #24's right heel and an Opti-foam dressing was in place. The Wound Nurse (RN #1), said when Resident #24 came to the facility from another facility her skin was intact. RN #1 said Resident #24 was not on an air mattress and the pad was placed after the ulcer developed on her right heel.</p> <p>On 9/12/18 at 3:44 PM, the DNS said there was a deep tissue injury on Resident #24's heel and it developed in the facility. The DNS said Resident #24 was at moderate risk for skin breakdown on admission. The DNS said every 2-hour turning was initiated for Resident #24 upon admission, but there was no place to document it was done.</p>	F 686			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135052</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/14/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COEUR D'ALENE OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814</b>		
(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 686	<p>Continued From page 31</p> <p>The DNS said the normal standard of care was to initiate measures on the 48-hour care plan, such as a pressure reduction mattress. The DNS said the heel lift pad was initiated on the care plan after the pressure ulcer developed on Resident #24's heel. The DNS said on 8/8/18, Resident #24's pressure sore was noted as a blister that was believed to be caused by the wheelchair.</p> <p>On 9/14/18 at 9:41 AM, RN #1 the wound nurse, stated on Resident #24's Weekly Pressure Ulcer BWAT Reports, dated 8/16/18 and 8/23/18, she meant to document the right heel wound measured 5.0 cm by 5.0 cm, not 0.5 cm by 0.5 cm.</p> <p>Resident #24 developed an avoidable pressure ulcer on her right heel at the facility, and it worsened from a Stage II to unstageable.</p> <p>2. Resident #1 was readmitted to the facility on 6/4/18, with multiple diagnoses including a stroke and muscle weakness.</p> <p>Resident #1's care plan, revised 8/8/18, documented she had a history of skin breakdown at the coccyx. The care plan did not address Resident #1's pressure ulcer to the coccyx found on 8/25/18.</p> <p>Resident #1's quarterly MDS assessment, dated 8/9/18, documented Resident #1 was moderately cognitively impaired and required 2 person extensive assistance with bed mobility and transfers. The MDS assessment documented Resident #1 was at risk for pressure ulcers and had no unhealed pressure ulcers.</p>	F 686			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135052</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/14/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COEUR D'ALENE OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814</b>		
(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 686	<p>Continued From page 32</p> <p>An Incident Report, identified as a late entry on 8/27/18 for an incident on 8/25/18 at 11:30 AM, documented during cares the CNAs found an open area to Resident #1's coccyx. The open area measured 2 cm x 0.5 cm and depth of 0.5 cm with no odor or drainage. The report documented RN #2 cleansed the area and applied an Opti-foam dressing to the open area.</p> <p>Nurse's progress notes from 8/25/18 to 9/3/18, and 9/7/18 to 9/10/18, did not include documentation of the Stage II pressure ulcer to Resident #1's coccyx.</p> <p>Weekly Pressure Ulcer BWAT Reports, from 8/31/18 to 9/12/18, had inconsistent documentation of when the Stage II pressure ulcer to Resident #1's coccyx was identified. Examples include:</p> <ul style="list-style-type: none"> <li>- On 8/31/18 at 9:59 AM, RN #1 the wound nurse, documented Resident #1 had a Stage II pressure ulcer to her coccyx that measured 3 cm x 1 cm with 0 cm in depth. The report documented the initial observation of the pressure ulcer was dated 8/29/18. The report documented there was a foam dressing on the coccyx area and the dressing was clean, dry, and intact.</li> <li>- On 9/4/18 at 1:30 PM, RN #2 documented Resident #1 had an initial observation of a Stage II pressure ulcer on 9/4/18. The pressure ulcer was on Resident #1's coccyx and measured 3 cm x 3 cm with a depth of 0.1 cm. The pressure ulcer had a scant amount of serosanguineous (yellow in color with small amounts of blood) drainage.</li> </ul>	F 686			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135052</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/14/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COEUR D'ALENE OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814</b>		
(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 686	<p>Continued From page 33</p> <p>- On 9/6/18 at 1:24 PM, RN #1 documented Resident #1 had a Stage II pressure ulcer to her coccyx which was initially observed on 8/8/18. The pressure ulcer measured 3.0 cm x 4.0 cm with a depth of 0 cm. RN #1 documented a foam dressing had a scant amount of serosanguineous drainage when removed from the coccyx.</p> <p>- On 9/12/18 at 5:01 PM, the report documented Resident #1 had a Stage II pressure ulcer to her coccyx which was initially observed on 8/31/18. The pressure ulcer measured 0.3 cm x 0.3 cm with a depth of 0 cm and no drainage.</p> <p>The 4 Weekly Pressure Ulcer BWAT Reports documented 4 different dates of when the Stage II pressure ulcer was initially observed or identified.</p> <p>An Incident Investigation Report, dated 9/4/18, documented on 8/25/18, staff noted 2 open areas to Resident #1's coccyx. The report documented both areas were superficial and small in area. The investigation report documented nursing staff were cleaning and dressing the wound as ordered and Resident #1 had a cushion for her wheelchair, which she spent large amounts of time sitting in.</p> <p>Resident #1's August 2018 and September 2018 weekly skin checks on the TAR were blank.</p> <p>A Nutrition Progress Note, dated 9/11/18 at 10:19 AM, documented Resident #1 had no skin issues.</p> <p>On 9/10/18 at 11:53 AM, Resident #1 was</p>	F 686			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135052</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/14/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COEUR D'ALENE OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814</b>		
(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 686	<p>Continued From page 34</p> <p>observed sitting in her electric wheelchair. Resident #1 stated she had an open area to her coccyx area. Resident #1's electric wheelchair did not have a cushion. Resident #1 stated she had never had a cushion for her wheelchair. Resident #1 stated she gets up by 9:00 AM and laid back down by 2:00 PM every day.</p> <p>On 9/10/18 at 3:00 PM, Resident #1 was observed in her room laying on her back on an air mattress bed.</p> <p>On 9/11/18 at 9:57 AM, Resident #1 was observed sitting in her electric wheelchair without a cushion.</p> <p>On 9/12/18 at 1:59 PM, RN #1 was observed assessing Resident #1's open area to her coccyx. RN #1 stated to Resident #1 the dressing to her coccyx had fallen off and needed to be replaced. RN #1 stated the wound was healing well and needed a dressing to protect the fragile healing skin for another week.</p> <p>On 9/12/18 at 2:01 PM, LPN #2 was observed applying an adhesive dressing. LPN #2 stated the open area to Resident #1's coccyx area was approximately 1 cm x 1 cm in size.</p> <p>On 9/13/18 at 4:10 PM, the DNS and the Clinical Resource Nurse stated the facility had a delay in treatment for Resident #1's open area to the coccyx that was discovered on 8/25/18. The DNS stated the nurses should have documented daily in the nurses' progress notes, updated the care plan, and transcribed the physician's orders to the TAR for dressing changes and monitoring to Resident #1's wound. The DNS stated if the TAR</p>	F 686			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135052</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/14/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COEUR D'ALENE OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814</b>		
(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 686	Continued From page 35 was left blank that meant the treatment was not done. The DNS was unable to explain why the "initial observation dates" were different on the Weekly Pressure Ulcer BWAT Reports and the reports were based on the pressure ulcer found on 8/25/18.	F 686			
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii)  §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and resident family interview, it was determined the facility failed to ensure residents received proper treatment and care to maintain good foot health. This was true for 1 of 2 residents (Resident #24) reviewed for foot care. This failed practice created the potential for harm should residents experience complications from their medical condition related to lack of proper foot care. Findings include:  Resident #24 was admitted to the facility on 7/26/18, with multiple diagnoses including unsteadiness on feet, unspecified dementia with behavioral disturbance, hemiplegia (paralysis)	F 687	F 687 Foot care  Resident Specific Resident # 24 received proper foot care.  Other Residents Other residents were assessed and provided proper foot care as indicated.  Facility Systems Nursing staff has been educated on standard of practice for foot care. Re-education was provided by the Director of Nursing to include but not	10/30/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135052</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/14/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COEUR D'ALENE OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814</b>		
(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 687	<p>Continued From page 36</p> <p>affecting the left nondominant side, cerebral infarction (stroke), and muscle weakness.</p> <p>Resident #24's Admission MDS assessment, dated 8/2/18, documented she had moderate cognitive impairment, required extensive assistance of 2 persons for bed mobility and dressing, required extensive assistance of 1 person with transfers and personal hygiene, and 1 person physical assistance with bathing.</p> <p>Resident #24's care plan documented she required extensive to total assistance of 1 person for bathing and extensive assistance of up to 2 people for bed mobility and dressing, initiated on 8/8/18.</p> <p>On 9/13/18 at 12:01 PM, LPN #1 was observed performing a dressing change to Resident #24's right heel. Resident #24's feet appeared dark in color with very dry, flaky skin, and long toenails. LPN #1 said she was not certain when Resident #24's toenails were last trimmed, and they needed to be trimmed and her feet could use lotion. LPN #1 said if the resident was diabetic it would be her responsibility to trim the toenails, otherwise a CNA could trim the toenails.</p> <p>On 9/13/18 at 12:08 PM, CNA #1 said unless the resident was diabetic, the CNAs could trim their toenails. CNA #1 said the staff liked the shower aide to trim residents' toenails after their shower, but she was busy, so the other staff would try to take up the slack. CNA #1 said CNAs could apply lotion to residents whenever they see dry flaky skin. CNA #1 said Resident #24 had dry skin on her feet and she applied lotion the previous day. CNA #1 said Resident #24's toenails needed to</p>	F 687	<p>limited to, reporting inability to perform foot care to DNS, frequency of providing foot care and notifying MD if nursing staff is unable to perform foot care. The system is amended to include oversight by the Director of Nursing with review in clinical meeting of completion of previous days assigned diabetic foot care orders.</p> <p>Monitor The Director of Nursing and/or designee will audit 3 residents weekly for proper diabetic foot care until no deficiency is identified. Starting the week of October 22nd, 2018 the review will be documented on the audit tool. Any concerns will be addressed immediately and discussed with the IDT Team. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135052</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/14/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COEUR D'ALENE OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814</b>		
(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 687	Continued From page 37 be trimmed.  On 9/13/18 at 2:24 PM, LPN #1 said she spoke to the shower aide and she did not address Resident #24's toenails when she gave her a shower, 3 days ago.  On 9/13/18 at 2:22 PM, the Clinical Resource Nurse said nail care should be performed at least weekly with showers and as needed.  On 9/14/18 at 9:47 AM, the DNS said the shower aide should be addressing residents' toenails and dry skin on the resident's shower day. The DNS said if the resident was diabetic, the shower aide should bring it to the attention of the nurse if the resident needed toenails trimmed. The DNS said an over the counter lotion did not require a physician's order, and the facility had lotion available. The DNS said she did not believe Resident #24 had been to a podiatrist. The DNS said resident's toenails which were difficult to trim were referred to a podiatrist. The DNS said she was not aware of any instances when the aide or nurse was not able to trim Resident #24's toenails.	F 687			
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)  §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and  §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 689		10/30/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135052</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/14/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COEUR D'ALENE OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814</b>		
(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 689	<p>Continued From page 38</p> <p>by: Based on observation, staff interview, policy review, and record review, it was determined the facility failed to provide adequate supervision to meet residents' needs. This was true for 1 of 2 residents (Resident #33) reviewed for supervision and accidents. Resident #33 was harmed when she fell and sustained a fractured forearm when staff failed to implement interventions and provide adequate supervision. Findings include:</p> <p>The facility's Fall Response and Management policy, dated 11/28/17, documented if there was no injury staff were to obtain vital signs including postural (orthostatic) vital sign measurement. Document the fall in the resident's medical record and implement immediate interventions to prevent a repeat fall.</p> <p>The policy further stated if there was an unwitnessed fall or resident injury staff were to obtain an x-ray if a fracture was suspected and monitor neurological assessments. Staff were also to complete a post-fall investigation and event report and revise the care plan as appropriate, and document the incident or injury in the resident's medical record.</p> <p>This policy was not followed.</p> <p>Resident #33 was admitted to the facility on 11/3/17, with multiple diagnoses including mild intellectual disability and difficulty in walking.</p> <p>A quarterly MDS assessment, dated 8/13/18, documented Resident #33 had moderate cognitive impairment, required supervision with</p>	F 689	<p>F 689 Free of accident hazards/supervision/devices</p> <p>Resident Specific Resident #33 has had therapy treatments and fall interventions implemented and adequate supervision.</p> <p>Other Residents The ID team reviewed other residents with falls in the past 30 days for intervention implementation and adequate supervision. Adjustments have been made as indicated.</p> <p>Facility Systems Nursing staff, therapy staff and ID Team have been educated to fall response and management policy with root-cause based fall intervention implementation. Re-education was provided by the Director of Nursing and/or designee to include but not limited to, completion of post fall evaluation, fall response and management post each fall, fall intervention implementation to include increased supervision, completion of neurological checks, referral to therapy as indicated with timely evaluation, update of care plan, clarification for weight bearing status, and prevention of falls plans. The system is amended to include over sight by the</p> <p>Director of Nursing with review of post fall assessment, care plan updates, and evaluation of care plan for effectiveness,</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135052</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/14/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COEUR D'ALENE OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814</b>		
(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 689	<p>Continued From page 39</p> <p>ambulation, had limited ROM (range of motion) impairment to her lower extremities, and had experienced 2 or more non-injury falls.</p> <p>A Fall Risk Assessment Tool, dated 8/20/18, documented Resident #33 had a history of falls within the last 3 months, impaired functional mobility, and had cognitive impairment. The Fall Risk Assessment scored Resident #33 a 7 out of 10 and was considered a risk for falling.</p> <p>The ADL care plan, dated 5/31/18, documented Resident #33 was independent with ambulation and transfers.</p> <p>Resident #33's care plan documented Resident #33 had a history of falls and had cognitive impairment. The care plan interventions were documented as follows:</p> <ul style="list-style-type: none"> <li>* Assist to steady/assist resident as needed due to impaired balance with right arm sling in place, dated 9/12/18.</li> <li>* Encourage resident to wear nonskid socks and/or shoes when ambulating, revised 6/1/18.</li> <li>* Fall risk assessment Quarterly and as needed, revised 6/1/18.</li> <li>* INFO: resident ambulates independently, revised 6/1/18.</li> <li>* Have commonly used items within easy reach, dated 5/17/18.</li> <li>* Request therapy evaluation as appropriate, revised 6/1/18.</li> </ul> <p>Resident #33's record included 4 incident reports of 5 falls, witnessed and unwitnessed, with 2 injuries in 2 days. Examples include:</p>	F 689	<p>during clinical meeting post each resident fall and periodically until resident is stable.</p> <p>Executive Director with review of investigation with implementation of interventions based on root-cause, during clinical meeting post each resident fall.</p> <p>Monitor The Director of Nursing and/or designee will audit 3 residents weekly for implementation of interventions post fall and adequate supervision for frequent fallers until no deficiency is identified. Starting the week of October 22nd, 2018 the review will be documented on the audit tool. Any concerns will be addressed immediately and discussed with the IDT team. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135052</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/14/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COEUR D'ALENE OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814</b>		
(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 689	<p>Continued From page 40</p> <p>a. An Incident Report, dated 8/23/18 at 9:00 AM, documented Resident #33 fell while she was walking at a fast pace. The report documented she hit her forehead and her right wrist was swollen and bruised.</p> <p>A physician's order, dated 8/23/18, documented "STAT" (immediate) x-ray of the right wrist.</p> <p>A Nurse Practitioner progress note, dated 8/23/18 at 12:40 PM, documented Resident #33 had a "goose-egg" size bump on her forehead and a noticeably swollen and bruised right wrist and they were waiting for x-ray results.</p> <p>A Radiology Report, dated 8/23/18 at 6:07 PM, documented Resident #33 sustained a fractured right wrist.</p> <p>A fax to the physician, dated 8/23/18 at 8:20 PM, documented, "...was not able to get a hold of on call provider. X-ray positive for distal radial fracture. Pt [patient] was sent to [name of hospital] ER for medical treatment at 7:00 PM."</p> <p>The ER Report, dated 8/23/18, documented Resident #33 was seen for a wrist fracture from a fall. The discharge instructions from the ER stated to have Resident #33 follow-up with an orthopedic physician and return to the ER if she experienced numbness or tingling of the fingers.</p> <p>A Nurse's progress note, dated 8/23/18 at 10:43 PM, documented Resident #33 returned from the ER with a splint on her right forearm and sling.</p> <p>The nurses' progress notes did not document Resident #33 had a fall, she was assessed by</p>	F 689			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135052</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/14/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COEUR D'ALENE OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814</b>		
(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 689	<p>Continued From page 41</p> <p>the Nurse Practitioner, x- rays were obtained, and Resident #33 sustained a right wrist fracture and a large bump on her forehead.</p> <p>b. An Incident Report, dated 8/24/18 at 3:00 PM, documented Resident #33 had a witnessed fall in the activity room. She landed on her knees and there was no injury.</p> <p>An Incident Investigation and Conclusion report signed by the DNS on 8/27/18, and signed by the Administrator on 9/5/18, documented Resident #33 had a second fall in 2 days. The report documented the IDT agreed to get an order for an OT evaluation and treatment, which was to be completed on 8/27/18.</p> <p>A physician's order, dated 8/27/18, documented Resident #33 was to receive an OT evaluation and treatment 5 times a week.</p> <p>An OT evaluation and plan of care, dated 8/27/18, documented Resident #33 was referred to OT due to new onset of decreased functional mobility, decreased strength, decreased coordination, decreased postural alignment, falls/fall risk, fracture, functional limitation with ambulation, and increased need for assistance from others.</p> <p>Resident #33's care plan did not include OT.</p> <p>The nurses' progress notes did not include documentation Resident #33 had a fall in the activity room on 8/24/18.</p> <p>c. An Incident Report, dated 8/25/18 at 3:50 PM, documented Resident #33 was found sitting on</p>	F 689			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135052</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/14/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COEUR D'ALENE OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814</b>		
(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 689	<p>Continued From page 42</p> <p>the floor in the dining room. The 3 witness statements documented Resident #33 was found on the floor and they did not witness her fall.</p> <p>A nurses' progress note, dated 8/25/18 at 4:12 PM, documented a volunteer found Resident #33 sitting on the ground in the dining room. Resident #33 stated she was trying to pick up candy off the ground and fell. Resident #33 stated she did not hit their head. The progress note also documented there were no injuries and Resident #33's vital signs were stable.</p> <p>An Incident Investigation and Conclusion report signed by the DNS on 8/27/18, and signed by the Administrator on 9/5/18, documented since Resident #33 had a third fall in three days, staff were to encourage her to use a wheelchair for the rest of the day, as she was scheduled to be evaluated by OT on Monday, 8/27/18. The report also documented Resident #33 agreed to use the wheelchair for a brief time and she was educated to ask for staff assistance to get items off the floor.</p> <p>Resident #33's clinical record did not include neurological evaluations for the fall on 8/25/18 at 4:12 PM.</p> <p>d. An Incident Report, dated 8/25/18 at 5:20 PM, documented Resident #33 was found on the ground near the entryway of the dining room. No injuries occurred, and Resident #33 was helped into a wheelchair and pushed to the table. Staff were helping with dinner and Resident #33 attempted to get up from the wheelchair and the wheelchair rolled back, Resident #33 fell on her bottom. The report documented no injuries</p>	F 689			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135052</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/14/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COEUR D'ALENE OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814</b>		
(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 689	<p>Continued From page 43 occurred, and Resident #33 did not hit her head.</p> <p>An Incident Investigation and Conclusion report signed by the DNS on 8/27/18, and signed by the Administrator on 9/5/18, documented:</p> <ul style="list-style-type: none"> <li>* Resident #33's sister stated she would like to have Resident #33 use a walker or a cane due to the high number of recent falls.</li> <li>* A cane or walker would be counter indicated, as Resident #33 could not bear weight on her right wrist.</li> <li>* Staff encouraged Resident #33 to use the wheelchair until she was evaluated by OT.</li> <li>* The IDT felt Resident #33 continued to be appropriate for independent ambulation despite recent falls.</li> <li>* Resident #33 would have a difficult time remembering to stay in a wheelchair due to her cognition.</li> <li>* Resident #33 continued to remain in areas of high visibility most of the time.</li> <li>* Resident #33 was independent with transfers and bed mobility.</li> <li>* An OT evaluation was pending.</li> </ul> <p>On 9/10/18 at 2:09 PM, Resident #33 stated she fell and broke her arm. Resident #33 was observed with a splint and wrap to her right forearm. She was ambulating around the facility at a hurried pace.</p> <p>On 9/11/18 at 9:00 AM, Resident #33 was observed greeting visitors when entering the facility. She did not have an assistive device for balance and a splint was in place to her right forearm.</p>	F 689			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135052</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/14/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COEUR D'ALENE OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814</b>		
(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 689	Continued From page 44 On 9/13/18 at 5:16 PM, the DNS stated the facility did not complete fall assessments after each fall and the care plan was not updated for Resident #33. The DNS stated the nurses should have documented the 8/23/18 and the 8/24/18 falls in the nurses' progress notes. The DNS was unable to provide documentation for weight bearing status and treatment for Resident #33's right forearm fracture. The DNS was unable to provide evidence of what changes had been made to Resident #33's care plan after each fall. The DNS was unable to provide evidence of increased supervision for Resident #33.  On 9/13/18 at 6:12 PM, the Clinical Resource Nurse stated Resident #33 should have had orders for Physical Therapy to evaluate and treat for balance and gait training.  On 9/14/18 at 10:25 AM, the DNS stated Resident #33 did not follow up with an orthopedic surgeon because she did not have surgery. She stated the Medical Director was following Resident #33's care for the right wrist fracture.  On 9/14/18 at 10:27 AM, the Medical Director stated he was following Resident #33's care for her right wrist fracture. The Medical Director stated he was ordering a follow-up x-ray to determine if the fracture was healing. The Medical Director stated Resident #33 should have been evaluated and treated by Physical Therapy after the fall on 8/23/18.	F 689			
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)  §483.60(i) Food safety requirements. The facility must -	F 812		10/30/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135052</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/14/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COEUR D'ALENE OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814</b>		
(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 812	Continued From page 45  §483.60(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 safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.  §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy and procedure review, it was determined the facility failed to ensure food was prepared and served under sanitary conditions when staff were observed in the kitchen without facial hair restraints. This affected 13 of 13 residents reviewed (#1, #3, #15, #17, #22, #24, #25, #28, #30, #32, #33, #34, and #37) and had the potential to affect all residents who dined in the facility. This failure created the potential for harm should residents become exposed to disease-causing pathogens. Findings include:  The facility's policy and procedure for Personal Hygiene when Handling Food, dated 11/28/17, documented the following:  * Hair restraints including hats, hair	F 812	F 812 Food procurement, Store/prepare/serve-sanitary  Resident Specific No residents were identified as negatively impacted  Other Residents No other residents were negatively impacted, but could potentially impact residents served from the kitchen.  Facility Systems Kitchen staff educated on personal hygiene when handling food. Re-education was provided by dietician and/or designee to include but not limited to wearing of facial hair restraints and		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135052</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/14/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>COEUR D'ALENE OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814</b>		
(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 812	<p>Continued From page 46</p> <p>coverings/nets, and beard restraints would be worn at all times in the kitchen.</p> <p>* Hair should be contained inside the covering.</p> <p>* Facial hair should be neatly trimmed and, if longer than trimmed eyebrows, are covered by a beard guard.</p> <p>On 9/12/18 at 3:13 PM, the Dietary Manager, who had a full goatee beard and moustache, and Cook #1, who had a full moustache, were observed in the kitchen performing various duties and were not wearing facial hair restraints.</p> <p>On 9/12/18 at 11:45 AM, the Dietary Manager and Cook #1 were not wearing facial hair restraints as they served food and prepared trays for the lunch tray line. The Dietary Manager said if facial hair was 1/2 inch in length or shorter they did not need to wear a facial hair restraint. The Dietitian, also present, said she believed it was correct if facial hair was 1/2 inch in length or shorter they did not need to wear a facial hair restraint per the Idaho Food Code.</p> <p>On 9/13/18 at 8:30 AM, the Dietary Manager said he was from Washington and thought facial hair could be 1/2 inch in length without having to wear a facial hair restraint. The Dietary Manager said he looked it up and that was not correct. The Dietary Manager said he and Cook #1 should have been wearing facial hair restraints.</p>	F 812	<p>handling food. The system is amended to include oversight by Executive Director with periodic observation rounds.</p> <p>Monitor The Executive Director and/or designee will audit intermittent meal services 3 times a week for proper hair restraints until no deficiency identified. Starting the week of October 22nd, 2018 the review will be documented on the audit tool. Any concerns will be addressed immediately and discussed with the IDT Team. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p>		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001600</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/14/2018</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>COEUR D'ALENE OF CASCADIA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814</b>
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the state licensing and complaint investigation survey conducted September 10, 2018 to September 14, 2018.</p> <p>The surveyors conducting the survey were:</p> <p>Jenny Walker, RN, Team Coordinator Cecilia Stockdill, RN</p>	C 000		
C 664	<p><b>02.150,02,a Required Members of Committee</b></p> <p>a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative. This Rule is not met as evidenced by: Based on review of Quality Assurance Performance Improvement meeting attendance records and staff interview, it was determined the facility failed to ensure a representative from each required department participated in the facility's Infection Control Meetings at least quarterly. This failure created the potential for negative outcomes for residents, visitors, and staff in the facility related to the prevention of infections and disease. Findings included:</p> <p>On 9/14/18 at 11:18 AM, the Administrator stated the facility held Quality Assurance Performance Improvement meetings every other month and infection control was a component of those meetings.</p> <p>The Administrator provided attendance records, dated 9/15/17, 11/10/17, 1/22/18, 5/30/18, and</p>	C 664	<p>C664 Required Member of Committee</p> <p>Resident Specific No specific residents were identified</p> <p>Other Residents All residents, visitors, and staff have the potential to be effected related to prevention of infections and disease.</p> <p>Facility Systems Medical Director, Executive Director, pharmacist, dietary supervisor, Director of Nursing, housekeeping representative, and maintenance director are educated to the regulatory requirement for infection control. Re-education was provided by the Infection Preventionist to include but not limited to, participation in infection control</p>	10/30/18

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Electronically Signed	TITLE	(X6) DATE  10/15/18
--	-------	---------------------------

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001600</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/14/2018</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>COEUR D'ALENE OF CASCADIA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814</b>
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

C 664	Continued From page 1  7/27/18, that documented the pharmacist and a housekeeping representative failed to attend any of those Infection Control Meetings. The Maintenance representative failed to attend the Infection Control Meetings on 11/10/17, 1/22/18, 5/30/18, and 7/27/18. The Dietary services representative failed to attend the Infection Control Meetings on 1/22/18, 5/30/18, and 7/27/18. The Administrator stated the facility did not have a meeting between 1/22/18 and 5/30/18.	C 664	meetings at least quarterly. The system is amended to include oversight by the Executive Director with review of infection control committee attendance during QAPI meeting to validate required attendance each quarter.  Monitor The Executive Director and/or designee will audit infection control meeting attendance monthly for required staff participation until no deficiency is identified. Starting the week of October 22nd, 2018 the review will be documented on the audit tool. Any concerns will be addressed immediately and discussed with the IDT Team. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.	
-------	---	-------	--	--



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

BRAD LITTLE – Governor  
DAVE JEPPESEN – 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](mailto:fsb@dhw.idaho.gov)

April 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 **September 10, 2018** through **September 14, 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 #ID00007922**

**ALLEGATION #1:**

Residents became malnourished while at the facility.

**FINDINGS #1:**

During the investigation, records were reviewed, thirteen residents were observed and interviews were conducted.

Residents were observed during two different mealtimes in the dining room and in their rooms.

Three of three residents' records documented appropriate monitoring and interventions regarding their weight. The dietician was appropriately involved with those residents who had weight concerns. Staff were observed providing appropriate meals, assisting residents to eat as needed, and offering snacks to residents. No observed residents exhibited signs of malnutrition.

Eric Miller, Administrator  
April 12, 2019  
Page 2 of 3

One resident's record documented a physician had modified his diet orders due to concerns with his eating.

The allegation was unsubstantiated based on the investigation findings.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

Residents became dehydrated while in the facility.

FINDINGS #2:

During the investigation resident records were reviewed, 13 residents were observed and interviews were conducted.

Thirteen residents were observed for signs of dehydration and availability of fluids to drink throughout the survey. Residents were observed during two different mealtimes in the dining room and in their rooms. Residents were observed at different times and during different activities throughout the survey.

Three of 3 residents' records documented appropriate monitoring and interventions regarding residents' hydration status. The dietician was appropriately involved with those residents who had hydration concerns. Staff were observed providing appropriate amounts of fluids with meals, assisting residents to drink as needed, and offering fluids to residents throughout the day. The residents observed did not exhibit signs of dehydration.

The allegation was unsubstantiated based on the investigative findings.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

Residents developed very high glucose levels while in the facility.

Eric Miller, Administrator  
April 12, 2019  
Page 3 of 3

FINDINGS #3:

During the investigation 3 clinical records were reviewed.

One resident's record documented he had a very high glucose level which was addressed by the physician.

Therefore, the allegation was substantiated. However, no deficient practice was identified.

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

LT/lj