

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

PRINTED: 03/20/2019  
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>R</b> <b>03/14/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>COEUR D'ALENE OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2514 NORTH SEVENTH STREET</b> <b>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}	<p><b>INITIAL COMMENTS</b></p> <p>An onsite revisit survey was conducted to verify correction of deficiencies noted during the follow up survey February 15, 2019, on March 13, 2019 to March 14, 2019. Coeur d'Alene of Cascadia was found to be in substantial compliance with federal health care regulations as of March 7, 2019.</p> <p>The surveyors conducting the survey were:</p> <p>Jenny Walker, RN, Team Coordinator Wendi Gonzales, RN Presie Billington, RN</p>	{F 000}			

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

TITLE

(X6) DATE

Electronically Signed

03/18/2019

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.

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>R</b> <b>03/14/2019</b>
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NAME OF PROVIDER OR SUPPLIER  <b>COEUR D'ALENE OF CASCADIA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2514 NORTH SEVENTH STREET</b> <b>COEUR D'ALENE, ID 83814</b>
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{C 000}	<p><b>INITIAL COMMENTS</b></p> <p>On March 11, 2019 through March 12, 2019, an onsite revisit and complaint investigation survey was conducted to verify correction of deficiencies noted during the survey December 14, 2018. Life Care Center of Post Falls it was found to be in substantial compliance with state health care regulations as of January 23, 2109.</p> <p>The surveyors conducting the survey were:</p> <p>Jenny Walker, RN, Team Coordinator Wendi Gonzales, RN Presie Billington, RN</p>	{C 000}		

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Electronically Signed	TITLE	(X6) DATE <b>03/18/19</b>
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>An onsite revisit survey and complaint investigation was conducted on March 13, 2019 to March 14, 2019. The facility was found to be in compliance with federal regulations.</p> <p>The surveyors conducting the survey were:</p> <p>Jenny Walker, RN, Team Coordinator Wendi Gonzales, RN Presie Billington, RN</p>	F 000			

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IDAHO DEPARTMENT OF  
HEALTH & WELFARE

BRAD LITTLE – Governor  
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR  
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July 30, 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 **March 13, 2019** through **March 14, 2019**, an unannounced on-site complaint survey was conducted at Coeur d'Alene of Cascadia. The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00008060**

ALLEGATION #1:

A resident eloped and was found near the street of the facility.

FINDINGS #1:

During the investigation residents were observed, staff and residents were interviewed, and records were reviewed.

One resident's record reviewed, documented he was unable to move his right upper and lower extremities due to right-sided paralysis following a stroke. The record documented the resident was admitted in November 2017, and readmitted in February 2019, and his cognition was severely impaired and he required one to two-person staff assistance with activities of daily living (ADLs).

Eric Miller, Administrator  
July 30, 2019  
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The resident's record documented he was reevaluated on 2/22/19 after he was found outside the facility unattended and near the street. The progress notes documented a wander guard was placed on his wheelchair on 2/23/19. The resident's care plan included elopement behavior monitoring.

The resident was observed for ADLs, cares and dining. The resident did not wander or elope from the facility during observation. The resident was observed being pushed in his wheelchair by a staff member to the activity room of the facility's 200 hall, to the activity room for bingo on the 300 hall, to the dining room, and then outside the facility. The resident did not open the two sets of double doors of the entrance to the facility and did not ambulate independently on the sidewalk of the facility.

In an interview, the Resource Clinical Coordinator (RCC) stated the resident was observed by the Business Office Manager on 2/22/19 outside the facility on the sidewalk near the street in his wheelchair unattended. The RCC said the Business Manager notified the Administrator, and with the help of the nurse, brought the resident back into the facility and assessed him. The RCC stated interventions included 15-minute checks, wandering evaluation, wander guard placement, and behavior monitoring for wandering. The RCC stated the facility placed a sign on the outside of the entrance doors notifying visitors not to assist residents with leaving the facility.

Based on the investigative findings, the allegation a resident eloped from the facility was substantiated, however no current deficient practice was identified.

#### CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

#### ALLEGATION #2:

Incontinent residents had to wait long periods of time for personal care assistance.

#### FINDINGS #2:

During the investigation, six resident records were reviewed, observations of incontinence care were conducted, and residents and staff were interviewed.

Six residents were observed for incontinence care and they were not left wet for long periods of time. CNAs were observed providing incontinence care according to the residents' needs and the directions of their care plans. Their records documented incontinence care was provided every two hours and as needed.

Eric Miller, Administrator  
July 30, 2019  
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In interviews, the six residents stated the staff provided incontinence care timely and they had no concerns with their personal care needs being met.

CNAs and nurses were interviewed and stated they checked and provided incontinence care to the residents at least every two hours or more if needed.

One resident who was continent of bowel and intermittently incontinent of bladder was observed at different times in his room and did not voice any concerns. The resident used his call light appropriately and staff were observed responding to this call light accordingly. There was no unpleasant smell noted in the resident's room. The resident said staff members visited him and asked questions about his needs.

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

#### CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

#### ALLEGATION #3:

A resident did not receive proper wound care.

#### FINDINGS #3:

Four residents were observed and their clinical records were reviewed for wound care management. Incident and Accident Reports and Grievances Reports were reviewed. CNAs and nurses, including the Director of Nursing were interviewed.

One resident's record was reviewed who was admitted to the facility with a sacral (area located at the base of the spine) pressure ulcer with a wound vacuum (a type of wound therapy to assist wounds to heal and close) in place. The resident's record documented his wound was treated and the dressing changed as directed by the physician orders, and the wound vacuum was working properly. A nurse's note documented the resident had a macerated (breakdown of skin) area developed from the wound vacuum bridge (a dressing to wick away moisture and keep the wound vacuum tubing from putting pressure on the skin). A nurse practitioner (NP) order documented staff were to discontinue the wound vacuum and clean the resident's wound with normal saline and a 1:1 mixture of Nystatin (antifungal) powder, and to apply barrier cream to the reddened rash surrounding the sacral wound twice a day and when necessary. A nurse's note, documented the resident's rash showed signs of healing and on 2/5/19, the resident's wound vacuum was restarted.

Eric Miller, Administrator  
July 30, 2019  
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A subsequent nurse's note, documented the resident was found unresponsive and was sent to the hospital. A Hospital Admission record documented the resident was admitted due to altered mental status related to possible sepsis and pneumonia. The Hospital Admission record also documented the resident had a wound vacuum in place and there were no other areas of erythema (reddened skin) or ecchymoses (bruising) noted on his skin. The resident was discharged from the hospital to the facility 17 days later. The resident's record documented the wound vacuum was discontinued prior to his discharge from the hospital and the wound was to have a wet to dry dressing prior to his transfer to the facility.

During the investigation there were no residents in the facility who had a wound vacuum. One resident's right heel wound dressing was observed and there was no concern noted.

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

#### CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

#### ALLEGATION #4:

Residents had multiple falls being left alone on the toilet for long periods of time.

#### FINDINGS #4:

During the investigation, facility and resident records were reviewed and staff were interviewed.

Review of the facility's Incident/Accident Reports and the Medication Administration/Treatment Administration Reports (MAR/TAR) from 2/15/19 through 3/11/19, documented one resident had five witnessed falls and one unwitnessed fall. None of these falls occurred in the bathroom. Each incident was investigated, and an assessment and neurological checks were initiated. Care planning was implemented for each fall and updated following each incident, and medications were evaluated.

Review of six residents' Incident/Accident Reports from 2/15/19 through 3/14/19, did not document their falls were related to being left alone in the bathroom.

In an interview, the Resource Clinical Coordinator (RCC) stated one resident had five witnessed falls and one unwitnessed fall from 2/15/19 through 3/11/19. The RCC stated each of the witnessed fall incidents had two care givers and a sitter and the resident was assisted to the floor.

Eric Miller, Administrator  
July 30, 2019  
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The RCC stated the care plan had been followed at the time of each incident and was updated following each incident. The RCC stated the resident had increased impulsive and restless behaviors and a recent cardiac event. She said the resident was assessed by the physician, and sent to the hospital for evaluation. The RCC also stated the Interdisciplinary Team reevaluated the resident and had the resident assessed by a neurologist and a follow up was scheduled in April 2019.

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

#### CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

#### ALLEGATION #5:

Staff did not follow the facility's hypoglycemic protocol for residents.

#### FINDINGS #5:

Two residents' Medication Administration Records/Treatment Administration Records (MAR/TAR) were reviewed for blood sugar management. There were no concerns identified in the documentation for blood sugar management from 2/15/19 through 3/14/19.

In an interview, the two residents stated they did not have concerns with their blood sugar management.

A review of a third resident's MAR/TAR, documented the resident had seven incidents of blood sugar levels less than 70 mg/dl (milligrams per deciliter) on 2/17/2019 through 3/4/2019, and the hypoglycemic protocol was initiated for each incident.

The resident's progress notes on 2/18/19, documented the resident had a blood sugar level of 67 mg/dl at 7:32 AM. The hypoglycemic protocol was initiated by the nurse.

In an interview, the resident stated he did not have any concerns about his diabetic management and was satisfied with the care provided by the facility.

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

#### CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Eric Miller, Administrator  
July 30, 2019  
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One of the allegations was substantiated, but not cited. Therefore, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

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

Sincerely,

A handwritten signature in cursive script that reads "Belinda Day".

Belinda Day, RN, Supervisor  
Long Term Care Program

BD/lj



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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E-mail: [fsb@dhw.idaho.gov](mailto:fsb@dhw.idaho.gov)

August 5, 2019

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

Provider #: 135052

Dear Mr. Miller:

On **March 14, 2019**, an unannounced on-site complaint survey was conducted at Coeur D'Alene of Cascadia. The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00008049**

ALLEGATION #1:

The facility failed to ensure residents were appropriately monitored and that they received morning medications and breakfast.

FINDINGS #1:

An unannounced follow-up survey and complaint investigation was conducted from 3/13/19 to 3/14/19. During the investigation nine residents were observed and their clinical records were reviewed for quality of care. Incident and Accident Reports and Grievance Reports were reviewed and residents and staff members were interviewed.

In resident interviews, the residents said their needs were being met by the staff and they had no concerns. However, the facility's records included a resident Grievance Report, dated 2/22/19, which documented the resident was upset because the staff did not check on him or wake him up for his morning medications and breakfast. The report documented the resident preferred not to

Eric Miller, Administrator  
August 5, 2019  
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be awakened if he was asleep but did want to be checked on periodically while he was sleeping. The resident's February 2019 MAR (Medication Administration Record), was reviewed and documented he did not receive his morning medications on 2/22/19. A corresponding Nurse's Note documented when the resident woke up on 2/22/19, the nurse attempted to give his medications but the resident refused to take his medications.

In an interview, the resident stated he was upset he wasn't awakened for his breakfast and medications on 2/22/19. The resident said he usually wakes up early in the morning every day. The resident said he takes his morning medication before going to the dining room for his breakfast. The resident said after he voiced his concern to the facility, they were checking on him more frequently, and he had no further concerns.

The Director of Nursing (DON) was interviewed and said she spoke to the resident when she found out about his concern of being checked on periodically while he was sleeping. The DON said she provided education to the staff to check on the resident while he slept. The DON also said the staff were aware the resident did not want to be disturbed, but to reassure him when he awakened and let him know they checked on him while he was asleep.

It was determined the facility did not wake a resident up for medications and breakfast. Therefore, the allegation was substantiated. However, the facility appropriately responded to the resident's grievance and resolved his concerns prior to the survey and no current deficient practice was identified.

#### CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

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

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

Sincerely,



BELINDA DAY, RN, Supervisor  
Long Term Care Program

BD/slj