



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

BRAD LITTLE- Governor  
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3232 Elder Street  
P.O. Box 83720  
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July 24, 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 **July 10, 2019**, 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 **August 5, 2019**. Failure to submit an acceptable PoC by **August 5, 2019**, may result in the imposition of civil monetary penalties by **August 26, 2019**.

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 Money Penalty**
- **Denial of payment for new admissions effective October 10, 2019**

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **January 10, 2020**, 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.**

Eric Miller, Administrator  
July 24, 2019  
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/ta/bid/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 **August 3, 2019**. If your request for informal dispute resolution is received after **August 3, 2019**, 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 Belinda Day, RN, or Laura Thompson, RN, Supervisors, Long Term Care Program at (208) 334-6626, option #2.

Sincerely,



Laura Thompson, RN, Supervisor  
Long Term Care Program

lt/lj

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

PRINTED: 08/08/2019  
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>C</b> <b>07/10/2019</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>		
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F 000	INITIAL COMMENTS  The following deficiencies were cited during the complaint survey conducted from July 9, 2019 through July 10, 2019.  The surveyors conducting the survey were: Cecilia Stockdill, RN, Team Coordinator Roxie Lacey, RN  Survey Abbreviations: CNO = Chief Nursing Officer LPN = Licensed Practical Nurse MAR = Medication Administration Record mg = milligrams ml = milliliters RN = Registered Nurse	F 000			
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)  §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.  §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.  §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed	F 755		8/5/19	

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

TITLE

(X6) DATE

Electronically Signed

08/02/2019

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.

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F 755	<p>Continued From page 1</p> <p>pharmacist who-</p> <p>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and</p> <p>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, policy review, record review, and staff interview, it was determined the facility failed to ensure ordered medications were available for administration. This was true for 1 of 5 residents (Resident #314) reviewed for medication administration. This deficient practice placed residents at risk of adverse events due to a lack of prescribed medications. Findings include:</p> <p>The facility's policy Medication Management, release date 11/28/17, did not include details on receiving ordered medications.</p> <p>Resident #314 was admitted to the facility on 12/19/18, with multiple diagnoses including Type 2 diabetes mellitus and obesity.</p> <p>Resident #314's physician orders documented atorvastatin (medication to reduce cholesterol) 20 mg daily for hyperlipidemia (elevated levels of fat particles in the blood), ordered on 6/14/19.</p>	F 755	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Coeur D'Alene 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>F755</p> <p>Resident Specific The ID team (clinical management team) reviewed resident #314. On July 10, 2019, physician notification was completed, medication ordered from pharmacy, and medication taken from</p>		

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F 755	Continued From page 2  Resident #314's July MAR documented the atorvastatin as ordered, and "NA" (not available) on 7/5/19, 7/7/19, 7/8/19, and 7/9/19. The MAR documented the atorvastatin was administered on 7/6/19.  On 7/9/19 at 4:45 PM, LPN #1 was observed administering medication to Resident #314. LPN #1 said she was not administering the atorvastatin because it was not available. On 7/9/19 at 5:15 PM, LPN #1 said the atorvastatin was not available because the pharmacy had not delivered it yet, and the medication might be delivered by 7:00 PM that night.  On 7/10/19 at 2:50 PM, the CNO said she was not aware Resident #314 had not received the atorvastatin. The CNO said she had problems with the pharmacy in the past due to its distance from the facility.	F 755	e-kit for July 10, 2019.  Other Residents The ID team (clinical management team) reviewed other residents to ensure medications were available for administration. Adjustments have been made as indicated.  Facility Systems One on one training/education was provided to specific licensed nurse. Licensed nurses were educated on the process of medication refills and e-kit usage. Re-education was provided by Chief Nursing Officer and Staff Development Coordinator to include, but not limited to, audit of medications daily, usage of e-kit medications, physician notification, and clinical documentation. The system has been amended to include oversight from Chief Nursing Office and IDT daily.  Monitor The Chief Nursing Officer and/or designee will audit compliance for pharmacy services daily for 4 weeks, then twice weekly for 4 weeks ensuring all ordered medications are available for administration starting the week of August 5, 2019. The review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI		

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F 755	Continued From page 3	F 755	committee may adjust the frequency of the monitoring after 8 weeks, as it deems appropriate. Chief Executive Officer will review all tools during clinical meetings.  Date of Compliance  July 31, 2019		
F 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2)  The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, review of medication error reports, and staff interview, it was determined the facility failed to ensure residents were free of significant medication errors. This affected 1 of 5 residents (Resident #24) reviewed for medication administration. Resident #24 was harmed when she received another resident's medication, including an antipsychotic medication and insulin, and was transported to the hospital. Findings include:  According to the manufacturer website, accessed on 7/24/19, Lantus is a long-acting insulin used to treat adults with type 2 diabetes to control high blood sugar in which the effect starts in 1 to 2 hours and peaks in 6 hours. The website stated the most common side effects are low blood sugar which can be serious and life threatening. Other side effects include trouble breathing, a fast hearbeat, sweating, and extreme drowsiness or confusion.	F 760	F760  Resident Specific Resident #24 has been discharged from the center.  Other Residents The ID team (clinical management team) reviewed other residents at risk for medication errors. Adjustments have been made as indicated.  Facility Systems Licensed Nurse that administered medication is no longer at center. Licensed Nurses have been educated on the Eight Rights of Medication Administration. Re-education was	8/5/19	

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F 760	<p>Continued From page 4</p> <p>Resident #24 was admitted to the facility on 7/26/18 with diagnoses including cerebral infarction (stroke), hypertension, hemiplegia (paralysis on one side of the body) affecting her left side, and chronic obstructive pulmonary disease (progressive lung diseases characterized by increasing breathlessness) with oxygen dependence.</p> <p>A quarterly MDS assessment, completed on 5/5/19, documented Resident #24's cognition was severely impaired, she was dependent for care, and had communication problems. There was no documentation in the MDS assessment to indicate Resident #24 required insulin injections.</p> <p>A progress note, dated 2/12/19 at 10:17 PM, documented Resident #24 received medication in error by the evening shift nurse and the physician was notified. The physician gave orders to monitor Resident #24's status in the facility. The note documented the medications Resident #24 received in error were Seroquel 12.5 mg (an antipsychotic medication), pravastatin 20 mg (to treat high cholesterol) and Lantus insulin 13 units.</p> <p>The physician returned the call on 2/12/19 at 10:48 PM and instructed staff to monitor Resident #24's medical status in the facility. The physician gave orders to provide nutrition of Resident #24's preference, as tolerated, to keep her blood glucose (sugar) within normal limits. The physician also gave orders to implement the facility's hypoglycemic (low blood glucose) protocol if needed, check Resident #24's blood glucose hourly, monitor her neurological status</p>	F 760	<p>provided by Chief Nursing Officer and Staff Development Coordinator to include, but not limited to, right resident and right medication. The system has been amended to include oversight by Chief Nursing Officer, IDT, and Quarterly Pharmacy Review of medication pass.</p> <p>Monitor The Chief Nursing Officer and/or designee will audit compliance for medication administration twice a week for 4 weeks, then once per week for 8 weeks ensuring licensed nurses comply with the eight rights of medication administration starting the week of August 5th, 2019. The review will be documented on the PI 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. Chief executive officer will review all tools during clinical meetings.</p> <p>Date of Compliance July 31, 2019</p>		

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F 760	<p>Continued From page 5</p> <p>and vital signs, and to monitor her for any side effects of the medications given in error.</p> <p>A late progress note documented at 6:20 AM on 2/13/19, for 2/12/19 10:00 PM, documented Resident #24 was assessed at baseline on 2/12/19 at 10:00 PM, and was being fed a strawberry nutritional drink and strawberry yogurt. Her blood glucose reading was within the normal range at 114 mg/dl (milligrams per deciliter).</p> <p>A progress note, dated 2/13/19 at 3:00 AM, documented Resident #24's status was unchanged and she continued to receive nutritional drinks and yogurt. A progress note, dated 2/13/19 at 5:20 AM, documented when the nurse entered Resident #24's room to check her blood glucose level Resident #24 had vomited a large amount of liquid on her chest and left shoulder, the head of her bed was in the high position, and her lungs had rhonchi (rattling lung sounds) throughout both upper lobes. Resident #24's temperature was 100.4 degrees Fahrenheit and her pulse was irregular at 118 per minute (normal resting heart rate for adults ranges from 60 to 100 beats per minute). Resident #24's respiration was high at 24 breaths per minute (normal for an adult at rest is 12 to 20 breaths per minute). Resident #24's oxygen blood saturation level was low at 76% on room air (normal readings range from 95 to 100 percent and below 90% is considered low) and oxygen was applied at 2 liters per minute. The note documented a Physician Assistant was notified and orders were received for a stat (immediate) chest x-ray. The note documented Resident #24's daughter was contacted and requested she</p>	F 760			

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F 760	Continued From page 6 be transferred to the hospital. 911 was called and Resident #24 was transferred to the hospital via ambulance on 2/13/19 at 6:10 AM. The assessment did not include documentation of Resident #24's blood glucose level.  Resident #24 was discharged from the hospital on 2/19/19 and admitted back to the facility.  The facility's medication incident report for Resident #24, initiated on 2/12/19 and and completed on 3/1/19, documented the medication error was related to Resident #24 being moved to a different room and the the name of the resident who previously occupied the room, remained on the outside of the door. The nurse administered the previous resident's medication to Resident #24. The facility did have a picture of each resident on the MAR for reference to prevent medication errors.  On 7/10/19 at 1:11 PM, the CNO stated she was not employed at the facility when the medication error occurred. She said the facility tracked medication errors in its Quality Assurance program.	F 760			
F 761 SS=F	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)  §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  §483.45(h) Storage of Drugs and Biologicals	F 761		8/5/19	

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F 761	<p>Continued From page 7</p> <p>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review, it was determined the facility failed to ensure medications were stored at appropriate temperatures. This was true for 2 of 2 medication refrigerators in the facility. This deficient practice had the potential to negatively impact all residents in the facility. This failure created the potential for residents to receive medications which were ineffective, or otherwise negatively affected, by out of range refrigerator temperatures. Findings include:  The facility's policy for Medication Management, dated 11/28/17, documented the following: * Medications were stored appropriately according to the manufacturer's guidelines. * Medications and biologicals were stored "under proper conditions of sanitation, light, ventilation, segregation, and security, following manufacturer's recommendations or those of the</p>	F 761	<p>F761</p> <p>Resident Specific On July 9, 2019, two new medication refrigerators were purchased and installed in center.</p> <p>Other Residents On July 9, 2019, two new medication refrigerators were purchased and installed in center, both old refrigerators were removed.</p> <p>Facility Systems Licensed nurses have been educated</p>		

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F 761	<p>Continued From page 8 supplier as well as in compliance with applicable federal and state laws/regulations and accreditation standards."</p> <p>The facility's policy for Refrigerator Temperature Monitoring, undated, documented the following: * On every night shift, a licensed nurse monitored medication refrigerators to ensure proper temperatures. The assigned staff checked the temperature of the refrigerator and documented the results on the Temperature Log. * Temperatures outside the safe range were reported to the Plant Director. * Concerns regarding medication storage were reported to the Director of Nursing Services or Nurse Manager.</p> <p>The Center for Disease Control and Prevention (CDC) website, accessed 7/12/19, documented the ideal temperature for storing vaccines was 40 degrees, and the recommended refrigerator temperature range was 36 to 46 degrees Fahrenheit.</p> <p>1. On 7/9/19 at 5:00 PM, the temperature log on the medication refrigerator in the 300 Hall medication room documented the temperature was 51.4 degrees on that day, and there were numerous medications observed in the refrigerator including PPD (Purified Protein Derivative-tuberculosis) skin testing vaccine. The thermometer inside the refrigerator read 48.5 degrees. The temperature log documented additional readings that were outside of acceptable parameters as follows:  * 47.4 degrees Fahrenheit on 7/7/19 * 47 degrees Fahrenheit on 7/6/19</p>	F 761	<p>using the CDC guidelines for storage of medication and new temperature tracking logs implemented. Re-education was provided by Chief Nursing Officer and Staff Development Coordinator to include, but not limited to, daily monitoring of temperatures, notification to maintenance director for any variances, and temperature ranges for storage of medication. The system has been amended to include oversight by Chief Nursing Officer and IDT for daily monitoring.</p> <p>Monitor The Chief Nursing Officer and/or designee will audit compliance for refrigerator temperatures daily for 4 weeks ensuring all medications are stored at acceptable temperatures starting the week of August 5, 2019. The review will be documented on the PI 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 4 weeks, as it deems appropriate. Chief Executive Officer will review all tools during clinical meetings.</p> <p>Date of Compliance  August 5, 2019</p>		

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

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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>C</b> <b>07/10/2019</b>
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F 761	<p>Continued From page 9</p> <ul style="list-style-type: none"> <li>* The temperature was not recorded on 7/4/19</li> <li>* 49 degrees Fahrenheit on 6/27/19</li> <li>* 48.2 degrees Fahrenheit on 6/26/19</li> <li>* 49.1 degrees Fahrenheit on 6/25/19</li> <li>* 49 degrees on Fahrenheit 6/24/19</li> <li>* The temperature was not recorded on 6/22/19</li> <li>* 51 degrees Fahrenheit on 6/21/19</li> </ul> <p>On 7/9/19 at 5:00 PM, LPN #1 said the temperature in the medication refrigerator should be 40 to 45 degrees Fahrenheit. LPN #1 said the temperature was checked by the night shift staff, and the temperature recordings were turned in to the Plant Director. LPN #1 said the temperature in the medication refrigerator was not where it should be, and it should have been reported to the Plant Director when the temperature was out of range.</p> <p>On 7/9/19 at 5:20 PM, the Plant Director said he was aware of previous temperature problems with the medication refrigerator on the 300 Hall, the thermostat was adjusted, and then the temperature went down in the refrigerator. The Plant Director said the temperature in the refrigerator should be no higher than 47 degrees Fahrenheit and no lower than 36 degrees Fahrenheit, and he should be notified of temperatures outside of that range. The Plant Director said he was not aware of the recent temperatures that were outside the safe range in the medication refrigerator.</p> <p>On 7/10/19 at 10:25 AM, RN #1 said the night shift checked the temperature in the medication refrigerator. RN #1 said the temperature should be between 40-46 degrees Fahrenheit in the medication refrigerator, and if the temperature</p>	F 761			

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F 761	<p>Continued From page 10 was out of range she would notify the Plant Director.</p> <p>2. On 7/10/19 at 10:55 AM, the medication Refrigerator in the main Medication Room contained numerous medications. The Temperature Log documented readings that were outside of acceptable parameters as follows:</p> <ul style="list-style-type: none"> <li>* 30 degrees Fahrenheit on 6/1/19, 6/3/19, 6/4/19, 6/13/19, 6/17/19, 6/20/19, 6/21/19, and 6/23/19</li> <li>* 32 degrees Fahrenheit on 6/2/19, 6/5/19, 6/6/19, 6/8/19, 6/11/19, 6/14/19, 6/15/19, 6/16/19, 6/18/19, 6/19/18, 6/19/19, and 6/24/19</li> <li>* 48 degrees Fahrenheit on 6/10/19</li> </ul> <p>On 7/10/19 at 11:00 AM, LPN #2 said she was not sure what the medication refrigerator temperature range should be, and the night shift checked the temperature. LPN #2 said if she noticed the refrigerator felt like it was out of range she would contact the pharmacy and discard the medications. LPN #2 said she could tell if the refrigerator temperature was out of range by how the refrigerator felt and if the thermometer reading was outside of the red zone (an area marked in red on the thermometer that indicated the temperature was out of acceptable range).</p> <p>On 7/10/19 at 12:55 PM, the Plant Manager said the facility needed to update its process for monitoring temperatures in the medication refrigerators. The Plant Manager said he was aware of the previous temperature readings that</p>	F 761			

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F 761	Continued From page 11 were out of range, and he did not know if any action was taken by the nurses. the Plant Manager said he previously adjusted the refrigerator, and he did not know if the CNO was aware or involved when the medication refrigerator temperatures were out of range.  On 7/10/19 at 1:35 PM, the CNO said if the temperature was out of range in the medication refrigerator, she expected nursing staff to notify her or the Plant Manager and call the pharmacy. The CNO said she was aware there were some temperatures that were out of range in the medication refrigerators, and the Plant Manager was adjusting the refrigerators and ordering a new refrigerator. The CNO said the refrigerator temperature should be 38 to 46 degrees Fahrenheit, and she did not know if the pharmacy was notified or if any other action was taken when the temperatures were out of range.	F 761			
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 -  §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	F 812		8/5/19	

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F 812	<p>Continued From page 12 facility.</p> <p>§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, review of refrigerator temperture logs, and facility policy review, it was determined the facility failed to ensure food was stored at acceptable temperatures and the temperature of the refrigerator was monitored appropriately. This was true for 2 of 2 food storage refrigerators in the nursing units, and had the potential to affect all residents in the facility. This failure created the potential for harm should residents experience adverse effects from food that was stored at unsafe temperatures. Findings include:</p> <p>The facility's policy for Food and Supply Storage, dated 11/28/17, documented the following: * All food, non-food, and supplies used for food preparation were stored in a manner to maintain the safety and sanitation of the food supply. * A thermometer should be placed to measure the temperature in the warmest part of the refrigerator. * The recommended temperature range was 36 to 38 degrees Fahrenheit. * Kitchen refrigerator and freezer temperatures were recorded twice a day, morning and evening.</p> <p>The Food and Drug Administration Food Code 2018 documents that to maintain food safety, food is be stored at 41 degrees Fahrenheit or below.</p>	F 812	<p>F812</p> <p>Resident Specific On July 31, 2019, a new nourishment refrigerator was purchased and installed.</p> <p>Other Residents On July 31, 2019, a new nourishment refrigerator was purchased and installed <input type="checkbox"/> old refrigerator was removed.</p> <p>Facility Systems The Certified Dietary Manager and Maintenance Director were educated on HSG's (consistent with FDA Food Code) policy for food storage. Re-education was provided by Chief Nursing Officer and Staff Development Coordinator to include, but not limited to, new temperature logs, temperature ranges, and daily documentation. The system is amended to include oversight by Chief Executive Officer or designee daily and Registered Dietitian weekly. Chief Executive Officer will ensure refrigerator temperatures are monitored daily to</p>		

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F 812	<p>Continued From page 13</p> <p>1. On 7/9/19 at 5:00 PM, LPN #1 opened the door to a small refrigerator in the 300 Hall Medication Storage Room. The refrigerator contained numerous food and drink items including milk, nutrition supplement drinks, pudding, and yogurt. There was no thermometer in the refrigerator and no documentation of temperature monitoring. LPN #1 said the items in the refrigerator were used for residents every day.</p> <p>On 7/9/19 at 5:20 PM, the Plant Manager said the food-containing refrigerator in the 300 Hall Medication Storage Room did not have a thermometer and it should have one.</p> <p>On 7/10/19 at 1:12 PM, the Dietary Manager said he was not aware the refrigerator in the 300 Hall Medication Storage Room was being used, and the nurses must have been stocking the refrigerator. The Dietary Manager said the kitchen staffed stocked, cleaned, and maintained the refrigerator in the Nutrition Room, and they would do the same for the refrigerator in the 300 Hall Medication Storage Room if they were asked.</p> <p>2. On 7/10/19 at 1:15, PM the refrigerator in the Nutrition Room was examined, and it contained numerous food and beverage items. The thermometer in the refrigerator read 40 degrees Fahrenheit. The Refrigerator Temperature Log documented the temperature was 50 degrees Fahrenheit on 7/9/19 and 46 degrees Fahrenheit on 7/1/19. The Dietary Manager, present at the time, said the nursing staff on the evening shift checked the refrigerator temperatures, and the refrigerator temperatures were too warm. The</p>	F 812	<p>ensure food stored at acceptable temperatures.</p> <p>Monitor The Certified Dietary Manager and/or designee will audit compliance for refrigerator temperatures daily for 4 weeks ensuring all food is stored at acceptable temperatures starting the week of August 5, 2019. The review will be documented on the PI 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 4 weeks, as it deems appropriate. Chief Executive Officer will review all tools during clinical meetings.</p> <p>Date of Compliance August 5, 2019</p>		

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F 812	Continued From page 14 Dietary Manager said if the temperature was above 40 degrees Fahrenheit then everything should be thrown out and the refrigerator should be cleaned.	F 812			



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

BRAD LITTLE – Governor  
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR  
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October 15, 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 **July 10, 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 #ID00008169**

**ALLEGATION #1:**

The facility did not transfer residents for emergency care when requested.

**FINDINGS #1:**

An unannounced complaint investigation was conducted on 7/9/19 to 7/10/19. During the investigation resident records were reviewed and staff were interviewed.

The records of 5 residents were reviewed with no concerns identified regarding not being transferred for emergency services when needed and/or requested.

One resident's record documented she had a significant change in her condition and her provider was notified by staff. The resident was minimally responsive with a fixed gaze, her respirations were even and unlabored, and she had increased secretions. The record included documentation oral care was provided and the resident's daughter was notified. There was no documentation in the record a request was made to transfer the resident to an emergency department for further evaluation.

The resident's record included a physician progress note, dated the same day as the change in her condition, which documented the resident presented with a change in level of consciousness. The provider documented the resident was awake but could not form words and had garbled speech, and was unable to manage her oral secretions. The provider documented the resident was not moaning or had visible signs of pain. The provider ordered scopolamine (used for adults to help prevent nausea and vomiting and decrease secretions).

A subsequent progress note, dated two days after the resident ' s change in condition, documented the daughter requested to speak with the provider. The note stated the resident ' s daughter was informed when the provider was expected to perform their rounds, but the daughter left during the time the provider was expected. The note documented the provider ' s office was called and given the phone number for the resident ' s daughter. There was no documentation a request was made to have the resident evaluated in an emergency department.

On 7/10/19 at 1:06 PM, a Licensed Practical Nurse said when family members requested transfer to an emergency room she called the doctor or her manager to get the orders.

On 7/10/19 at 1:30 PM, the Chief Nursing Officer said they transferred a resident to the emergency department if there was a problem and notified the provider.

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

#### CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

#### ALLEGATION #2:

Residents did not receive hospice when requested and did not receive appropriate end-of-life care for comfort including pain medications.

#### FINDINGS #2:

During the survey resident records were reviewed, friends of residents were interviewed, and staff interviews were conducted.

Four residents were on hospice services and four residents were on comfort care provided by the facility. The records of five residents were reviewed and there was no documentation residents did not receive hospice services when requested or were told the facility could provide the same level of comfort care as a hospice agency instead of referring them.

A resident who received hospice services had a friend visiting and they were interviewed. The friend said she was very impressed with the care, the resident was hydrated and clean each time they visited. She stated the resident has been here a long time and the care was very good.

One resident's record included an assessment which documented she was in the facility for palliative care. The resident's record documented she had a significant change in her condition and her provider was notified by staff on 6/18/19. The resident was minimally responsive with a fixed gaze, her respirations were even and unlabored, and she had increased secretions. The record included documentation oral care was provided and the resident's daughter was notified. A progress note the following day documented the resident continued to have minimal responsiveness and had a large amount of thick, beige mucous from her mouth and frequent mouth care was provided. The progress note also documented the resident was placed on her side to allow the mucous to drain from the mouth.

A subsequent progress note documented the resident was repositioned every two hours and oral care was provided as needed. The note also documented an order was received for a scopolamine patch to help decrease the amount of secretions. The note documented the daughter of the resident was at the bedside and the family was educated about end-of-life care. The resident's daughter agreed to comfort medications but they wanted to be called prior to administration of these medications due to her concern the medications "euthanize" people. The nurse documented the family was reassured the medications were used to manage end of life symptoms. The nurse also documented they went to the resident's room every 30 minutes to assess the resident and see if the family needed anything.

Progress notes in the resident's record documented staff notified the provider about the continued secretions and an order was received for a new medication, atropine drops, to help minimize them. The notes documented frequent oral care was provided and the resident was also frequently repositioned. One progress note documented the provider had not signed the order for morphine, one of the medications ordered to assist with keeping the resident comfortable. The note stated the provider called that day to get the prescription and the pharmacy was sending it later that day. The record documented the resident died later the same day.

Pain monitoring documentation for the resident showed a pain level of one, on a one to ten scale with one being the lowest, on 6/18/19 day shift and night shift. The pain monitoring document showed no pain for the resident on the other dates in June 2019. The resident was seen by the provider also on 6/18/19, and the provider documented the resident had no pain. The nurse progress notes from 6/19/19 to 6/22/19 noted agitation one time on 6/22/19, and the resident was given lorazepam by mouth which was effective.

On 7/10/19 at 1:11 PM the Chief Nursing Officer stated she has been in the position about 1 month. They use Omnicare for pharmacy services, and they have 2 deliveries a day. She said they needed a written script to get the morphine and said she was not aware of anyone being in pain because of medications not being available. The CNO also stated she could not recall an incident of a family requesting suctioning or a resident needing suctioning and not receiving it.

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

#### CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

#### ALLEGATION #3:

Residents received medications prescribed for another resident.

#### FINDINGS #3:

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

Five resident records were reviewed for medication administration. One resident 's record documented in a progress note the resident " ...received medication in error by the evening shift nurse. The Medical Director (MD) was notified ...the MD gave orders to monitor in house. The family was notified. Resident will continue to be monitored. Medications received in error are Seroquel 12.5 mg (an antipsychotic medication), pravastatin 20 mg (medication for cholesterol) and Lantus 13 units (insulin to lower blood sugar levels)."

The MD gave orders which included instruction to " ...provide nutrition of resident's preference as tolerated to keep blood glucose WNL, (within normal limits), apply the low blood sugar protocol if needed, check finger stick blood sugar hourly, monitor neurological signs, vital signs, and for any side effects."

A subsequent progress note documented the assessment of the resident was " ...unchanged, continues to receive ensure and yogurt. At 5:20 AM when nurse entered room to check blood sugar resident had vomited a large amount of liquid on her chest and left shoulder, HOB (head of bed) was in high fowler's position, lungs with coarse rhonchi throughout upper fields. Temperature was 100.4 axillary, pulse irregular 118, resp. 24, alert slightly diaphoretic. O2 sat (oxygen saturation) at 76% on room air, O2 applied at 2 L/m (liters per minute). PA (Physician Assistant) notified, order for stat chest x-ray given. Resident's daughter contacted and requested she be transferred to the hospital. "

Eric Miller, Administrator  
October 15, 2019  
Page 5 of 5

The progress note stated Emergency Medical Services was called and the resident was transferred via ambulance to the nearest hospital emergency department.

On 7/10/19 at 10:10 AM, the daughter of the resident stated her mother had received another resident's insulin a few months ago by mistake.

During an interview, the Chief Nursing Officer stated they were not employed at the facility at that time, but stated medication errors were tracked as part of their Quality Assurance program.

Based on the investigation, the allegation was substantiated and the facility was cited at F760 for a significant medication error.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

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