

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

PRINTED: 10/11/2019
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135052 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED R-C 09/12/2019 |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER COEUR D'ALENE OF CASCADIA | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| {F 000} | <p>INITIAL COMMENTS</p> <p>A revisit survey and complaint survey was conducted on September 10, 2019 to September 12, 2019. The facility was cited at 42 CFR 483.25 Quality of Care. Please refer to survey SKIW11.</p> <p>The surveyors conducting the survey were:</p> <p>Jim Troutfetter, QIDP, Team Coordinator Karen George, RN</p> | {F 000} | | | |

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

TITLE

(X6) DATE

Electronically Signed

10/07/2019

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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HEALTH & WELFARE

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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

September 27, 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 12, 2019**, we conducted an on-site revisit and a complaint investigation to verify that your facility had achieved and maintained compliance. We presumed, based on your allegation of compliance, that your facility was in substantial compliance as of **August 5, 2019**. However, based on our on-site revisit we found that your facility is not in substantial compliance with the following participation requirements:

42 CFR 483.25 Quality of Care at a scope and severity of D

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 7, 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.
- 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*.

As noted in the Bureau of Facility Standards' letter of **July 24, 2019**, following the survey of **July 10, 2019**, we have already made the recommendation to the Centers for Medicare and Medicaid Services (CMS) for imposition of a civil money penalty, Denial of Payment for New Admissions effective October 10, 2019 and termination of the provider agreement on **January 10, 2020**, if substantial compliance is not achieved by that time. The findings of non-compliance on **September 12, 2019**, has resulted in a continuance of the remedy(ies) previously mentioned to you by the CMS. On **September 25, 2019**, CMS notified the facility of the intent to impose the following remedies:

- DPNA made on or after **October 10, 2019**

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, it will provide you with a separate formal notification of that determination.

Eric Miller, Administrator
September 27, 2019
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If you believe the deficiencies have been corrected, you may contact please contact Luara Thompson, RN or Belinda Day RN, Supervisors LTC, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. 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 7, 2019**. If your request for informal dispute resolution is received after **October 7, 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 at (208)334-6626, option #2.

Sincerely,



Laura Thompson, RN, Supervisor
Long Term Care Program

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|-------|---|-------|---|---------|
| F 000 | <p>INITIAL COMMENTS</p> <p>The following deficiency was cited during the revisit and complaint survey conducted on September 10, 2019 to September 12, 2019.</p> <p>The surveyors conducting the survey were:</p> <p>Jim Troutfetter, QDIP, Team Coordinator Karen George, RN</p> <p>F 684 Quality of Care SS=D CFR(s): 483.25</p> <p>§ 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, staff interview, and record review it was determined the facility failed to implement care plan measures designed to assist a resident from experiencing future falls for 1 of 4 residents (Resident #3) reviewed for falls and fall care plans. This failure created the potential for injury due to falls. Findings include:</p> <p>Resident #3 was admitted to the facility on 12/31/18, with abnormalities of gait and mobility.</p> <p>A Quarterly MDS assessment, dated 8/01/19, documented Resident #3 was severely cognitively impaired and that Resident #3 had experienced two non-injury falls since the prior</p> | F 000 | <p>This plan of correction is prepared and submitted as required by law. By submitting this plan of correction, Coeur d'Alene Health and Rehabilitation 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> | 10/7/19 |
|-------|---|-------|---|---------|

| | | |
|---|-------|--------------------------------|
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed | TITLE | (X6) DATE 10/07/2019 |
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| F 684 | <p>Continued From page 1 assessment on 5/01/19.</p> <p>A Fall Investigation, dated 6/14/19, documented Resident #3 had fallen because she had gotten tangled in her blanket. A care plan recommendation documented to place a foot cradle on Resident #3's bed to reduce the risk of Resident #3 becoming tangled in her blankets.</p> <p>Resident #3's care plan, dated 6/27/19, stated "Foot cradle to bed to keep blankets for [sic] getting tangled for bed mobility."</p> <p>A Fall Investigation, dated 7/19/19, documented Resident #3 was found sitting on the foot pedals of her wheelchair and the foot pedals should not have been on the wheelchair while the resident was stationary and not in transport.</p> <p>Resident #3's care plan, dated 7/01/19, stated "Foot pedals are not to be on [Resident #3's] chair, foot pedals are to be in a bag on back of w/c [wheelchair] for transport use only and are to be removed otherwise."</p> <p>On 9/10/19, at 2:57 PM, Resident #3 was observed in the activities room seated in her Tilt in Space wheelchair. The wheelchair had the foot pedals attached. At 3:30 PM, Resident #3's foot pedals were still attached to the wheelchair. At 4:12 PM the foot pedals had been removed from the wheelchair.</p> <p>On 9/11/19, at 8:30 AM, Resident #3 was seated at the table in the dining room for breakfast. The pedals for the wheelchair were attached to the chair.</p> | F 684 | <p>Resident Specific The ID team reviewed resident #3's fall prevention plans. Adjustment and/or clarifications to the Kardex were completed as indicated.</p> <p>Facility Systems The facility staff are educated to follow the resident fall prevention plan. Re-education was provided by staff development coordinator (SDC), chief nursing officer (CNO), and/or designee to include but not limited to, access to the Kardex, monitoring implementation at the bedside, and communication of plan updates. The system is amended to include communication updates post fall, licensed nursing and department manager rounds to validate implementation at bedside, and review of rounding results in morning meeting.</p> <p>Monitor The SDC and/or designee will document rounds 5 times weekly for 4 weeks, then twice weekly for 8 weeks. Starting the week of October 6, 2019 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p> | | |

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| F 684 | <p>Continued From page 2</p> <p>On 9/11/19, at 11:50 AM, Resident #3 was in her bed lying on her right side, covered with a blanket. No foot cradle was in place or supporting the blanket.</p> <p>On 9/11/19 at 2:10 PM, CNA #1 stated the foot cradle on the bed was a new item added to the care plan in the last couple of days. CNA #1 stated she worked with Resident #3 one to two days a week. She stated that she had to check the Kardex [electronic CNA care plan] to see what had changed for residents.</p> <p>On 9/11/19 at 4:40 PM, the Director of Nursing stated the facility held a Falls meeting once per week. Any changes to the care plans were then passed on to the nurses, who then passed the information on to the CNAs. She stated that the CNAs also had access to the Kardex to update themselves on the interventions that were in place to help prevent falls for the residents.</p> | F 684 | | | |



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October 25, 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, 2019** through **September 12, 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 #ID00008236

ALLEGATION #1:

The facility does not report falls or assess falls in a timely manner.

FINDINGS #1:

During the survey, records were reviewed and interviews were conducted with the following results:

The records of four residents who had falls were reviewed. All falls were reported immediately and assessed to include neurological checks.

The record of one recently admitted resident, who had a fall, was reviewed. His record documented he had been assessed for fall risk.

The same evening the resident had fallen while attempting to get out of bed. His record documented the nursing staff responded immediately and provided on-site treatment for a 2.2 by 0.3 cm laceration to his left eye lid and a 0.5 by 0.3 cm laceration to the bridge of his nose. His record also documented a neurological check had been completed and that he had been seen by his physician the following day.

During an interview on 9/11/19, from 4:28 - 4:40 p.m., the Chief Nursing Officer stated the resident was assessed for falls based on his BIMS (Brief Interview for Mental Status) of 15 (13 and above shows little or no impairment), ability to use a call light, alertness and his continence status upon admission.

Additionally, an investigation and corrective action for the fall was completed on the same day as the fall. The corrective action included repositioning his side bed table so that it could not be used as a support to get out of bed and visual checks every 15 minutes.

His record also contained PT (physical therapy) Daily Treatment Notes which documented he had attended 7 sessions for lower extremity strengthening from 9/20/19 through 9/29/19.

It could not be determined the facility failed to report or assess falls in a timely manner. Therefore, the allegation was unsubstantiated due to lack of sufficient evidence with no deficient practice identified.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The facility does not ensure care plans are followed.

FINDINGS #2:

During the survey observations, record reviews, and interviews were conducted with the following results:

Five residents were selected for review. Four residents' care plans were reviewed and found to be current and followed.

One resident's care plan, revised 7/01/19, documented her foot pedals were not to be on her wheelchair except during transport to reduce the risk of falls. However, during an observation on 9/10/19 at 2:57 p.m. and 3:30 p.m., her foot pedals were noted to be in place while she was sitting in the activities room. During an observation on 9/11/19 at 8:30 a.m., she was again noted to have the have the foot pedals installed while sitting in the dining room.

Eric Miller, Administrator
October 25, 2019
Page 3 of 3

During an interview on 9/11/19 at 4:40 PM, the Director of Nursing stated the facility held a Falls meeting once per week. Any changes to the care plans were then passed on to the nurses, who then passed the information on to the CNAs.

The resident's care plan for removing the foot pedals and using a foot cradle while in bed was not followed.

The allegation was substantiated and deficient practice was cited at F684 related to the facility's failure to ensure the resident's care plan interventions were implemented.

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