



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

BRAD LITTLE – Governor  
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TAMARA PRISOCK—ADMINISTRATOR  
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October 1, 2019

Emily Engberson, Administrator  
Advanced Health Care of Coeur d'Alene  
1578 W. Riverstone Drive  
Coeur d'Alene, ID 83814

Provider #: 135142

Dear Ms. Engberson:

On **September 20, 2019**, a survey was conducted at Advanced Health Care of Coeur d'Alene 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 a widespread deficiency that constitutes no actual harm with potential for more than minimal 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) and on or before the "Opportunity to Correct." **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.

Emily Engberson, Administrator  
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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 12, 2019**. Failure to submit an acceptable PoC by **October 12, 2019**, may result in the imposition of penalties by **November 3, 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*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **October 25, 2019 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **December 20, 2019**. A change in the seriousness of the deficiencies on **November 4, 2019**, may result in a change in the remedy.

Emily Engberson, Administrator  
October 1, 2019  
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The remedy, which will be recommended if substantial compliance has not been achieved by **December 20, 2019** includes the following:

Denial of payment for new admissions effective **December 20, 2019**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying non-compliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **March 20, 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.**

If you believe these deficiencies have been corrected, you may contact Belinda Day, RN or Laura Thompson, RN, Supervisors Long Term Care, Bureau Chief, 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. 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.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **December 20, 2019** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, 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>

Emily Engberson, Administrator  
October 1, 2019  
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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 12, 2019**. If your request for informal dispute resolution is received after **October 12, 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,



Belinda Day, RN, Supervisor  
Long Term Care Program

bd/lj

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135142</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/20/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>ADVANCED HEALTH CARE OF COEUR D'ALENE LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1578 W RIVERSTONE DRIVE 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 investigation survey conducted at the facility from September 16, 2019 - September 20, 2019.  The surveyors conducting the survey were:  Juanita Stemen, RN, Team Coordinator Jenny Walker, RN Michael Brunson, RN	F 000			
F 686 SS=D	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 policy review, record review, observation, and staff interview and family interview, it was determined the facility failed ensure residents did not develop avoidable pressure ulcers. This was true for 1 of 5 residents (Resident #18) reviewed for pressure ulcers. This failure created the potential for Resident #18 to experience delayed healing, or further	F 686	F686 Patient Specific: 18: His wound is healed and all interventions continue to be in place and care planned appropriately  Other patients: All appropriate skin interventions are on	10/18/19	

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

TITLE

(X6) DATE

Electronically Signed

10/08/2019

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 686	<p>Continued From page 1</p> <p>deterioration, of a Stage II pressure ulcer. Findings include:</p> <p>The facility's pressure ulcer policy and procedure, dated 2/27/18, documented "Patients will receive care consistent with professional standards of practice to prevent pressure ulcers and/or ensure patients do not develop pressure ulcers unless the individual's clinical condition demonstrates they are unavoidable." The policy also documented "Residents having pressure ulcers receive necessary treatment and services to promote healing, prevent infection and [prevent] new pressure ulcers from developing."</p> <p>The National Pressure Ulcer Advisory Panel website (<a href="http://www.npuap.org">www.npuap.org</a>), accessed on 9/30/19, defines Stage II pressure ulcers/injuries as follows:</p> <p>*Stage II - Partial-thickness loss of skin with exposed dermis (thick layer of living tissue below the top of the skin that contains blood capillaries, nerve endings, sweat glands, hair follicles, and other structures). The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible.</p> <p>Resident #18 was admitted to the facility on 8/29/19, with multiple diagnoses including a right hip fracture and a stroke with hemiparesis (paralysis and weakness to one side of the body) and hemiplegia affecting his right side.</p> <p>The Admit Skin Assessment, dated 8/29/19, documented Resident #18 had right sided weakness, a right hip surgical incision with a</p>	F 686	<p>the Baseline Care Plan and are being used appropriately.</p> <p>Systemic Changes: Education to the nurses completing admission skin assessments will be provided regarding identifying and documenting the presence of suspected deep tissue injuries. Education will be provided to nursing personnel regarding the proper use of ordered skin interventions.</p> <p>Surveillance: Director of nursing or her designee will audit the following :Admit orders and Baseline Care Plans to ensure skin interventions have been implemented and they are care planned appropriately, and proper use of the identified interventions weekly x 4 weeks and report findings to the QA Committee and make changes as needed.</p>		

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F 686	<p>Continued From page 2</p> <p>dressing and had slight swelling and bruising to the right hip. The Admit Skin Assessment documented he had one plus pitting edema (swelling to the affected area when pressed will leave an indentation) to the right lower extremity. The Admit Skin Assessment did not document any further skin impairment to Resident #18.</p> <p>Resident #18's Braden Risk Assessment Scale (a tool used to assess a resident's risk for developing pressure ulcers), dated 8/29/19, documented he was at moderate risk for developing a pressure ulcer.</p> <p>Resident #18's Pressure Ulcer Risk Protocol and Care Plan, dated 8/29/19, documented Resident #18 was at risk for developing pressure ulcers related to impaired mobility. The interventions on the Pressure Ulcer Risk Protocol and Care Plan, included interventions for an air mattress and to float his heels (elevate the heels to prevent pressure) with a heel riser (device to elevate the heels) for moderate risk of skin impairment.</p> <p>Resident #18's Baseline Care Plan, dated 8/29/19, did not include use of an air mattress or to float his heels while in bed.</p> <p>Resident #18's physician's order, dated 8/29/19, included use of an air mattress and a heel riser while in bed.</p> <p>Resident #18's August 2019 Treatment Administration Record (TAR) documented staff were to verify placement of the heel riser every shift. The TAR, dated 8/31/19 at 1:03 PM, documented the heel riser was not utilized due to Resident #18's hip surgery. It was unclear why</p>	F 686			

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F 686	<p>Continued From page 3</p> <p>the heel riser was not used in relation to Resident #18's hip surgery.</p> <p>A Nurse's Progress Note, dated 8/31/19 at 8:56 PM, documented Resident #18 had a large, unopened blister to his right heel and there was no heel riser available in the facility. The Nurse's Progress Note documented the nurse elevated Resident #18's right lower extremity with pillows after the blister to the right heel was developed.</p> <p>An untitled Interdisciplinary Team (IDT) review summary, dated 9/2/19, documented Resident #18 developed a darkening, fluid filled blister and it was "most likely an unstageable pressure injury." The blister measured 6.2 cm (centimeters) x 5.3 cm to the right heel and the IDT review documented, the blister was formed when Resident #18's right heel rested against the bed.</p> <p>A Wound Healing Progress Note, dated 9/13/19, documented Resident #18 had a Stage II pressure ulcer to his right heel with measurements of 5.2 cm x 4 cm.</p> <p>On 9/17/19 at 5:23 PM, Resident #18's heel riser and air mattress were observed to be in place. Resident #18's spouse stated he had a "popped" blister to his right heel and wore a Prevalon boot (keeps pressure off of the heel) and used the heel riser when he was in bed.</p> <p>On 9/18/19 at 4:03 PM, the Wound Nurse stated Resident #18 was admitted to the facility with a right hip fracture and was unable to bear weight on his right leg. The Wound Nurse stated Resident #18 developed the blister to his right</p>	F 686			

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F 686	Continued From page 4 heel after he was admitted to the facility. The Wound Nurse stated the blister had popped a week later and physician orders were received for a Wound Healing team to evaluate and treat Resident #18's right heel.  On 9/19/19 at 10:39 AM, the Wound Nurse and the Clinical Nurse Manager stated Resident #18's spouse was floating his heels with pillows and did not use the heel riser. The Wound Nurse stated she found the heel riser in Resident #18's closet on 9/2/19.  On 9/19/19 at 11:05 AM, the Wound Nurse was observed providing wound care to Resident #18's right heel. The wound bed had granulation tissue (red, yellow, or pink connective tissue that forms on the surface of a wound when the wound is healing) with no drainage noted. The Wound Nurse stated measurements were completed on Fridays. The Wound Nurse stated Resident #18's right heel was healing very well and the Wound Healing team would be at the facility on 9/20/19 to reassess Resident #18's heel.  On 9/19/19 at 11:32 AM, Resident #18 stated he was non-weight bearing to his right leg related to his hip fracture. Resident #18 stated he was immobile on his right side after his stroke. Resident #18 stated he did not have pain to his right heel and was unaware he developed a blister. Resident #18's spouse stated after the evening nurse found the blister to his right heel on 8/31/19, the nurse applied pillows to float his heels. Resident #18's spouse stated the heel riser was initiated on 9/2/19.	F 686			
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		10/11/19	

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F 812	Continued From page 5  §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 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 policy review, observation, and staff interview, it was determined the facility failed to ensure measures were in place to prevent possible cross-contamination of dirty to clean areas in the kitchen. This had the potential to affect 30 of 30 residents residing in the facility who consumed food prepared by the facility. This failure created the potential for contamination if residents contracted food-borne illnesses. Findings include:  The facility's Cleaning Dishes/Dish Machine policy, dated 2013, documented, "The person loading dirty dishes should not handle the clean dishes unless they change into a clean apron	F 812	F812 Patient Specific: see systemic changes  Other Patients: see systemic changes  Systemic Changes: In-service provided to dietary staff regarding proper use of clean apron when putting clean dishes away to avoid cross contamination.  Surveillance: Administrator or her designee will observe dish handling procedures to ensure proper use of clean apron x 4 weeks and		

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F 812	<p>Continued From page 6 and wash hands thoroughly before moving from dirty to clean dishes."</p> <p>On 9/19/19 at 9:30 AM, Dietary Aide #1 was observed spraying the dirty dishes with water and loaded the dishes on a rack into the dishwasher. After the load was clean, she opened the dishwasher door, brought out the clean rack of dishes with a metal rod to air dry. Dietary Aide #1 then washed her hands and put away the clean dishes. Dietary Aide #1 did not change her apron from loading the dirty dishes or after washing her hands to put away the clean dishes.</p> <p>On 9/19/19 at 9:45 AM, Dietary Aide #1 stated she should have changed her apron prior to putting away the clean dishes.</p> <p>On 9/19/19 at 9:46 AM, the Registered Dietitian stated Dietary Aide #1 should have changed her apron prior to putting away the clean dishes to eliminate cross-contamination.</p>	F 812	<p>report findings to the QA Committee and make changes as needed.</p>		



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October 16, 2019

Emily Engberson, Administrator  
Advanced Health Care of Coeur d'Alene  
1578 W. Riverstone Drive  
Coeur d'Alene, ID 83814

Provider #: 135142

Dear Ms. Engberson:

On **September 16, 2019** through **September 20, 2019**, an unannounced on-site complaint survey was conducted at Advanced Health Care of Coeur d'Alene. The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00007985**

**ALLEGATION #1:**

The facility did not send residents to the emergency room after falls with injury.

**FINDINGS #1:**

During the survey four resident records, which included one closed record, were reviewed for falls and neglect. The facility's incident reports were reviewed and staff were interviewed.

One resident's record, admitted November 2018, documented they had a fall in the facility that resulted in a fractured hip. An incident report documented immediately after the fall, the resident had full range of motion to all extremities with no deformity, and denied pain. The resident's record documented 45 minutes later they complained of left hip pain and the on call physician was notified. The physician ordered x-rays to be completed at the bedside. The resident received Tramadol for pain which was not effective and new orders were received for Oxycodone for pain, which was effective.

The facility received the x-ray results that documented the resident had a left femur fracture and the on call physician was notified. The physician ordered for the resident to be transported to the hospital. The paramedics were notified and the resident was transported to the hospital for treatment.

Emily Engberson, Administrator  
October 16, 2019  
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The Administrator stated the resident complained of pain and the Oxycodone was effective and as soon as they received the results of the x-ray, they notified the physician and the resident was sent to the hospital.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The facility's nurses did not administer pain medication to residents.

FINDINGS #2:

During the survey three resident records were reviewed for pain management.

One resident's record included documentation they received Tramadol for pain after a fall. The resident's pain was not controlled with Tramadol and the staff called the physician and received new orders for Oxycodone (an opioid medication) for pain. The resident received the Oxycodone and the record documented it was effective. There were no concerns identified in the residents' records their pain was not managed.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

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

Sincerely,



Belinda Day, RN, Supervisor  
Long Term Care Program

BD/lj

Emily Engberson, Administrator  
October 16, 2019  
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December 5, 2019

Emily Engberson, Administrator  
Advanced Health Care of Coeur d'Alene  
1578 W. Riverstone Drive  
Coeur d'Alene, ID 83814

Provider #: 135142

Dear Ms. Engberson:

On **September 16, 2019** through **September 20, 2019**, an unannounced on-site complaint survey was conducted at Advanced Health Care of Coeur d'Alene. The complaint was done in conjunction with the annual recertification survey. The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00007937**

**ALLEGATION #1:**

The facility discharged residents home before the resident was ready.

**FINDINGS #1:**

During the review of records one resident, admitted August 2018, was admitted to the facility for rehabilitation for exacerbation of Chronic Obstructive Pulmonary Disease (COPD). The resident's record documented the resident was cognitively intact and was able to make own their own health care decisions. The resident received and signed a notice of Medicare non-coverage and appealed the decision. The decision was denied that the resident no longer required the skilled nursing facility services being provided by the facility.

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The resident and the resident's family declined the facility's recommendation for placement in a long-term care facility. The resident received discharge instructions, including a medication list, with Prednisone as one of the medications to continue to take at home. The resident's primary pharmacy was notified of medications to be filled after discharge. The resident was discharged home with a home health agency to provide Nursing, Physical Therapy, and Occupational Therapy. The resident was also approved to have 18 hours a week of home care services prior to discharge. The home health and the home care agencies were notified of the date the resident was discharged.

The Administrator stated the resident had been at the facility two other times earlier in 2018 and the resident was requiring more assistance at home. The Administrator had recommended assisted livings or long-term care facilities and the resident and family declined recommendations. The Administrator stated the home health agency was notified of their recommendations and social services were involved in the resident's discharge to home and followed up with the resident and family to assure the resident was safe at home.

The allegation was unsubstantiated due to lack of evidence regarding residents' being discharged home before they are ready.

#### 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