STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135052	A. Building B. Wing	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coeur D Alene Health of Cascadia	2514 North Seventh Street Coeur D'Alene, ID 83814

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48401 Based on record review and staff interview, it was determined the facility failed to ensure a resident's representative was notified when they experienced a change in condition. This was true for 1 of 2 residents (Resident #64) whose records were reviewed for notifications. This failure placed Resident #64 at risk when his family was not able to advocate for his needs. Findings include: Resident #64 was admitted to the facility on [DATE] for care following a traumatic brain injury with multiple diagnoses including a tracheostomy, respirator dependence, and acute respiratory failure. On 1/24/25 at 3:35 PM, a physician verbal order, received by a respiratory therapist, documented, if resident decannulates and [respiratory therapist] cannot get it back in, do not send to the [emergency room] to have it replaced, may leave trach out. A respiratory therapy note, dated 2/1/25, documented at approximately 11:00 AM, Resident #64 was found to be decannulated and the respiratory therapist (RT) attempted to insert a trach but was unable to do so. The physician was notified and staff continued to monitor Resident #64. On 3/20/25 at 11:54 AM, the DON stated, according to the documentation on 2/1/25, Resident #64's family was not notified when he experienced a change in condition.

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50981 Based on review of the Resident Assessment Instrument (RAI) Manual, record review, and staff interview, it was determined the facility failed to ensure residents' Minimum Data Set (MDS- standardized assessment tool used in nursing facilities to assess residents' health and functional status) assessments included correct information. This was true for 3 of 18 residents (#11, #20, and #44) whose records were reviewed for accuracy. This deficient practice had the potential for negative outcomes if residents were not assessed and/or monitored due to inaccurate assessments. Findings include: The RAI Manual, revised 10/1/24, documented section A1500, PASRR (Preadmission Screening and Resident Review), was to be coded yes when a PASRR Level II screening determined a resident had a serious mental illness and/or intellectual disability, or related condition. 1. Resident #11 was initially admitted to the facility on [DATE], with multiple diagnoses including depression, delusional disorder, and dementia. Resident #11's PASRR Level II dated 12/6/24, documented she had a diagnosis of depression, schizophrenia (mental disorder involving chronic or recurrent psychosis), and dementia. Resident #11's significant change in status MDS assessment, dated 12/12/24, under A1500 in section A, documented, No, for the question, Is the resident currently considered by the state PASRR Level II process to have serious mental illness and/or intellectual disability or a related condition? However, Resident #11's record also showed a PASRR Level II dated 12/6/24, which documented schizophrenia, depression, and dementia diagnoses. 2. Resident #20 was initially admitted to the facility on [DATE] with a diagnosis of schizophrenia, bipolar disorder (a mood disorder), obsessive-compulsive disorder (OCD), and anxiety. Resident #20's admission MDS assessment, dated 10/27/22, under A1500 in section A, documented, No, for the question, Is the resident currently considered by the state PASRR Level II process to have serious mental illness and/or intellectual disability or a related condition? However, there was a PASRR Level II, dated 8/12/22, in her record which documented she had a diagnosis of schizophrenia, OCD, bipolar disorder, and depression. 3. Resident #44 was admitted to the facility on [DATE] with the diagnoses autism, schizophrenia, depression, and anxiety. Resident #44's annual MDS assessment, dated 11/24/24, under A1500 in section A, documented, No, for the question, Is the resident currently considered by the state PASRR Level II process to have serious mental illness and/or intellectual disability or a related condition? However, there was a PASRR Level II, dated 2/28/24, in her record which documented she had a diagnosis of autism, schizophrenia, depression, and anxiety. On 3/19/25 at 3:34 PM, the MDS Coordinator confirmed Resident's #11, #20, and #44's MDS assessments were incorrectly coded indicating the residents did not have a serious mental health illness.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48402 Based on observation, record review, policy review, and staff interview, it was determined the facility failed to ensure resident care plans were revised to reflect current needs and interventions. This was true for 3 of 18 residents (Resident #60, #64, #182) whose care plans were reviewed. This placed residents at risk for adverse outcomes when care plans were not revised to reflect their updated needs. Findings include: The facility's Care Plan policy, revised on 10/15/22, documented a qualified person would monitor the resident's condition and effectiveness of the care plan interventions and revise the care plan quarterly, annually, and with a significant change in condition. 1. Resident #60 was readmitted to the facility on [DATE], with multiple diagnoses including congestive heart failure and chest pain. A hospital discharge summary, dated 3/13/25, documented Resident #60 was seen for an exacerbation for acute congestive heart failure. Resident # 60's Care Plan, dated 11/9/24, did not include revision or implementation of new interventions related to his congestive heart failure. On 3/19/25 at 11:46 AM, on review of Resident #60's records, the Director of Nursing (DON) stated the facility had room for improvement with care planning. 2. Resident #182 was admitted to the facility on [DATE], with multiple diagnoses including nicotine dependency. A smoking evaluation, dated 2/24/25, documented Resident #182 was able to smoke independently. On review of resident #182's care plan, initiated 2/24/25, no documentation was located related to his smoking needs. On 3/19/25 at 6:00 PM, the DON stated, Resident #182's care plan did not reflect his current smoking status. 48401 3. Resident #64 was admitted to the facility on [DATE], following a traumatic brain injury with multiple diagnoses including a tracheostomy (surgically created opening in the windpipe that provides an alternative airway for breathing), respirator dependence, and acute respiratory failure. On 1/24/25 at 3:35 PM, a physician verbal order, received by a respiratory therapist, documented, if resident decannulates and [respiratory therapist] cannot get it back in, do not send to the [emergency room] to have it replaced, may leave trach out. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A respiratory therapy note, dated 2/1/25, documented at approximately 11:00 AM, Resident #64 was found to be decannulated and the respiratory therapist (RT) attempted to insert a trach but was unable to do so. The physician was notified and staff continued to monitor Resident #64. Resident #64's care plan, revised on 3/16/25, documented the following: [Resident #64] has a Tracheostomy and potential for: Alteration in respiratory status and high risk for accidental self decannulation related to: thickened, dried secretions or mucous plugs, inability to protect airway need for tracheostomy, prior history of self-decannulation, confusion/agitation. On 3/20/25 at 11:28 AM, the Staff Development Coordinator Nurse (SDC) stated Resident #64 was decannulated on 2/1/25, and the care plan should have been updated to reflect that his tracheostomy had been removed.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48402 Based on record review and staff interview, it was determined the facility failed to ensure bathing was provided to residents who required assistance. This was true for 1 of 6 residents, (Resident #60) whose records were reviewed for bathing. This failure had the potential for embarrassment and compromised skin integrity due to lack of hygiene. Findings include: Resident #60 was admitted on [DATE], with multiple diagnoses including generalized muscle weakness, difficulty walking, and need for assistance with personal care. The facility's shower schedule, undated, documented Resident #60 was scheduled to receive a shower on Wednesday and Saturday evenings. Resident #60's care plan, revised on 11/4/24, documented he required assistance with bathing. The care plan also documented if he refused to bathe, the licensed nurse should be notified. Resident #60's bathing record from February-March 2025 was reviewed documenting the following: -2/1/25-2/16/25, no documentation a shower was offered or refused -2/17/25, a shower was refused -2/18/25-2/19/25, no documentation a shower was offered or refused -2/20/25, a shower was refused -2/21/25-3/6/25, no documentation a shower was offered or refused -3/7/25, he received a shower -3/8/25-3/16/25, no documentation a shower was offered or refused -3/17/24, he received a shower A request of documentation for bathing refusals was made and not provided. On 3/19/25 at 4:24 PM, the DON stated Resident #60 did not receive his shower opportunities as scheduled.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48401 Based on record review and staff interview, it was determined the facility failed to ensure quality care was provided to 1 of 18 residents whose bowel records were reviewed. This was true for Resident #49 when his physician orders were not followed placing him at increased risk for harm. Findings include: Resident #49 was admitted on [DATE] with multiple diagnoses including quadriplegia (condition in which both the arms and legs are paralyzed and lose normal motor function), respirator dependence, and a personal history of constipation and gastrointestinal hemorrhage. Resident #49's record documented the following physician orders, dated 5/21/24: -Milk of Magnesia (MOM) Suspension 1200 MG/15 ML, Give 30 ML orally as needed for no bowel movement (BM) for two (2) days. Give 1 dose. If no results within 24 hours, see Dulcolax Suppository order. -Dulcolax Suppository 10 MG, Insert 1 suppository rectally as needed for bowel care. Give if no results from MOM. If no results in 24 hours, see Fleet Enema order. -Fleet Enema 7-19 GM/118 ML, Insert 1 unit rectally as needed for bowel care. Give if no results from MOM and Dulcolax suppository. Complete bowel assessment and notify physician if no results. Resident #49's bowel movement records and medication administration records (MAR) for February-March 2025 were reviewed and documented the following: -A BM on Sunday 2/9/25 with the next recorded BM on Friday 2/14/25, no as needed medications were administered. -A BM on Saturday 2/15/25 with the next recorded BM on Friday 2/21/25, no as needed medications were administered. -A BM on Saturday 2/22/25 with the next recorded BM on Wednesday 2/26/25, no as needed medications were administered. -A BM on Friday 2/28/25 with the next recorded BM on Tuesday 3/4/25, no as needed medications were administered. -A BM on Tuesday 3/4/25 with the next recorded BM on Monday 3/10/25, no as needed medications were administered. -A BM on Tuesday 3/12/25 with the next recorded BM on Tuesday 3/18/25, no as needed medications were administered. On 3/19/25 at 5:48 PM, the DON stated Resident #49 did not receive BM medications as ordered and could not explain why they failed to be administered.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48402 Based on incident and accident (I&A) review, record review, and staff interview it was determined the facility failed to ensure adequate supervision for residents to prevent falls. This was true for 1 of 2 residents, (Resident #79) whose records were reviewed for falls. This resulted in actual harm to Resident #79. Findings include: The Centers for Medicare and Medicaid Services (CMS) State Operation Manual (SOM), Appendix PP, revised 8/8/24, defined 'Avoidable Accident' as an accident occurred because the facility failed to: Identify environmental hazards and/or assess individual resident risk of an accident, including the need for supervision and/or assistive devices. Resident #79 was admitted to the facility on [DATE], with multiple diagnoses including muscle weakness and abnormalities of gait and mobility. Resident #79's care plan, dated 12/4/24, documented he was assessed to be at risk for falls due to impaired mobility and required extensive assistance with chair to bed transfers. The care plan also directed staff to provide one-person extensive assist with bed mobility and direct supervision while toileting. An I&A report, dated 2/21/25, documented Resident #79 had a fall with injury on 2/16/25 at 12:45 PM and a second fall with injury on 2/16/25 at 5:45 PM. A post fall investigation, dated 2/16/25 at 12:45 PM, documented his first unwitnessed fall occurred while transferring from the toilet to his wheelchair. During that fall he obtained a skin tear measuring 0.4 cm x 0.04 cm. The report also documented Resident #79 verbalized having a 1 out of 10 pain level. Section G of the report documented the removal of Resident #79's wheelchair from within reach as an intervention and cleansing the skin tear. On review of Resident #79's care plan dated 12/4/24, no interventions were implemented to prevent further falls. The I&A report, dated on 2/16/25 at 5:45 PM, documented Resident #79 had a second unwitnessed fall with injury while transferring. During that fall he obtained a laceration to the back of his head. The report did not include the measurements of the laceration. A post fall investigation, dated 2/16/25, documented Resident #79's pain level to be a 10 out of 10 with facial grimacing and yelling inconsolably. The investigation documented the Licensed Nurse observed a rapid decline in his vital signs and called 911 to transfer Resident #79 to the hospital for further evaluation and treatment. The post fall investigation did not include documentation of the severity of Resident #79's injuries after his transfer to the hospital. On 3/19/25 at 3:08 PM, the DON stated the facility failed to train staff to update care plans and implement interventions post falls on the weekends.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48402 Based on observation, resident interview, staff interview, and record review, it was determined the facility failed to ensure residents are free from pain. This was true for 1 of 2 residents, (Resident #60) whose records were reviewed for pain management. This failure placed Resident #60 at risk of psychosocial harm and functional decline related to unrelieved pain, and not being offered effective pain management. Findings include: Resident #60 was readmitted to the facility on [DATE], after a short hospital stay, with multiple diagnoses including malignant neoplasm of the stomach (stomach cancer) and cognitive communication deficit. On 3/17/25 at 8:18 AM, Resident #60 was observed lying on his bed with no sheets on his right-side verbalizing 9 out of 10 abdominal pain and guarding his abdomen. When asked, Resident #60 stated he had already asked for pain medication. On 3/17/25 at 8:20 AM, LPN #3 entered the room and asked Resident #60 how he was feeling. Resident #60 verbalized having 8 out of 10 abdominal pain. She acknowledged his pain and left the room without conducting an assessment. On 3/17/25 at 2:20 PM, Resident #60 was observed in bed guarding his abdomen and stated he still had an 8 out of 10 pain. He also stated no one had provided pain management interventions or pharmacological interventions. When asked to describe his pain he stated I can't describe it. It just hurts and no one has given me anything. On 3/17/25 at 2:30 PM, Resident #60 was observed requesting pain medication. On 3/17/25 at 2:39 PM, LPN #2 entered the room with pain medication and administered it to Resident #60. On 3/17/25 at 2:57 PM, When asked if resident had received any non-pharmacological or pharmacological interventions to manage his pain since the morning request for medication at 9:18 AM, LPN #3 stated, I don't believe so, but I did notify the provider. A physician order, dated 3/13/24, documented Hydrocodone-Acetaminophen oral tablet 7.5-325 MG, give 1 tablet by mouth every 8 hours as needed for pain. Non-pharmacological interventions should be attempted prior to medication administration. On review of Resident #60's record, 9 out of 11 pain evaluations documented a pain level of 7 or higher. On 3/19/25 at 3:57 PM, the DON stated Resident #60 used to have a scheduled pain medication, but the order was not reinstated when he returned from the hospital.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 48401 Based on record review and staff interview, it was determined the facility failed to ensure a registered nurse (RN) was on-site for 8 consecutive hours a day, 7 days a week, to provide care to the residents. This was true for 2 of 21 days reviewed for sufficient staffing. This failure placed all residents at risk for harm if their routine and/or emergency needs could not be met without the care of a registered nurse. Findings include: The nursing staff hours worked were reviewed from 2/23/25-3/15/25. This review documented the facility did not provide 8 consecutive hours of registered nurse coverage on 2/24/25 and 3/3/25. On 3/20/25 at 1:22 PM, the Administrator confirmed those two dates did not have an RN on-site for 8 consecutive hours.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 48401 Based on observation, record review, and staff interview it was determined the facility failed to ensure nurse staffing data was completed accurately, posted daily, and the records were maintained for a minimum of 18 months. This failed practice had the potential to affect the 76 residents residing in the facility, their representatives, and any visitors who would like to review staffing data and census information. Findings include: The facility's daily nurse staffing data posting records were reviewed for 10/1/24-3/20/25 and documented the following: Missing dates: October 2024: 9, 12, 13, 19, 20, 26, 27 November 2024: 2. 3. 9, 10, 16, 17, 23, 24, 30 December 2024: 1, 3, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 19, 20, 21, 22, 23, 25, 26, 27, 28, 29, 30, 31 January 2025 : 1, 5, 11, 12, 18, 19, 25, 26 February 2025: 1, 2, 8, 9, 15, 16, 22, 23, 27 March 2025: 1, 2, 8, 9, 15 Incomplete data: October: 4, 17 December: 24 January: 2, 3, 4, 20, 21 February: 6, 7, 13, 14, 18 On 3/16/25 at 12:45 PM, the facility's daily nurse staffing data posting was observed. The data posting was dated 3/14/25. On 3/20/25 at 1:08 PM, the Administrator stated he was unsure why the nurse staffing data was not completed accurately and was not posted and retained as required.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48402 Based on observation, policy review, United States Food and Drug Administration (FDA) food code review, and staff interview, it was determined the facility failed to ensure sanitation of nutrition rooms and equipment. This failure had the potential to affect all residents who consumed food or ice from the nutrition rooms and increased the risk for transmission of food born illnesses. Findings include: The facility's Sanitizing Stationary Food Service Equipment and Food Contact Surfaces policy, dated 1/1/18, documented the facility will provide proper cleaning and sanitation of food service equipment to minimize the growth of microorganisms that may result in food contamination. The FDA Food Code Section 4-602.11 Equipment Food-Contact Surfaces and Utensils, documented: (E) Surfaces of utensils and equipment contacting food that is not time/temperature control for food shall be cleaned: (4) In equipment such as ice bins and beverages, dispensing nozzles and enclosed components of equipment such as ice makers, cooking oil storage tanks and distribution lines, beverages and syrup dispensing lines or tubes, coffee bean grinders, and water vending equipment: (a) At a frequency specified by the manufacturer, or (b) Absent manufacturer specifications, at a frequency necessary to preclude accumulation of soil or mold. On 3/20/25 at 2:50 PM, during a nutrition room inspection 1 out of 2 ice bins were observed to have a thick, slimy layer with different shades of pink surrounding the ice dispensing tray. Also observed were plastic containers of food with no indication of use by date and thickened cocktail cranberry juice with no indication of when it was open or when it should be disposed. On 3/20/25 at 2:55 PM, the Dietary Manager stated the ice bin in the nutrition room was not in sanitary conditions and he was unsure who was responsible for cleaning it. He also stated the food items in the refrigerator were unclear when they were opened or when they should be disposed.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50981 Based on record review, resident interview, and staff interview, it was determined the facility failed to ensure residents received physical therapy services as ordered by their physician. This was true for 5 of 18 residents (#19, #33, #37, #67, and #182) whose records were reviewed for rehabilitative services. This failure created the potential for all residents who required physical therapy services to experience decline in their physical functioning and ability to perform activities of daily living (ADL's) when these services were not provided consistently. Findings include: 1. Resident #19 was readmitted to the facility on [DATE], for surgical aftercare, and had multiple diagnoses including muscle weakness, and difficulty walking. A physician order, dated 3/4/25, documented Resident #19 was to have physical therapy evaluation and treatment. Resident #19's care plan, dated 1/15/25, documented physical therapy evaluation and treat as ordered. A Physical Therapy Evaluation and Treatment Plan, dated 3/4/25, documented Resident #19 was to have physical therapy 3 times a week for 8 weeks. Resident #19's record documented 2 out of 24 physical therapy sessions were provided with no documentation of resident refusals. 2. Resident #33 was readmitted to the facility on [DATE] with multiple diagnoses including, abnormality of gait and mobility, muscle weakness, and lack of coordination. A physician order, dated 11/14/24, documented Resident #33 was to have a physical therapy evaluation and treatment. Resident #33's care plan, dated 11/4/24, documented physical therapy evaluation and treatment. A Physical Therapy Evaluation and Treatment Plan, dated 11/4/24, documented Resident #33 was to have physical therapy 3 times a week for 8 weeks. Resident #33's record documented 7 out of 24 physical therapy sessions were provided with documentation of three resident refusals. 3. Resident #37 was admitted to the facility on [DATE], with multiple diagnoses including quadriplegia, muscle weakness, and contracture of the joint. A physician order, dated 1/24/25, documented Resident #37 was to have a physical therapy evaluation and treatment. Resident #37's care plan, dated 1/24/23, documented physical therapy evaluation and treatment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135052	A. Building B. Wing	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coeur D Alene Health of Cascadia	2514 North Seventh Street Coeur D'Alene, ID 83814

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Physical Therapy Evaluation and Treatment Plan, dated 1/24/25, documented Resident #37 was to have physical therapy 6 times a week for 4 weeks. Resident #37's record documented 0 out of 24 physical therapy sessions were provided with no documentation of resident refusals. 48402 4. Resident #67 was admitted to the facility on [DATE], with multiple diagnoses including muscle weakness, abnormalities of gait and mobility, and cognitive communication deficit. On 3/17/25 at 10:06 AM, Resident #67 stated she had not received physical therapy as ordered. A physician order, dated 2/17/25, documented Resident #67 was to have physical therapy evaluation and treatment. Resident #67's care plan, dated 2/17/25, documented physical therapy as ordered. A Physical Therapy Evaluation and Treatment Plan, dated 2/18/25, documented Resident #67 was to have physical therapy 5 times a week for 8 weeks. On review of Resident #67's record 16 out of 20 physical therapy sessions were provided before she discharged . 5. Resident #182 was admitted to the facility on [DATE], with multiple diagnoses including difficulty walking and absence of left leg below the knee. A physician order, dated 2/24/25, documented Resident #182 was to have a physical therapy evaluation and treatment. Resident #182's care plan, dated 2/24/25, documented physical therapy as ordered. A Physical Therapy Evaluation and Treatment Plan, dated 2/25/25, documented Resident #182 was to have Physical Therapy 5 times a week for 8 weeks. On review of Resident #182's record 9 out of 19 physical therapy sessions were provided with no documentation of resident refusal. On 3/20/25 at 8:42 AM, the Physical Therapy Director stated residents were not receiving therapy services according to the therapy evaluations due to insufficient staffing.

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	135052	A. Building B. Wing	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coeur D Alene Health of Cascadia	2514 North Seventh Street Coeur D'Alene, ID 83814

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 50981 Based on observation, CDC recommendation review, policy review, and staff interview, it was determined the facility failed to ensure infection control and prevention practices were maintained. This failure had the potential to impact all residents in the facility by placing them at risk for cross contamination and transmission of infection. Findings include: 1. The facility's Work Practices-Cleaning Policy, updated 1/1/18, documented multiple use resident care, such as resident lifts, items are properly cleaned/disinfected between each resident use. The following issue was observed: -On 3/18/25 at 4:55 PM, CNA #1 and LPN #2 were observed using a resident lift to transfer a resident, afterwards CNA #1 returned the lift to the hallway and was not observed cleaning or disinfecting the lift after use. -On 3/18/25 at 5:00 PM, CNA #1 stated that they are not required to clean or disinfect the lifts between resident use. -On 3/18/25 at 5:20 PM, the Infection Prevention (IP) Nurse and DON both confirmed the resident lifts should be cleaned/disinfected between resident use. 2. The Centers for Disease Control and Prevention (CDC) web page titled, Clinical Safety: Hand Hygiene for Healthcare Workers, updated 2/27/24, documented hand hygiene should be performed: -Immediately before touching a patient. -Before performing an aseptic task such as placing an indwelling device or handling invasive medical devices. -Before moving from work on a soiled body site to a clean body site on the same patient. -After touching a patient or patient's surroundings. -After contact with blood, body fluids, or contaminated surfaces. -Immediately after glove removal. The following was observed for hand hygiene and personal protective equipment (PPE): On 3/19/25 at 7:15 AM, LPN #1 was observed entering resident #71's room to administer her medication. No hand hygiene was observed before entering her room and after exiting her room. LPN #1 returned to her medication cart without performing hand hygiene and prepared the next resident's medications. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135052	A. Building B. Wing	03/20/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/19/25 at 8:34 AM, Resident #42 was observed to be on droplet transmission precautions for influenza. LPN #1 was observed preparing medications for Resident #42. LPN #1 was not observed performing hand hygiene before or after preparing the medications or before putting on gloves, gown, a second surgical mask, and face shield. LPN #1 was observed entering Resident #42's room and positioned the medication cart in the open doorway with the drawers facing inside the room, then she obtained her vital signs using a vital signs tower. Resident #42 was noted to have a productive cough throughout the observation. LPN #1 was observed administering Resident #42's medications by handing her a cup of her medications and then a cup of water. LPN #1 was observed returning to the medication cart positioned in the doorway, then leaning against the cart allowing the PPE gown to press against the front of the cart while she reached for disinfecting wipes. She was observed using disinfectant wipes on the vital signs tower, then removed her gown and put it in the garbage, removed her face shield and hung it on the outside doorknob, removed her gloves and disposed of them, and washed her hands with soap and water in the sink inside Resident #42's room. LPN #1 was observed pushing the medication cart away from the doorway without disinfecting the surface and left Resident #42's room. She then removed the outer of two surgical masks and disposed of it, then donned a new surgical mask over the one she was already wearing and then used disinfecting wipes to clean a small exposed area on top of the medication cart, but not cleaning the drawer fronts her gown had touched or any of the equipment on top of the medication cart. LPN #1 was not observed to perform hand hygiene and then began preparing medications for another resident. On 3/19/25 at 9:00 AM, LPN #1 confirmed she should have sanitized her hands between residents and stated she did not get any updated guidance on droplet transmission based precautions from the facility. On 3/18/25 at 5:30 PM, the DON stated the facility had not provided staff in-service training specifically dedicated to proper use of PPE for the current influenza outbreak. She further confirmed that she nor her team have performed any official staff observations to ensure quality control for hand hygiene or PPE use.