STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135122	A. Building B. Wing	10/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Coeur D'Alene	500 West Aqua Avenue Coeur D Alene, ID 83815

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 39411 Based on observation, interview, and policy review, the facility failed to serve residents consecutively while seated at five of the seven tables (one, two, three, four, and seven) observed during meal service which included one of one resident (Resident (R) 48) reviewed for dignity during meal service of 29 sample resident. This had the potential to affect meal satisfaction for the 17 residents eating meals in the dining room. Findings include: Review of the facility's policy titled, Resident Dining Services, dated 04/30/24, indicated that Residents seated together are served in consecutive order so they can eat at the same time. During a lunch meal observation on 10/02/24 at 11:37 AM, the following was observed: -Meals served at 11:37 AM for one resident at table one and one resident at table two, -Meals served at 11:39 AM, for one resident at table three and one resident at table four, -Meals served at 11:40 AM for one resident back to table three and one resident at table five, -Meals served at 11:41 AM for one resident back to table two, one resident at table six, and one resident at table seven, -Meals served at 11:45 AM for two residents back to table six, -Meals served at 11:46 AM for three residents back to table six, -Meals served at 11:48 AM for two residents back to table four and -The final meal was served at 11:49 AM for one resident back to table one. During an interview on 10/02/24 at 11:54 AM, R48, who was seated at table four stated that meals were served like this every day and they sat and waited for theirs. R48 stated they had one server, so they didn't expect much. (continued on next page)

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/02/24 at 11:58 AM, Cook1 stated that they just served the plates as they came off the tray line and they didn't know they should serve each table before serving the next table. During an interview on 10/02/24 at 1:24 PM, the Dietary Manager (DM) stated he did not know residents were not being served at the same table before the next table was served. The DM stated that residents should have all been served at each table before serving the next table.

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	135122	A. Building B. Wing	10/05/2024

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15406 Based on observation, record review, interview, and policy review, the facility failed to ensure that two out of four residents (Resident (R) 140 and R18) reviewed for abuse were free from sexual abuse from R139 as he was observed placing R140's hand on top of his genitals and on another occasion was observed placing his hand on R18's groin of 29 sample residents. The failure to protect R140 and R18 from R139 resulted in the potential for more than minimal phsychosocial harm from unwanted sexual contact. Findings include: Review of the facility's policy titled, Abuse-Prevention, dated 07/18/23 and provided by the facility, revealed It is the policy of this facility to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation . Procedure 1. Establishing a safe environment that supports, to the extent possible, a resident's consensual sexual relationship and by establishing policies and protocols for preventing sexual abuse . Review of the facility's policy titled, Abuse-Identification of Types, dated 06/17/24 and provided by the facility, revealed Sexual abuse-is defined as non-consensual sexual contact of any type with a resident. 1. Review of the Facility Reported Incident (FRI) investigation, dated 08/16/23 and provided by the facility, showed that on 08/16/23, R139 was observed by a Certified Nursing Assistant (CNA) with his hand on R140's hand, and R140 was rubbing R139's genitals with R139's hand on top of hers. The Report revealed R140's Brief Interview for Mental Status (BIMS) score on 08/02/23 was a six (severely impaired cognition) and R139's BIMS was 15 (cognitively intact) on 07/06/23. The residents were separated. R139 was interviewed by the Administrator and a police officer. R139 reported that R140 reached out and grabbed his hand; R139 stated he had no interactions with R140 prior to this incident. R139 denied he used R140's hand to rub his genitals. R139 was educated by the Social Service Director (SSD) that R140 was not able to consent to sexual activity and he could not engage in further sexual activity with her. Both residents were placed in line-of-sight supervision and were placed on alert charting. R140 had no change in baseline function with eating, activity or withdrawal noted. Review of R140's undated Admission Record in the electronic medical record (EMR) under the Profile tab, revealed R140 was admitted to the facility on [DATE] with a diagnosis of dementia. Review of the significant change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/24/24 in the EMR under the MDS tab revealed R140 was severely impaired in cognition with a Brief Interview for Mental Status (BIMS) score of three out of 15. R140 passed away in the facility on 02/13/24. Review of R139's undated Admission Record in the EMR under the Profile tab revealed R139 was admitted to the facility on [DATE] with a diagnosis of femur (thigh bone) fracture. Review of the annual MDS with an ARD of 01/13/23 in the EMR under the MDS tab revealed R139 had a BIMS score of 15 out of 15 indicating he was cognitively intact. R139 was discharged from the facility on 12/27/23. (continued on next page)

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	135122	A. Building B. Wing	10/05/2024

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R139's Care Plan, dated 08/23/23 in the EMR under the Care Plan tab, revealed a problem of, The resident has a psychosocial well-being problem (potential) r/t [related to] allegation of sexual abuse. The goals were, The resident will identify appropriate diversional activities . The resident will verbalize feelings related to emotional state . The resident will identify ways of increasing appropriate meaningful relationships. Interventions in total were, Line of sight supervision at all times when out of room . When conflict arises, remove residents to a calm safe environment and allow to vent/share feelings. R139's Care Plan was not updated until 12/16/23. During an interview on 10/04/24 at 10:18 AM, the SSD stated R139 targeted cognitively impaired female residents who did not have the mental capacity to consent for sexual activity. The SSD indicated R139 was discharged to an all-male unit in December 2023 due to his sexual targeting of cognitively impaired female residents. Review of a physician's Care Note, dated 12/19/23, revealed 12/14/23 [R139] is a pleasantly confused . male seen today for routine visit and medication management appointment for concerns for increased inappropriate/hypersexual behaviors. Currently not on any medications for dementia or depression. He continues to be out of bed daily and attempts to engage with others, however, his inappropriate talk impedes his ability to participate. 2. Review of the Facility Reported Incident (FRI) investigation, dated 12/18/23 and provided by the facility, showed that on 12/18/23, R139 was observed by CNA3 talking to R18 in the dayroom. R139 then put his hand on R18's groin area and CNA3 immediately separated the residents and reported the incident to the nurse on duty. R139 was placed on one-to-one supervision. R139's most recent BIMS score on 10/05/23 was 15 out of 15 (cognitively intact). R18's most recent BIMS score was eight out of 15 (moderately impaired cognition). When R139 was interviewed, he stated he did not recall the incident. R18 did not recall the incident due to her cognitive impairments and has not shown any s/s [signs and symptoms] of psychosocial harm. [R139] has a history of seeking out female attention . The investigation indicated R139 would be transferring to an all-male unit on 12/27/23. During an interview on 10/03/24 at 2:22 PM, CNA3 stated R139 touched female residents with memory issues inappropriately. CNA3 stated she observed R139 touch R18 and more than once. CNA3 stated she physically separated the residents when this occurred and redirected R139 to his room and the females to activities. CNA3 stated she observed more than one incident of R139 touching R18 inappropriately and sometimes R18 was ok with it and other times she was not. CNA3 stated the last two to three weeks before R139 discharged , his sexual behaviors increased. CNA3 stated R139 did not seem too upset when caught and made jokes that he was a lady's man. CNA3 stated she was not aware of any residents having consensual relations with R139. CNA3 stated R139's behaviors increased in the evenings, when staff were busy with dinner, and laying people down. CNA3 stated she reported all observed incidents to the nurse on duty and to the other CNAs who were working. CNA3 stated the nurses were all aware of the incidents and she had been instructed, to keep an eye on him [R139]. An attempt was made to interview R18 on 09/30/24 at 4:01 PM. R18 was pleasantly confused and stated she had resided in the facility for four to five weeks. Review of the undated Admission Record in the EMR under the Profile tab revealed R18 was admitted to the facility on [DATE]. During observation, R18 was of small stature, elderly, and frail in appearance. R18 was not interviewable regarding the incident that occurred on 12/18/23 between R139 and herself. (continued on next page)

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	135122	A. Building B. Wing	10/05/2024

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R139's Care Plan, dated 12/16/23 in the EMR under the Care Plan tab, revealed a problem of, [R139] has a behavior problem (hypersexuality) r/t dx [diagnosis] dementia w/ [with] bx [behavior] disturbances. [R139 seeks out female residents and does not maintain appropriate physical boundaries. The goals were, The resident will have fewer episodes hypersexuality by review date . The resident will not experience behaviors that are harmful to self and others Interventions were, Administer medications as ordered .Anticipate and meet the resident's needs .If reasonable, discuss the resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident . Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner, Divert attention. Remove from situation and take to alternate location as needed. Minimize potential for resident's disruptive behaviors by offering tasks/activities which divert attention such as group activities, exercise, and 1:1 visits. Praise an indication of the resident's progress/improvement in behavior. Provide a program of activities that is of interest and accommodates residents' status. Review of the Discharge Summary, dated 12/22/23 in the EMR under the Document tab, revealed Reason for Discharge: Transfer to higher level of care due to (hypersexual behavior) of seeking out cognitively impaired female residents . Any discussion of behavior and what is acceptable and unacceptable is denied, having no idea what staff are talking about. [R139] will state that there are very persistent female resident that reach out to touch him. Any discussion of changing his behaviors ends with [R139] stating that the female residents touch him. However, [R139] has consistently over a period of time seeks out cognitively impaired female resident to touch or have them touch him. Review of the physician's Care Note, dated 01/02/24 for a visit occurring on 12/27/23 in the EMR under the Documents tab, revealed [R139] is . being seen today for discharge visit. Pt [patient] has been sexually inappropriate with multiple female residents. He was placed on Paxil [antidepressant] recently but is needing to be moved immediately for pt safety. He is being transferred to the men's behavioral unit . During an interview on 10/02/24 at 5:26 PM, the Administrator and Director of Nursing (DON) were interviewed. They stated the incident between R139 and R18 occurred on 12/18/23 and an investigation was started immediately. They stated CNA3 reported the incident to the nurse who reported it to the Administrator. They verified CNA3 was the only witness. They stated the five-day report was sent to the State Survey Agency on 12/22/23, meeting the reporting period requirement. They stated because of this incident, R139 was put on 1:1 observation and a referral were made to an all-male unit that he was admitted to. When asked if R139 had a history of sexual abuse towards other residents the Administrator stated he had a consensual relationship with R141 who was alert and oriented, but other than that he had not exhibited sexually abusive behavior towards any other residents.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20940 Based on observation, record review, interview, and policy review, the facility failed to ensure the medication error rate of less than 5% by having a medication error rate of 7.69% for the 26 medication administration opportunities observed for two of five residents (Resident (R) 58 and R78) of 29 sample residents. The facility's failure to administer medications as ordered and placed residents who received medications at risk for medication errors. Findings include: Review of the facility's policy titled, Medication Administration via Enteral Access Devise, revised 08/08/23, directs staff under Medication Administration General Considerations 5. Administer each medication separately . 1. Review of R58's undated Admissions tab of the electronic medical record (EMR) revealed an admitted [DATE]. Review of the October 2024 Orders tab of the EMR revealed an order for Lantus Solostar insulin 25 units to be administered at 8:00 AM each day. During an observation on 10/01/24 at 9:59 AM, Registered Nurse (RN) 1 administered the Lantus Solostar. During an interview on 10/01/24 at 10:00 AM RN1 confirmed medications were to be administered within one hour of the physician's order time to be administered. RN1 confirmed the insulin was administered more than one hour after the physician ordered it to be administered. 2. Review of R78's undated Census tab of the EMR revealed an admitted [DATE]. Review of the Diagnoses tab of the EMR revealed diagnoses which included stoke and diabetes. Review the October 2024 Orders tab of the EMR revealed orders for docusate sodium (a stool softener) 100 milligrams (m)g (milligrams) tablet, vegetable laxative one tablet, amlodipine (to treat high blood pressure) tablet, 10 mg, Eliquis (prevents blood clots) 5mg tablet, Escitalopram (an antidepressant) 5mg tablet, famotidine (used to prevent heart burn) 20mg tablet, and metoprolol (used to treat high blood pressure). During an observation on 10/03/24 at 10:00 AM, RN1 obtained the docusate sodium 100 milligrams (m)g tablet, vegetable laxative one tablet, amlodipine tablet, 10 mg, Eliquis 5mg tablet, Escitalopram 5mg tablet, famotidine 20mg tablet, and metoprolol medications, crushed the medications and placed the medications in approximately 90 cubic centimeters (cc) of water and mixed them into water. RN1 then administered the combined medications to the resident through R78's percutaneous endoscopic gastrostomy (PEG) tube (a tube placed through the abdominal wall into the stomach for feeding). During an interview on 01/03/24 at 10:10 AM RN1 confirmed the medications were mixed with water and administered through the PEG tube and not separately as the facility's policy directed.

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	135122	A. Building B. Wing	10/05/2024

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 39411 Based on interview and job description review, the facility failed to ensure a qualified director of food and nutrition services was in place to oversee the dietary department with the potential to effect 82 census residents. Findings include: Review of the Food Service Director Job Description, date 09/28/22, indicated that the position required a minimum course of study in food safety before October 1,2023 (e.g., Serv Safe Food Manager Certification). During an interview on 10/01/24 at 11:18 AM, the Dietary Manager (DM) stated that he had been employed at the facility for one and a half years. The DM stated that he was not certified and did not have any Serv-Safe courses completed. The DM stated that he worked six months straight without a day off and had no time to do any training. During an interview on 10/01/24 at 11:45 AM, the Registered Dietitian (RD) stated that she was in the facility two days a week and was aware the DM was not certified. The RD stated that the DM needed to be certified so he could understand how to run the kitchen for long-term residents. The RD stated that she completed the resident assessments and did not manage the kitchen.

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	135122	A. Building B. Wing	10/05/2024

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39411 Based on observation, interview, and job description review, the facility failed to ensure there was sufficient staff with the appropriate competencies and training to carry out the functions of the dietary department. This failure had the potential to affect the ability of the dietary staff to safely and effectively carry out the functions of the food and nutrition service for 81 of 82 residents consuming food. Findings include: Review of the Food Service Job Description, dated 09/28/22, indicated that specific requirements of the position required that the manager must effectively conduct educational programs . Must be knowledgeable of food service practices and procedures as well as the laws, regulations, and guidelines governing food service functions in the post-acute care facility . Must be able to collaborate and work with the Registered Dietician . Must be able to ensure the patient's physician ordered diets are prepared and served accurately at meals and snacks. Review of the undated dietary schedule provided by the Dietary Manager (DM) revealed that there were two employees scheduled to prepare, serve, and clean-up the dinner meal for 81 residents on Sunday, Monday, Wednesday, Thursday, Friday, and Saturday and only one employee scheduled to work during the dinner meal on Tuesday. The schedule revealed that there was one employee in the kitchen from 2:00 PM until 7:00 PM to prepare, serve, and clean up the dinner meal for 81 of 82 residents who were served a meal. During observations of the kitchen on 09/30/24 at 10:09 AM, 10/01/24 at 10:47 AM, 10/02/24 at 11:37 AM and 10/02/24 at 6:04 PM, during the day, there were three staff, and, in the evening, there were two staff working. During an interview on 10/01/24 at 11:18 AM, the DM stated he had worked for the facility for one and a half years and had worked for six months without a day off. The DM stated that recently he hired a cook and would get a day off every two weeks. He stated they were very short-handed and sometimes ran the entire kitchen with only two staff. The DM stated he had no time to get his certification or to train any staff. The DM stated that he had no in-service training completed for the staff in the kitchen and that the staff needed more training. During an interview on 10/01/24 at 11:45 AM, the Registered Dietitian (RD) stated that she was not aware of any training provided to the kitchen staff. The RD stated she completed kitchen audits and would make suggestions, but the DM would not respond to any of her suggestions. During an interview on 10/02/24 at 1:50 PM, the DM stated they needed one more cook and two more dietary aides. The DM stated that the main office did the recruiting, and he had no idea how it was handled. (continued on next page)

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	135122	A. Building B. Wing	10/05/2024

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 10/03/24 at 3:56 PM, Cook1 stated he worked at the facility for approximately [AGE] years. Cook1 stated they had not had any in-service training in the kitchen since December 2022 and many staff walked off the job. Cook1 stated he only got one day off a week and there was just not enough time to do any training. Cook1 stated the staff needed more training and they did not have enough staff in the kitchen. Cook1 stated they ended up rushing around the kitchen and mistakes were made because they got worn out. Cook1 stated that they definitely needed more staff. During an interview on 10/03/24 at 10:03 AM, the RD stated she updated a resident's diet the day before from a regular diet to a diet that limited tomatoes and potatoes and that the tray ticket was supposed to be updated by kitchen staff. The RD reviewed and verified the tray ticket had not been updated. During an interview on 10/04/24 at 9:56 AM, the DM stated they had no documentation for any training in the kitchen.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 39411 Based on observations, interviews, and policy review, the facility failed to ensure food was not stored on the floor in the freezer and in the dry storage area, a dirty ice machine was cleaned, and proper handling of food and dishware on the tray line. These failures had the potential to increase the prevalence and spread of foodborne illness and infection for all 82 census residents. Findings include: Review of the facility's policy titled, Sanitation and Maintenance, dated 04/30/24, revealed that The Director of Food and Nutrition Services is responsible for ensuring that the department is maintained according to the standards of sanitation and in compliance with federal, state, and local requirements. During an observation of the kitchen and interview on 09/30/24 at 10:09 AM accompanied by Cook1, there was a black mold-like substance observed on the plastic lining inside the ice machine. The cleaning schedule revealed the ice machine had been cleaned on 07/16/24. Cook1 stated that the ice machine was cleaned every six months and looked like it needed to be cleaned again. Additional observations revealed five cases of health shakes on the floor of the walk-in freezer, and eight cases of soda with two cases of gloves on the floor of the dry storage room. During an interview on 09/30/24 at 10:09 AM, Cook1 stated that these items had been delivered a few days ago, they had not put them away yet and should not have been stored on the ground. During an observation of the tray line on 10/01/24 at 11:10 AM, Cook2 picked up every plate with his bare hand and held it with his thumb on the center of the plate. Cook2 was observed to arrange the food on the plates with his bare hand. Cook2 was observed to wipe his hands on his pants several times during tray line service. During an interview on 10/01/24 at 11:18 AM, the Dietary Manager (DM) stated he had just hired this cook and that the staff needed more training. During an interview on 10/1/24 at 11:45 AM, the Registered Dietitian (RD) stated that she conducted kitchen audits, but her recommendations were not followed. The RD stated that all kitchen staff needed to follow the sanitation policy. The RD stated that the cook should not be wiping his hands on his pants or touching food with his bare hands.

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	135122	A. Building B. Wing	10/05/2024

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15406 Based on record review, interview, and policy review, the facility failed to ensure one of three residents (Resident (R) 40) reviewed for insulin use had a medical record that was accurate regarding the treatment of high and low blood sugar (BS) levels of 29 sample residents. This failure created the potential for inadequate treatment of R40's diabetes. Findings include: Review of the facility's policy titled, Authentication of All Record Entries, dated 02/29/24 and provided by the facility, revealed Anyone documenting in the medical record should be credentialed and/or have the authority and right to document. Individuals must be trained and competent in the fundamental documentation practices of the facility and legal documentation standards. Review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/15/24 in the electronic medical record (EMR) under the MDS tab, revealed R40 was admitted to the facility on [DATE] with diagnosis which included diabetes mellitus. R40 had a Brief Interview for Mental Status (BIMS) score of 11 out of 15 which indicated the resident has moderately impaired cognition. R40 received insulin injections daily during the assessment period. During an interview on 09/30/24 at 11:59 AM, R40 stated she was a diabetic and had a history of issues with blood sugars, having accidentally overdosed on insulin at home. R40 verified receiving insulin twice a day in the facility. Review of the Medication Administration Record (MAR), dated September 2024 and located in the EMR under the Orders tab, revealed R40 had orders for: -Hypoglycemia [low blood sugar] Protocol - If resident awake/gag reflex intact - Give 120 ml [milliliters] juice every 15 minutes as needed for blood sugar less than 70. Recheck in 15 minutes and notify MD [Medical Doctor], initiated on 01/24/24. -Glucagon kit 1 mg [milligram], inject 1 mg intramuscularly every 15 minutes as needed for blood sugar <70 if unresponsive. Repeat in 15 minutes. Notify MD. Hold all insulin coverages unless otherwise indicated, initiated on 02/23/24. Review of the MAR, dated September 2024 and located in the EMR under the Orders tab, revealed on 09/15/21 at 5:51 AM [before breakfast BS check] R40's BS was 50, taken by Licensed Practical Nurse (LPN) 1. The next BS check was completed at 7:46 AM, almost two hours later at which time it was 72. There was no documentation of what action was taken in response to the low BS, whether R40 exhibited any signs and symptoms of hypoglycemia, if carbohydrate was administered, or whether the physician was called as specified in the order. There was no nursing progress note regarding the hypoglycemia incident. The MAR did not document any doses of glucagon being administered. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135122	A. Building B. Wing	10/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Coeur D'Alene	500 West Aqua Avenue Coeur D Alene, ID 83815

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/03/24 at 3:24 PM, Resident Care Manager (RCM) 2, a Licensed Practical Nurse (LPN) stated R40's next BS check on 09/15/24 was about two hours later following the BS of 50. RCM2 verified there was no nursing note or documentation on the MAR with details about treatment provided and the resident's condition. During an interview on 10/03/24 at 4:44 PM, LPN1 stated she had been working the overnight shift and took R40's BS at the end of her shift at about the time the day shift nurse was coming on duty. LPN1 stated she gave R40 two packets of glucose and R40 was awake and alert. LPN1 stated the day shift nurse came on duty and stated juice mixed with sugar worked better. LPN1 stated R40 was not able to swallow, and the oncoming nurse gave R40 an injection of glucagon, and then a second injection. LPN1 stated after giving glucose, R40's BS dropped to 35 and she checked it again in about 10 minutes. LPN1 stated R40 began to get clammy and started to be not as responsive. The two glucagon injections were given, and her BS went up to 56 within 10 - 15 minutes. LPN1 verified she did not document anything that occurred in a progress note in the EMR and that everything she did should have been documented. During an interview on 10/04/24 at 1:30 PM, the Director of Nursing (DON) stated LPN1 should have followed the hypoglycemia protocol and documented the information in a progress note. Review of the MAR, dated September 2024 and located in the EMR under the Orders tab, revealed R40 had an order initiated on 09/20/24 for sliding scale insulin, Humalog Kwik Pen Subcutaneous Solution Pen-injector 100 units/milliliter (ml) (Insulin Lispro). Inject as per sliding scale: if [blood sugar (BS)] 150 - 200 = 0 unit; 201 - 250 = 2 units; 251 - 300 = 4 units; 301 - 350 = 6 units; 351 - 400 = 8 units; 401 - 499 = 10 units, subcutaneously before meals related to type two diabetes mellitus with hyperglycemia. If [BS] >500 and asymptomatic give 10 units and push water, recheck in two hours if down. Monitor, if BS still >500 give 1 unit then continue to check BS Q [every] two hours and give 1 unit if [BS] over 500. if pt [BS] >500 and symptomatic, call MD . Review of the MAR for the month of September 2024 and located in the EMR under the Orders tab, revealed on 09/22/24 at 10:50 AM (before lunch BS check), R40's BS was elevated at 566. A code of 3 was documented on the MAR by Registered Nurse (RN) 2 indicating vital signs outside of parameters of administration. RN2 did not document administering 10 units of insulin as ordered. There was no documentation to show any insulin was administered at this time. In addition, RN2 did not document rechecking R40's BS until three hours later at 1:45 PM, at which time it was 356. The orders instructed recheck of the BS two hours later. During an interview on 10/03/24 at 3:24 PM, RCM2 verified a code of 3 was documented on the MAR on 09/22/24 and stated, It does not appear she gave the 10 units [of insulin]. RCM2 reviewed the progress notes and stated there was no documentation in progress notes regarding the elevated BS, administration of insulin, signs and symptoms of hyperglycemia or contact of the physician if applicable. RCM2 stated the next BS check was completed three hours later. During an interview on 10/04/24 at 1:35 PM, the DON reviewed R40's MAR for September 2024 and verified a code of 3 had been documented and there was no documentation insulin was administered. The DON stated RN2 should have documented whether there were any symptoms of hyperglycemia. (continued on next page)

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	135122	A. Building B. Wing	10/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Coeur D'Alene	500 West Aqua Avenue Coeur D Alene, ID 83815

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/05/24 at 8:42 AM, RN2 stated R40's BS was high (over 500) on 09/22/24 when she checked it and she called the on call physician who instructed her to administer water to the resident and recheck her BS. RN2 stated she administered the insulin according to the physician's orders and R40's BS came down within two hours. RN2 stated she wrote a progress note with all this information and stated she did not know why the progress note was not there.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15406 20940 Based on observation, record review, interview, and Centers for Disease Control (CDC) guidance, the facility failed to implement proper infection control procedures for one of four residents (Resident (R) 78) reviewed for infection control of 29 sample residents. R78 required enhanced barrier precautions (EBP) due to having an invasive device such as a feeding tube or catheter. This failure had the potential to increase the risk of infection. Findings include: Review of the Centers for Disease Control reference titled, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), updated 07/12/22 and located at https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html, required the use of gowns during high contact resident care acuities including the accessing of medical devises, which include percutaneous endoscopic gastric (PEG) tubes which were used for medication administration. 1. Review of R78's Census tab of the electronic medical record (EMR) revealed an admitted [DATE]. Review of the Diagnoses tab revealed diagnoses which included stoke and diabetes. Review of the Orders tab of the EMR, dated 08/01/24, revealed orders for tube feeding and medication administration through PEG tube. There was an order, dated 08/01/24, for enhanced barrier precautions. During an observation on 10/03/24 at 10:00 AM, Registered Nurse (RN) 1 administered medications to R78 via the PEG tube, which revealed RN1 was wearing gloves but lacked a protective gown. During an interview on 10/03/24 at 10:10 AM, RN1 confirmed R78 was in EBP, and staff were to wear a protective gown providing care for R78, including the medical device. RN1 confirmed that they failed to put on a gown prior to and when accessing R78's PEG tube to administer medications.