

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135142	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/20/2025
NAME OF PROVIDER OR SUPPLIER  Advanced Health Care of Coeur D'Alene		STREET ADDRESS, CITY, STATE, ZIP CODE  1578 W Riverstone Drive 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)
<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>36193</p> <p>Based on policy review, record review, observation, and staff interview, it was determined the facility failed to ensure the baseline care plan included resident's use of oxygen. This was true for 1 of 6 residents (Resident #90) whose baseline care plan were reviewed. This deficient practice created the potential for harm if residents' respiratory needs were not met. Findings include:</p> <p>The facility's Baseline Person Centered Care Plan, policy and procedure, revised September 2023, documented the baseline care plan is developed during the admission process to direct patient care, and it covers the basic information utilized to disseminate information to provide care for a newly admitted or readmitted patient.</p> <p>A physician's order, dated 3/12/24, documented Resident #90 was to receive oxygen per nasal cannula to maintain her oxygen saturation greater than 90 percent.</p> <p>On 3/18/25 at 9:57 AM, Resident #90 was observed in her room sitting in her recliner. Resident #90 was receiving oxygen via a nasal cannula at two liters per minute.</p> <p>Resident #90's Baseline Care Plan did not include her use of oxygen.</p> <p>On 3/18/25 at 11:25 AM, the DON reviewed Resident #90's Baseline Care Plan. The DON stated Resident #90's baseline care plan did not document she was on oxygen. The DON stated the baseline care plan should have addressed her use of oxygen, and it did not.</p>

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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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50603</p> <p>Based on record review, review of facility's policy and procedure, review of Incidents and Accidents (I&amp;As) reports, and staff interview, it was determined the facility failed to ensure residents were free from significant medication errors. This was true for 2 of 2 residents (#20 and #141) reviewed for medication errors. Findings include:</p> <p>The facility's Medication Error policy and procedure, undated, included following the six rights of medication:</p> <ol style="list-style-type: none"> <li>1. Right Patient</li> <li>2. Right Medication</li> <li>3. Right Dosage</li> <li>4. Right Dosage Form</li> <li>5. Right Route</li> <li>6. Right Time</li> </ol> <p>Upon identifying a medication error, the nurse should immediately assess the patient for adverse effects related to the error, and if significant, immediately notify the attending physician. The discovering nurse will initiate the Medication Error Event, and the nurse committing the error will complete the Medication Error Event to include notification to the physician (if not previously notified). The Director of Nursing (DON) will review the Medication Error Event for completeness, and provide additional interventions as needed to prevent future occurrence. The DON will track and report the facility's medication error rate to the Quality Assurance committee at least quarterly.</p> <p>1. Resident #141 was admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including Guillain-Barre syndrome (an autoimmune disorder), cancer of the lung, throat, and colon, and osteoporosis (bone weakening).</p> <p>A physician's order, dated 10/18/24, documented Resident #141 was to receive Oxycodone (narcotic pain medication), 5 mgs every 6 hours for pain.</p> <p>An I&amp;A report, dated 10/24/24, documented Resident #141 had missed a scheduled dose of oxycodone. Resident #141's medication administration record (MAR) documented she had received her medication; however, the medication was not signed out of the narcotic medication book. The patient reported she had not received her medication.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/19/25 at 5:01 PM, the DON stated the day shift nurse was notified by the patient she wanted her pain medication. The nurse checked the MAR and verified the medication was given to the patient, but found the medication had not been signed out of the narcotic medication book. Resident #141 usually received her Oxycodone between 5:00 to 7:00 AM. Once the error was discovered, she received it at 7:19 AM. The DON stated the nurse was educated on the six rights of medication administration. There is no additional information or investigation about why the nurse marked the medication as given, but did not check it out of the narcotic book.</p> <p>2. Resident #20 was admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including peritoneal abscess (a collection of pus within the lining of the abdomen usually caused by bacterial infections), and diverticulitis (inflammation or infection of the small pouches in the wall of the large intestine).</p> <p>A physician's order, dated 1/21/25, documented Resident #20 was to receive Zosyn in dextrose (antibiotic), 3.375 grams/50 mL (milliliters) intravenous (IV). Inject 3.375 grams in .9% NaCl (Sodium Chloride) 100 ml IV piggyback at 200 ml/hour, administer over 30 minutes every 6 hours.</p> <p>An I&amp;A report, dated 1/21/25, documented Resident #20 was to receive 3.375 mg (milligrams) IV every 6 hours. Instead, Resident #20 received 13.5 mg every six hours (4 doses given within 24 hours). The Medication Error Report documented the medication error occurred due to [nursing] misreading the physician's order. All parties [physician, DON, resident's family] were notified. The nursing staff was educated about the six rights of medication administration.</p> <p>On 3/19/25 at 4:57 PM, the DON stated Resident #20 had her labs (blood work) completed to ensure there were no adverse effects of the higher amount of antibiotics she had received. Resident #20's IV medication was premixed into the IV bag. The DON stated, the facility had used another pharmacy to fill Resident #20's medication order since there was a shortage with their usual pharmacy. The other pharmacy had prepared the entire 24-hour dose for Resident #20 into one IV bag. The nursing staff were used to the usual pharmacy breaking up the IV medication into four separate bags, related to the medication order.</p> <p>The DON stated, We should have administered only the correct amount [of IV medication] and used the IV bag four times for one day versus using four bags we were used to giving based on our usual pharmacy. The nurse who made the error did not read the label on the IV bag to verify the MD order. The following day, the nurse noticed the difference of medication amount on the bag, and we began our Medication Error Report process. The DON stated, we will not be using the other pharmacy. Resident #20 was monitored for two days, including her kidney function. The DON stated, Resident #20's laboratory results were normal. We educated all nursing staff regarding the six rights of medication administration, specifically on how to read the mg versus just the ml.</p> <p>These findings represent past non-compliance with this regulatory requirement. The facility did the following:</p> <ul style="list-style-type: none"> <li>-The resident was monitored.</li> <li>-The physician and family representative were notified.</li> <li>-The nurses were educated on the six rights of medication on 1/24/25.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Medication Administration/Medication Error Audits were completed on: 1/26/25, 1/27/25, 2/5/25, 2/11/25, and 2/14/25.</p> <p>There was sufficient evidence the facility corrected the non-compliance as of 2/28/25, as there were no further medication errors. At the time of this survey the facility was in substantial compliance and therefore does not require a plan of correction.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>50603</p> <p>Based on observation and staff interview, it was determined the facility failed to ensure kitchen equipment was maintained, cleaned, and sanitized. These deficiencies had the potential to affect the 43 residents who consumed food prepared by the facility. This placed residents at risk for potential foodborne illnesses and adverse health outcomes due to contaminated food services equipment. Findings include:</p> <p>1. The Food Drug Administration (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 beverage dispensing nozzles and enclosed components of equipment such as ice makers, cooking oil storage tanks and distribution lines, beverage 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.</p> <p>On 3/16/25 at 11:55 AM, and on 3/19/25 at 2:14 PM, the interior of the ice machine in the kitchen was observed to have a thin line of pink slimy residue.</p> <p>On 3/19/25 at 2:20 PM, the Dietary Manager (DM) stated the ice machine is cleaned by the company every 6 months, but the facility will clean it every month. It was last cleaned by our Maintenance director on 1/7/25 and 2/10/25. The DM stated she was unaware there was a dirty area in the ice machine, or she would have had maintenance clean it sooner.</p> <p>On 3/19/25 at 3:15 PM, the ice machine in the resident's nourishment room was observed to have a thin layer of pink slimy residue on the bottom level of the interior plastic cover.</p> <p>On 3/19/25 at 3:25 PM, the DM agreed the pink film should not be in the ice machine as maintenance had last cleaned it on 2/28/25.</p> <p>2. The FDA Food Code Section 6-501.14 (A) documented cleaning ventilation systems intake and exhaust air ducts shall be cleaned so they are not a source of contamination by dust, dirt, and other materials.</p> <p>On 3/16/25 at 11:55 AM, and on 3/19/25 at 2:22 PM, the kitchen refrigerator and freezer fan covers were observed to have a thin layer of dust, with larger particles billowing from the fan cover.</p> <p>On 3/19/25 at 2:24 PM, the DM stated the maintenance director will clean the covers as needed. However, she was not sure when the covers were last cleaned, but agreed they needed to be cleaned again.</p>		