NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
The Courtyard at Coeur d'Alene	RC-1283	2100 East Sherman Avenue	208-765-8364
Administrator	City	Zip Code	Survey Date
Janel Manning	Coeur d'Alene	83814	01/12/2024
Survey Team Leader	Survey Type		Response Due
Perry, Bradley	Health Care Initial Licensure + complaint investigation		02/11/2024

Item #	Rule (16.03.22)	Description
1	.009.01. Criminal History and Background Check.	Three of seven employees, whose personnel records were reviewed, did not have a Department Criminal History and Background Check. Upon interview with the business office manager, it was confirmed the Department Criminal History and Background Checks were not completed.
2	.151. ACTIVITY REQUIREMENTS.	During observations in house #4, which was a memory care unit, between 1/8/24 and 1/11/24, no activities were offered to the residents. In houses #2 and #3, activities were not offered consistently to all residents. Multiple staff, family members, and outside agency staff stated there were no activities offered in house #4 and were not consistently offered in houses #2 and #3. The administrator stated there was an activity calendar, and some residents went to another house for activities. The administrator stated in memory care, they did not have activities offered.
3	.215.08.b. Investigation within Thirty Days.	The administrator did not conduct investigations within 30 days when Resident #1 experienced falls on 4/26/23, 7/6/23, or 8/26/23; nor when Resident #2 had a fall on 9/8/23. Resident #7 had a fall on 6/18/23 which resulted in a hairline fracture to their pelvic bone which was not investigated. The facility administrator stated the investigations were not

		completed.
4	.215.08.e. Corrective Action.	The administrator did not implement corrective action to ensure incidents did not recur when Resident #1 had falls on 4/26/23, 7/6/23, 8/3/23, 8/26/23, and 9/9/23, nor when Resident #2 fractured their finger during a fall on 4/29/23 and when the resident experienced a fall on 7/25/23. Resident #3 had falls on 8/10/23, 8/18/23, and 8/19/23, nor when Resident #7 had a fall with fracture on 6/18/23. The administrator stated she did not complete corrective actions to prevent further events.
5	.216.02. Written Agreement.	Residents #1, #3, #4, #7, #8, and #9 did not receive new admission agreements when the facility underwent a change of ownership. The facility administrator stated she had not completed new admission agreements after the change of ownership for these residents.
6	.260.06. Toxic Chemicals.	The facility was not maintained in a clean, safe, and orderly manner. For example: House #3 was observed to have dirty ceiling vents, tile missing and lifting in the shower room, multiple areas of scratched and gouged baseboards and walls throughout. House #4 was observed to have multiple areas of scratched and gouged baseboards, dirt and debris along on the floor at the base of walls, and room 413 had a broken sink faucet handle with no running water from the faucet.
7	.260.07. Toxic Chemicals.	Toxic chemicals were observed to be stored in house #1 and house #4 in unlocked areas which were accessible to cognitively impaired residents. In house #1, cleaning disinfectant was observed under the kitchen bar sink on three different occasions from 1/9/24 to 1/10/24. In house #4, wound care spray and wound care cream was observed in several rooms at bedside and in bathrooms on three different occasions from 1/9/24 to 1/11/24.
8	.300.01. Licensed Registered Nurse (RN).	The facility's Registered Nurse (RN) did not perform the quarterly assessments for six of nine sampled residents. The RN stated she was unaware she was the nurse who had to

		perform the quarterly assessments.
9	.305.02.b. Quarterly Nursing Assessments.	The facility did not ensure residents consistently received their medications and treatments as ordered. For example, Resident #8 had not received ordered Melatonin from 12/16/23 to 1/11/24, Resident #9 did not receive their amlodipine for 8 days in January 2024, and an unsampled resident received only a half dose of a medication on 1/9/24. The facility nurse stated the facility did not have a discontinue order for Resident #8's Melatonin. She stated the missing doses for Resident #9 was a "pharmacy issue" and was not aware the medication had not been delivered or given, and she was not aware the unsampled resident only received half a medication dose on 1/9/24. The facility administrator stated she was unaware the residents were not receiving medication as ordered.
10	.305.03. Change in Resident Health Status.	A facility nurse did not conduct nursing assessments when residents experienced changes in physical or mental health status. For example, Resident #1 experienced falls on 7/28/23, 8/3/23, 9/9/23, and 9/10/23; Resident #2 fractured their finger on 4/29/23 and experienced falls on 7/25/23 and 9/25/23; Resident #3 experienced falls on 7/24/23, 8/10/23, 8/18/23, and 8/19/23; and Resident #7 fell and broke their pelvis on 6/18/23 and became bedbound. The facility Licensed Practical Nurse (LPN) stated she did not complete the change of condition assessments.
11	.310.01.c. Medication Distribution.	The facility's medication refrigerator temperatures, which contained insulin, were not monitored and documented accurately daily. Temperature logs for house #1 from 12/1/23 to 12/31/23, documented the refrigerator was below 37 degrees F on three days. House #4 temperature logs from 11/1/23 to 11/30/23, documented the refrigerator was below 37 degrees F on two days, not documented seven days, and December 2023 had not been monitored and documented daily. The administrator stated she was unaware the temperatures were out of range and not monitored.

12	.310.04.e. Psychotropic or Behavior Modifying Medication.	The following residents were taking psychotropic medications for longer than six months: Resident #3 was taking quetiapine, lorazepam, and Depakote, and did not have six-month psychotropic medication reviews, and Resident #7 was taking lorazepam and haloperidol and did not have six-month psychotropic medication reviews. The facility LPN stated the psychotropic medication reviews were not completed for these residents. The facility administrator stated the six month reviews were not completed.
13	.320.08. Periodic Review.	Residents' Negotiated Service Agreements (NSA) did not clearly reflect residents' needs nor describe the services to be provided. For example: Resident #7's NSA had no instructions for staff regarding mobility or transfers, documented they required prompting by staff for eating, assistance to the bathroom, prompting for grooming, reminders to wear appropriate clothing such as a jacket outside, and cueing and prompting to bathe with staff assistance, however they required assistance with eating and soft foods due to not wearing dentures. At the time of survey, Resident #7 was bedbound and required total assistance for all Activities of Daily Living (ADLs) including repositioning in bed and incontinence care. On 1/8/24, the resident was observed to be in the same position between 1:00 PM and 4:00 PM, and no caregivers were observed entering the resident's room during that time period. On 1/9/24, the resident was not offered breakfast and was only offered a protein shake at lunch time. On 1/10/24 between 8:15 AM and 9:55 AM, the resident was observed to be on their back in bed and a caregiver stated they did not know when the resident was turned last and had "not been able to get in there yet" and had been on shift since 6:00 AM. A caregiver stated they thought the resident should have been repositioned and provided incontinence PM care every two hours, however these instructions were not outlined in the NSA. On 1/10/24 between 8:15 AM and 11:00 AM, no staff

		were observed to enter the resident's room until 12:30 PM when the resident was offered a protein shake, water, and small amount of applesauce after the resident was able to express being hungry and thirsty. Between 12:45 PM and 3:00 PM, no caregivers were observed to go into Resident #7's room and staff bypassed the resident's room during the door-to-door shift change. The facility LPN stated staff were to check on Resident #7 during shift change, at a minimum and trusted staff were doing what they should be doing for the resident.
14	.330.06.b. Additional Resident Records.	The facility did not develop a behavior plan which included specific interventions for Resident #6 when they refused meals. Multiple staff stated Resident #6 refused multiple meals and stated they did not have a behavior plan to refer to. Resident #6's record documented in a three week period in October 2023, they did not eat meals 18 times. The facility LPN and administrator confirmed Resident #6 did not have a behavior plan with interventions for the resident's meal refusals.
15	.335.02. Standard Precautions.	The facility did not follow correct infection control procedures when a medication technician in house #1 was observed to allow an unsampled resident ingest a medication that had fallen onto the ground, and a staff member in house #4 was observed wearing the same pair of gloves while providing cares to multiple residents. Additionally, multiple resident rooms in house #4 did not have soap or paper towels in them and house #1 and house #2's staff bathrooms did not have paper towels in them.
16	.450. REQUIREMENTS FOR FOOD AND NUTRITIONAL CARE SERVICES.	The facility did not meet the standards for the Idaho Food Code when the kitchen inspection failed. Mandatory re-inspection required within 10 days. The facility did not have a Certified Food Protection Manager at the time of survey. The administrator stated she was unaware the kitchen manager's certification was not current.

17	.600.04.a. Sufficient Personnel.	The administrator did not ensure sufficient staff were consistently on the premises to provide care and supervision for all residents and did not schedule sufficient staff in each building on the night shift who were certified or delegated to pass medications. For example: The facility's as-worked schedule documented one staff member worked alone in houses #1, #2, #3, and #4 on night shift who were not all certified to pass medications. Multiple staff members stated they would either do a quick exchange of houses or would leave one building without staff for a short period of time so the medication technician could pass medications. Multiple staff, residents, and family members stated the facility was short staffed which lead to residents not always receiving care in a timely manner or not at all. The facility LPN stated the facility had been short staffed. he facility LPN and administrator stated when there was not a float person and medications needed to be passed, staff switched buildings and had to leave the buildings unsupervised.
18	.600.04.b. Sufficient Personnel.	Five of six employees, whose records were reviewed, did not have current first aid and cardiopulmonary resuscitation certification (CPR) training. The facility did not provide at least one direct care staff with certification in first aid and CPR in each building at all times. The administrator was unaware the staff certifications were expired.
19	.645.02. Delegation.	Five of five staff, who passed medications, were not delegated by the current facility nurse. The facility LPN stated she had delegated the medication technicians but the RN had not delegate her in order to delegate the medication technicians. The facility RN stated she had not delegated the LPN.