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
Mark Scroggin	Coeur d'Alene	83814	10/08/2025
Survey Team Leader	Survey Type		Response Due
Lu, Melvin	Health Care Licensure and Follow-Up		11/07/2025

Item #	Rule (16.03.22)	Description
1	.001.03. General Provider Responsibilities.	The Licensee failed to provide necessary resources to ensure the facility operated consistent with the rules and statutes at IDAPA 16.03.22 and title 39 and chapter 33. The facility did not receive sufficient support from the Licensee which resulted in multiple non-core deficiencies during the survey and the facility receiving repeat non-core deficiencies at: 260.07 for not securing toxic chemicals, at 305.03 for not completing change of condition assessments, at 310.01.c for not monitoring and documenting medication refrigerator temperatures daily, at 310.04.e for not conducting six-month psychotropic medication reviews, at 320.08 for not updating Negotiated Service Agreements (NSAs), at 330.06.a and .c for not evaluating and monitoring maladaptive behaviors, at 335.02 for not following infection control standards, at 450 for not having a certified food protection manager, which also resulted in a failed kitchen inspection for the second time in a row, at 600.04.b, at 600.04.b for staff not being current with first aid and CPR trainings, and at 645.02 for staff leaving the buildings unattended. The previous nurse stated she had voiced her concerns about multiple ongoing issues to the regional nurse and also to the corporate office, and stated she

		never received assistance in making sure the rules were being followed. The regional nurse stated the current survey was only the second time she had been to the facility to support staff. The administrator stated he was hired a few weeks ago and was still getting to know the residents and the systems which were in place. He said he could not speak to what support the previous administrator had received by the corporation.
2	.260.07. Toxic Chemicals.	Toxic chemicals were observed to be stored in two unlocked cabinets in building #4 memory care's kitchen which were accessible to cognitively impaired residents on four different occasions on 10/6/25 and 10/7/25. The kitchen had two partitions which could block access to the kitchen which were not always utilized during the observations and where residents were nearby and staff were elsewhere in the building. ***Previously cited on 1/12/24***
3	.305.02.b. Quarterly Nursing Assessments.	The facility failed to ensure residents' medications were available and given as ordered for three of seven sampled residents. For example, Resident #1 did not receive their oxycodone from 9/18/25 to 9/23/25 ordered for pain. Resident #7 was receiving the wrong dose of risperidone according to their 8/25/25 order and medication observation. Resident #5 did not receive five doses of their insulin medication Jardiance, 18 missed doses of Entresto for hypertension, and 22 missed doses with a fluticasone nasal spray. One 10/7/25 in building #2, two unsampled residents were observed during morning medication passes on 10/7/25 and one resident did not have their anti-psychotic medication available and the second resident did not have their blood pressure medication available on the medication cart. The resident care coordinator (RCC) stated they were having issues with their pharmacy and insurance issues. ***Previously cited on 1/12/24***
4	.305.03. Change in Resident Health Status.	The facility nurse did not assess residents after they

		experienced a change in mental or physical health status. For example, Resident #7 fell five times from 8/1/25 to 9/8/25 and had an injury of unknown origin, wounds to their right side, a bruise to the right side of their nose, and a scratch to their right cheek on 7/12/25, Resident #6 sustained injuries of unknown origin, bruises to their arms and legs, bilaterally, on 6/30/25, and an undated incident report which documented a scratch to their mouth, a bruise to the right side of their mouth, and scratches to the right side of their mouth, Resident #4 had a pressure sore on 2/15/25, left leg and ankle swelling on 3/29/25, a skin tear to their left forearm on 4/27/25, fell on 6/2/25 and 9/15/25, and had a rash with yeast on 8/24/25. The resident care coordinator stated the residents were not assessed by a facility nurse after they experienced a change in mental or health status. ***Previously cited on 1/12/24***
5	.310.01.c. Medication Distribution.	The facility did not monitor and document daily the temperatures for the medication refrigerator in all three houses, which contained insulin in two houses. The facility did not consistently document the medication refrigerator temperatures between 38-45 degrees F and did not have the documentation for the last three months. The Resident care coordinator stated she could not find the documentation.***Previously cited on 1/12/24***
6	.310.02. Discontinued and Expired Prescriptions.	The facility did not keep a record of all drug disposals nor was the method of destruction documented. The facility was observed to have an accumulation of unused, discontinued or expired medications for more than 30 days which included quetiapine, trazadone, gabapentin, and metoprolol. The former facility nurse stated she was unable to keep up with destroying medications.
7	.310.04.e. Psychotropic or Behavior Modifying Medication.	Residents who were taking psychotropic medications for longer than six months did not have a psychotropic medication review completed. For example, Resident #3 was taking Sertraline, Resident #4 was taking Escitolapram, Resident #5

		was taking Fluoxetine, Resident #6 was taking Quetiapine, Lorazepam, and Sertraline, and Resident #7 was taking Escitolapram and Risperidone. The resident care coordinator stated the six month psychotropic medication reviews were not completed. ***Previously cited on 1/12/24***
8	.320.01. Use of NSA.	Residents' NSAs did not clearly reflect the residents' needs nor describe the services to be provided. Resident #3's NSA did not document the use of a private duty caregiver who was providing cares and companionship to Resident #3 two days a week, Resident #4's NSA did not document they exhibited maladaptive behaviors, had skin issues, and received home health services, Resident #6's NSA did not specify they would sleep throughout the day if they were not woken up before 9:00 AM. Additionally, seven of seven sampled residents' NSAs did not include all the key elements to adequately describe residents to allow staff to meet their needs. The resident care coordinator stated the NSAs needed to be updated.
9	.320.08. Periodic Review.	NSAs were not updated to reflect significant changes in health status. For example, Resident #7's NSA did not document they had developed a stage 3 pressure injury, had home health treating the injury, and was utilized a pressure alarm for their wheelchair and bed. The RCC and the administrator stated the facility nurse was supposed to update the NSAs.***Previous cited on 1/12/24.***
10	.330.06.a. Additional Resident Records.	The facility did not evaluate Resident #1's behaviors of refusals of cares, verbal aggression and being sexually inappropriate. Resident #4's behaviors of physical/verbal aggression and refusing cares. Resident #7's behaviors of hitting, kicking and scratching staff. The resident care coordinator stated the facility had not completed evaluations of Resident #1, #4 or #7's behaviors. ***Previously cited on 11/19/24***
11	.330.06.b. Additional Resident Records.	The facility did not develop interventions after residents

		engaged in maladaptive behaviors. See non-core deficiency 330.06.a for examples. ***Previously cited on 01/12/24***
12	.330.06.c. Behavior Documentation.	The facility did not document the interventions used nor their effectiveness after Residents #1, #4 or #7 engaged in maladaptive behaviors. See non-core punch 330.06.a for examples. Residents #1 and #4 had progress notes that documented the behaviors but did not document what interventions were implemented nor their effectiveness. ***Previously cited on 11/19/24***
13	.330.13.e. Personnel Records.	Four of eight staff member files reviewed did not contain documentation of 16 hours of orientation training. Two of two staff members files reviewed did not have documentation of job-related continued training.
14	.335.02. Standard Precautions.	During medication pass observations, medication technicians were observed administering medications to multiple residents without conducting hand hygiene between medication pass with each resident. Multiple staff members in building #1, #2, and #4 were observed not wearing aprons in the kitchen during meal prep after providing care needs to residents. The administrator stated he would expect staff to follow infection control standards. ***Previously cited 1/12/24***
15	.404. FIRE AND LIFE SAFETY STANDARDS FOR EXISTING BUILDINGS LICENSED FOR SEVENTEEN OR MORE RESIDENTS AND MULTI-STORY BUILDINGS.	The facility was missing the kitchen hood suppression semi-annual inspection and kitchen hood inspection cleaning report. The last known inspection was 2023. The administrator confirmed the inspection was not completed.
16	.450. REQUIREMENTS FOR FOOD AND NUTRITIONAL CARE SERVICES.	The facility did not meet the standards for the Idaho Food Code. Kitchen inspection failed on 10/6/25. Mandatory re-inspection required within 10 days. The facility did not have a Certified Food Protection Manager at the time of survey. ***Previously cited 1/12/24***
17	.600.02. Detached Buildings or Units.	The facility did not ensure all buildings were staffed sufficiently to ensure one staff member was in each building at all times. For example, several staff members stated buildings were left

		unattended for short periods of time when they needed to "swap" a caregiver for a medication technician, because each of the three buildings only had one staff working in each building on night shift for several nights. The facility's as-worked schedules documented the facility only had three staff working to cover each building, and one or more of those staff were not delegated to pass medications. The RCC stated on nights when there was no float staff, medication technicians had to swap with a caregiver in order to pass medications.
18	.600.04.b. Sufficient Personnel.	Five of eight employees did not have current First Aid and CPR certifications. Each staff worked at the facility without any other staff present during the NOC shift. ***Previously cited 1/12/24***
19	.645.02. Delegation.	Four of four staff sampled, who passed medications, were not delegated by a current facility nurse. The administrator confirmed none of the current staff were not re-delegated following the departure of the previous facility nurse. ***Previously cited 1/12/24***
20	39-3308 Assessment (1) Initial Assessments	The facility nurse did not conduct an assessment within 30 days prior to Resident #2, #4, #5, and #7's admission to the facility. The former facility nurse stated the assessments were not completed for all residents.
21	39-3308 Assessment (4)a Assessments	The facility nurse did not conduct quarterly nursing assessments at least once every 90 days for six of six sampled residents who required them. The former facility nurse stated quarterly assessments were not completed by the prior nurse and was not able to get caught up on all required assessments in the time they worked at the facility.
22	39-3308 Assessment (4)b Assessments	The facility nurse did not implement all residents' orders. The former facility nurse stated they were not able to implement all residents' order. The RCC stated they implemented orders when the facility did not have a nurse available.
23	39-3321.2.c. Qualifications and Requirements of Administrator.	The facility did not ensure investigations were completed. For example, Resident #7 fell five times from 8/1/25 to 9/8/25 and

		had an injury of unknown origin, wounds to their right side, a bruise to the right side of their nose, and a scratch to their right cheek on 7/12/25, Resident #6 sustained injuries of unknown origin, bruises to their arms and legs, bilaterally, on 6/30/25, and an undated incident report which documented a scratch to their mouth, a bruise to the right side of their mouth, and scratches to the right side of their mouth, Resident #4 had a pressure sore on 2/15/25, left leg and ankle swelling on 3/29/25, a skin tear to their left forearm on 4/27/25, fell on 6/2/25 and 9/15/25, and had a rash with yeast on 8/24/25. The resident care coordinator stated the facility did not investigate these incidents/accidents.
24	39-3321.4. Qualifications and Requirements of Administrator.	The administrator did not immediately implement corrective action to ensure incidents and accidents did not reur. For example, Resident #7 fell five times from 8/1/25 to 9/8/25 and Resident #4 fell on 6/2/25 and 9/15/25. The resident care coordinator stated corrective action was not immediately implemented to prevent recurrence.
25	39-3321.5. Qualifications and Requirements of Administrator.	The facility did not notify the licensing agency within one business day of a reportable incident. For example: Resident #6 had injuries of unknown on 6/30/25 and 7/4/25. Resident #7 had an injury of unknown injury on 7/12/25. Resident #1 fell on 9/19/25 and was sent to the hospital. The administrator stated the nurse was supposed to report these incidents.
26	.330.04.a. Behavior Documentation.	Facility staff documentation was not completed by the staff making observations. Several staff members stated the caregivers did not have access to the computer system and the medication technicians charted for them, including witnessing incidents or changes in status. The RCC confirmed the medication technicians charted for the care staff.