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	09/15/2026
Survey Team Leader	Survey Type		Response Due
Walker, Jenny	Health Care Complaint Investigation		10/15/2026

Item #	Rule (16.03.22)	Description
1	.250.10. Secure Environment.	The facility did not provide a secure environment for Resident #7, who had a diagnosis of dementia. Multiple staff, including the facility administrator, stated Resident #7 was confused and could not function in the community without supervision. On 9/14/26 at 2:55 PM, Resident #7 was observed attempting to enter house #2 through the front door by standing on a chair to open the top crack of the door. The exterior courtyard was unsecured due to multiple cognizant residents who knew the code to exit the exterior gate. The administrator confirmed the exterior courtyard was unsecured.
2	.310.01.f. Medication Distribution.	Residents did not receive medications as ordered by their physician. For example, Resident #1 had orders for daily magnesium, gabapentin, and melatonin; and did not receive any of these medications from 8/20/26 through 9/15/26. Resident #4 had orders for acetaminophen and buspirone; and did not receive these medications 17 times and 12 times in August 2026, respectively. Resident #4 also did not receive acetaminophen and buspirone 26 times and 23 times in September 2026, respectively. Resident #3 was given the wrong frequency of a clonidine patch twice in July 2026 in the ordered frequency. The previous facility nurse stated the

		medication orders had not been implemented. The current facility nurse and administrator stated the current facility nurse did not have access to the facility's medication system.
3	.330.03. Resident Care Records.	The facility did not have documentation for Resident #2 regarding when they went to the hospital, the reason they were sent, nor when they returned to the facility. Several staff members stated they did not know when the resident went to the hospital. The facility administrator stated he did not have that information and there was no documentation.
4	.330.03.a.i. Resident Care Records.	The facility did not maintain physicians orders in residents records. For example; Resident #2's record did not include current physician's orders. The administrator stated they had to request Resident #2's physician orders from the pharmacy and confirmed the physician orders were not in Resident #2's record in the facility.
5	.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, multiple staff members stated buildings were left unattended for short periods of time when they "switched" between buildings, especially when one building did not have a medication technician scheduled and they had to switch places with a caregiver in order to pass medications in all three buildings. On 9/15/26 at 9:35 AM, a medication technician was observed leaving House #3 unattended and another resident was assisting Resident #4 with their meal. The as-worked night shift schedule for 8/16/26, 8/17/26, 8/22/26, 9/3/26, and 9/6/26 to 9/10/26, documented one caregiver and two medication technicians were scheduled for three buildings, which would have left buildings unattended while the caregiver and medication technician switched places to pass medications or when a resident in any of the three buildings needed two-person transfer assistance. The administrator stated they tried to schedule four staff on night shift and was unaware staff had been switching houses. ***Previously cited

		on 10/8/25***
6	39-3308 Assessment (4)b Assessments	The facility nurse did not implement all residents' orders. Multiple staff stated there had not been a nurse for the past few weeks nor had access to the current agency nurse. The resident care coordinator stated she implemented new orders due to the facility did not have a nurse for the past few weeks. The current agency nurse stated she just started the previous week and had not been given access to the facility's medication system to implement physician orders. ***Previously cited on 10/8/25***
7	39-3309.01 NEGOTIATED SERVICE AGREEMENT	The facility did not update residents' Negotiated Service Agreements (NSA) to reflect the residents' current status. For example, Resident #2's NSA documented they were independent with activities of daily living (ADLs) including bathing, dressing, grooming, transfers and ambulation, even after the resident experience a decline in June 2026 and required assistance by staff with their ADLs. Resident #4 and Resident #5's NSA documented they were receiving hospice services without specific instructions on who was the hospice agency and what services they were providing. Several staff stated Resident #2 had declined and the NSA had not been updated. The administrator stated the NSAs were not updated. ***Previously cited on 10/8/25 at 320.01***
8	39-3321.2.c. Qualifications and Requirements of Administrator.	The facility did not ensure investigations were completed. For example: Resident #3 experienced medication errors when administering a clonidine patch (blood pressure medication) at the wrong frequency, on two separate occasions in July 2026, with one time requiring a hospitalization. Multiple staff stated the patch was applied incorrectly twice, once before being sent to the hospital and another time after the hospitalization. Resident #3's care notes and a physician's note documented the patch was changed at least three days earlier than scheduled, making it a significant medication error and sending Resident #3 to the hospital. The facility incident reports did not

		document either incident were investigated. The administrator stated the nurse did not complete an investigation for the first medication error and was unaware of the second medication error. ***Previously cited on 10/8/25.***