IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7007 3020 0001 4044 7496

March 11, 2013

Gary L. Liesner, Administrator
Ivy Court
2200 Ironwood Place
Coeur d'Alene, ID 83814

Provider #: 135053

Dear Mr. Liesner:

On **February 28, 2013**, a Recertification and State Licensure survey was conducted at Ivy Court by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies, and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE**: The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 3). **Please provide ONLY ONE completion date for each federal and state tag in column (X5) Completion Date, to signify when you allege that each tag will be back in compliance**. WAIVER RENEWALS MAY BE REQUESTED ON THE PLAN OF CORRECTION. After each deficiency has been answered and dated, the administrator should

sign both Form CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **March 25, 2013**. Failure to submit an acceptable PoC by **March 25, 2013**, may result in the imposition of civil monetary penalties by **April 15, 2013**.

The components of a Plan of Correction, as required by CMS include:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;

- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

- What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;

- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. This monitoring will be reviewed at the follow-up survey, as part of the process to verify that the facility has corrected the deficient practice. Monitoring must be documented and retained for the follow-up survey. In your Plan of Correction, please be sure to include:

  a. Specify by job title who will do the monitoring. It is important that the individual doing the monitoring has the appropriate experience and qualifications for the task. The monitoring cannot be completed by the individual(s) whose work is under review.

  b. Frequency of the monitoring; i.e., weekly x 4, then q 2 weeks x 4, then monthly x 3. A plan for 'random' audits will not be accepted. Initial audits must be more frequent than monthly to meet the requirement for the follow-up.

  c. Start date of the audits;

- Include dates when corrective action will be completed in column 5.

  If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567 and the state licensure survey report, State Form.

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations.*

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **April 4, 2013 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **April 4, 2013**. A change in the seriousness of the deficiencies on **April 4, 2013**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **April 4, 2013** includes the following:

Denial of payment for new admissions effective **May 28, 2013**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **August 28, 2013**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0036; phone number: (208) 334-6626; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **February 28, 2013** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx

go to the middle of the page to **Information Letters** section and click on **State** and select the following:

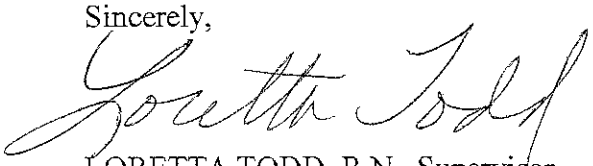
- BFS Letters (06/30/11)

  2001-10 Long Term Care Informal Dispute Resolution Process
  2001-10 IDR Request Form

This request must be received by **March 25, 2013**. If your request for informal dispute resolution is received after **March 25, 2013**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,



LORETTA TODD, R.N., Supervisor
Long Term Care

LT/dmj
Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135053		02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY COURT	2200 IRONWOOD PLACE COEUR D'ALENE, ID 83814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following deficiencies were cited during the annual recertification survey of your facility. The surveyors conducting the survey were: Lynda Evenson, BSN, RN - Team Coordinator Ashley Anderson, QMRP Bradley Perry, LSW Survey Definitions: ADL = Activities of daily living BIMS = Brief Interview for Mental Status BM= Bowel Movement CAA = Care Area Assessment CC= Cubic Centimeters CDM = Certified Dietary Manager CFL= Compact Fluorescent Light CNA = Certified Nurse Aide DON = Director of Nursing LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set MG= Milligrams ML= Milliliters PO= By Mouth TAR = Treatment Administration Record	F 000	This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. The submission of this plan of correction is not an admission or agreement with the deficiencies or conclusions contained in the Department's inspection report.	
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would	F 225		4/4/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE ____ TITLE Adm (X6) DATE 3/22/13

An [illegible]ciency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that oth[illegible]eguards 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.

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F 225	Continued From page 1 indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on review of investigations, review of concern reports, review of smoking policy, and staff interview, it was determined the facility failed to ensure all allegations of abuse, neglect and/or mistreatment were thoroughly investigated, and appropriate corrective action was taken. That failure directly impacted 5 of 8 residents (Residents #8, #20, #21, #22, #24) involved in	F 225		

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F 225	Continued From page 2 significant incidents. This resulted in a lack of sufficient information being available on which to base corrective action decisions. The findings include: 1. A Resident Incident investigation, dated 1/26/13, documented an allegation of verbal abuse by LN #1 to Resident #24. a. The investigation documented an interview, under the heading "Interview Summaries", without details of who the staff interviewed was or when the interview took place. The Director of Nursing stated, on 2/28/13 from 11:25 - 11:54 a.m., the interview was with CNA #8, but no documentation of that interview (i.e. what was asked, staff responses) was included with the investigation or submitted to the survey team. b. The investigation was attached to a Resident Concern Report that named CNA #9 and CNA #10 as additional witnesses. However, no statement from CNA #10 was included with the investigation. The Director of Nursing stated, on 2/28/13 from 11:25 - 11:54 a.m., an interview with CNA #10 occurred over the phone, but no documentation of that interview (i.e. what was asked, staff responses) was included with the investigation or submitted to the survey team. c. The investigation stated "[LN #1] suspended pending investigation." However, the investigation did not contain details of when LN #1 was suspended or when he was allowed back to work. It was unclear from the investigation if Resident #24 was immediately protected from continued abuse. The Director of Nursing stated, on 2/28/13 from 11:25 - 11:54 a.m., LN #1 was	F 225	It is the policy of Ivy Court to insure all allegations of abuse, neglect or mistreatment are thoroughly investigated. To enhance currently compliant operations and under the direction of the Administrator, all parties involved with investigating allegations of abuse, neglect or mistreatment will receive re-education utilizing the investigative protocols and algorithms found in a survey agency prepared investigative guideline book. As the specific investigations cited involve a lack of documentation specifying what investigation and interventions actually occurred, the staff involved in this process will be re-educated on documentation expectations. Residents #8, 20, 21, 22, 24 have been interviewed by the Director of Social Services and report satisfaction with the investigative process that occurred in their specific case and feel safe and secure in the center. All residents will be interviewed using the Abaquis interview tool and any concerns or complaints will be addressed immediately.	

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F 225	Continued From page 3 suspended on 1/29/13 and was allowed back to work 1/31/13 with written disciplinary action. 2. A Resident Concern Report, dated 2/8/13, documented an allegation of verbal abuse by CNA #11 to Resident #22. The Resident Concern Report was then treated as an investigation. a. The investigation stated "CNA reported to this LN [LN #2]." However, no details regarding the name of the CNA, or his/her statement, were included with the investigation. The Director of Nursing stated, on 2/28/13 from 11:25 - 11:54 a.m., she conducted a follow-up interview with LN#2 and LN #2 was unable to remember the name of the CNA. Additionally, no documentation of the follow-up interview with LN #2 (i.e. what was asked, staff responses, when the interview took place, etc.) was included with the investigation or submitted to the survey team. b. The investigation stated "I [DON] spoke to other male CNA's on Days & Eve [days and evenings] ... " However, the investigation did not include any documentation of the interviews with other male CNA's (i.e. staff names, what was asked, staff responses, when the interviews took place, etc.). c. The investigation stated "I suspend [CNA #11] pending investigation." However, the investigation did not contain details of when CNA #11 was suspended. It was unclear from the investigation if Resident #22 was immediately protected from abuse. The Director of Nursing stated, on 2/28/13 from 11:25 - 11:54 a.m., CNA #11 was suspended on 2/8/13.	F 225	The administrator, beginning 4/1/13, will review all documentation concerning allegations as well as all serious injury reports to insure all aspects of the investiagtive protocol are followed and completely documented on an ongoing basis. Any further deficiencies will be corrected immediately, and the findings of the audits will be submitted at the quality assurance committee meetings for further review or correction.	

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F 225	Continued From page 4 3. A Resident Incident investigation, dated 12/10/12, documented Resident #8 fell when having a cigarette outside, unsupervised. The investigation stated "Resident is not an independent smoker and ...she must be supervised to smoke. " a. The investigation stated "[LN #3] and [LN #1] were the initial responders." Additionally, the investigation listed CNA #12 and LN #4 under, "Nursing staff assigned to Resident's care." However, the investigation did not include interviews of LN #1, LN #3, CNA #12, or LN #4. Further, the investigation did not include documentation of all staff working that shift to determine staff whereabouts or if anything was witnessed regarding Resident #8's fall. b. The "Summary of Corrective Action Taken" section did not include any information related to staff (i.e. disciplinary action for assigned staff, re-training on supervised smoking policy, re-training on Resident #8's care plan, etc.). c. When asked about dependent smoking the Administrator stated in an interview on 2/28/13 at 11:05 a.m., if residents were determined to be dependent smokers, they could not have any smoking materials in their room or possession. He also stated dependent smokers were dependent on staff for both smoking materials and supervision. However, no information to determine how Resident #8 obtained smoking materials to smoke a cigarette unsupervised was included in the investigation. 4. A Resident Incident investigation, dated 11/22/12, documented Resident #21 was off the	F 225		

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F 225	Continued From page 5 property without staff. The facility received a call from Resident #21's family member, who received a call from the police department, stating that Resident #21 was at a restaurant .6 miles from the facility. The investigation did not include interviews of all staff working that shift to determine staff whereabouts or if anything was witnessed regarding Resident #21's elopement. The Director of Nursing stated, on 2/28/13 from 11:25 - 11:54 a.m., she and the RCM interviewed the five employees on shift, but did not have documentation of the interviews (i.e. what was asked, staff responses) or signed staff statements. Without details from interviews with all staff, the facility could not comprehensively assess if staff distribution needed to be altered or if staff needed re-training on their job responsibilities to prevent further incidents. 5. A Resident Incident investigation, dated 1/31/13, documented Resident #20 reported an allegation of abuse by CNA #7 to her "caring partner." The investigation stated "[CNA #7] was then suspended pending an investigation." However, the investigation did not contain details of when CNA #7 was suspended or when she was allowed back to work. It was unclear from the investigation if Resident #20 was immediately protected from continued abuse. The Administrator presented CNA #7's timecard and it was found that CNA #7 was suspended immediately and throughout the investigation.	F 225		

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F 225	Continued From page 6 When asked about the thoroughness of the investigations the Director of Nursing stated, in an interview on 2/28/13 from 11:25 - 11:54 a.m., more detail in the investigations would have been better. The facility failed to ensure all allegations of abuse, neglect or mistreatment were thoroughly investigated.	F 225		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on policy review and staff interview, it was determined the facility failed to sufficiently develop and operationalize policies and procedures that prohibited mistreatment, neglect, and abuse of residents and misappropriation of resident property for 5 of 8 residents (Residents #8, #20, #21, #22, #24) involved in significant incidents, with the potential to affect all residents residing in the facility. That failure resulted in potential harm by not clearly specifying how staff were to handle allegations of abuse, neglect or mistreatment. The findings include: 1. The facility's abuse policy, revised April 2012, was reviewed and was not sufficient to ensure residents were not subjected to mistreatment,	F 226		4/4

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F 226	Continued From page 7 neglect, abuse, and misappropriation of their property as follows: a. Under the section titled Policy, it stated all alleged violations were to be immediately reported to the Administrator and DON/designee. The policy did not include information as to what to do if the alleged staff were the Administrator and DON. b. The section titled Abuse included "Willful infliction of injury" and "Unreasonable confinement." The policy did not include information related to willful infliction without injury. Additionally, the policy did not define "Unreasonable confinement." c. Under the Physical Abuse definition, it referred to corporal punishment. Corporal punishment was not defined. Additionally, the definitions section listed Sexual Abuse and Mental /Emotional Abuse. However, definitions for sexual and mental/emotional abuse were not included in the policy. Further, the policy did not include information related to resident-to-resident abuse and self-injurious behavior. d. Under the section titled Training, it stated "Provide training for new employees through orientation and with ongoing training programs." The policy did not contain information related to how ongoing training would be conducted, at	F 226	It is the policy of Ivy Court to maintain policies and procedures that meet federal guidelines. To enhance currently compliant operations and under the direction of the Administrator, the center policies will be operationalized to include the cited deficient areas. Staff will be re-educated on the newly clarified guidelines. Residents #8, 20, 21, 22, 24 have been interviewed by the Director of Social Services and report satisfaction with the investigative process that occurred in their specific cases. Since all residents have the potential of being affected, residents will be interviewed using the Abaquis interview tool and any concerns or complaints will be addressed immediately. The Administrator, or designee, will review all accident and incidents to include allegations and serious injury reports utilizing the newly clarified guidelines to ensure all investigations are compliant with policy beginning immediately. Any deficiencies will be corrected immediately and the findings submitted at the quality assurance committee meetings for review.	

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F 226	Continued From page 8 what frequency, or who was responsible for training staff. e. Under the section titled Training, it stated staff would be trained on "Definitions of abuse, neglect, mistreatment ..." A definition for mistreatment was not included in the policy. f. Under the section titled Prevention, it stated "Instruct staff that they are required to report concerns, incidents, and grievances." The policy did not contain information related to who staff were to report and required timeframes for doing so. g. Under the section titled Identification, it stated "Identify events, such as resident-to-resident altercations, bruising of residents, occurrences, patterns, and trends that may constitute abuse, neglect and/or mistreatment." The policy did not include information on who was to identify such events and procedures to be followed to ensure timely identification of abuse, neglect and/or mistreatment. h. Under the section titled Protection, it stated "Additional means of providing protection may include, but are not limited to: Move resident to another room or unit, Provide 1:1 monitoring, Increase amount of resident supervision, Implement discharge process immediately, if the resident is a danger to self or to others." The policy did not include information related to	F 226		

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F 226	Continued From page 9 who was authorized to make these decisions and associated timeframes for implementation. i. Under the section titled Investigation, it listed five steps including "Review and investigate using the electronic Accident/Incident (eAI) report ...Complete investigation summaries and final outcome questions ...Complete and submit the eAI ...Report the results to other officials in accordance with State law ..." The policy did not include information related to who was responsible to complete each step and associated timeframes. j. Under the section titled Employee Suspension from Duty, it stated "In the case of an employee being investigated for abusing, neglecting, or mistreating a resident, the Administrator ...must relieve the individual of their duties ..." The policy did not include information as to what to do if the alleged staff was the Administrator. k. Under the section titled Reporting, it listed 4 steps including "Report all alleged violation and all substantiated incidents to the state agency and to all other agencies as required, and take all necessary corrective actions depending on the results of the investigation." The policy did not include information related to who was responsible to complete this step and associated timeframes. l. The section related to notifying the legal guardian, spouse or responsible family member, the physician, the State Nurse Aide Registry, and	F 226		

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F 226	Continued From page 10 other authorities required by State law did not include the person responsible for making the notifications. Additionally, it stated "Analyze the occurrences to determine what changes are needed, if any, to policies and procedures to prevent further occurrences." The policy did not specify the person responsible to complete the analysis or associated timeframes. When asked, the Administrator verified, during an interview on 2/28/13 from 10:40 - 10:54 a.m., that that the policy was not specific. The facility failed ensure policies and procedures that prohibited mistreatment, neglect, and abuse of residents and misappropriation of resident property were sufficiently developed and operationalized.	F 226		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to respect residents' private space when staff entered residents' rooms without knocking. This was true for 9 out of 47 (Resident #'s 1, 6, 9, 11, 16, 17, 18, 19, & 25)	F 241		4/4

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F 241	Continued From page 11 residents residing in the North and South hallways of the facility. This failed practice created the potential for the residents to experience a lack of respect for privacy. Findings included: 1. On 2/26/13 at 7:56 AM, CNA #1 was observed entering resident room #33 without knocking or announcing herself to Resident #1, who was in bed and Resident #6, who had his privacy curtain drawn. She walked past Resident #1's bed (approximately 6 feet into the room) and then said, "Nursing", while she continued to walk through the room. The CNA then proceeded to deliver a food tray to Resident #6. 2. On 2/26/13 at 8:10 AM, CNA #2 was observed entering resident room #37 (Resident #11 & #16's room) without knocking. 3. On 2/26/13 at 9:07 AM, CNA #1 was observed entering resident room #35 (Resident #17 & #18's room) without knocking. 4. On 2/26/13 at 9:08 AM, CNA #1 was observed entering resident room #33 (Resident #1 & #6's room) without knocking. 5. On 2/26/13 at 9:50 AM, CNA #3 was observed entering resident room #54 (Resident #25's room) without knocking. CNA #3 took a bag of soiled linen to the hallway soiled utility room, came back into room #54 without knocking or announcing herself and proceeded to wash her hands in the sink. 6. On 2/26/13 at 2:28 PM, CNA #2 was observed entering resident room #29 (Resident #9 & #19's	F 241	It is the policy of Ivy Court to insure all stsff knock and announce themselves prior to entering any resident room. To enhance currently compliant operations and under the direction of the Administrator, all staff will be re-educated on ensuring resident dignity and respect through knocking and announcing themselves before entering resident rooms. Residents # 1, 6, 9, 11, 16, 17, 18, 19, & 25 have been interviewed by the Director of Social Services and report feeling safe and respected by the staff. All residents will be interviewed using the Abaquis interview tool and any concerns or complaints will be addressed immediately. The department head staff (caring partners), will perform weekly audits x4, then bi-monthly x 4, then monthly x4 beginning 4/1/13 to ensure compliance. Any concerns will be corrected immediately and the findings of the audits will be submitted at the quality assurance committee meeting.	

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F 241	Continued From page 12 room) without knocking. CNA #2 left room #29 and entered room #35 (Resident #17 and #18's room) without knocking. On 2/27/13 at 4:55 PM, the Administrator and DON were informed of the staff entering rooms without knocking. No other information was provided by the facility.	F 241		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.	F 278		4/4

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F 278	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure the resident assessment accurately reflected the resident's status. This was true for 1 of 15 (#13) sampled residents. The assessment failed to document the resident's implanted intrathecal pump. This failed practice had the potential for inadequate care planning for the resident. Findings included: The MDS 3.0 Manual, 10/2011, documented, under Section O0100: Special Treatments, Procedures, and Programs, "OI00H, IV [intravenous] Medications: ...epidural, intrathecal, and baclofen pumps may be coded here, as they are similar to IV medications in that they must be monitored frequently and they involve continuous administration of a substance. ..." Resident #13 was admitted to the facility on 8/28/09 with diagnoses including spasticity and stroke syndrome. Resident #13's History and Physical from 6/17/10 documented, "...Recently had a pump implant for baclofen, which has been helping with her muscle spasms." A Session Data Report, dated 12/27/12 at 3:05 pm, documented the Baclofen pump was refilled and was continuously administering Baclofen to the resident. A review of the resident's most recent quarterly MDS assessment, dated 1/8/13, revealed the facility failed to code the resident's Baclofen	F 278	It is the policy of Ivy Court to complete accurate assessments. To enhance currently compliant operations and under the direction of the Administrator, the clinical reimbursement staff will receive re-education on the coding of implanted devices which provide the resident with medication. Resident #13 had no adverse effects from this cited deficiency. All center residents receiving medications through an implanted devise will have accurate assessments completed. The Clinical Reimbursement Coordinator, who does not complete the MDS, will begin auditing those MDS assessments completed on residents with implanted medication delivery systems to ensure proper MDS coding has occurred. This auditing will occur as assessments are due for those residents affected x 4 months beginning 4/1/13. Any concerns will be corrected immediately and audit results will be submitted at the quality assurance committee meeting.	

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F 278	Continued From page 14 pump as "IV Medications" in Section O100 H. On 2/28/13 at 9:55 am,the MDS Coordinator was interviewed regarding the coding of the Baclofen pump. She said that because staff were not accessing the pump, she thought she did not need to code the pump. She said she was told that the Baclofen pump was "subcutaneous" and that it did not need to be coded. She said she now knows that the Baclofen pump should be coded on the resident's future MDS assessments and that she would correct the current MDS assessment. On 2/28/13 at 12:20 pm, the Administrator and DON were informed of the issue. The facility provided no other information or documentation that resolved the concern.	F 278		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and policy and procedure (P&P) review, it was determined the facility failed to provide necessary bowel care when orders were not consistently followed for 8 out of 9 (#'s 2-9) sampled residents. This deficient practice had the	F 309		4/4

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F 309	Continued From page 15 potential to cause more than minimal harm when residents did not receive ordered interventions for bowel care, placing them at risk for developing fecal impaction. Findings included: The facility Bowel and Bladder Program policy and procedure documents the following: "Standard bowel care to relieve constipation (in the absence of a bowel obstruction) with a provider order may include the following: * Milk of Magnesia (MOM) 30 cc PO every third day without BM. * Bisacodyl Suppository rectally if no results from the Milk of Magnesia. * Fleets Enema rectally if no results from the Biscodyl Suppository." 1. Resident #7 was admitted to the facility on 8/10/12 with multiple diagnoses including episodic mood disorder and malaise and fatigue. Resident #7's Physician orders dated 8/12/12, documented the following: " Bowel medications should be offered on third day of no BM documented. * Milk of Magnesia: Give 30 ML orally as needed if no BM in 3 days for constipation. * If no results from MOM, give Dulcolax suppository (10MG) 1 rectally as needed for constipation. * If no results from Dulcolax, give Fleets Enema rectally as needed for constipation." Resident #7's November, December, January, and February Bowel and Bladder Report and MAR documented the following: * No BM 11/3/12-11/6/12 and no MOM given on 11/5/12 or Dulcolax suppository given on 11/6/12	F 309	It is the policy of Ivy Court to provide necessary bowel care as ordered. To enhance currently compliant operations and under the direction of the Director of Nursing, the standing orders for bowel care have been proceduralized and with specific instructions that include when to begin the protocol and when each step of the protocol are to be initiated. Residents # 2-9 have had no adverse effects from the postponement of or missing steps to the bowel protocol. No center residents have had a fecal impaction as a result of this cited practice. The Director of Nursing, or her designee, will audit the bowel report to ensure compliance with the clarified bowel protocol. The audits will occur weekly x4, then bi-monthly x4, then monthly x4 beginning 4/1/13. Any deficiencies will be corrected immediately, and the findings of the audits will be submitted at the quality assurance committee meetings for further review or corrective action.	

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F 309	Continued From page 16 as ordered. * No BM 11/14/12-11/16/12 and no MOM given on 11/16/12 as ordered. * No BM 11/18/12-11/20/12 and no MOM given on 11/20/12 as ordered. * No BM 11/23/12-11/25/12 and no MOM given on 11/25/12 as ordered. * No BM 11/27/12-11/29/12 and no MOM given on 11/29/12 as ordered. * No BM 12/7/12-12/10/12 and no MOM given on 12/9/12 or Dulcolax suppository given on 12/10/12 as ordered. * No BM 12/16/12-12/18/12 and no MOM given on 12/18/12 as ordered. * No BM 12/23/12-12/26/12 and no MOM given on 12/26/12 as ordered. * No BM 1/13/13-1/15/13 and no MOM given on 1/15/13 as ordered. * No BM 1/22/13-1/24/13 and no MOM given on 1/24/13 as ordered. * No BM 1/27/13-1/29/13 and no MOM given on 1/29/13 as ordered. * No BM 1/13/13-1/15/13 and no MOM given on 1/15/13 as ordered. * No BM 2/13/13-2/15/13 and no MOM given on 2/15/13 as ordered. * No BM 2/21/13-2/24/13 and no MOM given on 2/23/13 or Dulcolax suppository given on 2/24/13 as ordered. 2. Resident #3 was admitted to the facility on 2/1/12 with multiple diagnoses including delerium and anemia. Resident #3's Physician orders dated 8/12/12, documented the following: " Bowel medications should be offered on third day of no BM documented.	F 309		

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F 309	Continued From page 17 * Milk of Magnesia: Give 30 ML orally as needed if no BM in 3 days for constipation. * If no results from MOM, give Dulcolax suppository (10MG) 1 rectally as needed for constipation. * If no results from Dulcolax, give Fleets Enema rectally as needed for constipation." Resident #3's November, December, January, and February Bowel and Bladder Report and MAR documented the following: * No BM 11/17/12-11/19/12 and no MOM given on 11/19/12 as ordered. * No BM 11/25/12-11/27/12 and no MOM given on 11/27/12 as ordered. * No BM 11/29/12-12/2/12 and no MOM given on 12/1/12 or Dulcolax suppository given on 12/2/12 as ordered. * No BM 12/11/12-12/16/12 and no MOM given on 12/13/12, no Dulcolax suppository given on 12/14/12 or Fleets Enema on 12/15/12 as ordered. * No BM 12/21/12-12/23/12 and no MOM given on 12/23/12 as ordered. * No BM 1/1/13-1/3/13 and no MOM given on 1/3/13 as ordered. * No BM 1/17/13-1/20/13 and MOM was given on 1/19/13 as ordered, but no Dulcolax suppository given on 1/20/13 as ordered. * No BM 1/26/13-1/28/13 and no MOM given on 1/28/13 as ordered. * No BM 2/4/13-2/6/13 and no MOM given on 2/6/13 as ordered. * No BM 2/9/13-2/11/13 and no MOM given on 2/11/13 as ordered. * No BM 2/18/13-2/22/13 and no MOM was given on 2/20/13 as ordered, but no Dulcolax suppository given on 2/21/12 or Fleets Enema on	F 309		

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F 309	Continued From page 18 2/22/12 as ordered. 3. Resident #4 was readmitted to the facility on 11/8/12 with multiple diagnoses including urinary tract infection and delerium. Resident #4's Physician orders dated 11/8/12, documented the following: " Bowel medications should be offered on third day of no BM documented. * Milk of Magnesia: Give 30 ML orally as needed if no BM in 3 days for constipation. * If no results from MOM, give Dulcolax suppository (10MG) 1 rectally as needed for constipation. * If no results from Dulcolax, give Fleets Enema rectally as needed for constipation." Resident #4's November and December Bowel and Bladder Report and MAR documented the following: * No BM 11/19/12-11/24/12 and no MOM given on 11/21/23, no Dulcolax suppository given on 11/22/12, and no Fleets Enema given on 11/23/12 as ordered. * No BM 12/6/12-12/8/12 and no MOM given on 12/8/12 as ordered. * No BM 12/15/12-12/17/12 and no MOM given on 12/17/12 as ordered. 4. Resident #5 was admitted to the facility on 1/23/13 with multiple diagnoses including pressure ulcer stage III and hypertension. Resident #5's Standing Physician orders dated 1/23/13, documented the following: " Bowel medications should be offered on third day of no BM documented.	F 309		

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F 309	Continued From page 19 * Milk of Magnesia: Give 30 ML orally as needed if no BM in 3 days for constipation. * If no results from MOM, give Dulcolax suppository (10MG) 1 rectally as needed for constipation. * If no results from Dulcolax, give Fleets Enema rectally as needed for constipation." Resident #5's February Bowel and Bladder Report and MAR documented the following: * No BM 2/11/13-2/13/13 and no MOM given on 2/13/13 as ordered. * No BM 2/16/13-2/19/13 and MOM was given on 2/18/13 as ordered, but no Dulcolax suppository given on 2/19/13 as ordered. 5. Resident #8 was readmitted to the facility on 7/18/12 with multiple diagnoses including failure to thrive and multiple falls. Resident #8's Physician orders dated 7/18/12, documented the following: " Bowel medications should be offered on third day of no BM documented. * Milk of Magnesia: Give 30 ML orally as needed if no BM in 3 days for constipation. * If no results from MOM, give Dulcolax suppository (10MG) 1 rectally as needed for constipation. * If no results from Dulcolax, give Fleets Enema rectally as needed for constipation." Resident #8's February Bowel and Bladder Report and MAR documented the following: * No BM 2/8/13-2/10/13 and no MOM given on 2/10/13 as ordered. * No BM 2/21/13-2/25/13 and MOM was given on 2/23/13 as ordered, but no Dulcolax suppository	F 309		

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F 309	Continued From page 20 given on 2/24/13 as ordered. MOM was given again on 2/25/13. Similar findings were found for Resident 2, 6, and 9. The DON was interviewed on 2/28/13 at 9:48 AM regarding the lack of bowel orders being followed. The DON was asked to review a sample of all the residents in question, specifically, Resident #4 and Resident #6's Bowel and Bladder Report, Physicians orders, and the MAR. After the DON's review, she was asked to clarify if MOM is suppose to be given on the third day of no BM or on the fourth day, after three days without a BM, she said, "MOM on the third day." The DON also clarified the suppository is to be given on the fourth day, the enema on the fifth day, and the physician is to be called on the sixth day without a BM. The DON was asked if she felt staff understood the orders and the policy, she said, "We can clarify that policy." On 2/28/13 at 12:20 PM, the Administrator and DON were informed of the bowel care issues. No other information was provided by the facility.	F 309		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		4/4

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F 323	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and review of the facility's smoking policy, it was determined the facility failed to take the proper precautions regarding smoking, when a resident, who was assessed as needing supervision to smoke had access to smoking materials. This created the potential for harm when the facility failed to protect the resident's individual safety and the safety of other residents, family and visitors in the facility. This was true for 1 of 1 sampled residents reviewed for smoking (#8). In addition, the facility failed to ensure bathroom light bulbs had a protective covering in 3 of 13 rooms. This failed practice placed residents in those room at risk for potential harm if the bulbs came in contact with water and exploded. Findings included: 1. Resident #8 was admitted to the facility on 11/7/09, and readmitted on 7/18/12 with diagnoses including bipolar disorder and history of falls/multiple falls. The resident's quarterly MDS, dated 10/14/12, coded: * BIMS of 15 indicating cognitively intact * Required one person extensive assist for locomotion on and off the unit * Had one fall with injury (for example; skin tears, abrasions, lacerations) after the last assessment. (The last assessment was 7/22/12) The facility's Smoking Policy, effective 1/2006 and revised on 4/2012 and on 10/2012, documented, in part: * "...1. Residents admitted prior to the effective	F 323	To enhance currently compliant operations and under the direction of the Director of Nursing, re-education on the center's smoking policy will be completed. This will include the policies specific to the independent , as well as the dependent smoker. Resident #8 has been reassessed and continues to be a dependent smoker and does not have her smoking materials at bedside. Her husband has been educated to not bring in smoking materials and leave them with the resident. There have been no occasions of her trying to exit the building since the 12/2012 incident. All other center residents that smoke will be re-evaluated to insure they are in compliance with the center's smoking policy. The light covers were replaced during survey in all affected bathrooms. An audit of all bathrooms was completed and no further missing domes were identified. The Director of Nursing, or her designee, will conduct audits of all smoking resident's assessments and policy compliance weekly x4, then bi-weekly x4, then monthly x4 beginning 4/1/13. The Administrator, or designee, will complete audits of center light fixtures to ensure they are covered. Audits will occur weekly x4, bi-monthly x4, and monthly x4 beginning 4/1/13. Any deficiencies will be corrected immediately and audit results will be submitted at the quality assurance committee meeting for further review.	

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F 323	Continued From page 22 date of this policy and who are assessed as independent smokers may retain possession of their smoking materials if desires. In such circumstances a locked storage cabinet will be provided. * ...2. Resident assessed as being dependent with smoking may only smoke under staff supervision, in designated smoking areas and at times established by the Center." Resident #8's smoking assessment form, dated 10/14/12, documented that there were no changes to the sections evaluating medical history, smoking safety awareness or history of smoking related incidents and to "cont[inue] [with] dependent unless [with] spouse then may go out [with] him." Note: As stated in the policy above, because Resident #8 was assessed as a dependent smoker, she "may only smoke under staff supervision, in designated smoking areas..." Resident #8's Plan of Care included the problem, dated 9/30/12, "Resident requires assist in/out door to go smoke at this time due to increased weakness... Interventions included, "Smoking will be supervised by staff" and, "Assist resident in & out smoking door on East [with] general supervised smoking." Resident #8's Plan of Care also included the problem, dated 8/21/12, "Res[ident] resistive to cares (toileting, ADLs, DM [diabetes] management, diet, etc. [et cetera - and other things]). Interventions included, "Education r/t [related to] importance of cares, Back off & reapproach, Refer to SS [Social Services], Identify staff who work well [with] Res."	F 323		

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F 323	Continued From page 23 Resident #8's Resident Incident form, dated 12/10/12, documented the resident was "sitting on the sidewalk on south side of building surrounded by several staff members who had responded to resident's fall. Resident's face was bleeding and there was a large bruise on forehead. ... Resident stated that she had exited the building to smoke a cigarette and had fallen forward out of chair after her smoke. Resident is not an independent smoker and is aware of this. Cigarettes removed from resident,s (sic) possession and instructed that she must be supervised to smoke." The resident's Incident form documented, under Investigation Summaries, "...Resident is noncompliant with many ADLs. ...On day of event resident took self to undesignated area to smoke while in wheelchair. She had dropped her lighter, leaned down to pick it up, and fell forward. Incident occurred at front entrance of building. [Note: The front entrance of the facility had an automatic door that could be activated from a wheelchair by pressing a large round button.] Resident assessed and care planned as supervision with smoking due to not being able to safetly (sic) go in and out door safely to designated smoking area. resident (sic) choose (sic) to go out other door and smoke at undesignated times. Cigarettes are now to be kept at nurses station to decrease risk of reoccurance (sic) of unsupervised fall and/or injury." On 2/28/13 at 10:00 am, the DON was asked how Resident #8 obtained cigarettes if she was dependent on staff for smoking and needed supervision. The DON stated, at first, that the	F 323		

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F 323	Continued From page 24 resident's significant other probably brought them in to the resident and "she got out the front door and was out there smoking unsupervised." The DON stated that the investigation did not specifically say the significant other brought in the cigarettes. (Refer to F225). The DON said she would do more research to find out how the resident obtained her own cigarettes. At 10:20 am, the DON stated the Resident Care Manager at the time of the incident said that, "[Resident #8] kept her cigarettes at her bedside. All she needed was help to get out the door." The DON stated that staff sat with the resident while she smoked so that they could assist her into the building. She stated that the only barrier to smoking was "opening and closing the door." On 2/28/13 at 11:05, the Administrator was asked if a resident was a dependent smoker, can that resident have cigarettes at the bedside? Without hesitation, he responded, "No." He said if you were a dependent smoker, you were dependent on the staff for smoking materials and supervision. The facility failed to ensure the safety of Resident #8, who was noncompliant with activities of daily living, had a history of falls and was assessed as a "dependent smoker," when they allowed the resident to have access to smoking materials in her room and she, subsequently, let herself out of the facility, smoked in an undesignated area without supervision and fell. On 2/28/13 at 12:20 pm, the Administrator and DON were informed of the issue. The facility provided no other information or documentation	F 323		

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F 323	Continued From page 25 that resolved the concern. 2. On 2/25/13 at 3:15 PM, during the initial tour of the facility, the bathroom ceiling lights in rooms 59, 54, and 62 were observed. The light fixtures did not have a protective globe covering over them, exposing the CFL light bulb to potential damage from water and other elements. On 2/25/13 at 3:15 PM, RN Unit Manager #1 accompanied the surveyor during the initial tour, who also noticed the exposed lights in the bathrooms and indicated she would call maintenance immediately, where upon she asked another employee to contact maintenance for her. At 3:35 PM, RN Unit Manager #1 told the surveyor, "Those globes are already up." (Referring to the exposed light bulbs.) On 2/27/13 at 4:55 PM, the Administrator and DON were informed of the issues. No further information was provided.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.	F 325		4/4

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F 325	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review and review of the facility's Nutrition policies, it was determined the facility did not identify a weight loss trend and failed to evaluate the effectiveness of their interventions after the resident's weight loss became significant. This failed practice created the potential for the resident to experience a compromised nutritional status. This impacted 1 of 3 sampled residents reviewed for weight loss (#5). Findings included: The facility's policy on Weight Monitoring, effective 4/2010, documented, in part: * "...CNA Responsibilities: - ...3. Weigh the resident weekly for four weeks and/or until the weight is determined to be stable by the interdisciplinary team following admission and readmission. - 4. Weigh the resident monthly to monitor stability. - 5. Report the weight to the Licensed Nurse... * Licensed Nurse Responsibilities: - 1. Verify accuracy of the weight by comparing the weight with the most recently recorded weight. - 2. Compare weights using the Weight Change Grid to determined 3% weight change. - ...4. Monitor weight reports for significant changes and for gradual insidious changes that may indicate a risk factor for nutrition... - ...6. Report changes of 3% or more on the 24 hour report for review in the Daily Triage Meeting and possible follow-up at the Daily Clinical Review Meeting	F 325	It is the policy of Ivy Court to maintain each resident's nutritional status, unless unavoidable. To enhance currently compliant operations and under the directon of the Director of Nursing, re-education on the weight monitoring policy will occur. This policy outlines the roles and responsibilities of the appropriate team members in identifying weight loss and evaluating interventions once implemented. Resident #5's weight loss has stabelized and she is slowly gaining weight. The RD will follow weekly x 8 weeks then bi-monthly x 8, then monthly x 4. Weight reports for all center residents will be evaluated for significant or near significant weight loss with appropriate interventions implemented per RD / policy. The Director of Nursing , or designee, will review the Significant Weight Change report at least three days per week x 4 weeks, then bi-monthly x 4, then monthly x 4 beginning 4/1/13 and insure appropriate referrals occur. She will also follow up within five days after a referral is made to insure the RD and the Dietary Manager have assessed the weight loss and intervened as appropriate. Any deficiencies will be corrected immediately, and the findings of the audits will be submitted at the quality assurance committee	

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F 325	Continued From page 27 - ...7. Notify the Registered Dietitian (RD) using the Dietitian Referral Log. * Nutrition Services Manager Responsibilities - 8. Review significant weight change reports daily for review in Daily Triage Meeting. - 9. Review the weight reports at least weekly to assure that all residents with significant weight change are reviewed and assessed for nutrition risk factors." Resident #5 was admitted to the facility on 1/23/13 with diagnoses including Stage II and Stage III pressure ulcers and Barrett's esophagitis. The resident's admission MDS assessment, dated 1/30/13, coded: * BIMS of 14 indicating cognition intact * Depression score of 7 indicating mild depression * Required one person to set-up meals and to cue and/or encourage eating during meals * Height - 62 inches * Weight - 113 pounds * One Stage II pressure ulcer * One unstageable pressure ulcer Resident #5's Nutrition Risk Data Collection and Assessment form documented notes from the dietitian: * 1/25/13: "...admitted [with] pressure ulcers...had [increased] kcal [caloric]...needs...current po [oral intake at] 75%...Plan-...2. Add enhanced foods...3. Med Plus [MP] 2.0, 90 cc BID [90 cubic centimeters twice a day]...wkly wts x 4 wks [weekly weights for 4 weeks] * 2/4/13: "...po [decreased] to 61%. Request new	F 325		

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F 325	Continued From page 28 weight...Will [increase] MP 2.0 to 90 cc QID [four times a day]" * 2/6/13: "...at admit, 113.10 (1/28), 2/5 - 109.50 - MP 2.0 [increased] 2/4, po 60-65%...total po of foods & supplements should be adequate for healing and wt maintenance. Wkly wts. The dietitian had no further notes recorded on the Nutrition Risk Data Collection and Assessment form until 2/18/13. There was no documented evidence in Resident #5's record that the CDM evaluated the resident. Resident #5's Weights Detail Report recorded the following weights in pounds: * 1/24/13: "Enter the resident's admission weight in pounds - 111.4 * 1/28/13: 113.1 * 2/5/13: 109.5 * 2/11/13: 103.9 * 2/19/13: 104 * 2/26/13: 106.5 Note: Between 2/5/13 and 2/19/13, Resident #5 had a significant weight loss of 5.5 pounds or 5% in 14 days. Resident #5's MAR documented the resident received Med Plus 2.0, 90 cc, 4 times a day starting 2/5/13 until 2/12/13. On 2/14/13 and 2/15/13 (2 days), the resident refused the evening and bedtime doses of Med Plus. On 2/15/13 to 2/18/13 (4 days), the resident refused all doses of the Med Plus. Resident #5's Meal Intake Detail Report form documented the following meal intakes for the 14 days from 2/5/13 and 2/18/13:	F 325		

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F 325	Continued From page 29 * Breakfast Intake: - Refused all or most (0-25%) on one day (2/8), - Ate less than half (26-49%) on 6 days (2/5, 2/7, 2/11-2/13, 2/17) - Ate half or more than half (50-75%) on 5 days (2/6, 2/14-2/16, 2/18) * Lunch Intake: - Refused all or most (0-25%) - Ate less than half (26-49%) on 2 days (2/10, 2/11) - Ate half or more than half (50-75%) on 8 days (2/5-2/9, 2/12, 2/14, 2/16) * PM (afternoon) Snack / Supplement - % of afternoon snack consumed - Refused all or most (0-25%) on 14 days (2/5 - 2/18) * Dinner Intake: - Refused all or most (0-25%) on 3 days (2/6, 2/7, 2/17) - Ate less than half (26-49%) on 4 days (2/5, 2/10 - 2/12) - Ate half or more than half (50-75%) on 3 days (2/8, 2/15, 2/18) * HS Snack / Supplement - % of HS snack intake - Refused all or most (0-25%) on 14 days (2/5 - 2/18) Resident #5's nursing Progress Notes did not document any information regarding diet, meal consumption, weights or any other nutritional information from 2/5/13 to 2/12/13. On 2/13/13 at 10:10 pm, an entry documented, "...Good appetite..." On 2/16/13 at 1:00 pm, an entry recorded, "...OOB for meals [out of bed for	F 325		

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F 325	Continued From page 30 meals]..." On 2/27/13 at 1:30 pm, the RD and CDM were interviewed regarding Resident #5's weight loss from 2/5/13 to 2/18/13 and the process for recognition and interventions regarding weight loss. The RD agreed that Resident #5 was losing weight during this time. She stated that any significant weight loss of 3% in a week should be recorded on the Dietitian/DT Referral Log. That log, dated from 1/30/13 to 2/20/13, was provided by the RD. There was no record of Resident #5's name on the log. She acknowledged she did not see the resident from 2/7/13 until she reevaluated the resident on 2/18/13. She stated that nurses on the IDT team can call the physician and implement nutritional interventions. She reviewed Resident #5's record and said that there was no documentation the nurses notified the physician or recorded a nursing note regarding the weight loss, but that she could not speak for the nursing staff. The RD said that on her visit on 2/18/13, she found out the resident's intake was about 65% and that she was refusing her Med Plus supplement. The RD said she changed the supplement to Ensure based on an interview with the resident. She stated that if the resident's oral intake was low, the resident's preference list should be reevaluated. The CDM said that sometimes weight loss issues were presented at the "morning meeting," but that she does not attend those meetings. She said that sometimes nurses take care of weight loss issues. She was not able to provide any documentation that she reviewed and evaluated	F 325		

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F 325	Continued From page 31 Resident #5 or the resident's preference list during the time the resident was losing weight. On 2/27/13 at 2:30 pm, RCM #2 and RCM #3 were asked about Resident #5's weight loss during the time period 2/5/13 to 2/18/13 and the use of the Dietitian/DT Referral Log to report weight loss. RCM #1 stated, "Honestly, I've never seen that before." RCM #3 said that the Log was used to report to the RD a 3% weight loss in one week, then "we have a weight loss meeting and look into the weight loss." She said the IDT also discussed resident weight loss. RCM #3 was asked for all the documentation that this process was followed to address Resident #5's weight loss. On 2/27/13 at 4:15 pm, RCM #1 and RCM #2 were interviewed regarding Resident #5's weight loss. RCM #1 said she, in general, addressed a weight loss of 3% in one month for any resident by involving the RD and the CDM. She said the IDT team meets every week and reviews the weight loss issues. She said the RD and CDM tried to be at the weekly meetings but neither of them may attend. The RCMs did not provide any documented evidence that the facility's weight monitoring process was followed for Resident #5. RCM #s 1, 2 and 3 were unable to provide any documented evidence that Resident #5's weight loss from 2/5/13 to 2/18/13 was addressed according to the facility policy. From 2/5/13 to 2/18/13 Resident #5: * Had a 5% weight loss * Refused her Med Plus supplement starting on 2/13/13.	F 325		

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F 325	Continued From page 32 * Ate less than 75% of her meals most of the time and refused all afternoon and bedtime snacks There was no documented evidence that from 2/7/13 to 2/17/13: * The 5% weight loss was reported to any committee and/or team, such as the IDT team or Weight Loss Committee, for review and possible interventions. * The weight loss was reported to the RD by the LN. * The weight loss was recorded on the Dietitian / DT Referral Log. * The CDM reviewed and assessed Resident #5 for nutritional risk factors. On 2/28/13 at 12:20 pm, the Administrator and DON were informed of the weight loss issue. The facility provided additional information via faxed documents on 3/1/13 at 4:00 pm. The additional information was reviewed, but did not resolve the issue.	F 325		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not	F 329		4/4

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F 329	Continued From page 33 given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility did not ensure a resident was free from unnecessary drugs. This was true for 1 of 13 residents (Resident #4) reviewed for medication use, and had the potential to cause harm to the resident if he continued to receive more than double the ordered medication. Findings included: Resident #4 was readmitted to the facility on 11/8/12 with multiple diagnoses including vasculitis and chronic basic pain. The resident's Physician orders dated 11/21/12, documented to give a 5 MG tablet of Prednisone and a 10 MG tablet of Prednisone every morning. The resident's Physician's Telephone Orders dated 1/7/13, documented, "DC (discontinue) Prednisone 15 mg & start Prednisone 10 mg QD (every day)." The resident's February 2013 MAR, documented	F 329	It is the policy of Ivy Court to ensure drug regimens are free from unnecessary drugs. To enhance currently compliant operations and under the direction of the Director of Nursing, licensed staff will be re-educated on the medication pass policy. Resident #4 has experienced no adverse response .All residents MAR'S will be audited to check for errors. Resident #4's only card of 5mg Prednisone was located and there were no doses removed from it which would indicate the error was in documentation rather then actually administering the 5mg tablet. The Director of Nursing, or designee, will audit all MAR'S for errors weekly x 4, then bi-monthly x 4, then monthly x4 beginning 4/1/13. Any deficiencies will be corrected immediately and audits will be submitted at the quality assurance committee meetings for further review.	

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F 329	Continued From page 34 the 1/7/13 order hand written on the MAR, "Prednisone 10 mg p.o. (by mouth) QD" and also contained the 11/21/12 orders with a hand drawn line through them with a hand written, "DC" next to the order. There was no date indicating when the note was made. The resident's February 2013 MAR, documented on 2/4/13, the resident received the ordered 10 mg of Prednisone and also received an additional 10 and 5 mg from the discontinued order, two and a half times the indicated dose. On 2/28/13 at 9:55 AM, the DON was interviewed regarding the excessive dosage issue. When asked to review the February MAR, she stated, "What I think I see on the 4th, he got a 5 and a 10 (mg) and then another 10...On the 4th they [sic] got quite the dose of Prednisone." On 2/28/13 at 12:20 PM, the Administrator and DON were informed of the issue. No other information was provided by the facility.	F 329		
F 368 SS=E	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime,	F 368		4/4

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F 368	Continued From page 35 up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by: Based on resident group interview and staff interview it was determined residents were not consistently offered a bedtime snack, specifically residents in the South hall. This affected all residents who were not offered a bedtime snack, including 8 of 10 residents in the resident group interview. This had the potential for harm because the residents may be hungry and not get the opportunity for a snack. Lack of a bedtime snack may result in altered nutritional status of residents. Findings included: During the resident group interview on 2/26/13 at 1:30 PM, eight residents at the meeting voiced the staff do not offer snacks to them after dinner before bedtime. The two who did receive snacks indicated they received a snack after they asked a staff member. On 2/27/13 at 2:30 PM, CNA #4 (who primarily works evening shift in the North hall) was interviewed and asked if they routinely asked residents if they want a bedtime snack. CNA #4 said, "We always ask residents if they want a snack." On 2/27/13 at 2:33 PM, CNA #5 (who primarily works evening shift in the East hall) was interviewed and asked if they routinely asked	F 368	It is the policy of Ivy Court to offer snacks at bedtime. To enhance currently compliant operations and under the direction of the Director of Nursing, staff will be re-educated on the bedtime snack policy. Residents not offered a bedtime snack are affected and staff received re-education on the expectation of offering a bedtime snack at the time the DON was made aware of this concern during the survey. The caring partners have since asked their assigned residents during their rounds about bedtime snacks and all have reported they are now being offered these snacks. The Director of Nursing, or designee, will audit the Group Meal Intake report every week x 4 weeks, bi-monthly x 4, then monthly x 4 to verify residents are being offered and receiving bedtime snacks beginning 4/1/13. Any deficiencies will be corrected immediately and the findings of the audits will be submitted at the quality assurance committee meetings for further review or corrective action.	

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F 368	Continued From page 36 residents if they want a bedtime snack and she said they ask each night. On 2/27/13 at 2:36 PM, CNA #6 (who primarily works evening shift in the South hall) was interviewed and asked if they routinely asked residents if they want a bedtime snack. CNA #6 said, "If they ask for it we get them something." The Dietary Manager was interviewed on 2/27/13 at 4:07 PM and she indicated snacks are brought to the nurses station fridge daily and she checks the fridge herself to see what foods the kitchen needs to restock. She also indicated the CNA's were responsible for handing out the snacks to the residents each day. The DON was interviewed on 2/27/13 at 4:12 PM regarding the bedtime snack issue. When asked about the resident group compliant, she said, "I would assume they are getting them (snacks)." She then printed up the previous night's, Group Meal Intake and Total Fluid Chart, which documented, 24 out of 28 residents on South hall did not receive an evening snack. The surveyor then asked for the report from 2/20/13 to 2/26/13, which documented 21 out of 28 residents on South hall did not receive an evening snack anytime in that period. When told about the South hall CNA comment, she said, "I can fix that right now." The DON was then observed typing comments in the facility internal message board about evening snacks. The DON explained the message board is reviewed by staff when they clock into the computer system at the start of their shift. On 2/27/13 at 4:55 PM, the Administrator and	F 368		

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F 368	Continued From page 37 DON were informed about the evening snack issue. No further information was provided by the facility.	F 368		
F 518 SS=D	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on policy review and staff interviews, it was determined the facility failed to ensure all employees were sufficiently trained in emergency procedures. This was true for 1 of 3 employees (CNA #13) who were interviewed about emergency procedures. This resulted in the potential for employees to respond inappropriately to an emergency event. The findings included: 1. The facility's Policy and Procedure Manual, revised 11/12, documented the following regarding the subject: "Loss of Electricity 1. The red covered outlets in the hallways are connected to the emergency generator. If any medical equipment is required, obtain extension cords and plug into the red outlets." On 2/27/13 at 8:45 am, CNA #13 was asked what she would do in the event of a power outage. She stated there was a book at the nurses station that would tell her what to do. She stated she would also call maintenance because there was a	F 518		4/4

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F 518	Continued From page 38 "generator or something." She finally said, "I don't know to be really honest with you." After the interview, CNA #13 came back and stated she read the book at the nurses station and she now knows how to turn the generator on in the event of a power outage. CNA #13 was informed that the policy did not entail turning the generator on. 2. The facility's Policy and Procedure Manual, revised on 11/12, documented the following regarding the subject: "Intruders - Out of Control Persons (staff or visitor), ...2. Announce a "Code Grey" giving the location of the individual over the intercom. ..." On 2/27/13 at 8:45 am, CNA #13 was asked what she would do if a staff member lost control of him/herself in the facility. She stated she would make sure residents were safe and then "get hold of the manager." She said she would alert other staff by "using the intercom" and "asking for help" and "calling a Code Green." On 2/27/12 at 4:55 pm, the Administrator and DON were informed of the issue. The facility provided no other information or documentation that resolved the concern.	F 518	It is the policy of Ivy Court to ensure staff are aware of emergency procedures. To enhance currently compliant operations and under the direction of the Administrator, staff will be re-educated on emergency procedures. This cited deficiency has the potential of affecting all center residents. There have been no adverse outcomes related to this cited deficiency. The Administrator, or designee, will complete staff interviews on all three shifts questioning staff on emergency procedures. Interviews will include at least six staff each time and be completed weekly x 4, bi-monthly x 4, then monthly x4 beginning 4/1/13. Any deficiencies will be corrected immediately and audit results will be submitted at the quality assurance committee meetings for further review or corrective action.	

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C 000	16.03.02 INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiencies were cited during the annual licensure survey of your facility. The surveyors conducting the survey were: Lynda Evenson, BSN, RN - Team Coordinator Ashley Anderson, QMRP Bradley Perry, LSW	C 000		
C 125	02.100,03,c,ix Treated with Respect/Dignity ix. Is treated with consideration, respect and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; This Rule is not met as evidenced by: Refer to F241 regarding staffs failure to knock when entering resident rooms.	C 125	see F241	4/4/13
C 170	02.100,12,c,ii Factual Description of Incident/Accident ii. A factual description of the incident or accident; This Rule is not met as evidenced by: Refer to F225 & F226 related to lack of thorough investigations and an insufficient abuse policy.	C 170	see F 225 226	4/4
C 243	02.106,05 ORIENTATION, TRAINING & DRILLS 05. Orientation, Training and Drills. All employees shall be instructed in basic fire and life	C 243		4/4

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE 3/22/13

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C 243	Continued From page 1 safety procedures. This Rule is not met as evidenced by: Please refer to F518 regarding employee training on emergency procedures.	C 243	see 7518	4/4
C 297	02.107,05,a Bedtime Snacks a. Bedtime snacks of nourishing quality shall be offered, and between-meal snacks should be offered. This Rule is not met as evidenced by: Refer to F368 regarding no bedtime snacks offered.	C 297	see 7368 It is the policy of Ivy Court to have required attendees at the Infection Control Committee meetings. To enhance currently compliant operations and under the direction of the Administrator, the center's Maintenance Director will attend all future Infection Control meetings. The cited deficiency has the potential of affecting all residents, staff and visitors. No adverse outcomes have been noted as a result of the cited deficiency. The Administrator will insure that beginning on 4/1/13, all required members of the Infection Control Committee attend the monthly meetings.	4/4
C 664	02.150,02,a Required Members of Committee a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative. This Rule is not met as evidenced by: Based on staff interview and review of the Infection Control Meeting Minutes, it was determined the facility did not ensure the Maintenance Supervisor attended the Infection Control Committee. This had the potential to affect all residents, staff and visitors in the facility. Findings included: On 2/28/13 at 7:55 am, the Infection Control Chairperson was interviewed. She said that during the Infection Control meeting, Infection Control data was presented and discussed. The Infection Control Chairperson indicated the Maintenance Supervisor did not attend the meetings, but could be invited to the	C 664		4/4

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C 664	Continued From page 2 meetings and said, "We can do that." On 2/28/13 at 10:00 am, the Administrator provided the Quality Performance Improvement Meeting attendance sheets (which is part of the same meeting for Infection Control) for 12/18/12, 1/9/13, and 2/11/13. The Maintenance Supervisor signature was not on any of the attendance records. The Administrator and DNS were informed of the finding on 2/28/13 at 12:20 p.m. The facility provided no other information or documentation that resolved the concern.	C 664		
C 787	02.200,03,b,iii Fluid/Nutritional Intake iii. Adequate fluid and nutritional intake, including provisions for self-help eating devices as needed; This Rule is not met as evidenced by: Refer to F325 regarding weight loss issues.	C 787	Rec 7 325	4/4
C 788	02.200,03,b,iv Medications, Diet, Treatments as Ordered iv. Delivery of medications, diet and treatments as ordered by the attending physician, dentist or nurse practitioner; This Rule is not met as evidenced by: Refer to F309 regarding lack of medication for bowel care. Refer to F329 regarding excessive dosage of medication.	C 788	Rec 7 309 329	4/4
C 790	02.200,03,b,vi Protection from Injury/Accidents vi. Protection from accident or	C 790		4/4

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C 790	Continued From page 3 injury; This Rule is not met as evidenced by: Refer to F323 regarding exposed light bulbs amd resident supervision.	C 790	See F323	