



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

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BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0009  
PHONE 208-334-6626  
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FILE COPY

CERTIFIED MAIL: 7012 1010 0002 0836 1734

April 9, 2014

Gary L. Liesner, Administrator  
Ivy Court  
2200 Ironwood Place  
Coeur d'Alene, ID 83814-2610

Provider #: 135053

Dear Mr. Liesner:

On **March 28, 2014**, a Recertification, Complaint Investigation and State Licensure survey was conducted at Ivy Court by the Idaho Department of Health and Welfare, Division of Licensing and Certification, 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 an isolated deficiency that constitutes actual 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 the 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 **April 22, 2014**. Failure to submit an acceptable PoC by **April 22, 2014**, may result in the imposition of civil monetary penalties by **May 12, 2014**.

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 will you make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice does 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 have 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 (X5).

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.

Gary L. Liesner, Administrator  
April 9, 2014  
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- 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 **May 2, 2014 (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 **May 2, 2014**. A change in the seriousness of the deficiencies on **May 2, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **May 2, 2014** includes the following:

Denial of payment for new admissions effective **June 28, 2014**. [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 **September 28, 2014**, 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 Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; 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 **March 28, 2014** and continue until substantial

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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 **April 22, 2014**. If your request for informal dispute resolution is received after **April 22, 2014**, 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, comments or concerns, please contact Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care at (208) 334-6626.

Sincerely,



DAVID SCOTT, R.N., Supervisor  
Long Term Care

DS/dmj  
Enclosures

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

PRINTED: 04/09/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135053</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>03/28/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>IVY COURT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2200 IRONWOOD PLACE</b> <b>COEUR D'ALENE, ID 83814</b>	
(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	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the Recertification and Re-licensure survey and complaint investigation of your facility.</p> <p>The survey team included:</p> <p>Nina Sanderson, LSW BSW - team coordinator Karen Marshall, MS RD LD Lauren Hoard, RN BSN</p> <p>The survey team entered the facility on Monday 3/24/14 and exited Friday 3/28/14.</p> <p>Survey Definitions:</p> <p>ADLs = Activities of Daily Living CBC = Complete Blood Count CM = Centimeters CMP = Comprehensive Metabolic Panel CNA = Certified Nurse Aide C&amp;S = Culture &amp; Sensitivity DNS/DON = Director Nursing Services / Director of Nursing DX = Diagnosis ER = Emergency Room FDA = Food and Drug Administration LE = Lower Extremity/ies LN = Licensed Nurse MAR = Medication Administration Record MD = Medical Doctor MDS = Minimum Data Set Assessment ORIF = Open Reduction Internal Fixation RCM = Resident Care Manager TAR = Treatment Administration Record / Treatment Record</p>	F 000	<p>This plan of correction constitutes this center'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 this inspection report.</p>	
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE	F 176		

**RECEIVED**  
**MAY - 5 2014**  
**FACILITY STANDARDS**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

**NHA**

(X8) DATE

**5/5/14**

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 176	<p>Continued From page 1</p> <p>An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure residents were assessed by the IDT team as safe to have physician ordered medications in the resident's room. This affected 1 of 9 (#9) sampled residents. This failure created the potential for the resident to not receive the medication as ordered by the physician. Findings included:</p> <p>Resident #9 was admitted to the facility with multiple diagnoses including osteoporosis.</p> <p>The resident's 1/1/14 annual MDS coded cognition intact and required one person extensive assistance for dressing, personal hygiene, and bathing.</p> <p>The resident's 1/4/14 "Self-Medication Data Collection and Assessment" form documented, in part, under the section titled Assessment Results... "Res. [resident] does not wish to self medicate..."</p> <p>The resident's Skin Integrity Care Plan identified, "Problem, 3/21/14 "Yeast [under] breasts...goal, 3/21/14, Yeast [under] breasts will resolve [without] complications." The two interventions were, "3/21/14 See TAR and Interdry sheets to area under breasts."</p>	F 176	<p>It is the policy of Ivy Court to allow residents to self-administer medications if this practice is determined to be safe.</p> <p>To enhance currently compliant operations and under the direction of the Director of Nursing, nursing department staff have been re-educated on self-medication policies and procedures.</p> <p>Resident # 9 has completed a self-medication assessment. The spray in question has been secured in the nurse's cart and is applied by licensed staff only.</p> <p>Since all residents may be affected by the cited deficiency, self-medication assessments have been completed on residents identified as able and desiring to participate in a self-medication program. Residents in a self-medication program will be monitored for accuracy of delivery daily, Monday-Friday, for 30 days then weekly for 8 weeks by the DON or her designee beginning 4/25/14. Any deficient practice will be corrected immediately and audit results will be presented to the QAPI committee monthly x3 for tracking and trending.</p>	4/30

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F 176	Continued From page 2  The resident's Physician's Telephone Orders (PTOs) contained an order, "3/24/14, diagnosis yeast, Coloidal Silver Spray [CSS] - may use home supply to affected skin area BID [two times a day], Interdry sheets to area under breasts..."  On 3/25/14 at 9:10 a.m., the surveyor observed a pink plastic spray bottle with the handwritten words on the bottle, "Colidal {sic} Silver [CSS]..." The bottle contained a clear liquid and was located on the seat of the chair next to the resident's bed. The resident was sitting in a wheelchair (wc) next to the bed. CNA #1 applied the CSS and the Interdry sheets to the underside of the resident's breasts.  Note: Please refer to F492 as it related to the administration of physician ordered medications by a CNA.  On 3/25/14 at approximately 1:00 p.m., the surveyor interviewed CNA #1 and asked why he sprayed the CSS under the resident's breasts. The CNA stated, "[Resident #9] asked me to."  On 3/28/14 at 11:30 a.m., the Administrator and DON were informed of the concern. The facility did not provide any additional information.	F 176			
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS  The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.	F 221			

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F 221	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, staff interview Policy and Procedure review and record review, it was determined the facility failed to:</p> <ul style="list-style-type: none"> <li>* Identify medical symptoms for the use of restraints;</li> <li>* Assess residents for reducing the use of restraints; and,</li> <li>* Evaluate residents to assure the least restrictive device was used.</li> </ul> <p>In addition, the facility failed to follow it's own policy for evaluating and reducing the use of restraints.</p> <p>The facility used a seatbelt to restrain a resident in their wheelchair without identifying a medical symptom to be treated, without attempting alternative interventions, without assessing the seatbelt to be the least restrictive, and without making attempts to reduce use or to remove the seatbelt. This was true for 1 of 2 (#6) sampled residents reviewed for seatbelts. The failed practice created potential for harm as residents could potentially slide down in their chairs and be strangled by the restraint. In addition, the residents who are restrained may experience a reduction in independence, functional capacity, and quality of life. Findings included:</p> <p>The Safety Device Program Policy and Procedure, dated 1/2009 and revised 1/2010 and 1/2011, documented in part:</p> <ul style="list-style-type: none"> <li>* "The least restrictive safety device will be applied for the shortest duration of time to assist the resident in reaching their highest level of physical and psychosocial well-being... The center will demonstrate and document the presence of specific medical symptoms(s) that requires the</li> </ul>	F 221	<p>It is the policy of Ivy Court to never utilize physical restraints for discipline or convenience, and if not required to treat the resident's medical symptoms.</p> <p>To enhance currently compliant operations and under the direction of the Director of Nursing, staff have been re-educated on the Safety Device Program policies and procedures.</p> <p>Resident #6 has been reassessed and her self-release seat belt has been removed from her wheelchair. Since the seat belt in question is held together with a thin piece of Velcro, there was no reduction in the resident's independence, functional capacity, quality of life or any chance of it strangling the resident.</p> <p>Since all residents using a self-release seat belt for safety are potentially affected by the cited deficiency, the Director of Nursing or her designee will audit all residents utilizing self-release seat belts to ensure they are appropriate, least restrictive and being monitored per policy. Audits of residents utilizing self-release seat belts will be completed by the DON or her designee twice a day, Monday through Friday, for 30 days, then daily for 2 weeks, then weekly for 4 weeks beginning 4/25/14. Any deficient practice will be corrected immediately, and the findings will be submitted to the QAPI committee x 3 months for tracking and trending.</p> <p style="text-align: right;">4/30</p>

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F 221	<p>Continued From page 4</p> <p>use of the safety device to treat the cause of the symptom. The Interdisciplinary Team (IDT) will assess medical symptoms by evaluating resident condition, circumstances, and environment...3. Complete and/or review the Safety Device Data Collection for any resident showing potential need for or using a safety device.</p> <p>a. Identify the medical symptom being treated by the safety device.</p> <p>b. What will the safety device do to improve self function?</p> <p>c. Determine type of least restrictive safety device required.</p> <p>d. Determine if the safety device is a physical restraint.</p> <p>e. Determine when the safety device will be used.</p> <p>f. Determine shortest interval of application needed to meet goal.</p> <p>g. Plan for safety device reduction/release. 4. Obtain a physician's order for the safety device that includes the following:</p> <ul style="list-style-type: none"> <li>* Medical symptoms requiring safety device use</li> <li>* Type of safety device</li> <li>* Length of time safety device is to be used</li> <li>* Plan for safety device reduction/release... 12.</li> </ul> <p>Provide training to staff on safety device application and release as needed.</p> <ul style="list-style-type: none"> <li>* Check and release restraining safety device at least every two hours and PRN." </li></ul> <p>Resident #6 was admitted to the facility on 11/15/12 and readmitted on 4/3/13 with multiple diagnoses which included Lewy body dementia and depression with psychosis.</p> <p>Resident #6's quarterly MDS Assessment, dated 10/7/13, coded in part:</p> <ul style="list-style-type: none"> <li>* BIMS score of 11 indicating moderately impaired cognition;</li> </ul>	F 221			

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F 221	<p>Continued From page 5</p> <ul style="list-style-type: none"> <li>* Extensive assistance needed with 2 or more people for bed mobility, transfers, dressing and toilet use;</li> <li>* Extensive assistance needed with 1 person for locomotion on and off the unit, personal hygiene, and bathing;</li> <li>* Walking in room and corridor did not occur;</li> <li>* Two or more falls with minor injury since admission or prior assessment; and,</li> <li>* Restraint was not coded.</li> </ul> <p>Resident #6's most recent quarterly MDS assessment, dated 1/3/14, coded in part:</p> <ul style="list-style-type: none"> <li>* BIMS score of 10 indicating moderately impaired cognition;</li> <li>* Extensive assistance needed with 2 or more people for bed mobility, transfers, dressing and toilet use;</li> <li>* Extensive assistance needed with 1 person for locomotion on and off the unit, personal hygiene, and bathing;</li> <li>* Walking in room and corridor did not occur;</li> <li>* One fall with no injury since admission or prior assessment; and,</li> <li>* Restraint was not coded.</li> </ul> <p>The Fall/Injury Care Plan documented Resident #6 required general supervision. Note: The Care Plan had a date column which documented a range of dates from 4/8/13 through 1/12/14, making it unclear when the intervention of general supervision was check marked on the Care Plan.</p> <p>The Safety Device Plan of Care for Resident #6 documented in the Problem column, "Self Release seatbelt when [up] in w/c [.] Poor Safety Awareness [.] Weakness." The Interventions column documented, "Apply Safety Device (date)</p>	F 221		

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F 221	<p>Continued From page 6</p> <p>10/7/13[,] Type: Self release seatbelt when [up] in w/c. Medical Symptoms: Poor Safety awareness/weakness." The Intervention column had an area for "Safety device Reduction" and "Safety Device Release." However, those areas were left blank.</p> <p>Note: The Care Plan had a date column which documented a range of dates from 4/8/13 through 1/24/14, making it unclear when Problem areas were added to the Care Plan.</p> <p>The March 2014 recapitulation Physician Orders documented, "SELF RELEASE SEATBELT WHEN UP IN WHEELCHAIR DUE TO POOR SAFETY AWARENESS" with a date of 10/7/13.</p> <p>A Safety Device Date Collection (SDDC) form for Resident #6, dated 10/7/13, documented:</p> <ul style="list-style-type: none"> <li>* Type of Safety Device: "self release seatbelt, when [up] in w/c"</li> <li>* Will improve self-function to, "remind res[ident] to ask for assist/ [increase] safety"</li> <li>* Medical Symptom treated: "Has Poor Safety Awareness"</li> <li>* Past Interventions: Blank</li> <li>* Resident could easily remove safety device and was cognitively aware</li> <li>* Not used as a restraining safety device (physical restraint)</li> <li>* If not a physical restraint what does the safety device enable: Blank</li> <li>* Describe when safety device will be used: "when res[ident] is [up] in w/c. Res[ident] observed [and] assessed [and] found to be safe [with] use. [No] entrapment risk noted."</li> <li>* Safety Device Reduction Plan: PRN [as needed]</li> <li>* Describe when physical restraint safety device will be used: Blank</li> </ul>	F 221		
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(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 221	<p>Continued From page 7</p> <p>* Restraining Safety Device Reduction/Release Plan: Blank.</p> <p>The back side of the SDDC form included an area for quarterly reviews which documented on 1/12/14;</p> <p>* "Restraining Safety Device/Safety Device Reduction Warranted?" There was an area to check mark a box yes or no. The "No. If no, why does current safety device continue to meet resident's needs?" was check marked and documented, "Conts [continues] to meet res[ident] needs when [up] in w/c for [increased] safety. To remind res[ident] to call for assist if needed. res[ident] observed [and] assessed [and] found to be safe [with] used [no] entrapment risk noted."</p> <p>A note written from a Physician's Assistant at a local Neurological clinic, dated 1/6/14, documented in part, "To Whom it May Concern... [Resident name]'s Dementia with Lewy Bodies has been well documented, not only her diagnosis but her cognitive function. We have tracked her cognitive decline with neurocognitive testing in our office. On the last testing that was performed she was noted to have cognitive impairment placing her in the range, approximately, of an 8 to 12-year-old."</p> <p>The following observations were made of Resident #6 with the seatbelt secured:</p> <p>* 3/24/14 at 1:38 p.m., the resident was observed sitting in her room in her wheelchair with the seatbelt secured around her waist;</p> <p>* 3/25/14 at 10:40 a.m., the resident was observed sitting in her room in her wheelchair the seatbelt secured around her waist. When asked if she could release her seatbelt, she stated, "I've</p>	F 221		

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F 221	<p>Continued From page 8</p> <p>tried" and touched the seatbelt but did not release it.</p> <p>On 3/26/13 at 2:36 p.m., RCM #3 was asked when the seatbelt was initiated for Resident #6. The RCM said she would look into it and find out. When asked what medical symptom was being treated with the seatbelt, the RCM said, "Poor safety awareness" and "Falls." The RCM added she wanted the resident to be safer and said the resident had several falls and would lean forward in her wheelchair. RCM #3 described Resident #6 as having periods of confusion and varied cognition, and was not able to have an in-depth conversation with the resident. When asked if Resident #6 could release the seatbelt, the RCM stated, "I think she can." The RCM was asked if the facility had tried to increase supervision for the resident prior to the use of the seatbelt, and how the seatbelt was determined to be the least restrictive. The RCM said the staff would put the resident in the hallway because the resident enjoyed interaction with people walking by, which would increase resident supervision. RCM #3 added the facility may have increased supervision but would need to look into it. When the RCM was asked if the facility had tried to discontinue the seatbelt, she said, "I haven't lately. I don't know that I have. We may need to do that."</p> <p>On 3/27/13 at 9:14 a.m., RCM #3 said the seatbelt for Resident #6 was initiated on 10/7/13 and reassessed on 1/12/14 and added, "At the time I felt it kept her safe, [and was] going off of what I was told." The RCM was asked if the resident's skin was being assessed and the seatbelt released at least every 2 hours. RCM #3 looked at the Safety Device Plan of Care for Resident #6 and noted an unchecked area which</p>	F 221			

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F 221	Continued From page 9 read, "Check and release safety device every 2 hours." The RCM stated it, "Should have been checked" and check marked the box and added the date. The RCM also noted the unchecked area which read, "Monitor skin integrity at area of safety device for signs of impairment." RCM #3 check marked the box and added the date.  Note: Resident #6 wore the seatbelt restraint from 10/7/13 through 3/27/14, over 5 months, without it being released every 2 hours, and without monitoring skin integrity for signs of impairment.  On 3/26/14 at 6:45 p.m., the Administrator and DON were informed of the restraint issue.  On 3/31/14 addition information was provided by the facility. However, it did not resolve the issue.	F 221			
F 225 SS=D	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 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	F 225			

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F 225	<p>Continued From page 10</p> <p>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).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on resident and staff interview and record review, it was determined the facility did not complete a thorough investigation of an unwitnessed incident. This was true for 1 of 7 residents (R #4) sampled for incident investigations. The deficient practice had the potential to cause more than minimal harm if the facility did not have complete information to prevent further incident occurrences. Findings included:</p> <p>BFS letter 2005-1, regarding incident investigations, documented, "In cases of unwitnessed incidents, the facility needs to determine when the resident was last observed by staff and what the resident was doing at that time. The facility must determine whether specific</p>	F 225	<p>It is the policy of Ivy Court to thoroughly investigate any unwitnessed incidents.</p> <p>To enhance currently compliant operations and under the direction of the Director of Nursing, staff have been re-educated on obtaining witness statements per policy and to meet the regulatory intent of BSF letter 2005-1.</p> <p>Resident #4 has had an addendum added to the incident report that was cited. Current incident reports have been reviewed to insure they meet the intent of BSF 2005-1. Incident reports will be brought to the IDT meetings by the DON or designee and reviewed by the IDT to insure witness statements are present for any unwitnessed incident daily, Monday through Friday, for 30 days then weekly for 8 weeks beginning 4/25/14.</p> <p>Any deficiency will be corrected immediately and audit results will be submitted at the QAPI committee meetings x 3 months for tracking and trending.</p>	4/30	

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F 225	<p>Continued From page 11</p> <p>care plan approaches intended to prevent incidents (such as alarms, call light within reach, observation at designated intervals), were being implemented as planned."</p> <p>Resident #4 was originally admitted to the facility on 1/6/14, with multiple diagnoses which included a fall at home resulting in a left hip fracture with ORIF, lower extremity neuropathy, and chronic stasis changes in both lower extremities.</p> <p>Resident #1's admission MDS assessment, dated 1/13/14, coded: *BIMS of 15, indicating the resident was cognitively intact; *Was not resistive to cares, no other behavioral symptoms; and *Extensive assist of 2 for toilet use and transfers.</p> <p>On 1/20/14 at 9:15 PM, a Resident Incident report (I/A) documented: *Incident Description: "Resident was in room sitting on bedside commode when I heard her start yelling. I went into the room with aide [CNA name] and found her on the commode thrashing and yelling that she dislocated her [left] hip..." *Resident description of the incident : "States she leaned forward and felt her hip pop." *Resident activity prior to the incident: "...sitting on the bedside commode." *Interview summaries: "Res. was in her room sitting on her BSC [bedside commode] when LN heard her start yelling. LN went into res room with another CNA and found her on the BSC thrashing around yelling that she dislocated her [left] hip..." *Resident interview summary: "Res stated that she had bent over to pull up her pants and felt her [left] hip pop out, dislocate." *The question, "Was the incident witnessed?",</p>	F 225		

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F 225	<p>Continued From page 12 was answered, "No."</p> <p>On 3/25/14 at 9:00 AM, the resident was interviewed in her room. The resident recalled dislocating her hip as she attempted to pull her pants up while on the commode, but could not recall how long she had been on the commode or whether or not she had activated the call light. The resident stated, "Honey, it hurt so bad, that's all I can remember about it now."</p> <p>On 3/26/14 at 1:05 PM, RCM #3 was asked about the investigation for the above incident. Specifically, which staff had assisted the resident to the commode, how long the resident had been there before attempting to pull up her pants unassisted, and if the resident had activated the call light prior to the dislocation. The RCM reviewed the I/A form, but was unable to determine those details from the investigation which had been completed at the time. The RCM stated she would look into the details further.</p> <p>On 3/27/14 at 8:55 AM, RCM #3 reported since meeting with the surveyor the day before, she had contacted 3 staff members caring for the resident at the time of the dislocation. RCM #3 stated one person did not recall any of the details requested, one said the resident had been on the commode for 5-10 minutes, and the third stated the resident had been there, "not long." The RCM stated, "I didn't even think about asking those things."</p> <p>On 3/27/14 at 3:15 PM, the Administrator and the DNS were informed of the surveyor's findings. On 3/31/14, the facility faxed additional information, asserting since the resident was alert and oriented, and was on the commode at the time of</p>	F 225			

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F 225	Continued From page 13 the incident, it was not felt any additional investigation should have been done. This information did not resolve the surveyor's concerns.	F 225		
F 253 SS=E	<p><b>483.15(h)(2) HOUSEKEEPING &amp; MAINTENANCE SERVICES</b></p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to maintain the transition strips from resident rooms to the bathrooms. This affected 7 of 13 observed resident rooms. This practice created the potential for a non-cleanable floor surface. Findings included:</p> <p>On 3/27/14 at 2:39 p.m., the Maintenance Manager (MM) and the surveyor observed the following rooms on the East hallway. The floor tile in the bathrooms was different than floor tiles in each of the identified rooms. The area where the resident room floor tiles and the bathroom floor tiles met was observed dark brown in color and fuzzy in appearance.</p> <p>The transition strip was missing at the bathroom entrances from rooms 26, 30, 32, 33, 34, 35, and 36.</p> <p>The MM stated, "I can replace the strips without any problem."</p>	F 253	<p>It is the policy of Ivy Court to maintain a sanitary, orderly and comfortable interior.</p> <p>To enhance currently compliant operations and under the direction of the Administrator, the maintenance director and housekeeping director were re-educated on the need for transition strips at the bathroom entrances.</p> <p>Rooms: 26, 30, 32, 33, 34, 35 and 36 have had the transition strips replaced. All facility rooms have been audited and the transition strips are in place in all rooms. The housekeeping department will audit all rooms daily during their routine cleaning and report any missing transition strips to maintenance for immediate correction beginning 4/25/14. Audits will be reviewed at QAPI committee meetings monthly x3 for tracking and trending.</p>	4/30

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F 253	Continued From page 14	F 253	It is the policy of Ivy Court to revise and update care plans as changes occur.	4/30
F 280 SS=D	On 3/28/14 at 11:30 p.m., the Administrator and the DON were informed of the observations. 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment, prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.  This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to revise and update care plans as resident changes occurred. This was true for 1 of 9 (#1) residents sampled for care plans. This practice created the potential for the resident to experience unmet care needs. Findings included:  Resident #1 was admitted to the facility with	F 280	To enhance currently compliant operations and under the direction of the Director of Nursing, nursing staff have been re-educated regarding ensuring changes of condition / treatments are care planned and using the 24 Hour Nursing Report to communicate resident changes.  Resident #9 has had his care plan updated to include his transient skin condition and associated treatments. Since all residents with care plans are potentially affected by the cited deficiency, the nurse managers have completed an audit to ensure all care plans reflect the resident's current condition. Using the 24 Hour Nursing Report and telephone orders care plans will be audited to insure they reflect resident changes. The RCM'S will audit daily, Monday through Friday, beginning 4/25/14 for 30 days then 3 x week for 8 weeks.  Any deficiencies will be corrected immediately. Audit results will be submitted at the centers QAPI committee meetings x 3 months for tracking and trending.	

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F 280	<p>Continued From page 15 multiple diagnoses including arthritis and debility.</p> <p>The resident's 2/12/14 quarterly MDS coded cognition intact, required extensive one person assistance with bed mobility, transfer, dressing, toilet use, personal hygiene, and bathing.</p> <p>On 3/24/14 at 1:36 p.m., 3/25/14 at 9:00 a.m., at 10:30 a.m., at 12:05 p.m., and on 3/26/14 at 5:28 p.m., the surveyor observed Resident #1's face had irregular areas of redness and flakiness to the skin.</p> <p>The resident's Physician's Telephone Orders (PTOs), signed by the physician on 3/2/14, documented, "Hydrocortisone cream 1% to facial rash daily until healed."</p> <p>Review of the resident's care plan did not provide evidence the facility care planned the resident's facial rash and the use of hydrocortisone cream for the rash.</p> <p>The resident's 3/14 TAR documented, "Hydrocortisone 1% to facial rash q d [every day] until healed. Monitor rash on face q shift if worsens or develops s/s of allergic rxn [signs and symptoms of allergic reaction], call MD." The TAR provided evidence nursing staff administered the cream on the evening shift and monitored the rash on the resident's face every shift.</p> <p>On 3/26/14 at 3:37 p.m., the surveyor interviewed RCM #6 and asked if the use of Hydrocortisone cream 1% and the resident's skin rash was identified on the resident's care plan. RCM #6 reviewed the CP and stated, "The Hydrocortisone and the resident's skin rash are not on the resident's CP. I'll update that."</p>	F 280		
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F 280	Continued From page 16	F 280		
F 309	<p>On 3/26/14 at 4:30 p.m., RCM #6 provided the surveyor with a copy of the CP updated for the use of hydrocortisone and the resident's facial rash.</p> <p>On 3/28/14 at 11:30 p.m., the Administrator and the DON were informed of the care plan concern.</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure care plan interventions for fall prevention were implemented. This was true for 1 of 13 (#3) sampled residents when two transfers were observed which were not in accordance with the resident's care plan. This failure created potential for increased falls. Findings included:</p> <p>Resident #3 was admitted to the facility on 12/20/13 and readmitted on 3/12/14 with multiple diagnoses which included muscular wasting and disuse atrophy and difficulty in walking.</p> <p>Resident #3's most recent quarterly MDS assessment, dated 3/3/14, documented in part:</p>	F 309		

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F 309	<p>Continued From page 17</p> <ul style="list-style-type: none"> <li>* BIMS score of 14 indicating intact cognition;</li> <li>* Extensive assistance needed with 1 person for bed mobility, transfers, walking in room and corridor, locomotion on and off the unit, dressing, toilet use and personal hygiene;</li> <li>* One fall since admission or prior assessment;</li> <li>* Received scheduled and PRN pain medication; and,</li> <li>* Received a hypnotic in the previous 7 days.</li> </ul> <p>The ADL/Mobility Care Plan for Resident #3, dated 2/13/14, documented to "Provide assistive device as needed for ambulation: fww [front wheel walker] 2 person" and "Provide assistive device as needed for transfer: fww 2 person."</p> <p>The Fall/Injury Assessment: Prevention and Management Care Plan for Resident #3, dated 2/13/14 and 3/12/13, documented:</p> <ul style="list-style-type: none"> <li>* Assessment - Fall/injury risk related to: history of falls, pain, unsteadiness, acute infection, exhaustion, weakness, pulse irregularities, cardiovascular diagnosis, bowel incontinence, bladder incontinence and mental status change.</li> <li>* Interventions - Ambulation: 2 person assist and Transfer: 2 person assist. Device: FWW.</li> </ul> <p>A Resident Incident report for Resident #3, dated 3/18/14, documented, "CNA was ambulating resident to the restroom using her FWW. CNA reached to open the door and resident fell over backward. Resident denied feeling weak or dizzy she stated that she lost her balance and fell. Resident was wearing gripper socks at the time of the incident. She stated she hit her head but not very hard no lumps were palpable to the back of her head and no bruising was noted." The actions taken following the incident were, "Updated residents care deliver guide- resident is</p>	F 309	<p>It is the policy of Ivy Court to insure implementation of care planned interventions.</p> <p>To enhance currently compliant operations and under the direction of the Director of Nursing, nursing staff were re-educated on transfer/ambulation assistance and the assessments required to alter this status.</p> <p>Resident #3 received no adverse event related to the cited deficiency and has had her fall risk assessed, care plans updated and implemented.</p> <p>Since all residents requiring assistance with transfers/ambulation may be potentially affected, their care plans and care delivery guides have been audited and are accurate.</p> <p>Transfers and ambulation of those residents requiring assistance will be monitored to insure the care plans are being followed by the DON or her designee Monday through Friday, twice daily x 30 days then weekly for 8 weeks beginning 4/25/14.</p> <p>Any deficient practice will be corrected immediately, and the findings will be submitted at the QAPI committee meetings x 3 months for trending and tracking.</p>	4/30

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NAME OF PROVIDER OR SUPPLIER  <b>IVY COURT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2200 IRONWOOD PLACE</b> <b>COEUR D'ALENE, ID 83814</b>		
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F 309	<p>Continued From page 18</p> <p>to be a two person assist with ambulation. Informed staff of new guidelines when getting resident up to restroom."</p> <p>On 3/24/14 at 1:50 p.m., Resident #3 was observed sitting in her room in a recliner. CNA #4 was observed setting up the resident's wheelchair perpendicular to the recliner. The CNA engaged the wheelchair brakes and stood behind the wheelchair holding onto the handlebars while the resident stood from her recliner and transferred herself to the wheelchair.</p> <p>On 3/26/14 at 11:15 a.m., CNA #5 was observed as she placed a gait belt around Resident #3's waist while the resident sat in her recliner. The CNA placed the wheelchair perpendicular to the recliner and engaged the brakes. The CNA instructed Resident #3 to scoot to the edge of the recliner and while holding onto the resident's left arm, the CNA assisted the resident to stand and transfer to the wheelchair. After the CNA assisted the resident to the restroom, she was asked to describe how the resident should be transferred. She stated the resident was a 1 person transfer but required 2 people for ambulation in the room.</p> <p>On 3/26/14 at 11:42 a.m., RCM #6 was asked for Resident #3's transfer status. The RCM stated, "It's a 2 person now" and added the most important element was assist of 2 people with ambulation and the resident was not cleared to be independent in the room.</p> <p>On 3/26/14 at 1:07 p.m., the DON said she had a confession to make and stated the resident was care planned for 2 person transfers, however, on the previous day the RCM told CNA #5 she could transfer the resident with 1 person. The DON</p>	F 309			

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F 309	Continued From page 19 added, "This occurred, we know about it."  On 3/26/14 at 6:47 p.m., the Administrator and DON were informed of the transfer observations. However, no further information or documentation was provided.	F 309	It is the policy of Ivy Court to insure residents do not develop avoidable pressure ulcers and insure interventions are in place to prevent pressure ulcers.	4/30	
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.  This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and record review, it was determined the facility failed to ensure residents did not develop avoidable pressure ulcers in the facility, nor did the facility ensure interventions to prevent pressure ulcers were implemented. This was true for 3 of 5 residents (#s 1, 4, and 7) sampled for pressure ulcers. Resident #4 was harmed when she developed an unstageable pressure ulcer to her left heel, and did not have all prescribed measures in place to promote healing once the pressure ulcer developed. Residents #s 1 and 4 had the potential for more than minimal harm when they were not provided with offloading boots per their respective plans of care to prevent pressure ulcers. Findings included:	F 314	To enhance currently compliant operations and under the direction of the Director of Nursing, the nursing staff has been re-educated on the Braden Tool and associated interventions that are to be care planned based upon this assessment. Staff has been re-educated on the use of offloading boots.  Resident # 4 has had her care plan reviewed and measures to prevent pressure to her heel are current and implemented. Risks vs. benefits of wearing offloading boots has been explained to the resident. Wound continues to resolve. Resident # 1 has had a Braden Tool completed and has current interventions care planned and in place to reduce the risk of ulcer development. Resident # 7 has had a Braden Tool completed and has current interventions care planned and in place to reduce the risk of ulcer development.  Since all residents are potentially affected by the cited deficiency, using the Braden Tool, residents at risk for developing or worsening pressure areas have been identified.		

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F 314	<p>Continued From page 20</p> <p>1. The facility's Procedure for Pressure Ulcer Prevention/Development, Effective November 1998, Revised January 2008 and April 2009, documented, "...requires the use of the Braden Risk Assessment...All residents will be assessed on admission and weekly for four weeks... The following interventions are efforts to stabilize, reduce, or remove underlying risk factors." For the "At Risk" residents, identified as a Braden score of 15-18, the procedure documented, "...reduce pressure to heels...manage...friction and shear..."</p> <p>Resident #4 was originally admitted to the facility on 1/6/14, with multiple diagnoses including a fall at home with a left hip fracture with ORIF, lower extremity neuropathy, and chronic stasis changes in both lower extremities. The facility discharged the resident to the acute care hospital and re-admitted her to the facility on 2 occasions, with the most recent readmission to the facility documented as 2/13/14.</p> <p>On 1/6/14, a Braden Risk Assessment Scale for the resident documented her pressure ulcer risk at a score of 18, which indicated minimal risk.</p> <p>Resident #1's admission MDS assessment, dated 1/13/14, coded: *BIMS of 15, indicating the resident was cognitively intact; *Not resistive to cares, no other behavioral symptoms; and *Extensive assist of 2 for bed mobility and transfers.</p> <p>The resident's care plan, initially dated 1/6/14, documented an "Assessment/Problem" area of,</p>	F 314	<p>(continued)</p> <p>Residents identified at risk have been reviewed and there are current and appropriate pressure reducing interventions in place. Braden Tools and care plans will be reviewed upon admission, with significant changes, quarterly and annually to insure appropriate interventions are in place to reduce pressure. Pressure reducing interventions including the use of offloading devices will be monitored by the DON or her designee daily, Monday through Friday, x 30 days and then weekly for 8 weeks beginning 4/25/14.</p> <p>Any deficiencies will be corrected immediately and audit results will be reviewed at QAPI committee meetings for tracking and trending x 3 months.</p>	

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F 314	<p>Continued From page 21</p> <p>"At risk" of skin breakdown. The form for the care plan contained columns with pre-printed options for "Assessment/Problem", "Goal", and "Interventions", along with a check box next to these options to indicate which specific items applied to the resident. There were also blank columns, labeled as "Date" for the "Assessment/Problem" column, and, "Due date" for the "Interventions" column. Several dates were listed in the date and due date columns, so it was unclear when, exactly, the problems and interventions had been identified or updated. However, a hand-written addition, dated 3/5/14, was made under the "Assessment" area of the care plan which documented, "[Left] heel neuropathic ulcer (full thickness with pressure.)" Under the "Interventions" column, the option of, "Position calves on pillows to elevate heels off of the bed", was unchecked. There were no care plan assessment areas which indicated the resident was non-compliant, nor any approaches to address non-compliance. [NOTE: No MDS significant change assessment had been completed by the facility since the onset of her pressure ulcer as documented on 3/5/14 and the facility's annual recertification survey of 3/24/14.]</p> <p>Facility documentation regarding the wound included a "Skin Grid - Pressure/Venous Insufficiency Ulcer/Other" form (PU form), Physician's Telephone orders (PTOs), facility physician's notification forms, Braden skin assessments, "Admission Skin Assessment" forms, Resident Incident forms (I/As), "Pressure Ulcer Healing Chart" (PUSH) forms, Physician's Progress Notes (MD PNs), Nurse's Progress Notes (PNs), Physician's Orders, MARs, and TARs. The timeline of the wound was</p>	F 314		

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F 314	<p>Continued From page 22 documented as:</p> <p>[NOTE: The PUSH form in Resident #4's record was identified as PUSH Tool version 3.0 from the National Pressure Ulcer Advisory Panel. The directions on the form documented, "Observe and measure pressure ulcers at regular intervals using the PUSH tool. Date and record PUSH Sub-scores and Total Scores on the Pressure Ulcer Healing Record Below."]</p> <p>*On 1/23/14, an MD PN documented, "...seen for evaluation of ongoing leg and body pain. She was sent to the ER last weekend due to sudden onset of severe [left] hip pain...Portable X-ray showed a dislodgement of her prosthesis..."</p> <p>*On 1/27/14, an MD PN documented, "Since ER visit for [left] hip dislocation, she has had on-going [left] hip pain again. No known trauma..."</p> <p>*On 2/13/14, the date the resident was most recently admitted to the facility, the Admission Skin Assessment sheet documented no skin concerns with either of her feet.</p> <p>*On 3/2/14 at 8:19 AM, a facility I/A documented, "resident complained of a sore left heel on assessment noted pressure area to heel...stated it hurt for a couple of days and was told to float heels...didn't float heels because she didn't know what that meant."</p> <p>*The 3/2/14 I/A Post Incident Action documentation included, "floated heels and requested an order for Sage boots."</p> <p>*The 3/2/14 I/A Investigation Summaries documented, "Wound specialist saw resident on 3/4 assessed [left] heel site. Dx of [left] heel neuro pathic [sic] ulcer (full thickness with pressure). Probable cause related to this res has had recent [left] hip surgery [sic]."</p>	F 314			

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F 314	<p>Continued From page 23</p> <p>*On 3/2/14, a facility physician notification form documented, "Resident has pressure area 1.0 cm X 1.0 cm on left heel..." [NOTE: The form documented no further description of the wound for physician notification.]</p> <p>*On 3/2/14 a PU form documented a Stage II pressure ulcer to the left heel, 1.0 cm in length X 1.0 cm in width, with no documented depth. The form was modified on 3/4/14 to document, "[Left] heel neuropathic ulcer (full thickness with pressure)."</p> <p>*On 3/3/14 at 7:07 PM, an MD PN documented, "...Per staff, [Resident #4] had developed an area of softening and skin breakdown on [left] heel..." [NOTE: This development was not addressed in the physician's plan of treatment documented on the MD PN. Additionally, the area was described on the 3/2/14 PU form as "full thickness with pressure."]</p> <p>*3/4/14 the PU form documented the wound as, "U" for unstageable, 3 cm X 4.2 cm X 0.2 cm. "Per [Wound Nurse's name] - unstageable D/T small questionable area... most of wound bed St[age] II... Sage boots at all times."</p> <p>*A 3/4/14 PTO documented a diagnosis of, "[Left] heel neuropathic ulcer (full thickness with pressure)." Orders were documented as, "...Sage boots on at all times..."</p> <p>*A 3/5/14 Braden Risk Assessment Scale documented the resident's risk for pressure ulcers was documented as an 18, which indicated minimal risk of pressure ulcer development. [NOTE: This was the first pressure ulcer risk assessment noted since Resident #4's most recent re-admission to the facility on 2/13/14, and was the same score as the resident had received prior to her skin breakdown. The score had not changed although the resident had dislocated her hip and was required to wear a brace for</p>	F 314			

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F 314	Continued From page 24 stabalization, and had developed a pressure ulcer on her left heel. The facility assessed the resident had not changed in her activity level, mobility, or friction and shear risk despite the above identified changes.] *On 3/6/14, Resident #4's PUSH tool documented the area of the wound (length times width, in centimeters) as "9", exudate amount as, "0", and tissue type as, "1" (epitheal tissue), with a total PUSH score of, "10." *A 3/11/14. the PU form documented the wound as, "Neuropathic ulcer," 3 cm X 4.5 cm X 0.2 cm. *On 3/12/14, Resident #4's PUSH form documented an area of, "9", exudate amount as, "1" (light), tissue type as "1", and a total PUSH score of, "11", indicating deterioration from the 3/6/14 score. *On 3/18/14, an MD PN documented, "The patient states that she is using Sage boots bilaterally when in bed, but the Velcro is bad and they come loose,, Ulcer of the...left heel, healing slowly... Continue pressure-reducing boots to bilateral [lower extremities] at all times except when standing or ambulation...avoid use of left shoe until heel ulcer is resolved..." *A 3/18/14 PTO documented, "Please obtain new offloading boot (old one falls off) for left lower extremity...document refusals..." [NOTE: There was an area on the resident's TAR for March 2014 to document resident refusals. The area was blank, which indicated the resident had not refused use of the boot.] *A 3/18/14 PU form documented the wound as, "Neuropathic ulcer," 1.8 cm X 2.2 cm X 0.2 cm. "...Cont[inue] to educate res[ident] on pressure relief..." *On 3/18/14, Resident #4's PUSH form documented area as, "6", exudate amount as, "1", tissue type as, "2" (granulation tissue), and a	F 314			

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F 314	<p>Continued From page 25</p> <p>total PUSH score of, "9", indicating overall improvement in the pressure ulcer since the 3/12/14 assessment.</p> <p>*A 3/25/14 PU form documented the wound as "Neuropathic Ulcer, " 1.8 X 3 X 0.2 cm.</p> <p>"...Res[ident] educated on importance of pressure relief [and] use of Sage boot to [left] foot."</p> <p>*On 3/25/14, Resident #4's PUSH form documented an area of, "6", exudate amount of, "0", tissue type of, "2", and an overall PUSH score of, "8", indicating overall improvement since the 3/18/14 assessment.</p> <p>*On 3/25/14 at 1:30 PM, R #4's physician documented, "Given the patient's co-morbid conditions at the time of the L heel ulcer formation...the heel ulcer would be considered un-avoidable."</p> <p>On 3/25/14 at 9:00 AM, the resident was observed sitting in her wheelchair in her room. Her left heel was resting on the foot pedal. She was wearing only a yellow slipper sock on her left foot. A blue padded boot was lying on the floor underneath her wheelchair. The resident stated she had a sore on her left foot. The resident stated, "I got that from it rubbing on the bed." The resident stated that since the development of the sore, "Now sometimes they lift my heels off the bed with pillows." At 9:10 AM, CNA #8 entered the resident's room and stated, "[R #4], your boot has come off. Can I put it back on for you?" The resident was agreeable to having the blue padded boot placed on her left foot.</p> <p>On 3/25/14 at 12:00 noon, CNA Student #9 was observed pushing the resident in her wheelchair to the dining room for lunch. The resident was wearing only yellow slipper socks on her feet, with the backs of her feet and heels resting on the foot</p>	F 314		
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F 314	<p>Continued From page 26</p> <p>pedals. The blue padded boot was not present. The resident was observed in this state throughout the lunch meal, until 12:50 PM. At 12:50 PM, CNA #1 was observed to take the resident to her room. In less than 5 minutes, CNA #1 returned to the lobby area with the resident. She was now wearing Deerfoam-type slippers on her feet, with the backs of her feet and heels continuing to rest on her foot pedals. The CNA escorted the resident outside to the facility van, where she left the facility to go to a physician's appointment. The surveyor returned to the resident's room, and noted the blue padded boot to be lying on the resident's bed. At 2:00 PM, the resident was still out of the facility at her physician's appointment.</p> <p>On 3/25/14 at 2:45 PM, the surveyor observed the resident to be back in the facility, sitting in her wheelchair in her room. She was still wearing the Deerfoam-type slippers on her feet, which were resting on her foot pedals, and the blue padded boot was still on her bed. The resident stated the footwear she had on was what she had been wearing since she left for her physician's appointment. The surveyor left the room and summoned the DNS. The DNS arrived at the resident's room. The DNS identified the blue padded boot on the resident's bed as a, "Sage boot," which the resident was to wear due to the pressure ulcer on her foot. The DNS was asked if the footwear the resident currently had on was considered pressure-relieving, the DNS stated, "No."</p> <p>On 3/25/14 at 2:50 PM, the DNS brought CNA #1 to talk with the surveyor. CNA #1 stated he took the resident back to her room after lunch to get her sweater, and the resident insisted on having</p>	F 314		

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F 314	<p>Continued From page 27</p> <p>her Sage boot removed and her Deerfoam-type slippers put on. When informed of the surveyor's observations of the Sage boot not being on at lunch, the CNA stated, "Oh. She didn't have it on at lunch. She was wearing her yellow slipper socks. But she insisted she wanted to wear those other slippers to her appointment." CNA #1 was asked if the resident had been educated about the benefit of wearing the Sage boot. The CNA stated, "All the time." CNA #1 was asked if the nurse had been informed of the resident's refusal to wear the Sage boot on the outing, the CNA stated, "No. I didn't tell the nurse." The DNS stated, "Well, [R #4] is non-compliant. You can ask the RCM about it. She's always non-compliant with this kind of thing." The DNS was asked if the resident had been educated about the potential consequences of her non-compliance, and if the facility had tried to overcome her objections to utilizing the Sage boots. The DNS stated, "Oh, yes." The DNS was asked if this information would be included in the resident's record and included in her care plan. The DNS stated, "It should be."</p> <p>On 3/26/14 at 1:05 PM, RCM #3 was asked about the pressure ulcer on the resident's left heel. The RCM stated: *The resident developed the pressure ulcer because she had been "so compromised" by her hip fracture and subsequent dislocation. *The RCM was unable to identify specific interventions put in place to protect the resident's heels from skin breakdown in light of the resident's compromised status. After reviewing the resident's care plan, the RCM was unable to determine when problems or interventions had been identified or implemented regarding the resident's risk for skin breakdown, aside from the</p>	F 314			

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F 314	<p>Continued From page 28</p> <p>entries noted on 3/5/14.</p> <p>*When asked why the intervention of offloading the resident's heels had not been selected for the resident's care plan, the RCM stated, "It must have been an oversight. I can't imagine we didn't do it."</p> <p>*When asked about the 3/2/14 I/A for the pressure ulcer [see above], and if the staff had offered to assist the resident to float her heels or just instructed the resident to, the RCM stated, "Well, she does move a lot." When asked how the resident would place pillows to float her heels, or don her Sage boot, while maintaining the strict hip precautions, as ordered by the physician, and using the 2-person assist required for bed mobility, as specified in the MDS, the RCM stated, " Well, she did progress to one-person assist at one time." [NOTE: On 3/27/14 at 9:00 AM, RCM provided 2 memos. The first documented the resident had been upgraded to one-person assist for transfers per therapy on 3/18/14. The second documented the resident was downgraded to a 2 person assist again after a fall on 3/23/14. The facility I/A documented the development of the pressure ulcer on 3/2/14.]</p> <p>*The RCM suggested perhaps the pressure ulcer developed during one of the resident's hospitalizations. However, the resident's most recent admission date was 2/13/14, and the pressure ulcer was first noted 3/2/14, 17 days later. There were no skin issues identified on Resident #4's Admission Skin Assessment form, completed 2/13/14.]</p> <p>*When asked whether the resident was non-compliant or resistive to cares, the RCM stated, "No, not at all. She is one of the nicest people you could meet. She does get restless and move around a lot, so I think the boots come off, but she will let you put them back on."</p>	F 314			

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F 314	Continued From page 29  On 3/26/14 at 3:15 PM, 2 surveyors observed RCM #3 and the DNS-In-Training (DNSIT) change the dressing on R #4's left heel. The DNSIT positioned and held the resident's leg while RCM #3 changed the dressing. The wound was on the lateral aspect of the resident's left heel. RCM #3 measured the wound as 2.4 cm X 1.8 cm. RCM #3 did not measure the depth of the wound. There was a crescent moon-shaped darkened area along the distal aspect of the wound. This area of the wound was not measured as part of the wound assessment. It appeared to cover approximately 1/3 of the circumference of the wound. The DNSIT stated, "At one point it was unstageable because we couldn't see the wound bed. Now we can see the wound bed, so it's visualized as a Stage II. But we can't reverse stage, so it's considered unstageable." RCM # 3 described the wound as, "Pink and getting more superficial." When asked to describe the darkened crescent moon-shaped area, RCM #3 stated, "Around the edges, it's unstageable, because we can't see the wound bed." [NOTE: Neither RCM #3 nor the DNSIT was able to explain how the wound could be considered both "Unstageable" and "Stage II" at the same time. RCM #3 stated the wound bed could not be visualized under the darkened area, and no depth measurement could be obtained.]  On 3/27/14 at 10:15 AM, the surveyor was present as the resident's physician (MD) changed the dressing and assessed the resident's heel. The wound was not measured, but appeared consistent with the surveyor's observations the day before.  On 3/27/14 at 10:30 AM, the MD and the facility	F 314			

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F 314	<p>Continued From page 30</p> <p>Administrator were then interviewed about the resident's pressure ulcer. The MD stated the wound looked "good", and was "healing nicely." The MD was asked about the development of the pressure ulcer [NOTE: The MD did not object to, nor correct, the term "pressure ulcer" during the conversation.] The MD stated the resident was a complicated case because of her medical history. The MD was informed about the lack of heel protection on the resident's care plan, the details of the incident report regarding the pressure ulcer, and the surveyor's observation of the blue padded boot not being in place. The MD stated, "Hmm. I remember on two occasions seeing her heels floated. I think that was right after a trip to the ER, but it's hard to say if it wasn't documented." The Administrator stated, "But today it's obvious it was always a Stage II. It was never a Stage IV." The Administrator was informed of the dressing change observation on 3/26/14, and the assessment of the DNSIT and RCM #3 that the wound was unstageable. The Administrator stated, "But it's so shallow, it's obviously not a Stage IV." The MD and the Administrator stated they were unable to visualize the entire wound bed during the 3/27/14 dressing change, due to the darkened crescent moon-shaped area. The MD and Administrator were also informed of the wound nurse's documentation of the area being unstageable, full thickness loss with pressure. The MD stated, "I don't think we were aware that calling it that meant harm. I think the wound nurse was trying to help us by calling it unstageable."</p> <p>On 3/27/14 at 3:15 PM, the Administrator and DNS were informed of the surveyor's findings. On 3/31/14, the facility mailed additional information regarding the deficiency at F 314, including a</p>	F 314			

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F 314	Continued From page 31 3/27/14 dictation from the physician which documented, "...[Left] heel ulcer examined and is consistent with neuropathic ulcer that would be considered unavoidable given medical co-morbidities at time of the event. Initial exam was deemed un-stageable since base of ulcer site could not be seen..." However, the physician's dictation did not address the surveyor's concerns that: *The facility did not implement interventions, per regulatory requirement and facility policy and procedure, to prevent pressure ulcers to Resident #4's heels, even though she had a number of known risk factors, including decreased mobility to her left lower extremity following a hip fracture and subsequent dislocation of the surgical repair; *The facility I/A at the time the wound was first noted identified the nature of the wound as, "pressure", and the cause as the resident not floating her heels because she did not know what that meant; *The wound nurse's assessment of the wound after its development which documented the nature of the wound as neuropathic with pressure, and the wound as unstageable; *The facility was using PUSH forms, identified as specific to tracking pressure ulcers, and had identified pressure as a component on other skin assessment forms used to track the progression of the wound; *The physician had not documented on the nature of the wound between the time of its discovery on 3/2/14 and the surveyor's inquiry on 3/27/14; *The resident was assessed as cognitively intact, and stated the wound resulted from her heels rubbing on the bed; and *The surveyor had observations of pressure prevention measures, specified in Resident #4's	F 314			

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F 314	<p>Continued From page 32 care plan, to not be implemented.</p> <p>2. Resident # 7 was admitted to the facility on 5/19/06 and readmitted on 6/5/11 with multiple diagnoses which included coronary artery disease and diabetes.</p> <p>Resident #7's most recent quarterly MDS assessment, dated 2/18/14, coded in part: * BIMS score of 14 indicating intact cognition; * Extensive assistance needed with 1 person for bed mobility, transfers, locomotion on and off the unit, dressing, toilet use, personal hygiene and bathing; * At risk of developing pressure ulcers; and, * No healed or unhealed pressure ulcers.</p> <p>Resident #7's Care Delivery Guide documented, "[Right] Heel wear sage boot." No date was provided for the intervention.</p> <p>Resident #7's March 2014 recapitulated Physician's Orders documented, "R HEEL: WEAR SAGE BOOT WHEN UP, FLOAT HEEL WHEN IN BED OR MAY WEAR SAGE BOOTS PER HER PREFERENCE." The date provided was 1/13/12.</p> <p>The March 2014 Treatment Administration Record for Resident #7 documented the aforementioned Physician's order as information only and did not require initials by the nursing staff.</p> <p>The following observations were made of Resident #7 without the sage boot on her right heel: * 3/25/14 at 8:45 a.m., the resident was sitting in</p>	F 314		

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F 314	<p>Continued From page 33</p> <p>her room in the wheelchair. The resident was wearing slippers on both feet as her feet rested on the foot pedals of the wheelchair; * 3/26/14 at 6:04 p.m., the resident was sitting in her room in the wheelchair with slippers on both feet. The resident denied having worn a cushion boot to either foot and said she had not worn one since she was admitted to the facility; and, * 3/27/14 at 8:15 a.m., the resident was sitting in her room in the wheelchair with slippers on both feet.</p> <p>On 3/27/14 at 10:06 a.m., RCM #3 was asked why Resident #7 needed a sage boot to her right heel. The RCM stated the resident, "Bruises really easily and her skin is really fragile." The RCM was informed of the observations of the resident without the sage boot at which she responded, "She probably did at one time. I'll go talk to her about it."</p> <p>On 3/27/14 at 3:10 p.m., the Administrator and DON were informed of the sage boot issue. However, no further information or documentation was provided.</p> <p>3. Resident #1 was originally admitted to the facility in 2012 and readmitted on 5/31/13 with multiple diagnoses including debility.</p> <p>The resident's 6/7/13 admission MDS coded cognition intact, required extensive assistance of one person for ADLs except eating, at risk for developing pressure ulcers (PUs), no current PUs, and pressure relieving devices for chair and for bed. Section V of the MDS documented the PU care area triggered and was care planned.</p> <p>The resident's 2/12/14 quarterly MDS coded</p>	F 314			

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F 314	<p>Continued From page 34</p> <p>cognition intact, required extensive assistance of one person for all ADLs except eating, at risk for developing PUs, no current PUs, and pressure relieving devices for chair and for bed.</p> <p>The resident's "Skin Integrity Assessment: Prevention and Treatment Plan of Care" identified the 5/31/13 problem, "Protect heels." One of the interventions was, "Sage boots on when in bed."</p> <p>The resident's 3/14 Physician's Orders (recapitulation orders) contained a 10/25/13 order, "Resident to wear sage boots when in bed."</p> <p>The resident's 3/14 TAR documented, "10/25/13 resident to wear sage boots when in bed" during day, evening and night shifts. The 3/14 MAR contained handwritten initials for all three shifts from 3/1/14 through 3/24/14 indicating the resident wore the Sage boots daily when in bed on the day, evening, and night shifts.</p> <p>On 3/26/14 at 1:40 p.m., the surveyor observed a pair of Sage boots (blue and grey padded foam boots with velcro straps) on the chair in the resident's room.</p> <p>On 3/26/14 at 5:28 p.m., the resident was observed in his room sitting in a wheelchair (wc). The Sage boots were in the same location in the resident's room as observed at 1:40 p.m. The resident was interviewed about the use of Sage boots when in bed. The surveyor pointed to the Sage boots and asked the resident about wearing the Sage boots while in bed. The resident stated, "I do not wear them." The resident lifted both his feet from off the wc footrests, moved his feet around in the air, and stated, "I haven't had any</p>	F 314		

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F 314	Continued From page 35 skin breakdown yet. I do not need them. My skin is fine. I did have the boots on at one time when I was in bed. While I slept, the boots would come off and the boots were just not comfortable to wear when I wanted to sleep.  On 3/26/14 at 5:40 p.m., the surveyor showed the DON the documentation on the resident's 3/14 TAR, including the day, evening, and night shifts with nursing staff initials. The DON looked at the Sage boot order on the 3/14 TAR and stated, "The nursing staff initials mean the resident wore the Sage boots when in bed." The surveyor asked the DON to speak with the resident about wearing the Sage boots while in bed.  On 3/26/14 at approximately 6:00 p.m., LN #7 stated, "We spoke with the resident. [Resident #1] said he can not remember when the last time was that he wore the Sage boots when in bed. We will contact the resident's doctor to request discontinue the order. The nurses have been spoken to about this concern."	F 314		
F 323 SS=D	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		

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F 323	<p>Continued From page 36</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure residents received adequate supervision to prevent falls. This was true for 1 of 7 (#13)sampled residents reviewed for falls when the resident had four falls in a four day period. The lack of supervision placed the residents at risk for serious injury. Findings included:</p> <p>Resident #13 was admitted to the facility on 9/29/13 and readmitted on 10/25/13 with multiple diagnoses which included morbid obesity and bipolar disorder.</p> <p>The most recent quarterly MDS assessment for Resident #13, dated 2/24/14, documented in part: * BIMS score of 12 indicating moderately impaired cognition; * extensive assistance needed with 2 or more people for bed mobility, transfers, walking in room, dressing, toilet use and personal hygiene; and, * Two or more falls without injury since admission or prior assessment.</p> <p>A Resident Incident report for Resident #13, dated 11/19/13, documented in part: * Incident Description: "Observed resident sitting on floor beside bed. Did not hit head. Resident states trying to scoot self up in bed and slid out onto floor. Denies any injury." * Summary of Investigation Outcome: "Was noted and witnessed by staff at the time that resident had been refusing many cares. Refusing to let staff reposition her when needed. Res[ident] had been observed on occasions lying with her lower legs over bottom edge of bed, but refusing to</p>	F 323	<p>It is the policy of Ivy Court to provide adequate supervision to protect residents from accidents.</p> <p>To enhance currently compliant operations and under the direction of the Director of Nursing, nursing staff were re-educated on the components of increased supervision and when to implement such components.</p> <p>Resident # 13 has had no further falls since February owing to the interventions presently in place. Since all residents potentially requiring increased supervision may be affected by the cited deficiency, care plans for those residents have been reviewed and are current and accurate. If increased supervision is required, the care plan clearly reflects how that supervision will be achieved. Resident #13 has been assessed and found to not require increased supervision.</p> <p>Residents requiring and care planned for increased supervision will be monitored to insure their specific interventions are in place. Audits will be performed by the DON or her designee daily, Monday through Friday, x 30 days and then 2 x week for 8 weeks beginning 4/25/14.</p> <p>Any deficient practice will be corrected immediately and the findings will be submitted at the QAPI committee meetings x 3 months for tracking and trending.</p>	4/30
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NAME OF PROVIDER OR SUPPLIER  <b>IVY COURT</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2200 IRONWOOD PLACE</b> <b>COEUR D'ALENE, ID 83814</b>		
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F 323	<p>Continued From page 37</p> <p>allow staff to help her reposition. Resident at time of fall was being treated for klebsiella UTI [urinary tract infection] and was on antibiotic ciprofloxacin, which she still had not completed. Has poor safety awareness. Behaviors probable related to current UTI."</p> <p>* Summary of Corrective Action Taken: "Staff assisted res.[resident] back to bed. Educated resident on importance of proper positioning when in bed, with staff assist, reminding resident to keep lower legs on bed. Instructed staff verbally to do frequent visual checks on res. due to poor safety awareness. Resident was placed on alert charting to monitor for latent injuries. Antibiotic {sic} therapy was continued to treat Klebsiella UTI. MD was notified and aware."</p> <p>* Describe the final outcome: "Resident had no latent injuries noted related to fall. Antibiotic {sic}therapy ciprofloxacin completed. Follow up UA [urinary analysis] done at 11/22. New order received for Keflex, antibiotic {sic} for UTI."</p> <p>Included in the investigative packet for the aforementioned incident was the Care Delivery Guide, with an updated date of 9/29/13 which documented in part, "Frequent visual checks due to Poor Safety Awareness [,] Monitor res[iden]t for proper positioning when in bed. Remind to use callight {sic} prn [and] Keep legs on bed."</p> <p>Resident #13's Fall Injury Assessment Prevention and Management Plan of Care documented, "Remind res[iden]t to use call light prn [and] keep legs in bed" and "Offer assistance to resident (for needs) Q 2 [every 2 hours and] prn," dated 12/5[13].</p> <p>Note: The Care Plan had a date column which documented a range of dates from 10/25/13</p>	F 323		

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F 323	<p>Continued From page 38</p> <p>through 3/6/14, making it unclear when the intervention of reminding the resident to use the call light and keep legs in bed was added to the Care Plan.</p> <p>Note: The aforementioned incident occurred in 11/2013. The interventions documented did not have a date next to them, making it unclear when the interventions were added to the Care Delivery Guide. In addition, the intervention of "Frequent visual checks due to Poor Safety Awareness" did not provide a clear frequency for the visual checks, nor was there documented evidence the checks were performed.</p> <p>A Resident Incident report for Resident #13, dated 11/21/13 at 12:50 p.m., documented in part:</p> <p>* Incident Description: "Observed resident sitting on floor with back toward bed. CNA reports that she observed resident sliding out of bed between bed and wheelchair and assisted resident to floor. Skin tears x 3 on left shin. Area cleansed and transparent dressing applied.</p> <p>* Summary of Investigation Outcome: "Found that resident had attempted to get out of bed without assistance. Probable related to her self transferring without staffs help. Resident is forgetful and often refuses staff assistance and will want to do it herself. resident had been being treated for a UTI at the time and had been noted to be having some increased behaviors."</p> <p>* Summary of Corrective Action Taken: "Skin tear sites were cleansed with NS [normal saline]. dressing applied. Family and MD informed. Order received from MD to monitor for latent injuries x 72 hours. Care delivery guide updated to offer resident assist with needs q 2hrs [every 2 hours] and prn."</p>	F 323		
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F 323	<p>Continued From page 39</p> <p>* Describe the final outcome: "Will monitor skin tears until resolved. Dr. [doctor] aware of lower extremity open areas and to follow up. Will offer res[ident] assistance with needs q 2hours and prn, due to res. forgetfulness {sic}."</p> <p>Included in the investigate packet for the aforementioned incident was the Care Delivery Guide, with an updated date of 9/29/13 which documented in part, "Offer Resident Assist [with] needs Q 2 [hours and] prn."</p> <p>Note: The aforementioned incident occurred in 11/2013. The intervention documented did not have a date next to it, making it unclear when the intervention was added to the Care Delivery Guide.</p> <p>A Resident Incident report for Resident #13, dated 11/21/13 at 10:30 p.m., documented in part:</p> <p>* Incident Description: "cna called to room noted resident sitting on floor leaning on bed attempting to raise herself from floor."</p> <p>* Summary of Investigation Outcome: "Found that resident felt she wanted to get out of the facility and had stated that she knows she can walk. Resident at times is unaware of her physical impairments related to diagnosis, possibly exacerbated by recent UTI."</p> <p>* Summary of Corrective Action Taken: "Family and MD notified. Resident assisted back to bed. Resident reminded that she requires assist to get up out of bed. Follow up with MD regarding getting labwork and possible repeat UA, regarding residents episodes of confusion, forgetfulness."</p> <p>* Describe the final outcome: "On 11/22 orders received to get stat CBC, CMP, UA C&amp;S. Order to</p>	F 323		

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F 323	<p>Continued From page 40</p> <p>D/C [discontinue] Remeron, Seroquel 50mg [milligrams] po qd [by mouth every day] at noon and cont. [continue] 200mg at hs [bedtime]. Res[ident] on alert charting to monitor effects UA pos. [positive]. New orders received for Keflex for UTI. Cont[inue] to monitor until resolved."</p> <p>Note: No new interventions were added to the resident's Fall/Injury Assessment: Prevention and Management Plan of Care related to the second fall on 11/21/13.</p> <p>A Resident Incident report for Resident #13, dated 11/22/13, documented in part: * Incident Description: "LN walked out of room 9 after giving meds [medications]. Heard voice requesting assistance. Walked into room 14. No one was in first bed walked around bed and found resident on hands and knees with head under the bed. Asked her what she was doing. She said she was waiting for me at the foot of bed. Denied pain or discomfort. Very pleasant not combative. She was surprised I didn't think she should be on floor. Checked for injuries. None noted. she was hoyered back into bed." * Summary of Investigation Outcome: "Probable cause related to UTI, increased confusion, delusions. Res[ident] has poor safety awareness, impulsive. Res[ident] believes she can get up without assist." * Summary of Corrective Action Taken: "Labwork, UA done on 11/22. UA positive {sic} for UTI. New orders obtained from MD to treat with antibiotics. Medication changes made related to delusions [noted elsewhere in the clinical record] res. has been having. On 12/5/Airflow mattress was DC,d [discontinued] and changed to bari foam mattress with bil[ateral] bed bolsters to increase safety, define bed edges to help prevent falls from</p>	F 323			

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F 323	<p>Continued From page 41</p> <p>bed.Res. placed on alert charting to monitor. Braden risk assessment done. Care delivery guide updated. Pain assessment done. Care plan updated. Continue to treat current UTI."</p> <p>* Describe the final outcome: "Resident continues on antibiotic therapy for UTI. Also on bari bed with bari foam pressure relief mattress with bil. [bilateral] bed bolsters. Continue to monitor and offer res. assist q 2 hrs and pm."</p> <p>Note: The Fall/Injury Assessment: Prevention and Management Plan of Care for Resident #13 had no additional interventions related to the fall on 11/22/13.</p> <p>A Safety Device Plan of Care for Resident #13 documented the use of a bariatric bed with bilateral bed bolsters with a medical symptom of weakness, added on 11/17/13 (prior to the falls beginning on 11/19/13) as well as a bariatric foam pressure relief mattress with bilateral bed bolsters, initiated on 12/5/13.</p> <p>On 3/27/14 at 2:00 p.m., RCM #3 was asked if the facility increases supervision such as every 15 or 30 minute checks during times of infection. The RCM stated, "Yeah, we had to." When asked who was responsible for the checks the RCM said it was probably the aides closer by the resident who did them. Documentation of every 15 or 30 minute checks was requested, however, no documented evidence was provided.</p> <p>Resident #13 experienced 4 falls from 11/19/13 through 11/22/13 with 2 of the falls on the same day. However, the clinical record did not provide evidence of increased interventions or increased supervision to provide resident safety to prevent future falls.</p>	F 323			

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F 323  F 328 SS=D	<p>Continued From page 42</p> <p>On 3/27/14 at 3:10 p.m., the Administrator and DON were informed of the lack of supervision issue. However, no further information or documentation was provided.</p> <p><b>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS</b></p> <p>The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, it was determined the facility failed to provide oxygen (O2) therapy as ordered by the resident's physician. This affected 1 of 4 (#5) residents sampled for O2 therapy. This practice created the potential for more than minimal harm should the resident's O2 saturations drop causing the resident to become anxious, confused and experience respiratory distress. Findings included:</p> <p>Resident #5 was admitted to the facility with multiple diagnoses including chronic obstructive pulmonary disease (COPD).</p>	F 323  F 328	<p>It is the policy of Ivy Court to insure oxygen therapy is administered as prescribed.</p> <p>To enhance currently compliant operations and under the direction of the Director of Nursing, the licensed staff were re-educated regarding following the prescribed flow rates for oxygen.</p> <p>Resident # 5 is receiving the prescribed oxygen flow rate of 3 liters. He has had his oxygen saturations checked every shift since admission. They have consistently been &gt; 90% on a reduced flow rate of 2.5 liters. His oxygen orders have been clarified to read 1-3 liters continuous, titrate to keep SAT'S at or &gt; 89%.</p> <p>Since other residents receiving oxygen therapy may be affected by this cited deficiency, all such residents have had their orders verified and are receiving the prescribed amounts.</p> <p>Residents using oxygen will be monitored to insure correct flow rates are being administered. Audits will be conducted by the DON or designee 3 times a week for 4 weeks then weekly for 8 weeks beginning 4/25/14.</p> <p>Any deficiency will be corrected immediately, and the findings of the audits will be submitted at the QAPI committee meeting for tracking and trending x 3 months.</p>	4/30

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F 328	<p>Continued From page 43</p> <p>The resident's annual 8/20/13 MDS coded cognition intact and no O2 therapy. Section V of the resident's annual MDS triggered for dehydration but did not trigger for delirium.</p> <p>The resident's quarterly 2/18/14 MDS coded cognition intact and received O2 therapy.</p> <p>The resident's Respiratory Plan of Care identified the 8/19/13 problem potential/actual for alteration in oxygen exchange related to COPD. One of the problem interventions was, "O2 as ordered."</p> <p>The resident's 3/14 Physician's Orders (recapitulation orders) contained the order, "8/14/13, O2 @ 3 liters via [at 3 LPM by way of] (mask/nasal cannula) continuously for Dx: COPD to keep sats [blood O2 saturation levels] at or above 89%."</p> <p>On 3/24/14 at 1:55 p.m., the resident was observed in his room sitting in a wheelchair (wc). The resident was wearing a nasal cannula. The surveyor requested and the resident gave permission for the surveyor to observe the O2 setting on the O2 companion tank on the resident's wc back. The liter flow on the companion tank was, "2.0 liters per minute [LPM]." The surveyor said to the resident, 2 LPM. The resident nodded his head in an up and down motion.</p> <p>Review of the resident's 3/14 TAR, from 3/1/14 through 3/24/14, provided evidence nursing staff evaluated the resident's O2 sats each shift (day, evening, night) and the sats ranged from a low of 92% to a high of 99%.</p> <p>The resident's 3/14 TAR contained an entry,</p>	F 328		

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F 328	Continued From page 44 "8/14/13 O2 @ 3 liters via (mask/nasal cannula) continuously for DX: COPD to keep Sats at or above 89%." Nursing staff documented the resident's O2 was administered at 2.5 LPM from 3/1/14 through 3/24/14. [Note: The physician ordered O2 at 3 LPM continuously.]  On 3/26/14 at 11:16 a.m., the surveyor interviewed LN #10, with RCM #3 present, about Resident #5's O2 liter flow. LN #10 stated, "It is always at 2.5 LPM." At 11:18 a.m., RCM #3 stated, "We'll get a clarification order to allow nursing to administer the O2 in a range such as 1 - 3 LPM. [Resident #5] has been doing well [with the O2 at 2.5 LPM]."	F 328		
F 369 SS=D	483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS  The facility must provide special eating equipment and utensils for residents who need them.  This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, it was determined the facility failed to care plan the use of an assistive device, monitor the use of the device, develop alternative recommendations, or inform the Occupational Therapist (OT) when the resident refused to use the assistive device. This affected 1 of 6 (#1) residents sampled for assistive devices. This practice created the potential for more than	F 369		

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F 369	<p>Continued From page 45</p> <p>minimal harm should the resident experience a compromised nutrition status. Findings included:</p> <p>Resident #1 was admitted to the facility with multiple diagnoses including debility.</p> <p>The resident's 6/7/13 admission MDS coded cognition intact and required set up help for eating.</p> <p>On 3/25/14 at 12:25 p.m., the surveyor observed the resident eating independently in the main dining room. The resident's place setting had non-descript eating utensils: a fork, knife and spoon. The resident's dietary card documented in the lower left hand corner, "Rocker Knife." The surveyor asked RCM #11 what a rocker knife looked like. The RCM asked staff to obtain a Rocker Knife from the kitchen. In the meantime, the resident stated, "I used to get both types of knives but I do not use the Rocker Knife. The other one is good enough." The Rocker Knife provided from the kitchen had a large, black built-up handle and the knife blade was curved.</p> <p>On 3/25/14 at 1:45 p.m., the surveyor interviewed the DON, RCM #11 and the Nutrition Services Director (NSD) about the resident not receiving the Rocker Knife. The NSD stated, "I am looking for the therapy order for the Rocker Knife."</p> <p>Review of the resident's clinical record revealed the following:</p> <ul style="list-style-type: none"> <li>- The resident's 3/14 Physician's Orders (recapitulation orders) contained, in part, 7/14/13 Occupational Therapy to evaluate and treat as indicated.</li> </ul>	F 369	<p>It is the policy of Ivy Court to provide special eating equipment and utensils for residents who need them.</p> <p>To enhance currently compliant operations and under the direction of the Director of Nursing, staff have been re-educated on using the 24 Hour Nursing Report to communicate the addition of or the discontinuation of adaptive equipment. Nursing will care plan such and dietary will be notified using a Dietary Communication Slip.</p> <p>Resident # 1 has been evaluated and the use of the rocker knife has been discontinued. No adverse effects were noted from not using a rocker knife. Residents requiring adaptive devices for nutritional purposes have been evaluated and adaptive equipment is appropriate and care planned.</p> <p>Residents using adaptive devices for eating will be monitored to verify their use during meals. Audits will be conducted by the DON or her designee and / or the Nutrition Services Manager with each meal Monday through Friday x 7 days then daily x 30 days then weekly x 4 weeks beginning 4/25/14.</p> <p>Any deficiency will be corrected immediately, and the audit results will be submitted at the QAPI committee meeting for tracking and trending x 3 months.</p>	4/30

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NAME OF PROVIDER OR SUPPLIER  <b>IVY COURT</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2200 IRONWOOD PLACE</b> <b>COEUR D'ALENE, ID 83814</b>		
(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 369	<p>Continued From page 46</p> <p>- The 7/15/13 OT Daily Treatment Note documented, in part, "... Trial rocker style knife with pt [patient]; Pt demos [demonstrates] increased independence requiring sba [stand by assistance] for occasional instruction for technique. Placed order for kitchen to provide rocker knife for use with all meals..."</p> <p>Note: The resident's Nutrition Risk Plan of Care identified the 6/3/13 through 11/16/13 problem, at nutritional risk. The interventions did not include the use of any assistive devices during the timeframe of 6/3/13 through 11/16/13.</p> <p>On 3/25/14 at 2:30 p.m., the DON provided the surveyor with a copy of a handwritten, undated statement signed by the OT. The statement documented, in part, "It was the full intent of this therapist to have patient continue with use of adaptive rocker knife [with] all meals to reduce caregiver burden during patient meals and to allow patient to independently cut food items."</p> <p>On 3/26/14 at 12:50 p.m., the NSD stated, "We did not have an order for the Rocker Knife." The surveyor asked the NSD, why was the "Rocker Knife" entry made at the lower left hand corner of the dietary card? The NSD did not reply.</p> <p>On 3/26/14 at approximately 1:00 p.m., the DON provided a Nursing - Therapy Communication (NTC) form dated 3/26/14. The NTC form documented, in part, "...Please evaluate for ability to cut up food, use of ADL equipment."</p> <p>Note: The resident's physician ordered Occupational Therapy to evaluate and treat. The OT evaluated and recommended the use of the Rocker Knife. The use of the Rocker Knife was</p>	F 369		

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NAME OF PROVIDER OR SUPPLIER  IVY COURT			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 IRONWOOD PLACE COEUR D'ALENE, ID 83814		
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F 369	Continued From page 47 added to the resident's dietary card. The resident was not care planned for the assistive device. The resident was not provided a Rocker Knife on 3/25/14 at 12:25 p.m. The resident was not monitored for the use of the Rocker Knife. Therapy was not informed when the resident refused to use the Rocker Knife.	F 369			
F 371 SS=E	On 3/28/14 at 11:30 p.m., the Administrator and the DON were informed of the concern regarding the resident's refusal and therapy not informed of the refusals. 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by: Based on observation, sanitizing solution evaluation and staff interviews, it was determined the facility failed to ensure food was stored and sanitizing solutions were maintained under sanitary conditions. This had the potential to affect 13 of 13 (#s 1-13) sampled residents and any resident who dined in the facility. This practice created the potential for contamination of food and exposed residents to potential sources of disease causing pathogens. Findings included:	F 371			

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F 371	<p>Continued From page 48</p> <p>On 3/24/14 from 8:55 a.m. to 9:36 a.m., the Registered Dietitian (RD) accompanied the surveyors during the initial tour of the facility's kitchen. The following was observed:</p> <p>1. One of 2 red buckets contained what appeared to be sanitizing solution. Cook #12 placed a test strip into the solution located in Bucket #1. The test strip changed color and when asked what the level was, the Cook stated, "100 [ppm]." The RD placed a test strip into the solution located in Bucket #2. The test strip changed color and the RD said the level was, "200 [ppm]."</p> <p>Federal guidance at F371 specified, in part, "...the recommended sanitization concentrations are...QAC space (Quaternary) 150-200 ppm concentration..."</p> <p>2. A large industrial mixer was located near the food preparation counter and covered with an opaque plastic bag. The surveyor requested to observe the mixer for cleanliness. The RD removed the plastic cover. The mixer had visible light pink and white debris on the mixer frame and was sticky, tacky and rough to the touch. The area directly above where the mixing bowl would be placed when in use had a white and light brown substance that was sticky, tacky and rough to the touch.</p> <p>3. The grill, the backsplash located behind the grill, the stainless steel covered wall between the grill and the food preparation area, and the outside surfaces of the ovens had dark brown debris build-up and was tacky to the touch.</p> <p>4. The top surface of the convection oven had a</p>	F 371	<p>It is the policy of Ivy Court to procure/store/prepare/serve food under sanitary conditions.</p> <p>To enhance currently compliant operations and under the direction of the Nutrition Services Manager (NSM), the dietary staff have been re-educated on mixing the sanitizing solution correctly and environmental practices necessary to maintain a sanitary kitchen environment.</p> <p>Resident #'s 1-13 have had no negative outcomes from the cited deficiency. All residents dining in the center have the potential to be affected by this cited deficiency but have experienced no negative outcomes.</p> <p>All environmental findings have been corrected and sanitizing solutions have been recorded between 150-200 ppm.</p> <p>A Quick Kitchen Sanitation Rounds form will be completed daily, Monday through Friday, by the NSM x 30 days then 3 times a week x 30 days then weekly x 30 days beginning 4/25/14.. The more extensive RD Sanitation Rounds will be completed by the Registered Dietician weekly x 30 days then twice a month x 2 months beginning 4/25/14.</p> <p>Any deficiencies will be corrected immediately, audit results will be brought to QAPI committee meetings for tracking and trending x 3 months.</p>	4/30

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F 371	<p>Continued From page 49</p> <p>thick layer of dark brown debris build-up and was rough to the touch.</p> <p>5. The walk-in refrigerator had a creamy white substance stuck onto the top side and underside of the blue storage shelves which was sticky and tacky to the touch.</p> <p>6. The walk-in freezer had a creamy white, light pink substance frozen onto the top side and underside of the blue storage shelves which was sticky and tacky to the touch. The RD said the substance was, "Melted ice cream."</p> <p>7. A big black fan was attached to the wall in the warewashing room. The cage was covered with dark gray, stringy dust bunnies. The fan blades were covered in a brown, flaky and dusty debris. The RD stated, "I see that."</p> <p>8. A rack of 20 Dynex mugs were observed with the assistance of the RD. Two of the 20 mugs were found to have deep gouges and scratches on the inside near the rim making an uncleanable, uneven surface. The RD promptly removed the mugs.</p> <p>The 2009 FDA Food Code chapter 4 Equipment, Utensils, and Linens, Subpart 4-202 Cleanability documented, "4-202.11 Food-Contact Surfaces. (A) Multiuse food-contact surfaces shall be: (1) Smooth; (2) Free of breaks, open seams, cracks, chips, inclusions, pits, and similar imperfections..."</p> <p>The 2009 FDA Food Code, Chapter 4, Part 4-6, Cleaning of Equipment and Utensils, Subpart 601.11 Equipment, Food-Contact Surfaces, Nonfood Contact Surfaces, and Utensils</p>	F 371		

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F 371	Continued From page 50 indicated, "(C) Non food-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris...(5) At any time during the operation when contamination may have occurred." Subpart 602.13, Nonfood-Contact Surfaces, indicated, "Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues."  On 3/25/14 at 8:22 a.m., the Nutrition Services Director (NSD) was interviewed about the observations in the kitchen the day before. When asked how a substance was melted, yet frozen onto the storage shelves in the walk-in freezer, she said when ice cream is scooped it may drip onto the shelves. The NSD was asked how often the convection oven, the outside of the oven, the grill, the grill backsplash, and the stainless steel covered wall between the grill and the food preparation area were to be cleaned. She said they were to be cleaned as they get dirty, and cleaning the equipment was also closing duty. At 8:30 a.m., the NSD stated, "Many of these concerns have been fixed. We had a new cook over the weekend - the first weekend the cook worked by herself."	F 371			
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission	F 441			

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F 441	<p>Continued From page 51 of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure infection control measures were consistently implemented. This was true for 1 of 13 (#1) sampled residents</p>	F 441	<p>It is the policy of Ivy Court to maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to prevent the development and transmission of disease and infection.</p> <p>To enhance currently compliant operations and under the direction of the Director of Nursing, staff were re-educated on infection control practices in regard to urinal placement on the over bed / bedside tables.</p> <p>Residents # 1, 17, 18, and 19 have had their urinals relocated from the over bed tables. Residents using urinals have been assessed and their urinals have been relocated from the over bed / bedside table. Resident preferences were included in the care planning of urinal location.</p> <p>Through the Caring Partner program and under the direction of the Administrator, rooms will be audited daily, Monday through Friday, for urinal location x 30 days then weekly x 60 days beginning 4/25/14.</p> <p>Any deficiencies will be corrected immediately and results of audits brought to QAPI committee meetings for tracking and trending x 3 months.</p>	4/30

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F 441	<p>Continued From page 52</p> <p>and 3 random residents (#s 17, 18 &amp; 19) whose urinals were in close proximity to hand-held electronic devices, water pitchers and cups. Failure to follow standard infection control measures placed the residents at risk for infections. Findings included:</p> <p>On 3/24/14 the following observations were made:</p> <ul style="list-style-type: none"> <li>* 1:32 p.m., a urinal was observed on Resident #17's bedside table next to a watcher pitcher;</li> <li>* 1:35 p.m., a urinal was observed on Resident # 18's bedside table next to electronic remotes;</li> <li>* 1:52 p.m., a urinal was observed on Resident #19's bedside table next to a water pitcher.</li> </ul> <p>On 3/25/14 the following observations were made in Resident #18's room:</p> <ul style="list-style-type: none"> <li>* 8:40 a.m., a urinal was observed on the bedside table next to a computer device;</li> <li>* 10:38 a.m., a urinal was observed on the bedside table next to a glass containing orange liquid; and,</li> <li>* 1:45 p.m., a urinal was observed on the bedside table next to a glass with a straw in it.</li> </ul> <p>On 3/27/14 at 1:55 p.m., the DON was asked where she would expect urinals to be placed in resident rooms. She stated, "Not on their bedside table" and added she preferred to have them hang on the bed siderails.</p> <p>On 3/28/14 at 3:10 p.m., the Administrator and DON were informed of the urinal observations. No further information or documentation was provided.</p> <p>2. On 3/24/14 at approximately 9:45 AM, Resident #1 was observed sitting in his room in his motorized wheelchair. His overbed table was</p>	F 441		

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F 441	Continued From page 53 slightly behind him. His water mug, urinal, and a roll of toilet paper were sitting on top of the overbed table. The water mug was approximately 1 foot from his urinal.  On 3/24/14 at 9:55 AM, RCM #6 was asked if it was acceptable for the resident's urinal to be on the overbed table. RCM #6 stated, "Not with his water mug, it's not."  On 3/27/14 at 3:15 PM, the Administrator and DNS were informed of the surveyors' findings. The facility offered no further information.	F 441		
F 492 SS=D	<b>483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD</b>  The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility.  This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of the facility's Medication Administration Procedure, review of the Bureau of Facility Standards (BFS) Informational Letter #97-3, resident interview, and staff interviews, it was determined the facility failed to ensure a physician ordered medication was administered and documented as administered by a licensed nurse. This affected 1 of 9 (#9) residents sampled for quality of care. This practice created the potential for the resident's skin condition to worsen should the resident not receive the medication and treatment	F 492		

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F 492	<p>Continued From page 54 as ordered. Findings included:</p> <p>The BFS Informational Letter #97-3 documented, in part, "...The Board's [Idaho Board of Nursing] expectation, and the accepted standard of practice, is that licensed nurses document those things they have done, not what they intend to do..."</p> <p>Resident #9 was admitted to the facility with multiple diagnoses, including osteoporosis.</p> <p>The resident's 1/1/14 annual MDS coded cognition intact and required one person extensive assistance for dressing, personal hygiene, and bathing.</p> <p>The resident's Physician's Telephone Orders (PTOs) contained, in part, "2/17/14, yeast under breasts...Interdry sheets under breasts..."</p> <p>The resident's "Skin Integrity Assessment Prevention and Treatment Care Plan" (CP) included, in part, a handwritten entry, "Problem, 2/18/14 Yeast [under] breasts...goal..."2/18 [no year documented] Yeast [under] breasts will resolve without complications...intervention, "2/18 See TAR."</p> <p>The above identified 2/18/14 CP problem was lined through and following was the next handwritten entry on the CP. "Problem, 3/21/14 Yeast [under] breasts...goal, 3/21/14, Yeast [under] breasts will resolve [without] complications." The two interventions were, "3/21/14 See TAR and Interdry sheets to area under breasts."</p> <p>The resident's PTOs also contained, in part,</p>	F 492	<p>It is the policy of Ivy Court to follow accepted professional standards.</p> <p>To enhance currently compliant operations and under the direction of the Director of Nursing, nursing staff have been re-educated using BFS Informational Letter #97-3 and medication administration policies and procedures. LN # 2 and CNA # 1 have been educated / disciplined as appropriate.</p> <p>Resident # 9 is having her treatment performed by a licensed nurse. Residents receiving physician prescribed treatments were reviewed and it was determined they were being completed by the licensed staff as ordered.</p> <p>Treatments will be monitored to insure they are carried out using accepted professional standards. Under the direction of the DON audits will be completed daily, Monday through Friday, x 30 days then 3 times per week x 30 days then weekly x 30 days beginning 4/25/14.</p> <p>Any issues will be corrected immediately and audit results will be presented at the QAPI committee meetings for tracking and trending x 3 months.</p>	4/30

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F 492	<p>Continued From page 55</p> <p>"3/24/14, diagnosis yeast, CSS - may use home supply to affected skin area BID [two times a day], Interdry sheets to area under breasts..."</p> <p>The resident's 3/14 TAR contained an entry, "3/24/14 CSS (may use home supply) to affected skin area BiD and Interdry sheets to area under breasts [after] CSS." The TAR identified the treatment hours, "am and pm." On 3/24/14, the am and pm medication hours were initialed indicating the resident received the treatments. On 3/25/14, the "am" medication hour was "initialed" indicating the resident received the treatment. The initials were not distinguishable or legible.</p> <p>On 3/25/14 from 9:10 a.m. to 9:12 a.m., the surveyor observed the following. A pink plastic spray bottle with the words "Colidal {sic} Silver [CSS]..." handwritten with black marker on the bottle. The plastic spray bottle contained a clear liquid and was located on the seat of the chair next to the resident's bed. The resident was sitting in a wheelchair (wc) next to the bed. CNA #1 rinsed a white washcloth with water from the sink faucet, used the wet washcloth to wipe under the resident's breasts, patted the area dry, then sprayed the CSS under the breasts. After spraying the CSS under the resident's breasts, the CNA applied the Interdry sheets under the breasts.</p> <p>Note: Please refer to F176 as it related to physician ordered medication maintained in the resident's room.</p> <p>On 3/25/14 at 1:13 p.m., the surveyor interviewed the resident about who administered the CSS under her breasts. The resident stated, "One of</p>	F 492		

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(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 492	<p>Continued From page 56</p> <p>the aides gives me the CSS to my breasts." The surveyor asked the resident if the nurses who gave her medications applied the CSS. The resident stated, "No, the nurses do not, the CNAs do it [apply CSS under her breasts]."</p> <p>On 3/25/13 at 3:09 p.m., the surveyor asked the DON, who should administer the CSS for Resident #9? The DON stated, "The nurse(s)."</p> <p>On 3/25/14 at 3:10 p.m., the surveyor interviewed CNA #1 and asked why he sprayed the CSS under the resident's breasts. The CNA stated, "[Resident #9] asked me to." The surveyor then asked the CNA where the administration of the CSS would be documented. The CNA stated, "I did not document the administration of the CSS anywhere."</p> <p>On 3/25/14 at 3:28 p.m., the surveyor interviewed RCM #3 about the CSS order. The RCM stated, "The order is not clear that the CSS can be at bedside or in the room. I need to get a clarification for the order." The surveyor then showed the RCM the resident's 3/14 TAR and asked, who was the nurse who initialed the CSS 3/25/14 am timeframe? RCM #3 said LN #2.</p> <p>On 3/25/14 at 3:31 p.m., the surveyor, with RCM #3 present, interviewed LN #2 about the CSS 3/25/14 am timeframe. The surveyor asked LN #2 if the initials were hers and what the initials meant. LN #2 stated, "Those are my initials. The initials mean [Resident #9] received the CSS." The surveyor asked LN #2, "Did you do it, administer the CSS to the resident?" LN #2 looked at RCM #3. LN #2 then asked RCM #3, "Did you do it?" RCM #3 moved her head in a back and forth motion indicating no, she did not</p>	F 492			

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

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FORM APPROVED  
OMB NO. 0938-0391

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F 492	<p>Continued From page 57</p> <p>administer the CSS. LN #2 stated, "I asked [Resident #9] if she got it [the CSS] and she said yes." The surveyor informed RCM #3 and LN #2, a CNA was observed administering the CSS for the resident earlier that day.</p> <p>On 3/26/14 at 2:20 p.m. a surveyor and RCM #3 observed and measured the affected area under the resident's breasts. The affected area measured approximately 25 centimeters in length. RCM #3 stated, "The area is not as dark as it used to be." The area was observed to be pink in color with a yeast smell. The resident stated, "It never hurt bad - was itchy. But it does feel better than it used to feel. I think it is getting better."</p> <p>On 3/26/14 at 6:43 p.m., the survey team requested a copy of the facility's MAR and TAR documentation policy and procedure. The facility's Medication Administration Procedure, revision date of November 2012, documented, in part, "...8...The licensed nurse and/or medication assistant will...Administer medication...16. Document...administration of medication on the MAR as soon as medications are given..."</p> <p>On 3/28/14 at 11:30 a.m., the Administrator and DON were informed of the concern the CNA administered the resident's CSS and nursing documented the TAR as administered. The facility did not provide any additional information.</p>	F 492		

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C 000	<p><b>16.03.02 INITIAL COMMENTS</b></p> <p>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.</p> <p>The following deficiencies were cited during the Recertification and Re-licensure survey and complaint investigation of your facility.</p> <p>The survey team included:</p> <p>Nina Sanderson, LSW BSW - team coordinator Karen Marshall, MS RD LD Lauren Hoard, RN BSN</p> <p>The survey team entered the facility on Monday 3/24/14 and exited Friday 3/28/14.</p> <p>Survey Definitions:</p> <p>ADLs = Activities of Daily Living CBC = Complete Blood Count CM = Centimeters CMP = Comprehensive Metabolic Panel CNA = Certified Nurse Aide C&amp;S = Culture &amp; Sensitivity DNS/DON = Director Nursing Services / Director of Nursing DX = Diagnosis ER = Emergency Room FDA = Food and Drug Administration LE = Lower Extremity/ies LN = Licensed Nurse MAR = Medication Administration Record MD = Medical Doctor MDS = Minimum Data Set Assessment ORIF = Open Reduction Internal Fixation RCM = Resident Care Manager TAR = Treatment Administration Record /</p>	C 000	<p style="text-align: right;"><b>RECEIVED</b></p> <p style="text-align: right;"><b>MAY - 5 2014</b></p> <p style="text-align: right;"><b>FACILITY STANDARDS</b></p>	
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Bureau of Facility Standards LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>NNA</b>	(X6) DATE <b>5/5/14</b>
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C 000	Continued From page 1 Treatment Record	C 000		
C 123	02.100,03,c,vii Free from Abuse or Restraints  vii. Is free from mental and physical abuse, and free from chemical and (except in emergencies) physical restraints except as authorized in writing by a physician for a specified and limited period of time, or when necessary to protect the patient/resident from injury to himself or to others;  This Rule is not met as evidenced by: Refer to F221 as it relates to physical restraints.	C 123	See F221	4/30
C 141	02.100,05,a Opportunity for Motion & Exercise  a. Opportunity for motion and exercise, including activities of daily living, shall be provided during normal waking hours to patients/residents in mechanical restraints for a period of not less than ten (10) minutes during each two (2) hours in which restraints are employed. During normal sleeping hours, patients/residents in restraints shall continue to be checked every thirty (30) minutes, with supporting documentation. Circulation and skin integrity shall be assessed, and mechanical restraints loosened for range of motion exercises and turning and repositioning at least every two (2) hours.  This Rule is not met as evidenced by: Based on observation, staff interview and record	C 141		

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C 141	<p>Continued From page 2</p> <p>review, it was determined the facility failed to ensure a mechanical restraint was loosened, for range of motion exercise and turning and repositioning, for not less than 10 minutes during each 2 hours a seat belt was in use. This was true for 1 of 2 (#6) sampled residents reviewed for use of seat belts. Findings included:</p> <p>Resident #6 was admitted to the facility on 11/15/12 and readmitted on 4/3/13 with multiple diagnoses which included Lewy body dementia and depression with psychosis.</p> <p>The resident's March 2014 recapitulation Physician's Orders documented, "SELF RELEASE SEATBELT WHEN UP IN WHEELCHAIR DUE TO POOR SAFETY AWARENESS" with a date of 10/7/13.</p> <p>The Safety Device Plan of Care for Resident #6 documented in the Problem column, "Self Release seatbelt when [up] in w/c [.] Poor Safety Awareness [.] Weakness." The Interventions column documented, "Apply Safety Device (date) 10/7/13[.] Type: Self release seatbelt when [up] in w/c. Medical Symptoms: Poor Safety awareness/weakness." The Intervention column had an area for "Safety device Reduction" and "Safety Device Release." However, those areas were left blank.</p> <p>The following observations were made of Resident #6 with the seat belt secured:</p> <ul style="list-style-type: none"> <li>* 3/24/14 at 1:38 p.m., the resident was sitting in her room in her wheelchair with the seat belt secured around her waist;</li> <li>* 3/25/14 at 10:40 a.m., the resident was sitting in her room in her wheelchair the seat belt secured around her waist. When asked if she could release her seat belt, she stated, "I've tried" and</li> </ul>	C 141	<p>Refer to F221</p> <p>It is the policy of Ivy Court to keep residents free from physical restraint.</p> <p>To enhance currently compliant operations and under the direction of the Director of Nursing, staff have been re-educated on the Safety Device Program policies and procedures. As the center did not view a Velcro self-release seat belt as a restraint, the seat belt in question was not released every two hours.</p> <p>Resident # 6 has been reassessed and the Velcro seat belt has been removed from her chair. Since other residents utilizing such a safety device are at risk, the DON or designee has completed assessments to insure they are the least restrictive device and are monitored per policy. Audits of residents using self-release seat belts will be completed by the DON or designee twice daily, Monday through Friday, for 30 days, then daily for 2 weeks, then weekly for 4 weeks beginning 4/25/14. Any deficient practice will be corrected immediately and the findings will be submitted to the QAPI committee x 3 month for tracking and trending.</p>	4/30
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C 141	<p>Continued From page 3</p> <p>touched the seat belt but did not release it.</p> <p>Review of Resident #6's clinical record did not provide evidence that the wheelchair seat belt was loosened every two hours when the seat belt was in use.</p> <p>On 3/27/13 at 9:14 a.m., RCM #3 was asked if the resident's skin was being assessed and the seat belt released at least every 2 hours. The RCM looked at the Safety Device Plan of Care for Resident #6 and noted an unchecked area which read, "Check and release safety device every 2 hours." The RCM stated it, "Should have been checked" and check marked the box and added the date. The RCM also noted the unchecked area which read, "Monitor skin integrity at area of safety device for signs of impairment." RCM #3 check marked the box and added the date.</p> <p>On 3/26/14 at 6:45 p.m., the Administrator and DON were informed of the restraint issue.</p> <p>On 3/31/14 addition information was provided by the facility. However, it did not resolve the issue.</p>	C 141		
C 143	<p>02.100,05,c Checked &amp; Recorded Every 30 Minutes</p> <p>c. The patient/resident in mechanical restraints shall be checked at least every thirty (30) minutes by the staff and a record of such checks shall be kept.</p> <p>This Rule is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure residents were checked every 30 minutes when seat belts were in use. This affected 1 of 2</p>	C 143		

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C 143	<p>Continued From page 4</p> <p>residents (#6) reviewed for use of seat belts. Findings included:</p> <p>Resident #6 was admitted to the facility on 11/15/12 and readmitted on 4/3/13 with multiple diagnoses which included lewy body dementia and depression with psychosis.</p> <p>The resident's March 2014 recapitulation Physician's Orders documented, "SELF RELEASE SEATBELT WHEN UP IN WHEELCHAIR DUE TO POOR SAFETY AWARENESS" with a date of 10/7/13.</p> <p>The Safety Device Plan of Care for Resident #6 documented in the Problem column, "Self Release seatbelt when [up] in w/c [.] Poor Safety Awareness [.] Weakness." The Interventions column documented, "Apply Safety Device (date) 10/7/13[.] Type: Self release seatbelt when [up] in w/c. Medical Symptoms: Poor Safety awareness/weakness." The Intervention column had an area for "Safety device Reduction" and "Safety Device Release." However, those areas were left blank.</p> <p>The following observations were made of Resident #6 with the seat belt secured:                      * 3/24/14 at 1:38 p.m., the resident was sitting in her room in her wheelchair with the seat belt secured around her waist;                      * 3/25/14 at 10:40 a.m., the resident was sitting in her room in her wheelchair the seat belt secured around her waist. When asked if she could release her seatbelt, she stated, "I've tried" and touched the seat belt but did not release it.</p> <p>Review of Resident #6's clinical record did not provide evidence that the facility checked the resident every 30 minutes when the seat belt was</p>	C 143	<p>Refer to F 221</p> <p>It is the policy of Ivy Court to check residents in mechanical restraints every 30 minutes.</p> <p>To enhance currently compliant operations and under the direction of the Director of Nursing, staff have been re-educated on the Safety Device Program policies and procedures. As the center did not view a Velcro self-release seat belt as a restraint, it was not checked every 30 minutes.</p> <p>Resident # 6 has been reassessed and her seat belt removed. Since other residents utilizing such a safety device are at risk, the DON or designee has completed assessments to insure they are the least restrictive device and are monitored per policy. Audits of residents using self-release seat belts will be completed by the DON or designee twice daily, Monday through Friday, for 30 days, then daily for 2 weeks, then weekly for 4 weeks beginning 4/25/14. Any deficient practice will be corrected immediately and findings will be submitted to the QAPI committee meetings x 3 months for tracking and trending.</p>	4/30

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C 143	<p>Continued From page 5</p> <p>in use.</p> <p>On 3/27/13 at 9:14 a.m., RCM #3 was asked if the resident's skin was being assessed and the seat belt released at least every 2 hours. The RCM looked at the Safety Device Plan of Care for Resident #6 and noted an unchecked area which read, "Check and release safety device every 2 hours." The RCM stated it, "Should have been checked" and check marked the box and added the date. The RCM also noted the unchecked area which read, "Monitor skin integrity at area of safety device for signs of impairment." RCM #3 check marked the box and added the date.</p> <p>On 3/26/14 at 6:45 p.m., the Administrator and DON were informed of the restraint issue.</p> <p>On 3/31/14 addition information was provided by the facility. However, it did not resolve the issue.</p>	C 143		
C 175	<p>02.100,12,f Immediate Investigation of Incident/Injury</p> <p>f. Immediate investigation of the cause of the incident or accident shall be instituted by the facility administrator and any corrective measures indicated shall be adopted. This Rule is not met as evidenced by: Please see F 225 as it pertains to incident investigations.</p>	C 175	see F 225	4/30
C 325	<p>02.107,08 FOOD SANITATION</p> <p>08. Food Sanitation. The acquisition, preparation, storage, and serving of all food and drink in a facility shall comply with Idaho</p>	C 325		

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C 325	Continued From page 6  Department of Health and Welfare Rules, Title 02, Chapter 19, "Rules Governing Food Sanitation Standards for Food Establishments (UNICODE)." This Rule is not met as evidenced by: Refer to F371 as it relates to sanitary conditions in the kitchen.	C 325	see 7371	4/30
C 362	02.108,07,a Interior Surfaces Kept Clean & Sanitary  a. Floors, walls, ceilings, and other interior surfaces, equipment and furnishing shall be kept clean, and shall be cleaned in a sanitary manner. This Rule is not met as evidenced by: Please refer to F253 as it related to the transition strips in rooms on the East hallway.	C 362	see 7253	4/30
C 669	02.150,03 PATIENT/RESIDENT PROTECTION  03. Patient/Resident Protection. There is evidence of infection control, prevention and surveillance in the outcome of care for all patients/residents as demonstrated by: This Rule is not met as evidenced by: Refer to F441 as it relates to infection control measures.	C 669	see 7441	4/30
C 782	02.200,03,a,iv Reviewed and Revised  iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by:	C 782		

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C 782	Continued From page 7  Please refer to F280 as it related to not updating a resident's care plan.	C 782	see 7280	4/30
C 784	02.200,03,b Resident Needs Identified  b. Patient/resident needs shall be recognized by nursing staff and nursing services shall be provided to assure that each patient/resident receives care necessary to meet his total needs. Care shall include, but is not limited to: This Rule is not met as evidenced by: Please refer to F314 as it related to the use of Sage boots for the resident. Refer to F309 as it relates to not following the care plan for transfers.	C 784	see 7314 7309	4/30
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: Please refer to F369 as it related to a resident refusing the use of assistive devices.	C 787	see 7369	4/30
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: Please refer to F328 as it related to not following physician's orders for oxygen therapy.	C 788	see 7328	4/30

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C 789 C 789	Continued From page 8 02.200,03,b,v Prevention of Decubitus  v. Prevention of decubitus ulcers or deformities or treatment thereof, if needed, including, but not limited to, changing position every two (2) hours when confined to bed or wheelchair and opportunity for exercise to promote circulation; This Rule is not met as evidenced by: Please see F 314 as it pertains to pressure ulcers.	C 789 C 789	All 7314	4/30
C 790	02.200,03,b,vi Protection from Injury/Accidents  vi. Protection from accident or injury; This Rule is not met as evidenced by: Refer to F323 as it relates to preventing accidents.	C 790	All 7323	4/30
C 835	02.201,02,i Meds in Possession of Resident Limitations  i. No medication shall be in the possession of the patient/resident unless specifically ordered by the physician on the patient's/resident's medical record, and in no case shall exceed two (2) units of dosage. All such medications shall be individually packaged by the pharmacist in units of dose, labeled with the patient's/resident's name, unit of dose, and date of distribution. The charge nurse shall maintain an inventory of these drugs on the patient's/resident's medical record.	C 835	All 7176	4/30

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NAME OF PROVIDER OR SUPPLIER  <b>IVY COURT</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2200 IRONWOOD PLACE</b> <b>COEUR D'ALENE, ID 83814</b>
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(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) COMPLETE DATE
C 835	Continued From page 9  This Rule is not met as evidenced by: Please refer to F176 as it related to a physician ordered medication observed in the chair in the resident's room.	C 835		
C 854	02.201,04,a RECORD OF MEDICATIONS  04. Record of Medications.  a. An accurate and complete record of all medication given, both prescription and nonprescription, shall be recorded in the patient's/resident's chart. The record shall also include the time given, the medication given, date, dosage, method of administration, and the name and professional designation (R.N., L.P.N.) of the person preparing and administering the medication. The first and last name initials may be used if identified fully elsewhere in the medical record.  This Rule is not met as evidenced by: Based on observation, record review, review of the facility's Medication Administration Procedure, review of the Bureau of Facility Standards (BFS) Informational Letter #97-3, resident interview, and staff interviews, it was determined the facility failed to ensure a physician ordered medication was administered and documented as administered by a licensed nurse. This affected 1 of 9 (#9) residents sampled for quality of care. This practice created the potential for the resident's skin condition to worsen should the resident not receive the medication and treatment as ordered. Findings included:  The BFS Informational Letter #97-3 documented,	C 854	All 7 492	4/30

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001150</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C <b>03/28/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>IVY COURT</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2200 IRONWOOD PLACE COEUR D'ALENE, ID 83814</b>
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C 854	<p>Continued From page 10</p> <p>in part, "...The Board's [Idaho Board of Nursing] expectation, and the accepted standard of practice, is that licensed nurses document those things they have done, not what they intend to do..."</p> <p>Resident #9 was admitted to the facility with multiple diagnosis including osteoporosis.</p> <p>The resident's 1/1/14 annual MDS coded cognition intact and required one person extensive assistance for dressing, personal hygiene, and bathing.</p> <p>The resident's Physician's Telephone Orders (PTOs) contained, in part, "2/17/14, yeast under breasts...Interdry sheets under breasts..."</p> <p>The resident's "Skin Integrity Assessment Prevention and Treatment Care Plan" (CP) included, in part, a handwritten entry, "Problem, 3/21/14 Yeast [under] breasts...goal, 3/21/14, Yeast [under] breasts will resolve [without] complications." The two interventions were, "3/21/14 See TAR and Interdry sheets to area under breasts."</p> <p>The resident's PTOs also contained, in part, "3/24/14, diagnosis yeast, CSS - may use home supply to affected skin area BID [two times a day], Interdry sheets to area under breasts..."</p> <p>The resident's 3/14 TAR contained an entry, "3/24/14 CSS (may use home supply) to affected skin area BID and Interdry sheets to area under breasts [after] CSS." The TAR identified the treatment hours, "am and pm." On 3/24/14, the am and pm medication hours were initialed indicating the resident received the treatments. On 3/25/14, the "am" medication hour was</p>	C 854		

Bureau of Facility Standards

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C 854	<p>Continued From page 11</p> <p>"initialed" indicating the resident received the treatment. The initials were not distinguishable.</p> <p>On 3/25/14 from 9:10 a.m. to 9:12 a.m., the surveyor observed the following. A pink plastic spray bottle with the words "Colidal {sic} Silver [CSS]..." handwritten with black marker on the bottle. The plastic spray bottle contained a clear liquid and was located on the seat of the chair next to the resident's bed. The resident was sitting in a wheelchair (wc) next to the bed. CNA #1 rinsed a white washcloth with water from the sink faucet, used the wet washcloth to wipe under the resident's breasts, patted the area dry, then sprayed the CSS under the breasts. After spraying the CSS under the resident's breasts, the CNA applied the Interdry sheets under the breasts.</p> <p>On 3/25/14 at 1:13 p.m., the surveyor interviewed the resident about who administered the CSS under her breasts. The resident stated, "One of the aides gives me the CSS to my breasts." The surveyor asked the resident if the nurses who gave her medications applied the CSS. The resident stated, "No, the nurses do not, the CNAs do it [apply CSS under her breasts]."</p> <p>On 3/25/13 at 3:09 p.m., the surveyor asked the DON, who should administer the CSS for Resident #9? The DON stated, "The nurse(s)."</p> <p>On 3/25/14 at 3:10 p.m., the surveyor interviewed CNA #1 and asked why he sprayed the CSS under the resident's breasts. The CNA stated, "[Resident #9] asked me to." The surveyor then asked the CNA where the administration of the CSS would be documented. The CNA stated, "I did not document the administration of the CSS anywhere."</p>	C 854		

Bureau of Facility Standards

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C 854	<p>Continued From page 12</p> <p>On 3/25/14 at 3:28 p.m., the surveyor interviewed RCM #3 about the CSS order. The RCM stated, "The order is not clear that the CSS can be at bedside or in the room. I need to get a clarification for the order." The surveyor then showed the RCM the resident's 3/14 TAR and asked, who was the nurse who initialed the CSS 3/25/14 am timeframe? RCM #3 said LN #2.</p> <p>On 3/25/14 at 3:31 p.m., the surveyor, with RCM #3 present, interviewed LN #2 about the CSS 3/25/14 am timeframe. The surveyor asked LN #2 if the initials were hers and what the initials meant. LN #2 stated, "Those are my initials. The initials mean [Resident #9] received the CSS." The surveyor asked LN #2, "Did you do it, administer the CSS to the resident?" LN #2 looked at RCM #3. LN #2 then asked RCM #3, "Did you do it?" RCM #3 moved her head in a back and forth motion indicating no, she did not administer the CSS. LN #2 stated, "I asked [Resident #9] if she got it [the CSS] and she said yes." The surveyor informed RCM #3 and LN #2, a CNA was observed administering the CSS for the resident earlier that day.</p> <p>On 3/26/14 at 6:43 p.m., the survey team requested a copy of the facility's MAR and TAR documentation policy and procedure. The facility's Medication Administration Procedure, revision date of November 2012, documented, in part, "...8...The licensed nurse and/or medication assistant will...Administer medication...16. Document...administration of medication on the MAR as soon as medications are given..."</p> <p>On 3/28/14 at 11:30 a.m., the Administrator and DON were informed of the concern the CNA administered the resident's CSS and nursing</p>	C 854		

Bureau of Facility Standards

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C 854	Continued From page 13  documented the TAR as administered. The facility did not provide any additional information.  Note: Please refer to F492 as it related to the CNA administering the CSS and nursing documented the TAR as administered.	C 854		



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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May 13, 2014

Gary L. Liesner, Administrator  
Ivy Court  
2200 Ironwood Place  
Coeur d'Alene, ID 83814-2610

FILE COPY

Provider #: 135053

**RE:** Corrected copy of the March 28, 2014 Complaint Investigation findings for  
Complaint #6384

Dear Mr. Liesner:

On March 28, 2014, a Complaint Investigation was conducted in conjunction with the Recertification & State Licensure survey. On **May 9, 2014**, your facility was sent a letter from our office notifying you of the results of that survey.

The **May 9, 2014**, findings letter is revised as follows as in the previous sent findings letter the last paragraph needed to be deleted to avoid conflicting information.

On **March 28, 2014**, a Complaint Investigation survey was conducted at Ivy Court. Nina Sanderson, L.S.W., Karen Marshall, R.D. and Lauren Hoard, R.N. conducted the complaint investigation. This complaint was investigated in conjunction with the facility's annual Recertification and State Licensure survey.

The resident's closed clinical record was reviewed. The resident was admitted to the facility on December 12, 2013, from a local hospital and discharged to a different local hospital's emergency room on December 27, 2013, at 7:00 p.m.

Gary L. Liesner, Administrator  
May 13, 2014  
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Documentation reviewed:

- Incident and Accident reports from October 1, 2013 through March 23, 2014;
- Grievances from January 1, 2014 through March 23, 2014; and
- Resident Council Meeting minutes from January 2014 through March 2014.

Nine residents were observed during the survey process for quality of life, quality of care, room and daily life reviews, drug therapies, minimum data set and care area assessments.

Interviews were conducted with the Resident Care Manager who provided care for the identified resident, the Licensed Social Worker, the Social Services Assistant, the Speech Language Pathologist and the Administrator.

Interviews were conducted individually with four residents and the family members of two other residents. The individual residents and residents' family members did not express any concerns with the facility's pain management program, Dietary Services or catheter care, as applicable.

Eleven residents who attended the resident group interview did not express any concerns with nursing staff, pain management, Dietary Services or catheter care, as applicable.

Eight sampled residents were reviewed for pain management. Two sampled residents were reviewed for catheter care.

The survey team did not identify any concerns with pain management or catheter care.

The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00006384**

**ALLEGATION #1:**

The complainant stated an identified resident had increased abdominal pain for about a week after admission, and the nurses did not contact the physician regarding the pain the resident experienced.

**FINDINGS:**

The identified resident was admitted to the facility with multiple diagnoses: quadriplegia, acute on chronic sacral osteomyelitis involving the coccyx and left ischium, polymicrobial sacral decubitus wound infection with cultures positive for Escherichia coli, methicillin-resistant

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Staphylococcus aureus, and vancomycin-resistant enterococcus, severe protein calorie malnutrition, chronic hypotension, anemia status post course of Venofer for iron deficiency, multiple myeloma, off all chemotherapy, chronic pain, narcotic dependence, weakness and debilitation.

The resident had numerous orders for pain management. Those orders included Baclofen five milligrams for spasticity, Neurontin one hundred milligrams every morning, Neurontin three hundred milligrams every evening for neuropathy, Dilaudid two milligrams one hour before dressing changes, Dilaudid four milligrams every four hours as needed and Oxycontin ten milligrams two times a day.

According to the documentation in the resident's clinical record, nursing staff monitored the resident's response to pain medication administration, and the resident said the pain medications were effective.

The resident's December 17, 2013, Progress Note signed by the Resident Care Manager, documented the resident reported no pain at that time. The Resident Care Manager and the resident reviewed the resident's care log that was initiated the prior evening and discussed that the resident's pain reports and concerns were addressed. The resident stated his pain reports and concerns were addressed. The Resident Care Manager also discussed with the resident, that the doctor's office said they received the request for intravenous medications prior to dressing change but wanted to see the resident's medication list prior to making any changes. The Resident Care Manager also documented the local ombudsman visited with the resident on December 17, 2013.

On December 18, 2013, the facility received an additional order for Dilaudid 0.2 milligrams thirty minutes prior to dressing changes.

On December 20, 2013, the facility held a care conference with the resident, the resident's family member, physical therapy, occupational therapy, speech therapy, social services and nursing. Neither the resident nor the resident's family member voiced a concern at the meeting about changes in the resident's pain levels, or that the resident's physician had not been contacted regarding these changes.

At the December 20, 2013, care conference; the resident's family member voiced a concern for an antidepressant. The facility contacted the local hospital where the resident was admitted from and requested the doctor review the use of an antidepressant for the resident as the resident was undergoing antibiotic therapy.

The Resident Care Manager was interviewed about the resident's pain management program. The Resident Care Manager said that during the December 20, 2013, Care Conference with the

Gary L. Liesner, Administrator  
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resident and the resident's family member, there were no concerns that the resident had increased abdominal pain for about a week after admission or that the facility did not contact the resident's physician to deal with the pain the resident experienced.

The Social Worker and the Social Services Assistant were interviewed about the resident's pain management program. Both the Social Worker and the Social Services Assistant said they could not remember the resident or the resident's family member voicing a concern that the resident had increased abdominal pain for about a week after admission or that the facility did not contact the resident's physician to deal with the pain the resident experienced.

The Social Worker said when any resident expresses concerns with pain or any area not being addressed by staff, she completes a concern form on behalf of the resident so the issues could be addressed and tracked.

On December 23, 2013, the resident's pain medication Oxycontin was increased from ten milligrams to twenty milligrams two times a day.

On December 27, 2013, at 1:35 p.m., the resident's Progress Notes documented the resident complained of pain and was medicated with effective relief.

On December 27, 2013, at 7:00 p.m., the resident's Progress Notes documented the resident was medicated with four milligrams of Dilaudid for complaints of pain with minimal relief. The resident was sent to a local hospital's emergency room per physician order due to possible small bowel obstruction. The resident's family member was notified.

The survey team determined the facility was in compliance with Federal guidelines.

#### CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

#### ALLEGATION #2:

The complainant stated an identified resident was seen by the speech therapist who made dietary recommendations. The dietary recommendations were not followed.

Facility Standards called the complainant to determine what speech therapist dietary recommendations were not followed. The complainant said the resident was served pudding once when it was on his list as a disliked food.

FINDINGS:

The eleven residents who attended the Resident Group interview did not express any dissatisfaction or concerns about Dietary Services providing foods that were on their list of disliked foods.

Four residents who were interviewed individually did not express concerns with Dietary Services providing foods that were on their list of disliked foods.

The two residents' family members who were interviewed did not express any concerns with Dietary Services providing foods that were on the residents' list of disliked foods.

Two surveyors observed Dietary Services' tray line. During this observation, the surveyors did not observe Dietary Services staff providing residents with foods that were identified on the disliked foods section of the residents' dietary cards.

The Speech Language Pathologist was interviewed about the resident's diet texture. The Speech Language Pathologist said the identified resident did not like ground or chopped meats and did not like vegetables pureed. The Speech Language Pathologist said trials were conducted with regular textured foods. The resident's diet was upgraded to regular textures after the trials were successful for the resident. The Speech Language Pathologist said she had no concerns about the food the facility gave the resident.

The survey team determined the facility was in compliance with Federal guidelines.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant said the nursing home had a meeting with an identified resident's family member because the resident yelled at the staff and made a nurse cry. The resident was in pain and very sick. The family member thought the facility should be able to deal with the resident.

FINDINGS:

This allegation was not an allegation of non-compliance.

Therefore, this allegation was not investigated, as there are no Federal guidelines for the survey team to investigate when a nursing home has a meeting with residents and or resident family

Gary L. Liesner, Administrator  
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members because a resident yelled at staff or made a staff member cry.

When a resident yelled at staff and or made a nurse cry, the facility was obligated to review, with the resident and or any interested family member, the specific circumstances to ensure the resident was receiving the necessary care and services.

It was determined the facility was in compliance with Federal guidelines.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #4:**

The complainant said an identified resident's urine turned chocolate brown. A family member told the nursing staff about the chocolate brown urine, but the nursing staff did not call the resident's physician. The complainant stated a resident family member then called the physician and requested the resident be sent to the hospital. The complainant stated after transfer to the hospital, the resident required transfusions and surgery for an abdominal abscess.

**FINDINGS:**

During the survey process, two residents were sampled for the use of catheters and catheter care. The survey team did not identify concerns regarding the use of the catheters or catheter care received by residents.

Review of the facility's grievances did not include any concerns regarding the use of catheters or catheter care.

The eleven residents who attended the Resident Group interview did not express any concerns regarding catheter use or catheter care, as applicable.

The identified resident was admitted to the facility on December 12, 2013, with multiple diagnoses including multiple myeloma, off all chemotherapy and Foley catheter use.

The identified resident's Progress Notes from December 12, 2013, at 11:00 p.m. through December 27, 2013, at 7:00 pm. were reviewed.

On admission, the resident's Foley catheter was patent with amber colored urine output.

In addition, nursing staff assessed and documented the Foley catheter and color of urine as

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follows:

- One time, the Foley was draining with yellow urine output;
- One time, the Foley was draining with clear dark yellow urine output;
- One time, the Foley was draining with amber urine output;
- One time, the Foley was draining with dark amber urine output;
- Two times, the Foley was draining with dark yellow urine output; and
- Twenty-two times, the Foley was draining with clear yellow urine output

In addition, the resident's Progress Note dated December 27, 2013, at 7:00 p.m. documented the resident's urine output was clear yellow. The resident was sent to a local hospital's emergency room per the resident's doctor order due to possible small bowel obstruction. The resident's family member was notified.

The survey team was not able to verify that after the resident was discharged to a local hospital's emergency room, the resident required transfusions and was taken to surgery the following day for an abscess in his abdomen from the multiple myeloma.

The survey team determined the facility was in compliance with Federal guidelines.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

As none of the complaint's allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,



LORENE KAYSER, L.S.W., Q.M.R.P., Supervisor  
Long Term Care

LKK/dmj