IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
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BUREAU OF FACILITY STANDARDS
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December 31, 2015

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

Provider #: 135053

Dear Mr. Liesner:

On **December 18, 2015**, a 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 one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided 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." **Please provide ONLY ONE completion date for each federal and state tag (if applicable) 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 the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **January 13, 2016**. Failure to submit an acceptable PoC by **January 13, 2016**, may result in the imposition of civil monetary penalties by **February 2, 2016**.

The components of a Plan of Correction as required by CMS must:

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

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

- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;

- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained; and

- 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.

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

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 **January 28, 2016 (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 **January 28, 2016**. A change in the seriousness of the deficiencies on **January 28, 2016**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **January 28, 2016** includes the following:

Denial of payment for new admissions effective **March 18, 2016**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying non-compliance, 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 **June 18, 2016**, 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, CMS will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 2; 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 **December 18, 2015** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance 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 **January 13, 2016**. If your request for informal dispute resolution is received after **January 13, 2016**, 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 David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2.

Sincerely,

Nina Sanderson (BK)

NINA SANDERSON, L.S.W., Supervisor
Long Term Care

NS/lj
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135053	A. BUILDING _____ B. WING _____	12/18/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following deficiencies were cited during the federal recertification and complaint survey conducted at the facility from December 14, 2015 to December 18, 2015. The surveyors conducting the survey were: Amy Barkley, RN, BSN, Team Coordinator Kendra Delnes, RN, BSN Angela Morgan, RN, BSN Definitions Included: DNS = Director of Nursing Services LN = Licensed Nurse QAPI = Quality Assurance and Performance Improvement UTI = Urinary Tract Infection	F 000	Submission of this plan of correction does not constitute an admission by the provider of any fact or conclusion set forth in this statement of deficiency. This plan is being submitted because it is required by law. RECEIVED JAN 25 2016 FACILITY STANDARDS	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in	F 431		1/28/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Exec Director	01/11/2016

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 431	Continued From page 1 locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure expired medications were removed from the medication room and medication carts and expiration dates were legible. This was true for the medication room and for 3 of 4 medication carts checked for expired medications. This failed practice created the potential for residents to experience decresed effectiveness from expired medications. Findings included: 1. On 12/16/15 at 9:45 am, one bag of Intravenous (IV) Vancomycin with an expiration date of 12/14/15 and one bottle of influenza vaccination with an expiration date of 11/29/15 were found in the central medication storage room. LN #1 stated the medications should be removed from the storage area. 2. On 12/16/15 at 10:00 am, one bottle of Solosite, an exudate absorbing wound gel, with	F 431	It is the policy of Ivy Court to ensure expired medications are approriately disposed of. White all residents receiving medications from the involved carts and medication room were potentially affected by this deficient practice, there were no adverse consequences noted. To enhance currently compliant operations and under the directo of the Director of Nursing, the ward clerk, a LPN, will conduct monthly inspections of all medication carts and the central medication room to check for outdated medications. The licensed staff well be re-educated on the importance of checking expiration dates on medications.	

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F 431	Continued From page 2 an expiration date 6/2013 was found on medication cart #1. LN #2 stated the medication was expired. RCM #5 said she would dispose of the medication. 3. On 12/6/15 at 11:15 am, one bottle of antifungal cream with an expiration date of 1/2014 was found on medication cart #2. LN #3 said the medication should be removed from the cart. 4. On 12/16/15 at 1:35 pm, during an observation of the East Medication Cart with RCM #5 in attendance, the following were found on the East medication cart: *One Glucagon emergency kit with an expiration date of 9/2015, *One bottle of fluocinocide 0.05% solution with an expiration date of 9/30/14, *One bottle of Nystop containing nystatin powder with an unreadable expiration date, *Two containers of bacitracin/nystatin cream with expiration dates of 8/19/15 and 9/27/15. RCM #5 said the above medications were expired and she would dispose of the expired medications.	F 431	Any concerns will be addressed immediately. Inspection reports will be reviewed at the monthly QAPI meeting.	
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 of disease and infection. (a) Infection Control Program The facility must establish an Infection Control	F 441		1/28/16

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F 441	Continued From page 3 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. (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on staff interview and review of the facility's infection control policy and procedure, it was determined the facility did not ensure the infection control program completely analyzed UTI data, implemented an action plan to prevent the onset and spread of infection, and re-evaluated the effectiveness of the action plan. This deficient practice had the potential to affect 8	F 441	It is the policy of Ivy Court to analyze infection data, implement action plans as warranted and evaluate the effectiveness of the action plans. The 8 residents cited were treated for their infections and all have recovered. While all residents have the potential	

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F 441	Continued From page 4 of 8 residents infected with UTIs and anyone at risk for infection in the facility. Findings included: 1. The facility's Infection Control Manual Procedure documented data of infections for surveillance was drawn from antibiotic lists, clinical rounds, resident infection tracking log, laboratory data, medical records, and the twenty-four hour status report. The data from all resident infections was to be documented on the Infection Surveillance Worksheet form, then on the Monthly Line Listing Report to identify and track all Healthcare Associated Infections. It documented the Monthly Line Listing Report was to be presented at the Quality Assurance Performance Improvement committee, then the committee would provide an action plan to control outbreaks of Healthcare Associated Infections where identified. It documented staff were to be monitored by observation of Standard and Transmission-based Precautions, and other infection control procedures. A 12/23/15 Curriculum Completion History documented staff in the nursing and dietary departments were educated on infection control in August 2015. On 12/18/15 at 10:15 am, the Infection Control Nurse said when an antibiotic was ordered, the RCM for that particular resident was to document infection data on the surveillance worksheet. That worksheet then came to the Infection Control Nurse and she would input the data onto the Monthly Line Listing Report. The Infection Control nurse stated she input the data, and the DNS stated she tracked the infections. The DNS stated a pattern of UTIs was identified in August 2015 with the QAPI committee. The root cause of the	F 441	to be affected by this deficient practice, it is noted that we have seen a decrease in infections (UTI'S) from this time last month To enhance currently compliant operations and under the direction of the Director of Nursing, nursing staff will have skill validations completed on handwashing and perineal care. The Director of Nursing will begin completing the Infection Surveillance Worksheets and placing data on the Monthly Line Listing Report. Infections will be discussed during each morning triage meeting. A Performance Improvement Project (PIP) will be undertaken. An Infection Control Committee will be formed; meeting at least monthly. If trends are identified between meetings, the Infection Control Committee will meet at that .time determine a root cause and implement interventions as warranted. Any concerns will be addressed immediately. The tracking and trending will be discussed at monthly QAPI meetings. NOTE: F441 - Per telecom with Exec Director on 1-14-16 at 2:02PM (MT), the Education Director will perform auditing of handwashing and peri-care. Audit Results will be reviewed at the Infection Control and QAPI meetings. Audits weekly on all shifts for 30 days, then monthly for 6 months. KM	

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F 441	Continued From page 6 pattern was identified as poor handwashing and perineal care, and education on handwashing and perineal care was provided to staff. When asked if staff had been monitored on that education by observation, or reevaluation on the effectiveness of the plan, the DNS stated Administration had not yet followed up on those issues.	F 441		

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January 26, 2016

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

Provider #: 135053

Dear Mr. Liesner:

On **December 18, 2015**, an unannounced on-site complaint survey was conducted at Ivy Court. The complaint was investigated in conjunction with the facility's Federal Recertification and Complaint Investigation survey from December 14, 2015 to December 18, 2015.

Facility nurses were observed administering medications to eight residents during a medication pass observation, to ensure accurate administration was completed per the physicians' orders.

Eight residents interviewed during the group interview stated medications were administered per physician's orders and medications were provided when they asked or needed them.

The identified resident's medical record was reviewed, in addition to 9 other residents' medical records regarding bowel care and treatment. The identified resident's January and February 2015 physician orders, medication administration records, nurse progress notes, and hospital admission notes were reviewed. Grievances and Incident and Accident reports from June to December 2015 were reviewed for incidents of bowel obstruction or adverse consequences of inaccurate medication administration.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006856

Allegation #1:

The reporting party had concerns the facility failed to administer bowel medications to a resident and, as a result, the resident was sent to the Emergency Room with possible bowel obstruction.

Findings:

Nurses during the medication pass task were observed to administer medications per physicians' orders. Residents in the group interview did not voice any concerns with their medications being unavailable or being administered incorrectly. Upon review of residents' records regarding bowel care and treatment, when the facility identified instances of occasional constipation with these residents it was treated in an appropriate and timely manner, according to physician orders.

The identified resident had multiple bowel medications to treat constipation, and the facility identfied constipation as a problem for the resident. Benefiber was started for constipation in the beginning of February 2015 and the resident was determined to be safe to self administer medications at that time. Grievances and Incident and Accident reports did not document any adverse consequences to inaccurate medication administration for other residents.

Based on observations, record review, and interviews, the allegation was unsubstantiated due to lack of evidence.

Conclusions:

Unsubstantiated. Lack of sufficient evidence.

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

Sincerely,

Nina Sanderson, LSW, Supervisor
Long Term Care

NS/lj