



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSSELL S. BARRON – Director

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

October 27, 2017

Patrick McNabb, Administrator
Ivy Court
2200 Ironwood Place
Coeur d'Alene, ID 83814-2610

Provider #: 135053

**RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER
LETTER**

Dear Mr. McNabb:

On **October 16, 2017**, a Facility Fire Safety and Construction survey was conducted at **Ivy Court** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency 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. 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. **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 2). After each deficiency has been answered and dated, the administrator should sign the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office. If a State Form with deficiencies was issued, it should be signed, dated and returned along with the CMS-2567 Form.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **November 9, 2017**. Failure to submit an acceptable PoC by **November 9, 2017**, may result in the imposition of civil monetary penalties by **November 29, 2017**.

Your PoC must contain the following:

- 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 into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.
- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567. If a State Form was issued as well, it should also be signed, dated and returned.

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

Remedies may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **November 20, 2017**, (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 **November 20, 2017**. A change in the seriousness of the deficiencies on **November 20, 2017**, may result in a change in the remedy.

Patrick McNabb, Administrator
October 27, 2017
Page 3 of

The remedy, which will be recommended if substantial compliance has not been achieved by **November 20, 2017**, includes the following:

Denial of payment for new admissions effective **January 16, 2018**.
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 **April 16, 2018**, 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 Nate Elkins, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, option 3; Fax #: (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 **October 16, 2017**, 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:

Patrick McNabb, Administrator
October 27, 2017
Page 4 of

<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:

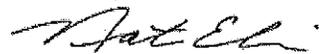
BFS Letters (06/30/11)

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

This request must be received by **November 9, 2017**. If your request for informal dispute resolution is received after **November 9, 2017**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626, option 3.

Sincerely,



Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosures

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

Printed: 10/26/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135053	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/16/2017
NAME OF PROVIDER OR SUPPLIER IVY COURT		STREET ADDRESS, CITY, STATE, ZIP CODE 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)	(X6) COMPLETION DATE
K 000	INITIAL COMMENTS The facility is a single story, Type V (111) construction with a complete automatic fire suppression and fire alarm system. Smoke detection covers the corridors and open areas. The facility was built in 1973 and is currently licensed for 80 SNF/NF beds. The following deficiencies were cited at the above facility during the annual fire/life safety code survey conducted on October 16, 2017. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Chapter 19, Existing Healthcare Occupancies, in accordance with 42 CFR 483.70 and 42 CFR 483.65. The survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety & Construction	K 000	ON GOING MONITORING Reference actions taken under K-100, K-161, K-211, K-293, K-325, K-353, K-511, K-521, K-915 and K-926 PERSON RESPONSIBLE Maintenance Director or Designee Date of compliance December 14, 2017	
K 100 SS=F	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This Standard is not met as evidenced by: Based on record review and interview, the facility failed to demonstrate a water management program for waterborne pathogens such as Legionella, in accordance with 42 CFR 483.65. Failure to implement a water management program to avert transmission of waterborne pathogens which considers CDC standards and the guidance of ASHRAE 188, has the potential to expose residents to Legionella and other water	K 100	K100 INDIVIDUAL RESIDENTS No individual residents were identified during survey. RESIDENTS IN SIMILAR SITUATIONS Residents have the potential to be affected by this practice. A review of the October Infection Control log was completed to ensure no evidence of water contamination effects.	

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

TITLE

(X6) DATE

Ratnick M Nagb *[Signature]* *ED* *Nov 8 17*

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135053	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/16/2017
NAME OF PROVIDER OR SUPPLIER IVY COURT		STREET ADDRESS, CITY, STATE, ZIP CODE 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
K 100	Continued From page 1 source bacterium. This deficient practice affected 67 residents on the date of the survey. The facility is currently licensed for 80 SNF/NF beds and had a census of 67 on the day of the survey. Findings include: During review of provided maintenance and inspection records conducted on October 16, 2017 from approximately 9:00 AM to 10:00 AM, no records were available demonstrating the facility had completed or implemented a water management plan, which included a risk assessment and testing protocols for the prevention of waterborne pathogens such as Legionella. When asked about the missing documentation, the interim Maintenance Director stated he was not aware of the requirement for such a plan. CFR standard: 42 CFR 483.65 § 483.65 Infection control. 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. Additional reference: Center for Medicaid/Medicare Services S & C letter 17-30	K 100	METHOD TO PREVENT REOCCURRANCE The facility ED was educated to the requirements of maintaining a water management plan that includes assessments and testing protocols to prevent Legionella. The facility implemented the Legionella prevention protocol and policy. ON GOING MONITORING The Maintenance Director will maintain compliance with the Legionella policy and testing requirements and monitor compliance through the TELS system. PERSON RESPONSIBLE Maintenance Director or designee DATE OF COMPLIANCE December 14, 2017 K161 INDIVIDUAL RESIDENTS No individual residents were identified during survey.	
K 161 SS=D	NFPA 101 Building Construction Type and Height Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by	K 161		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135053	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/16/2017
NAME OF PROVIDER OR SUPPLIER IVY COURT		STREET ADDRESS, CITY, STATE, ZIP CODE 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
K 161	<p>Continued From page 2 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5</p> <p>Construction Type</p> <p>1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered</p> <p>2 II (111) One story non-sprinklered Maximum 3 stories sprinklered</p> <p>3 II (000) Not allowed non-sprinklered</p> <p>4 III (211) Maximum 2 stories sprinklered</p> <p>5 IV (2HH)</p> <p>6 V (111)</p> <p>7 III (200) Not allowed non-sprinklered</p> <p>8 V (000) Maximum 1 story sprinklered</p> <p>Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5)</p> <p>Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that the fire and smoke resistive properties of the structure were maintained. Failure to seal penetrations in rated construction</p>	K 161	<p>RESIDENTS IN SIMILAR SITUATIONS Residents have the potential to be affected by this practice. Penetrations identified in the 2567 in the central supply room, north hall and business offices were corrected.</p> <p>METHOD TO PREVENT REOCCURRENCE The facility ED was provided education on ensuring that penetrations are identified and corrected through daily rounds.</p> <p>ON GOING MONITORING Facility rounds will be conducted by maintenance director or designee. Weekly observations for penetrations will be conducted and corrected upon discovery and maintain documentation in the facility TELS program.</p> <p>PERSON RESPONSIBLE Maintenance Director or designee</p> <p>DATE OF COMPLIANCE 12/14/17</p>	

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

Printed: 10/26/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135053	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/16/2017
NAME OF PROVIDER OR SUPPLIER IVY COURT		STREET ADDRESS, CITY, STATE, ZIP CODE 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
K 161	<p>Continued From page 3</p> <p>assemblies has the potential to allow fire, smoke and dangerous gases to pass between compartments during a fire. This deficient practice affected 15 residents in 1 of 4 smoke compartments, staff and visitors on the date of the survey. The facility is licensed for 80 SNF/NF beds and had a census of 67 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on October 16, 2017 from approximately 10:30 AM to 2:30 PM, following unsealed penetrations in the one-hour construction were revealed:</p> <p>1) Two (2) open six inch by six inch holes, one through the north wall and one through the west wall of the central supply room, exposing the wall cavity.</p> <p>2) Observation of data cabling bundles approximately 1-1/2" diameter, passing into the attic space through unsealed penetrations in the soiled linen room in the north hall and the business office.</p> <p>When asked about the unsealed penetrations, the interim Maintenance Director stated he was not aware of these penetrations prior to the survey.</p> <p>Actual NFPA standard:</p> <p>19.1.6 Minimum Construction Requirements. 19.1.6.1 Health care occupancies shall be limited to the building construction types specified in Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7. (See 8.2.1.)</p>	K 161		

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

Printed: 10/26/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135053	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/16/2017
NAME OF PROVIDER OR SUPPLIER IVY COURT		STREET ADDRESS, CITY, STATE, ZIP CODE 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
K 161	Continued From page 4 8.2 Construction and Compartmentation. 8.2.1 Construction. 8.2.1.1 Buildings or structures occupied or used in accordance with the individual occupancy chapters, Chapters 11 through 43, shall meet the minimum construction requirements of those chapters. 8.2.2.2 Fire compartments shall be formed with fire barriers that comply with Section 8.3. 8.3.5.6 Membrane Penetrations. 8.3.5.6.1 Membrane penetrations for cables, cable trays, conduits, pipes, tubes, combustion vents and exhaust vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a membrane of a wall, floor, or floor/ceiling assembly constructed as a fire barrier shall be protected by a firestop system or device and shall comply with 8.3.5.1 through 8.3.5.2.	K 161		
K 211 SS=F	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This Standard is not met as evidenced by: Based on observation, the facility failed to ensure means of egress were maintained free of obstructions. Failure to maintain corridors free of projections extending into the path of travel, has the potential to hinder egress during an emergency. This deficient practice affected 67 residents in 4 of 4 smoke compartments on the	K 211	K211 INDIVIDUAL RESIDENTS No individual residents were identified during survey. RESIDENTS IN SIMILAR SITUATIONS Residents have the potential to be affected by this practice. Fans were removed from impeding into the hallways that block means of egress. METHOD TO PREVENT REOCCURRENCE The facility ED was educated to the requirements of having egresses free of blockages. Facility staffs were educated to requirements of maintaining egresses free of blockages. ON GOING MONITORING The facility maintenance director or designee will conduct daily rounds of the facility and correct blocked egresses upon discovery. Documentation of rounds will be completed in TELS.	

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

Printed: 10/26/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135053	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/16/2017
NAME OF PROVIDER OR SUPPLIER IVY COURT		STREET ADDRESS, CITY, STATE, ZIP CODE 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
K 211	<p>Continued From page 5 date of the survey. The facility is currently licensed for 80 SNF/NF beds and had a census of 67 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on October 16, 2017 from approximately 10:30 AM to 2:30 PM, observation of the North, South and East resident room corridors revealed these corridors measured approximately eight feet wide. Further observation revealed circular fans were installed on corridor walls at a height approximately 50 to 54 inches when measured from the floor and projected from the wall approximately 22 to 24 inches from the wall into the corridor path.</p> <p>Actual NFPA standard:</p> <p>NFPA 101 19.2.1 General Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7, unless otherwise modified by 19.2.2 through 19.2.11.</p> <p>19.2.3.4* Any required aisle, corridor, or ramp shall be not less than 48 in. (1220 mm) in clear width where serving as means of egress from patient sleeping rooms, unless otherwise permitted by one of the following: (1) Aisles, corridors, and ramps in adjunct areas not intended for the housing, treatment, or use of inpatients shall be not less than 44 in. (1120 mm) in clear and unobstructed width. (2)*Where corridor width is at least 6 ft (1830 mm), noncontinuous projections not more than 6 in. (150 mm) from the corridor wall, above the handrail height, shall be permitted. (3) Exit access within a room or suite of rooms</p>	K 211	<p>PERSON RESPONSIBLE</p> <p>Maintenance Director or designee</p> <p>DATE OF COMPLIANCE Immediately</p>	

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

Printed: 10/26/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135053	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/16/2017
NAME OF PROVIDER OR SUPPLIER IVY COURT		STREET ADDRESS, CITY, STATE, ZIP CODE 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
K 211	Continued From page 6 complying with the requirements of 19.2.5 shall be permitted. (4) Projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in. (1525 mm). (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c)*The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment (5)*Where the corridor width is at least 8 ft (2440 mm), projections into the required width shall be permitted for fixed furniture, provided that all of the following conditions are met: (a) The fixed furniture is securely attached to the floor or to the wall. (b) The fixed furniture does not reduce the clear unobstructed corridor width to less than 6 ft (1830 mm), except as permitted by 19.2.3.4(2). (c) The fixed furniture is located only on one side of the corridor. (d) The fixed furniture is grouped such that each grouping does not exceed an area of 50 ft ² (4.6 m ²). (e) The fixed furniture groupings addressed in 19.2.3.4(5)(d) are separated from each other by a distance of at least 10 ft (3050 mm). (f)*The fixed furniture is located so as to not obstruct access to building service and fire protection equipment. (g) Corridors throughout the smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance	K 211		

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

Printed: 10/26/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135053	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/16/2017
NAME OF PROVIDER OR SUPPLIER IVY COURT		STREET ADDRESS, CITY, STATE, ZIP CODE 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
K 211	Continued From page 7 with 19.3.4, or the fixed furniture spaces are arranged and located to allow direct supervision by the facility staff from a nurses ' station or similar space. (h) The smoke compartment is protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.8.	K 211		
K 293 SS=F	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This Standard is not met as evidenced by: Based on observation, the facility failed to ensure means of egress signage was provided in accordance with NFPA 101. Failure to provide exit signs which are clear and identifiable has the potential to confuse residents and hinder egress during an emergency. This deficient practice affected 67 residents in 3 of 4 smoke compartments on the date of the survey. The facility is currently licensed for 80 SNF/NF beds and had a census of 67 on the day of the survey. Findings include: During the facility tour conducted on October 16, 2017 from approximately 10:30 AM to 2:30 PM, observation of installed exit signs, revealed the following signs would not clearly identify the path of egress during a fire or other emergency: 1) At the South and East exit corridor, no signs were provided above the bulkheads of the	K 293	K293 INDIVIDUAL RESIDENTS No individual residents, staff or visitor were identified during survey. RESIDENTS IN SIMILAR SITUATIONS Residents, staff or visitors have the potential to be affected by this practice by not having clearly marked and illuminated "Exit" signs indicating means of egress. Temporary exit signs have been placed to ensure proper notification.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135053	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/16/2017
NAME OF PROVIDER OR SUPPLIER IVY COURT		STREET ADDRESS, CITY, STATE, ZIP CODE 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
K 293	Continued From page 8 cross-corridor doors, held open by magentic hold-open devices interconnected to the fire alarm. Further observation revealed no exit signs were visible in the egress path through these doors when activated. 2) The chevrons for the exit sign leading to the North corridor exit off the Physical Therapy wing and the exit sign leading South outside the Private Dining/Bistro, had been removed making clear identification of egress confusing by directing travel into a wall. Actual NFPA standard: 7.10.1.2 Exits. 7.10.1.2.1* Exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign that is readily visible from any direction of exit access. 7.10.2 Directional Signs. 7.10.2.1* A sign complying with 7.10.3, with a directional indicator showing the direction of travel, shall be placed in every location where the direction of travel to reach the nearest exit is not apparent.	K 293	METHOD TO PREVENT REOCCURRANCE The ED has been educated on the requirements of properly placed and lighted exit signs. Permanent signs will be implemented. ON GOING MONITORING The maintenance director or designee will monitor the exit signs during fire drills. The maintenance director will document and correct any concerns with signs that are misleading or not functioning according to code. PERSON RESPONSIBLE Maintenance Director or designee DATE OF COMPLIANCE 12/14/17	
K 325 SS=F	NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR) Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing	K 325		

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

Printed: 10/26/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135053	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/16/2017
NAME OF PROVIDER OR SUPPLIER IVY COURT		STREET ADDRESS, CITY, STATE, ZIP CODE 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
K 325	<p>Continued From page 9</p> <ul style="list-style-type: none"> * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 <p>This Standard is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure automatically operated Alcohol Based Hand Rub Dispensers (ABHR) were maintained in accordance with NFPA 101. Failure to test and document operation of ABHR dispensers could result in inadvertently spilling flammable liquids increasing the risk of fires. This deficient practice affected 67 residents, staff and visitors on the date of the survey. The facility is licensed for 80 SNF/NF residents and had a census of 67 on the day of the survey.</p> <p>Findings include:</p> <p>1) During the review of facility inspection records conducted on October 16, 2017 from approximately 9:00 AM to 10:00 AM, no records were available indicating inspection and testing of ABHR dispensers was performed when refilling dispensers in accordance with manufacturer's care and use instructions.</p>	K 325	<p>K325</p> <p>INDIVIDUAL RESIDENTS No individual residents were identified during survey.</p> <p>RESIDENTS IN SIMILAR SITUATIONS Residents have the potential to be affected by this practice. The identified dispensers were replaced and validated to work correctly.</p> <p>METHOD TO PREVENT REOCCURRANCE The Executive Director educated housekeeping department on the proper method of changing the dispensers, types of dispensers and to document when they have completed and are functioning properly.</p> <p>ON GOING MONITORING The housekeeping director will maintain documentation to show the proper placement, function and condition of dispensers. Documentation will be reviewed by the Executive Director as needed for validation.</p>	

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

Printed: 10/26/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135053	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED 10/16/2017
NAME OF PROVIDER OR SUPPLIER IVY COURT			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
K 325	<p>Continued From page 10</p> <p>2) During the facility tour conducted on October 16, 2017 from approximately 10:30 AM to 2:30 PM, observation of installed ABHR dispensers revealed manually activated dispensers had been installed in four of four smoke compartments, with one automatic dispenser noted in the Central Supply area. When asked about ABHR dispenser refill testing and documentation, the Interim Maintenance Director stated he was aware of the requirement.</p> <p>Actual NFPA standard: NFPA 101</p> <p>19.3.2.6* Alcohol-Based Hand-Rub Dispensers. Alcohol-based hand-rub dispensers shall be protected in accordance with 8.7.3.1, unless all of the following conditions are met:</p> <p>(1) Where dispensers are installed in a corridor, the corridor shall have a minimum width of 6 ft (1830 mm).</p> <p>(2) The maximum individual dispenser fluid capacity shall be as follows:</p> <p>(a) 0.32 gal (1.2 L) for dispensers in rooms, corridors, and areas open to corridors (b) 0.53 gal (2.0 L) for dispensers in suites of rooms</p> <p>(3) Where aerosol containers are used, the maximum capacity of the aerosol dispenser shall be 18 oz. (0.51 kg) and shall be limited to Level 1 aerosols as defined in NFPA30B, Code for the Manufacture and Storage of Aerosol Products.</p> <p>(4) Dispensers shall be separated from each other by horizontal spacing of not less than 48 in. (1220 mm).</p>	K 325	<p>PERSON RESPONSIBLE</p> <p>House-Keeping Director or designee</p> <p>DATE OF COMPLIANCE October 31, 2017</p>		

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

Printed: 10/26/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135053	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/16/2017
NAME OF PROVIDER OR SUPPLIER IVY COURT		STREET ADDRESS, CITY, STATE, ZIP CODE 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
K 325	Continued From page 11 (5) Not more than an aggregate 10 gal (37.8 L) of alcohol-based hand-rub solution or 1135 oz (32.2 kg) of Level 1 aerosols, or a combination of liquids and Level 1 aerosols not to exceed, in total, the equivalent of 10 gal (37.8 L) or 1135 oz (32.2 kg), shall be in use outside of a storage cabinet in a single smoke compartment, except as otherwise provided in 19.3.2.6(6). (6) One dispenser complying with 19.3.2.6 (2) or (3) per room and located in that room shall not be included in the aggregated quantity addressed in 19.3.2.6(5). (7) Storage of quantities greater than 5 gal (18.9 L) in a single smoke compartment shall meet the requirements of NFPA 30, Flammable and Combustible Liquids Code. (8) Dispensers shall not be installed in the following locations: (a) Above an ignition source within a 1 in. (25 mm) horizontal distance from each side of the ignition source (b) To the side of an ignition source within a 1 in. (25mm) horizontal distance from the ignition source (c) Beneath an ignition source within a 1 in. (25 mm) vertical distance from the ignition source (9) Dispensers installed directly over carpeted floors shall be permitted only in sprinklered smoke compartments. (10) The alcohol-based hand-rub solution shall not exceed 95 percent alcohol content by volume. (11) Operation of the dispenser shall comply with the following criteria: (a) The dispenser shall not release its contents except when the dispenser is activated, either manually or automatically by touch-free activation. (b) Any activation of the dispenser shall occur only when an object is placed within 4 in. (100	K 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135053	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/16/2017
NAME OF PROVIDER OR SUPPLIER IVY COURT		STREET ADDRESS, CITY, STATE, ZIP CODE 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
K 325	Continued From page 12 mm) of the sensing device. (c) An object placed within the activation zone and left in place shall not cause more than one activation. (d) The dispenser shall not dispense more solution than the amount required for hand hygiene consistent with label instructions. (e) The dispenser shall be designed, constructed, and operated in a manner that ensures that accidental or malicious activation of the dispensing device is minimized. (f) The dispenser shall be tested in accordance with the manufacturer ' s care and use instructions each time a new refill is installed.	K 325		
K 353 SS=E	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure installed fire suppression systems were maintained in accordance with NFPA 25.	K 353	K353 INDIVIDUAL RESIDENTS No individual residents were identified during survey. RESIDENTS IN SIMILAR SITUATIONS Residents have the potential to be affected by this practice. Replacement sprinkler heads were ordered to ensure proper supply is on hand. METHOD TO PREVENT REOCCURRENCE Facility ED was educated to the requirements of having extra sprinkler heads on site.	

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

Printed: 10/26/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135053	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/16/2017
NAME OF PROVIDER OR SUPPLIER IVY COURT		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
K 353	<p>Continued From page 13</p> <p>Failure to provide the required number and type of spare fire suppression system pendants has the potential to leave the facility not fully sprinklered in the event of damage or system activation. This deficient practice affected residents who utilize the Activities room, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on October 16, 2017 from approximately 10:30 AM to 12:00 PM, observation of the Activities space and the Maintenance/Central Supply area revealed installed 212 degree pendants, along with 155 degree pendants. During subsequent inspection of the spare sprinkler box located at the main fire suppression riser, no spare 212 degree pendants were discovered.</p> <p>When asked about the missing spare pendants, the interim facility Maintenance Director stated he was not aware of the missing pendants prior to the survey.</p> <p>Actual NFPA standard:</p> <p>NFPA 25</p> <p>5.4 Maintenance.</p> <p>5.4.1 Sprinklers.</p> <p>5.4.1.1* Replacement sprinklers shall have the proper characteristics for the application intended, which include the following:</p> <p>(1) Style</p> <p>(2) Orifice size and K-factor</p> <p>(3) Temperature rating</p> <p>(4) Coating, if any</p> <p>(5) Deflector type (e.g., upright, pendent, sidewall)</p>	K 353	<p>ON GOING MONITORING</p> <p>The facility maintenance director or designee will conduct quarterly audits on fire suppressant inventory and verify that there are at least 2 spare sprinkler heads per fire ratings.</p> <p>PERSON RESPONSIBLE</p> <p>Maintenance Director or designee</p> <p>DATE OF COMPLIANCE: 12/14/17</p>

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

Printed: 10/26/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135053	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/16/2017
NAME OF PROVIDER OR SUPPLIER IVY COURT		STREET ADDRESS, CITY, STATE, ZIP CODE 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
K 353	Continued From page 14 (6) Design requirements 5.4.1.4* A supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have operated or been damaged in any way can be promptly replaced. 5.4.1.4.1 The sprinklers shall correspond to the types and temperature ratings of the sprinklers in the property.	K 353		
K 511 SS=D	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This Standard is not met as evidenced by: Based on observation, the facility failed to ensure safe electrical equipment installations in accordance with NFPA 70 and their respective listings. Failure to use equipment in accordance with the UL listing has the potential to expose residents to the risks of over current electrical arc fires. This deficient practice affected staff and visitors on the date of the survey. The facility is currently licensed for 80 SNF/NF beds and had a census of 67 on the day of the survey. Findings include: During the facility tour conducted on October 16, 2017 from approximately 10:30 AM to 3:00 PM, the following electrical installations were noted:	K 511	K511 INDIVIDUAL RESIDENTS No individual residents were identified during survey. RESIDENTS IN SIMILAR SITUATIONS Residents have the potential to be affected by this practice. Unapproved power strips, combustibles and blocking items were corrected and/or removed.	

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

Printed: 10/26/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135053	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/16/2017
NAME OF PROVIDER OR SUPPLIER IVY COURT		STREET ADDRESS, CITY, STATE, ZIP CODE 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
K 511	<p>Continued From page 15</p> <p>1) Observation of the Maintenance office revealed three (3) relocatable power taps (RPTs which were connected in series (daisy-chained).</p> <p>2) Observation of the Activities room revealed a RPT plugged into an extension cord (daisy-chained).</p> <p>3) Observation of the electrical closet in the private dining area revealed the electrical panel was blocked by boxes of records.</p> <p>4) An above the ceiling inspection at room #63 revealed an open four inch by four inch square electrical box with exposed wiring.</p> <p>Actual NFPA standard: NFPA 70</p> <p>Findings 1 and 2</p> <p>110.3 Examination, Identification, Installation, and Use of Equipment. (B) Installation and Use. Listed or labeled equipment shall be installed and used in accordance with any instructions included in the listing or labeling.</p> <p>Reference UL 1363 XBYS, GuideInfo Relocatable Power Taps</p> <p>Finding 3</p> <p>II. 600 Volts, Nominal, or Less</p> <p>110.26 Spaces About Electrical Equipment. Access and working space shall be provided and maintained about all electrical equipment to permit ready and safe operation and maintenance of such equipment</p>	K 511	<p>METHOD TO PREVENT REOCCURRENCE</p> <p>The facility ED was educated to the requirements of the proper use of UL1363 rated power strips. The potential risk of storing combustible material in close proximity of an electrical panels and permanent fixtures that impede egression from the hallways.</p> <p>ON GOING MONITORING</p> <p>The Maintenance Director will insure proper use of power strips. Prevent the storage of combustible material near electrical panels and the removal of permanent fixtures that impede the egress of hallways. Facility rounds will be conducted weekly to validate on-going compliance.</p> <p>PERSON RESPONSIBLE</p> <p>Maintenance Director or designee</p> <p>DATE OF COMPLIANCE 12/14/17</p>	

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

Printed: 10/26/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135053	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/16/2017
NAME OF PROVIDER OR SUPPLIER IVY COURT		STREET ADDRESS, CITY, STATE, ZIP CODE 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
K 511	Continued From page 16 (1) Depth of Working Space. The depth of the working space in the direction of live parts shall not be less than that specified in Table 110.26(A)(1) unless the requirements of 110.26(A)(1)(a), (A)(1)(b), or (A)(1)(c) are met. Distances shall be measured from the exposed live parts or from the enclosure or opening if the live parts are enclosed. Finding 4 110.12 Mechanical Execution of Work. Electrical equipment shall be installed in a neat and workmanlike manner. Informational Note: Accepted industry practices are described in ANSI/NECA 1-2006, Standard Practices for Good Workmanship in Electrical Contracting, and other ANSI-approved installation standards. (A) Unused Openings. Unused openings, other than those intended for the operation of equipment, those intended for mounting purposes, or those permitted as part of the design for listed equipment, shall be closed to afford protection substantially equivalent to the wall of the equipment. Where metallic plugs or plates are used with nonmetallic enclosures, they shall be recessed at least 6 mm (1/4 in.) from the outer surface of the enclosure.	K 511		
K 521 SS=F	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2	K 521		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135053	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/16/2017
NAME OF PROVIDER OR SUPPLIER IVY COURT		STREET ADDRESS, CITY, STATE, ZIP CODE 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
K 521	Continued From page 17 This Standard is not met as evidenced by: Based on record review and interview, the facility failed to ensure electrically operated smoke dampers were inspected and tested in accordance with NFPA 105. Failure to periodically test smoke dampers has the potential to allow smoke and dangerous gases to pass between smoke compartments during a fire. This deficient practice affected residents, staff and visitors on the date of the survey. The facility is currently licensed for 80 SNF/NF beds and had a census of 67 on the day of the survey. Findings include: During review of facility inspection and testing records conducted on October 16, 2017 from approximately 9:00 AM to 10:30 AM, no records were available indicating smoke dampers had been inspected or tested within the last four years. Subsequent inspection above the ceiling at the North and East resident halls revealed electronic smoke dampers were installed on the return air ducting of the HVAC (Heating Ventilation and Air Conditioning) system. When asked if these dampers had been inspected, the interim Maintenance Director stated he was not sure of the last time the inspection had been conducted. Actual NFPA standard: NFPA 101 9.2 Heating, Ventilating, and Air-Conditioning. 9.2.1 Air-Conditioning, Heating, Ventilating Ductwork, and Related Equipment. Air-conditioning, heating, ventilating ductwork,	K 521	K521 INDIVIDUAL RESIDENTS No individual residents were identified during survey. RESIDENTS IN SIMILAR SITUATIONS Residents have the potential to be affected by this practice. The facility had damper inspections completed to ensure compliance. METHOD TO PREVENT REOCCURRENCE The facility ED was educated to the requirements of maintaining 4 year maintenance inspections on the dampers. The ED will keep records on file of the inspections and present when indicated. ON GOING MONITORING The Maintenance Director will maintain compliance with the Air-conditioning, heating, ventilating, ductwork and related equipment which involves paperwork to verify testing and monitor compliance through the TELS system according to manufacturers and state requirements.	

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

Printed: 10/26/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135053	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/16/2017
NAME OF PROVIDER OR SUPPLIER IVY COURT		STREET ADDRESS, CITY, STATE, ZIP CODE 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
K 521	Continued From page 18 and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems, or NFPA 90B, Standard for the Installation of Warm Air Heating and Air-Conditioning Systems, as applicable, unless such installations are approved existing installations, which shall be permitted to be continued in service. NFPA 90A 4.3.10 Smoke Dampers. 4.3.10.1 Approved smoke dampers shall be provided as required in Chapter 5 5.4.8 Maintenance. 5.4.8.2 Smoke dampers shall be maintained in accordance with NFPA 105, Standard for Smoke Door Assemblies and Other Opening Protectives. NFPA 105 6.5 Periodic Inspection and Testing. 6.5.1 Smoke dampers for dedicated and non-dedicated smoke control systems shall be inspected and tested in accordance with NFPA 92A, Standard for Smoke-Control Systems Utilizing Barriers and Pressure Differences. 6.5.2* Each damper shall be tested and inspected one year after installation. The test and inspection frequency shall then be every 4 years, except in hospitals, where the frequency shall be every 6 years.	K 521	PERSON RESPONSIBLE Maintenance Director or designee DATE OF COMPLIANCE: 12/14/17 K915 INDIVIDUAL RESIDENTS No individual residents were identified during survey. RESIDENTS IN SIMILAR SITUATIONS Residents have the potential to be affected by this practice. An e-stop for the generator was installed to ensure compliance.	
K 915 SS=D	NFPA 101 Electrical Systems - Essential Electric System Electrical Systems - Essential Electric System Categories *Critical care rooms (Category 1) in which electrical system failure is likely to cause major injury or death of patients, including all rooms	K 915	METHOD TO PREVENT REOCCURRANCE The facility ED was educated to the requirements of having an emergency shut off switch outside of the containment.	

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

Printed: 10/26/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135053	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/16/2017
NAME OF PROVIDER OR SUPPLIER IVY COURT		STREET ADDRESS, CITY, STATE, ZIP CODE 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
K 915	<p>Continued From page 19 where electric life support equipment is required, are served by a Type 1 EES. *General care rooms (Category 2) in which electrical system failure is likely to cause minor injury to patients (Category 2) are served by a Type 1 or Type 2 EES. *Basic care rooms (Category 3) in which electrical system failure is not likely to cause injury to patients and rooms other than patient care rooms are not required to be served by an EES. Type 3 EES life safety branch has an alternate source of power that will be effective for 1-1/2 hours. 3.3.138, 6.3.2.2.10, 6.6.2.2.2, 6.6.3.1.1 (NFPA 99), TIA 12-3 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure the Emergency Electrical System (EES) was installed in accordance with NFPA 110. Failure to provide a remote manual stop station for emergency generators has the potential to prevent shutdown of the emergency generator during a system malfunction, or unintentional operation. This deficient practice affected staff and vendors charged with related work for the performance of the EES generator on the date of the survey. The facility is currently licensed for 80 SNF/NF beds and had a census of 67 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on October 16, 2017 from approximately 10:30 AM to 2:30 PM, observation of the EES generator revealed a manual stop located on the side of the generator housing. When asked if the facility had a remote manual stop station located in another area, the interim Maintenance Director stated he was not aware of any other location.</p>	K 915	<p>ON GOING MONITORING E-stop generator function will be observed with routine generator testing for on-going compliance.</p> <p>PERSON RESPONSIBLE Maintenance Director or designee</p> <p>DATE OF COMPLIANCE 12/14/17</p>	

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

Printed: 10/26/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135053	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/16/2017
NAME OF PROVIDER OR SUPPLIER IVY COURT		STREET ADDRESS, CITY, STATE, ZIP CODE 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
K 915	Continued From page 20 6.3.2.2.10.2 General care rooms (Category 2 Room) shall be served by a Type I or Type II EES 6.4.1.1.6 General. Generator sets installed as an alternate source of power for essential electrical systems shall be designed to meet the requirements of such service. 6.4.1.1.6.1 Type 1 and Type 2 essential electrical system power sources shall be classified as Type 10, Class X, Level 1 generator sets per NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110 5.6.5 Control Functions. 5.6.5.6* All installations shall have a remote manual stop station of a type to prevent inadvertent or unintentional operation located outside the room housing the prime mover, where so installed, or elsewhere on the premises where the prime mover is located outside the building. 5.6.5.6.1 The remote manual stop station shall be labeled.	K 915		
K 926 SS=D	NFPA 101 Gas Equipment - Qualifications and Training Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This Standard is not met as evidenced by: Based on record review, and interview, the facility failed to ensure staff were trained in the risks associated with the storage, handling and use of	K 926	K926 INDIVIDUAL RESIDENTS No individual residents were identified during survey. RESIDENTS IN SIMILAR SITUATIONS Residents and staff have the potential to be affected by this practice. Facility staff were educated to the proper use and handling of oxygen storage.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135053	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/16/2017
NAME OF PROVIDER OR SUPPLIER IVY COURT		STREET ADDRESS, CITY, STATE, ZIP CODE 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
K 926	<p>Continued From page 21</p> <p>medical gases. Failure to provide training of safety and risks associated with medical gases, hinders staff response and affects those residents utilizing supplemental oxygen. This deficient practice potentially affected oxygen dependent residents, staff and visitors on the date of the survey. The facility is licensed for 80 SNF/NF residents and had a census of 67 on the day of the survey.</p> <p>Findings include:</p> <p>During an initial interview of the Administrator, interim Maintenance Director and Director of Nursing conducted on October 16, 2017 from approximately 9:00 AM to 10:30 AM, all three stated they were not aware of having participated in any oxygen training conducted by the facility.</p> <p>During subsequent review of provided facility training records conducted on October 16, 2017 from approximately 2:30 PM to 3:00 PM, no records were available indicating that the facility provided a continuing education program for staff which includes periodic review of safety and usage requirements for medical gases. Asked about the provided information on initial training, the Administrator, interim Maintenance Director and Director of Nursing all confirmed that online training was provided upon initial hire, but no ongoing programs were currently documented.</p> <p>Actual NFPA standard:</p> <p>NFPA 99 11.5.2 Gases in Cylinders and Liquefied Gases in Containers. 11.5.2.1 Qualification and Training of Personnel. 11.5.2.1.1* Personnel concerned with the application and maintenance of medical gases</p>	K 926	<p>METHOD TO PREVENT REOCCURRANCE</p> <p>The facility ED was educated to the requirements of re-educating and maintaining records of oxygen safety and proper protocols filling portable oxygen cylinders. The facility implemented the Oxygen safety protocol and policy.</p> <p>ON GOING MONITORING</p> <p>The facility educator or designee will provide annual and upon hire education to facility staff related to oxygen usage and handling. The education will be reviewed annually through facility safety committee.</p> <p>PERSON RESPONSIBLE</p> <p>The ED or designee</p> <p>DATE OF COMPLIANCE 12/14/17</p>	

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

Printed: 10/26/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135053	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED 10/16/2017
NAME OF PROVIDER OR SUPPLIER IVY COURT		STREET ADDRESS, CITY, STATE, ZIP CODE 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
K 926	Continued From page 22 and others who handle medical gases and the cylinders that contain the medical gases shall be trained on the risks associated with their handling and use. 11.5.2.1.2 Health care facilities shall provide programs of continuing education for their personnel. 11.5.2.1.3 Continuing education programs shall include periodic review of safety guidelines and usage requirements for medical gases and their cylinders.	K 926		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135053	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/16/2017
--	---	---	---

NAME OF PROVIDER OR SUPPLIER IVY COURT	STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The facility is a single story, Type V (111) construction with a complete automatic fire suppression and fire alarm system. Smoke detection covers the corridors and open areas. The facility was built in 1973 and is currently licensed for 80 SNF/NF beds.</p> <p>The following deficiencies were cited at the above facility during the annual fire/life safety code survey conducted on October 16, 2017. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Chapter 19, Existing Healthcare Occupancies, in accordance with 42 CFR 483.70, 42 CFR 483.65 and IDAPA 16.03.02, Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities in Idaho.</p> <p>The survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety & Construction</p>	C 000	<p style="text-align: center;">RECEIVED</p> <p style="text-align: center;">NOV 13 2017</p> <p style="text-align: center;">FACILITY STANDARDS</p>	
C 229	<p>02.106,02,a Life Safety Code Standards Requirements</p> <p>02. Life Safety Code Requirements. The facility shall meet such provisions of the Life Safety Code of the National Fire Protection Association (26th ed., 1985) as are applicable to a health care facility except:</p> <p>a. As modified herein, the facility shall comply with the standards for "Health Care Occupancies" contained in Chapters 12 and 13, and applicable provisions of</p>	C 229		<p>C229</p> <p>INDIVIDUAL RESIDENTS No individual residents were identified in the survey.</p> <p>RESIDENTS IN SIMILAR SITUATIONS Residents have the potential to be affected by this practice. The corrected the specific K-tags listed under this regulation.</p> <p>METHOD TO PREVENT REOCCURENCE Reference actions taken under K-100, K-161, K-211, K-293, K-325, K-353, K-511, K-521, K-915 and K-926</p>

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

TITLE

(X6) DATE

Patrick McNabb

[Signature]

ED 11/8/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135053	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/16/2017
NAME OF PROVIDER OR SUPPLIER IVY COURT		STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
C 229	Continued From Page 1 Chapters 1 through 7, Chapter 31, and Appendices A, B, and C of the Life Safety Code; or This RULE: is not met as evidenced by: Please refer to federal CMS "K" tags: K-100 Water Management K-161 Continuity of penetrations K-211 Means of Egress K-293 Marking of Exits K-325 ABHR refilling K-353 Sprinkler system maintenance K-511 Electrical installations K-521 Smoke Dampers K-915 Emergency Generators K-926 Medical gas training	C 229		
C 246	02.106,05,c Minimum 1 Fire Drill/Shift/Quarter c. A minimum of one (1) fire drill per shift per quarter shall be held. The drills shall be unannounced, shall include transmission of a fire alarm signal (may be silent during the late night/early morning) and shall be conducted at irregular intervals during the day and night. At least one (1) drill per year shall include at least a partial evacuation of the building. A basic written record of each drill shall be maintained and include at least the following: This RULE: is not met as evidenced by: Based on record review and interview, the facility failed to ensure a full or partial evacuation was conducted annually. Failure to perform a partial or full evacuation during the annual exercises, hinders staff ability to be prepared should the facility have to evacuate during an emergency.	C 246		

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135053	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/16/2017
NAME OF PROVIDER OR SUPPLIER IVY COURT		STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
C 246	<p>Continued From Page 2</p> <p>This deficient practice affected 67 residents, staff and visitors on the date of the survey. The facility is currently licensed for 80 SNF/NF beds and had a census of 67 on the day of the survey.</p> <p>Findings include:</p> <p>During review of provided facility emergency fire and evacuation drills, no records were provided indicating the facility had completed a partial or full evacuation in the last twelve months. When asked about the missing documentation, the interim Maintenance Director stated he was not sure when the last drill had been completed.</p> <p>Actual IDAPA standard:</p> <p>16.03.02.106.05 (c) c. A minimum of one (1) fire drill per shift per quarter shall be held. The drills shall be unannounced, shall include transmission of a fire alarm signal (may be silent during the late night/early morning) and shall be conducted at irregular intervals during the day and night. At least one (1) drill per year shall include at least a partial evacuation of the building. A basic written record of each drill shall be maintained and include at least the following:</p> <p>i. Date and time of drill; ii. Brief description of the drill, including problems encountered; iii. Recommendations for improvement (if any); and iv. Signature of employees supervising the drill together with the names of all employees participating in the drill.</p>	C 246		

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.