



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor  
RUSS BARRON – Director

TAMARA PRISOCK—ADMINISTRATOR  
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P.O. Box 83720  
Boise, Idaho 83720-0009  
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March 1, 2018

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

Provider #: 135053

Dear Mr. McNabb:

On **February 26, 2018**, 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 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. **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 **March 12, 2018**. Failure to submit an acceptable PoC by **March 12, 2018**, may result in the imposition of penalties by **April 5, 2018**.

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 **April 2, 2018 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the

Patrick McNabb, Administrator  
March 1, 2018  
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enforcement actions recommended (or revised, as appropriate) on **May 27, 2018**. A change in the seriousness of the deficiencies on **April 12, 2018**, may result in a change in the remedy. The remedy, which will be recommended if substantial compliance has not been achieved by **May 27, 2018** includes the following:

Denial of payment for new admissions effective **May 27, 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 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 **August 25, 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, CMS will provide you with a separate formal notification of that determination.**

If you believe these deficiencies have been corrected, you may contact Debby Ransom, RN, RHIT, Bureau Chief, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 5; 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 **May 27, 2018** 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:

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[http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/t  
abid/434/Default.aspx](http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/t<br/>abid/434/Default.aspx)

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

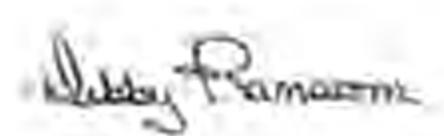
- BFS Letters (06/30/11)

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

This request must be received by **March 12, 2018**. If your request for informal dispute resolution is received after **March 12, 2018**, 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 Debby Ransom, RN, RHIT, Bureau Chief at (208) 334-6626, option 5.

Sincerely,



Debby Ransom, RN, RHIT, Chief  
Bureau of Facility Standards

dr/lj  
Enclosures

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

PRINTED: 04/04/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135053</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/26/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>IVY COURT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2200 IRONWOOD PLACE</b> <b>COEUR D'ALENE, ID 83814</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS  The following deficiencies were cited during a complaint investigation survey conducted at the facility February 23, 2018 and February 26, 2018.  The surveyors conducting the survey were:  Jenny Walker, RN , Team Coordinator Brad Perry, LSW Cecilia Stockdill, RN  Abbreviations:  CNA = Certified Nursing Assistant DNS = Director of Nursing MDD = Management of Market Development	F 000			
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii)  §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid	F 622		3/28/18	

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

TITLE

(X6) DATE

Electronically Signed

03/07/2018

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 622	<p>Continued From page 1</p> <p>under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or</p> <p>(F) The facility ceases to operate.</p> <p>(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.</p> <p>§483.15(c)(2) Documentation.</p> <p>When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.</p> <p>(i) Documentation in the resident's medical record must include:</p> <p>(A) The basis for the transfer per paragraph (c) (1)(i) of this section.</p> <p>(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident</p>	F 622			

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F 622	<p>Continued From page 2</p> <p>needs, and the service available at the receiving facility to meet the need(s).</p> <p>(ii) The documentation required by paragraph (c) (2)(i) of this section must be made by-</p> <p>(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and</p> <p>(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.</p> <p>(iii) Information provided to the receiving provider must include a minimum of the following:</p> <p>(A) Contact information of the practitioner responsible for the care of the resident.</p> <p>(B) Resident representative information including contact information</p> <p>(C) Advance Directive information</p> <p>(D) All special instructions or precautions for ongoing care, as appropriate.</p> <p>(E) Comprehensive care plan goals;</p> <p>(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview and record review, it was determined the facility failed to ensure a resident was given an appropriate notice of involuntary discharge. This was true for 1 of 3 (#1) sampled residents for involuntary discharge. This deficient practice had the potential to cause psychosocial harm if the resident was unnecessarily discharged/transferred to another setting. Findings include:</p> <p>The facility's Admission Packet revised April</p>	F 622	<p>This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report.</p> <p>Deficiencies related to F622 will be corrected as follows:</p>		

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F 622	<p>Continued From page 3</p> <p>2017, documented, "Our admissions committee determines whether we can meet the unique needs of each person who applies for admission. ...we will not retain a resident who requires services beyond those for which we are licensed, or services that we do not have the functional ability to provide. In the event we determine that it is necessary for you to be discharged or transferred, we will give you advance notice of the discharge or transfer and will tell you and your family the reasons for your discharge or transfer...we will help you arrange for appropriate continuing care in the community."</p> <p>The facility's MMD (Management of Marketing Development) job description, dated 7/1/15, documented, "This position is responsible for marketing the center to referral sources using a strategic marketing plan for the purpose of generating consistent admissions of appropriate residents into the center that maintain a census level and payer mix at or above budget." The essential functions documented, "to abide by all policies and procedures, communicates market changes and census development barriers to the Executive Director, and maintains thorough knowledge of the Center's products and services."</p> <p>A corporate Sales System Implementation and Adjustments recommendations, dated 2/6/18, documented, "the AC (Admission Coordinator) should run financial's and contact the case manager immediately to accept the patient...upload the patient clinical file and inform the MMD that you accepted the patient...provide the patient chart along with a completed pink sheet to nursing and indicate the patient was</p>	F 622	<p>1)Correction/s as it relates to the resident/s: Resident #1 is no longer in the facility.</p> <p>2)Action/s taken to protect residents in similar situations: Review of the past 30 days worth of discharges there have been no other involuntary discharge notices.</p> <p>3)Measures taken or systems altered to ensure that solutions are sustained: The facility will evaluate potential new admissions for clinical needs to make a determination for admission. The MMD when hired and DON will be educated to the policies and procedures of admissions and clinical capabilities of the center. The Interdisciplinary team will be educated to include the policies and procedures related involuntary discharges.</p> <p>4)Plans to monitor performance to ensure solutions are sustained and person responsible: Involuntary discharges will be reviewed in the monthly QAPI committee monthly x3 months for continued quality improvement.</p> <p>5) Who is responsible to ensure compliance: The Executive Director will monitor compliance.</p>		

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F 622	<p>Continued From page 4 accepted."</p> <p>Resident #1 was admitted to the facility on 2/16/18 with multiple diagnoses, including dementia and a non-weight bearing ankle fracture and discharged to the hospital on 2/17/18.</p> <p>A facility's Admission Assessment, dated 2/16/18 at 5:15 PM, documented Resident #1's level of cooperation was unpredictable or varied, very forgetful, poor safety awareness, and required 2 person extensive assistance.</p> <p>Resident #1's Incident and Accident Reports, dated 2/17/18, documented the resident was found on the floor 3 times at 12:45 AM, 5:30 AM, and 5:45 AM. The interventions did not include increased supervision for Resident #1.</p> <p>On 2/23/18 at 2:50 PM, E #1 stated when Resident #1 was admitted to the facility on 2/16/18, the resident required 1:1 supervision due to the resident's non-weight bearing status and was an "incredible challenge" and the facility did not have enough staff to place a 1:1 for Resident #1 at that time.</p> <p>On 2/23/18 at 3:07 PM, E #3 stated the facility sometimes admitted residents that they could not provide adequate care and services for.</p> <p>On 2/23/18 at 10:55 AM, the DNS stated the MMD did not provide clinical information from the hospital regarding Resident #1. The DNS stated Resident #1 arrived at the facility with an envelope that had all the clinical information including diagnoses, history and physical, nurses</p>	F 622			

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F 622	Continued From page 5 notes, medication list, and other clinical information for Resident #1. The DNS stated the MMD accepted Resident #1 without nursing review of the clinical information to determine the ability to provide care and services for Resident #1. The MMD was unavailable to interview from 2/23/18 through 2/26/18.  On 2/23/18 at 10:55 AM, the DNS stated the facility provided an involuntary discharge notice to Resident #1, dated 2/17/18, documented the reasons for discharge were frequent falls, confusion, dementia, not re-directable, and altered mental status.  On 2/23/18 at 12:25 PM, the Administrator and the DNS stated they had informed the hospital discharge planner on 2/17/18 that the facility would re-admit Resident #1 when her condition stabilized, but not before 2/19/18. They thought when the involuntary discharge notice was given, it would have been an indication that the hospital needed to further admit and treat the resident.  On 2/23/18 at 11:40 AM, the Admissions Coordinator stated she had been reviewing Resident #1's clinical status and visiting her at the hospital from 2/20/18 through 2/22/18, to determine appropriate placement after hospital discharge.	F 622			
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2)  §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest	F 725			3/28/18

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F 725	<p>Continued From page 6</p> <p>practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).</p> <p>§483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>(i) Except when waived under paragraph (e) of this section, licensed nurses; and</p> <p>(ii) Other nursing personnel, including but not limited to nurse aides.</p> <p>§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interviews and record review, it was determined the facility failed to ensure there was adequate staffing to provide for the needs and well-being of residents. This was true for 1 of 4 sampled residents (#1) and placed the health and safety of all 70 residents in the facility at risk of harm should the staffing shortage result in the failure to deliver care as physician ordered, as care planned, or otherwise needed. Findings include:</p> <p>Resident #1 was admitted to the facility on 2/16/18 with multiple diagnoses, including dementia and a non-weight bearing ankle</p>	F 725	<p>Deficiencies related to F725 will be corrected as follows:</p> <p>1) Correction/s as it relates to the resident/s: Resident #1 is no longer in the facility.</p> <p>2) Action/s taken to protect residents in similar situations: Staffing levels will be maintained at a level to meet resident's individual needs. No other residents are requiring 1:1 supervision at this time.</p>		

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F 725	<p>Continued From page 7 fracture.</p> <p>An Admission Assessment, dated 2/16/18 at 5:15 PM, documented Resident #1's level of cooperation was unpredictable or varied, very forgetful, poor safety awareness, and required 2 person extensive assistance.</p> <p>A Fall Risk Assessment, dated 2/16/18 at 5:15 PM, documented Resident #1 had history of multiple falls.</p> <p>An Incident and Accident Report, dated 2/17/18 at 12:45 AM, documented Resident #1 was found sitting on the floor next to her bed with legs stretched out in front of her. The nurse completed a physical assessment and initiated a neurological assessment and Resident #1 assisted back to bed.</p> <p>A Nurse's Progress Note, dated 2/17/18 at 2:31 AM, documented Resident #1 was awake at the nurse's station.</p> <p>An Incident and Accident Report, dated 2/17/18 at 5:30 AM, documented Resident #1 was found sitting on the floor next to her bed with legs stretched out in front of her. The nurse completed physical and neurological assessments and Resident #1 was assisted back to bed.</p> <p>An Incident and Accident Report, dated 2/17/18 at 5:45 AM, documented Resident #1 was found sitting on the floor next to her bed. Resident #1 stated she hit her head and the nurse completed physical and neurological assessments and two staff members assisted Resident #1 to her wheelchair and was brought to the nurse's</p>	F 725	<p>3) Measures taken or systems altered to ensure that solutions are sustained: Residents requiring 1:1 will be accommodated by assigning staff appropriately. Additional staff on both a full time and PRN basis to assist when needed. Facility will utilize non-clinical trained staff to assist with one to one supervision when needed and deemed appropriate by facility leadership. The facility will continue to recruit for licensed and unlicensed staff as needed through local agencies, online advertising and other means deemed necessary to maintain sufficient staffing patterns in the facility. Facility will also continue to partner with the internal staffing float pool to provide additional support staff as necessary.</p> <p>4) Plans to monitor performance to ensure solutions are sustained and person responsible: Audit staffing levels for current and next day staffing needs Monday through Friday for 4 weeks then it will be audited weekly for 8 weeks. Audits will be reviewed in QAPI monthly x3 months. Facility recruitment and retention will be reviewed monthly in QAPI to determine needed changes and interventions x3 months.</p> <p>5) Person responsible to ensure compliance: The Executive Director and/or Director of Nursing will monitor compliance</p>		

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135053</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/26/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>IVY COURT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2200 IRONWOOD PLACE</b> <b>COEUR D'ALENE, ID 83814</b>		
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F 725	<p>Continued From page 8 station.</p> <p>A Nurse's Progress Note, dated 2/17/18 at 7:30 AM, documented Resident #1 was sent to ER due to falls and confusion during the night.</p> <p>The Night Shift Assignment Sheet, dated 2/16/18, documented 2 Nurses and 3 CNAs for all three halls.</p> <p>The facility's Close Visual Supervision policy and procedure, revised January 2017, documented if general or increased supervision was not sufficient to ensure the safety of the resident, the resident would have "one-to-one" staff supervision and assistance. The assigned staff member must stay one to two arm lengths of the resident at all times.</p> <p>On 2/23/18 at 10:55 AM, the DNS stated during the night shift on 2/16/18, one of the three CNAs was assigned as a 1:1 for another resident and was unable to provide a 1:1 for Resident #1 due to the lack of staff.</p> <p>On 2/23/18 at 2:30 PM, the DNS stated to be "fully" staffed, for day and evening shift the facility needed:</p> <ul style="list-style-type: none"> <li>* South Hall - 1 Nurse and 3 CNAs.</li> <li>* East Hall - 1 Nurse and 3 CNAs.</li> <li>* North Hall - 2 Nurse's and 3 CNAs.</li> <li>* Night Shift - 2 Nurse's and 3 CNAs.</li> </ul> <p>The Evening Shift Assignment Sheet, dated</p>	F 725			

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F 725	<p>Continued From page 9 2/17/18, documented for each hall as follows:</p> <ul style="list-style-type: none"> <li>* South Hall - 1 LPN and 2 CNAs.</li> <li>* East Hall - 1 RN and 2 CNAs with a CNA float between South and East Hall.</li> <li>* North Hall - 2 LPNs and 2 CNAs</li> </ul> <p>The Day Shift Assignment Sheet, dated 2/18/18, documented for each hall as follows:</p> <ul style="list-style-type: none"> <li>* South Hall - 1 RN and 2 CNAs</li> <li>* East Hall - 1 LPN and 2 CNAs with a CNA float between South and East Hall.</li> </ul> <p>The Evening Shift Assignment Sheet, dated 2/18/18, documented for each hall as follows:</p> <ul style="list-style-type: none"> <li>* South Hall - 1 LPN and 2 CNAs.</li> <li>* North Hall - 1 RN, 1 LPN, and 1 CNA.</li> </ul> <p>On 2/23/18 at 2:30 PM, the DNS stated when staff called off for the shift, the facility called other staff members to work and if unable to fill the shift, the facility called the corporate float pool agency to assist in filling the call off. She said due to short notice to the float pool, the float pool rarely covered the shift and the facility's staff would work short due to lack of staff.</p> <p>On 2/23/18 at 2:50 PM, E #1 stated when Resident #1 was admitted to the facility on 2/16/18, the resident required 1:1 supervision due to the resident's non-weight bearing status and was an "incredible challenge" and the facility</p>	F 725			

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F 725	Continued From page 10 did not have enough staff to place a 1:1 for Resident #1 at that time.  On 2/23/18 at 3:00 PM, E #2 stated the facility worked short when staff called off and the float pool was not available to help. E #2 said the facility was not equipped to provide 1:1 supervision to residents.  On 2/23/18 at 3:07 PM, E #3 stated there was not enough staff and burn out was happening due to having to pick up extra shifts and the float pool was unable to help out.  On 2/23/18 at 3:45 PM, E #4 stated the night shift was the hardest to work when a resident required 1:1 supervision and the facility did not have enough staff.  On 2/26/18 at 10:15 AM, the Float Pool Director stated the float pool had CNAs working for the float pool agency, but most of the CNAs worked between two states. When the facility called to request a shift to be covered that day due to a "call off", occasionally the Float Pool Director was able to fill the shift, but was not always able to due to the short notice because the CNAs were already scheduled at another facility.	F 725			
F 838 SS=F	Facility Assessment CFR(s): 483.70(e)(1)-(3)  §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at	F 838			3/28/18

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F 838	<p>Continued From page 11</p> <p>least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include:</p> <p>§483.70(e)(1) The facility's resident population, including, but not limited to,</p> <ul style="list-style-type: none"> <li>(i) Both the number of residents and the facility's resident capacity;</li> <li>(ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population;</li> <li>(iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population;</li> <li>(iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and</li> <li>(v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.</li> </ul> <p>§483.70(e)(2) The facility's resources, including but not limited to,</p> <ul style="list-style-type: none"> <li>(i) All buildings and/or other physical structures and vehicles;</li> <li>(ii) Equipment (medical and non- medical);</li> <li>(iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies;</li> <li>(iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies</li> </ul>	F 838			

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F 838	<p>Continued From page 12 related to resident care;</p> <p>(v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and</p> <p>(vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.</p> <p>§483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview, it was determined the facility failed to ensure the facility assessment identified resources and staffing to provide person centered care and services required by residents. This was true for 3 of 4 (#s 1, 3, and 4) sampled residents and all other residents residing in the facility. This created the potential for harm if the facility did not have the resources to provide the necessary care and services the residents required. Findings include:</p> <p>The Facility's Assessment, dated November 2017, documented</p> <p>*Section 1A a low number of residents with Alzheimer's (0.9%) and Non-Alzheimer's Dementia (12.3%)</p> <p>*Section 1B.2. A majority of the residents are not high acuity considering the of needs based on diagnosis, condition and treatment.</p> <p>*Section 1C.1. Identified that a large percentage of the residents have dementia and are a risk for wandering. This section seems to conflict with</p>	F 838	<p>Deficiencies related to F838 will be corrected as follows:</p> <p>1) Correction/s as it relates to the resident/s: Resident #1 no longer resides in the facility. Residents #3 and #4 had their care plans reviewed for services and interventions to ensure that resident specific needs are being met. Care plans were updated as needed.</p> <p>2) Action/s taken to protect residents in similar situations: A review of residents admitted within the last 30 days still residing in the facility were reviewed for potential unmet needs. Care plans were updated as needed to ensure that individual resident services are being provided. Additional residents will be reviewed and care plans will be updated in conjunction with their MDS schedule and care conferences.</p>		

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F 838	<p>Continued From page 13</p> <p>Section A.</p> <p>*Section 2 B.1,C.1,D.1 documents that staff scheduling is based on acuity and level of care needed in the facility.</p> <p>*Section 3 C.2 documents that the facility is unable to care for the needs of residents with behavioral issues due to a lack of equipment or the "resources to handle this type of clinical dynamics". The section further indicates the facility has appropriate systems to handle mild behavioral symptoms due to dementia.</p> <p>On 2/26/18 at 11:00 AM, the Administrator and the DNS stated they had used a check-mark type questionnaire assessment to fill out the facility assessment and did not realize the facility assessment did not include 1:1 supervision for residents.</p> <p>The admission of Resident #1 does not seem consistent with the care and services the facility identified they could serve.</p>	F 838	<p>3)Measures taken or systems altered to ensure that solutions are sustained: Education was provided to facility leadership in facility assessment completion, meeting resident needs through person centered care and providing on-going education and training related to areas self-identified as deficient. Education included but was not limited to, admission practices and required interventions when a resident's needs exceeds facility capabilities.</p> <p>4) Plans to monitor performance to ensure solutions are sustained and person responsible: Facility leadership will review the facility assessment on an on-going basis to ensure that additional training and updating occurs with the changes in the facility and needs of residents. Facility assessment will be brought to monthly QAPI x3 months for on-going review and auditing.</p> <p>5) Person responsible to ensure compliance: The Executive Director will ensure ongoing compliance.</p>		



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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January 11, 2019

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

Provider #: 135053

Dear Mr. McNabb:

On **February 26, 2018**, an unannounced on-site complaint survey was conducted at Ivy Court. The complaint investigation survey was conducted at the facility on February 23, 2018 and February 26, 2018.

The complaint allegation, findings and conclusions are as follows:

**Complaint #ID00007764**

ALLEGATION #1:

The identified resident was admitted to the facility on 2/16/18 and received an involuntary discharge on 2/17/18.

FINDINGS #1:

The clinical records of the identified resident and two other residents were reviewed for quality of care and an involuntary discharge from the facility. The facility's grievance files and allegations of abuse investigations, from January 2018 through February 2018, were reviewed. The facility's policies and procedures for admissions and discharges, were reviewed. The admission and marketing job descriptions were reviewed. The facility's assessment was reviewed. The facility's daily assignments for nurse staffing, for 1/25/18 to 2/23/18, were reviewed.

Patrick McNabb, Administrator  
January 11, 2019  
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Several Nurses, Certified Nursing Aides (CNAs), and management staff were interviewed regarding quality of care and residents being discharged. The Administrator and the Director of Nursing were interviewed.

Based on observation, record review, and staff interview, the allegation was substantiated and the facility was cited at F622, F725, and F838. Please refer to federal 2567 report for details.

**CONCLUSIONS:**

Substantiated. Federal deficiencies related to the allegation are cited.

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,



Belinda Day, RN, Supervisor  
Long Term Care Program

BD/lj