



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 30, 2018

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 23, 2018**, 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

Patrick McNabb, Administrator
October 30, 2018
Page 2 of 4

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 12, 2018**. Failure to submit an acceptable PoC by **November 12, 2018**, may result in the imposition of civil monetary penalties by **December 4, 2018**.

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 **October 27, 2018**, (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 **October 27, 2018**. A change in the seriousness of the deficiencies on **October 27, 2018**, may result in a change in the remedy.

Patrick McNabb, Administrator
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The remedy, which will be recommended if substantial compliance has not been achieved by **October 27, 2018**, includes the following:

Denial of payment for new admissions effective **January 23, 2019**.
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 23, 2019**, 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 23, 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/tabid/434/Default.aspx>

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

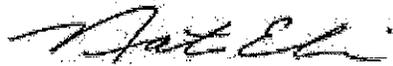
BFS Letters (06/30/11)

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

This request must be received by **November 12, 2018**. If your request for informal dispute resolution is received after **November 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, 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: 11/08/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 138063	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/23/2018
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NAME OF PROVIDER OR SUPPLIER

IVY COURT

STREET ADDRESS, CITY, STATE, ZIP CODE

2200 IRONWOOD PLACE
COEUR D'ALENE, ID 83814

(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
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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 23, 2018. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Chapter 19, Existing Healthcare Occupancies, in accordance with 42 CFR 483.70.

The survey was conducted by:

Nate Elkins, Supervisor
AHJ-Fire Life Safety Program

K 222
§§-E

Egress Doors
CFR(a): NFPA 101

Egress Doors
Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements:

CLINICAL NEEDS OR SECURITY THREAT LOCKING

Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available

K 000

K 000

"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"

K 222

RECEIVED

NOV 13 2018

FACILITY STANDARDS

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

TITLE

(X6) DATE

Chocklett Acting ED 11/12/18

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 required to continued program participation.

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

PRINTED: 11/06/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135063	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/23/2018
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NAME OF PROVIDER OR SUPPLIER IVY COURT	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 IRONWOOD PLACE COEUR D'ALENE, ID 83814
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K 222	<p>Continued From page 1 to the staff at all times.</p> <p>18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fall safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation.</p> <p>18.2.2.2.5.2, 19.2.2.2.6.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system.</p> <p>18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted.</p> <p>18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout</p>	K 222		

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NAME OF PROVIDER OR SUPPLIER IVY COURT	STREET ADDRESS, CITY, STATE, ZIP CODE 2280 IRONWOOD PLACE COEUR D'ALENE, ID 83814
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K 222	<p>Continued From page 2</p> <p>by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, the facility failed to ensure that exit doors were arranged to be readily opened from the egress side. Failure to maintain means of egress for full instant use could hinder the safe evacuation of residents during an emergency through a marked Exit. This deficient practice affected 88 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour on October 23, 2018 at approximately 1:00 PM, observation of the sliding glass doors exiting from the dining area revealed the door was equipped with a wanderguard system with delayed egress, but was also equipped with a deadbolt style lock on the the egress side. When asked, the Maintenance Supervisor stated the facility uses the deadbolt lock after hours to deter unwanted visitors.</p> <p>Actual NFPA standard: 18.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side, unless otherwise permitted by one of the following: (1) Locks complying with 19.2.2.2.5 shall be permitted. (2)*Delayed-egress locks complying with 7.2.1.6.1 shall be permitted. (3)*Access-controlled egress doors complying with 7.2.1.6.2 shall be permitted.</p>	K 222	<p>K 222</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Emergency signage was removed. There were no resident identified.</p> <p>How will you identify other residents who have the potential to be affected by the deficient Practice and what corrective action will be taken. There are no residents identified. Residents at the Facility have the potential to be affected by this Deficient practice. Exit signage was removed from sliding glass door That indicated emergency exit. Floor plan never indicated that sliding glass door was an emergency Exit. Measures in place and what systemic changes will be made to ensure that the deficient practice does not recur. Facility will review weekly the status of emergency Exit doors and documentation in TELS to validate Compliance.</p> <p>How the facility plans to monitor performance to ensure the corrective actions are effective and compliance is sustained. TELS reports will be reported in QAPI monthly X 3 to ensure compliance and any educational Opportunities.</p> <p>Person responsible for compliance Maintenance Director or designee is responsible for Compliance</p> <p>Date of compliance. 12/23/2018</p>	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 136053	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED 10/23/2018
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 222	Continued From page 3 (4) Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted. (5) Approved existing door-locking installations shall be permitted	K 222			
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure semi-annual inspection of the kitchen hood was conducted. Failure to conduct	K 324			

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K 324	Continued From page 4 semi-annual inspections of cooking ventilation systems could increase the risk of fires due to excessive build-up of grease laden vapors. This deficient practice affected 69 residents, staff and visitors on the date of survey. Findings Include: Review of inspection records on October 23, 2018 from 9:00 AM to 12:00 PM, revealed cleaning for the Kitchen Hood System was completed in July 2018 but the previous report revealed June 5, 2017. When asked, the Maintenance Director stated the facility was unaware the hood inspection was not completed between June 2017 and July 2018. Actual NFPA standard: NFPA 96 11.4* Inspection for Grease Buildup The entire exhaust system shall be inspected for grease buildup by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction and in accordance with Table 11.4. 11.6 Cleaning of Exhaust Systems 11.6.1 Upon inspection, if the exhaust system is found to be contaminated with deposits from grease-laden vapors, the contaminated portions of the exhaust system shall be cleaned by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction.	K 324	K 324 What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Bi-annual hood inspections are up to date and in compliance. There were no residents identified. How will you identify other residents who have the potential to be affected by the deficient practice and what corrective action will be taken. There were no residents identified. Residents At the facility have the potential to be affected By this deficient practice. Measures in place and what systemic changes will be made to ensure that the deficient practice does not recur. Required bi-annual inspection and service is up to date and results documented and reviewed in TELS for compliance. How the facility plans to monitor performance to ensure the corrective actions are effective and compliance is sustained. Hood cleaning and inspection is schedule via TELS and upcoming service results after the fact will be reviewed in QAPI monthly X 3 for correction or educational purposes. Person responsible for compliance Maintenance Director or designee will be Responsible for compliance. Date of compliance. 12/23/2108		
K 351	Sprinkler System - Installation	K 351			

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NAME OF PROVIDER OR SUPPLIER IVY COURT	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 IRONWOOD PLACE COEUR D'ALENE, ID 83814
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K 351 SS=E	Continued From page 5 CFR(s): NFPA 101 Sprinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation it was determined the facility failed to provide a means to keeping continuous obstructions away from a sprinkler. Failure to provide clear space for the sprinkler system to effectively operate could hinder protection for egress and protection from fires to fully develop. This deficient practice affects 69 residents, staff, and visitors on the day of survey. Findings Include: During the facility tour on October 23, 2018, at approximately 1:00PM, observation of the front main entrance exit sign, which measures 12" x 7.6" x 1.6", revealed the sign was within 2-4 inches from the installed sprinkler head. When	K 351	K 351 What corrective action will be accomplished for those residents found to have been affected by the deficient practice. There were no residents identified. The exit/flood light was installed 32 inches away from sprinkler head. How will you identify other residents who have the potential to be affected by the deficient Practice and what corrective action will be taken. There are no residents identified. Residents at the Facility have the potential to be affected by this Deficient practice. Measures in place and what systemic changes will be made to ensure that the deficient practice does not recur. Emergency lighting will be inspected weekly through TELS system. How the facility plans to monitor performance to ensure the corrective actions are effective and compliance is sustained. TELS results of inspections will be reported during QAPI monthly X 3 for corrections or educational opportunities. Person responsible for compliance Maintenance Director or designee will Be responsible for compliance. Date of compliance. 12/23/2018	
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NAME OF PROVIDER OR SUPPLIER IVY COURT	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 IRONWOOD PLACE COEUR D'ALENE, ID 83814
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K 351	Continued From page 6 asked, the Maintenance Director stated the facility was unaware of the obstruction.	K 351		
K 712 SS=F	Actual NFPA Standard 8.6.5.2.1.3* Sprinklers shall be positioned away from obstructions a minimum distance of three times the maximum dimension of the obstruction. See Table 8.6.5.1.2 Positioning of Sprinklers to Avoid Obstructions to Discharge Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure fire drills were conducted one per shift per quarter. Failure to perform fire drills quarterly for each shift has the potential to hinder staff response in the event of a fire. This deficient practice affected 69 residents, staff and visitors on the date of the survey. Findings Include: During review of provided facility records	K 712		

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K 712	Continued From page 7 conducted on October 23, 2018 from 9:00AM to 12:00PM, no records were provided demonstrating fire drills were performed for the 4th quarter PM and 4th quarter NOC shifts. When asked, Maintenance Director stated he was not aware of the missing fire drills. Actual NFPA standard: 19.7* Operating Features. 19.7.1 Evacuation and Relocation Plan and Fire Drills. 19.7.1.6 Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions.	K 712	K 712 What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Fire drills are up to date since 12/29/2017. There were no residents identified. How will you identify other residents who have the potential to be affected by the deficient Practice. All residents may be affected by this deficient Practice. Practice and what corrective action will be taken. Fire drills will be completed for compliance and Reviewed in Safety Committee monthly. Measures in place and what systemic changes will be made to ensure that the deficient practice does not recur. All fire drills will be document and reviewed in TELS to ensure compliance. How the facility plans to monitor performance to ensure the corrective actions are effective and compliance is sustained. Results of all fire drills will be reported to QAPI via TELS reports monthly X 3 to ensure corrective action and or educational opportunities. Person responsible for compliance Maintenance Director or designee will be responsible for compliance. Date of compliance. 12/23/2018	



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 30, 2018

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

Provider #: 135053

RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER

Dear Mr. McNabb:

On **October 23, 2018**, an Emergency Preparedness 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 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. 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.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **November 12, 2018**. Failure to submit an acceptable PoC by **November 12, 2018**, may result in the imposition of civil monetary penalties by **December 4, 2018**.

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 **October 27, 2018**, (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 **October 27, 2018**. A change in the seriousness of the deficiencies on **October 27, 2018**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **October 27, 2018**, includes the following:

Denial of payment for new admissions effective **January 23, 2019**.
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 23, 2019**, 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 23, 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:

<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

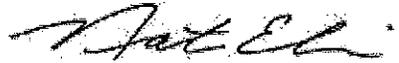
This request must be received by **November 12, 2018**. If your request for informal dispute resolution is received after **November 12, 2018**, the request will not be granted.

Patrick McNabb, Administrator
October 30, 2018
Page 4 of 4

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,

A handwritten signature in black ink, appearing to read "Nate Elkins". The signature is fluid and cursive, with a prominent initial "N" and a long, sweeping underline.

Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosures

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

PRINTED: 11/06/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 136053	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/23/2018
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
E 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 during the Initial Emergency Preparedness Survey conducted on October 23, 2018. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73. The Survey was conducted by: Nate Elkins, Supervisor AHJ-Fire Life Safety Program	E 000	E 000 "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"	
E 006 SS=D	Plan Based on All Hazards Risk Assessment CFR(a): 483.73(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* *[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. *[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and	E 006		

RECEIVED
NOV 13 2018
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [Signature] TITLE: Interim ED (X6) DATE: 11/13/18

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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E 006	<p>Continued From page 1 community-based risk assessment, utilizing an all-hazards approach, including missing clients.</p> <p>(2) Include strategies for addressing emergency events identified by the risk assessment.</p> <p>* [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to develop an Emergency Preparedness program that included a relevant facility based and community-based risk assessment. Failure to provide a relevant facility and community-based risk assessment, has the potential to focus staff training and resources on hazards that are not site specific. This deficient practice could potentially affect all residents, staff, and visitors on the date of the survey.</p> <p>Findings Include:</p> <p>1) On October 23, 2018 from 9:00AM to 10:30 AM, review of the provided emergency plan, policies and procedures, revealed the facility HVA (Hazard Vulnerability Analysis) stated zero risk for Hurricanes, Tropical Storms, and Tsunami's. Upon further review, the facility provided policies and procedures for these types of disasters.</p> <p>2) On October 23, 2018, during review of the provided emergency plan, the facility did not</p>	E 006	<p>E 006</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice. There were no residents identified. Hazard Vulnerability Assessment has been Updated to reflect hazards relative to our area.</p> <p>How will you identify other residents who have the potential to be affected by the deficient Practice and what corrective action will be taken. All resident may be affected. The Emergency Preparedness manual will be Reviewed annually to ensure that the correct Hazards are identified.</p> <p>Measures in place and what systemic changes will be made to ensure that the deficient practice does not recur. The Emergency Preparedness manual will be Reviewed/updated and in-serviced annually.</p> <p>How the facility plans to monitor performance to ensure the corrective actions are effective and compliance is sustained. Review and assessment of Emergency Manual will occur in QAPI monthly X 3 for corrective and or educational opportunities.</p> <p>Person responsible for compliance Maintenance Director or designee will be Responsible for compliance.</p> <p>Date of compliance. 12/23/2018</p>		

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E 006	Continued From page 2 provide a community-based Risk Assessment. When asked, the Maintenance Director and the Administrator stated they were unaware of the non-relevant policies and procedures as well as no community-based risk assessment was provided. Reference: 42 CFR 483.73 (a) (1) - (2) EP Program Patient Population CFR(s): 483.73(a)(3) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *Note: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC, FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on record review, It was determined the facility failed to provide an emergency plan, policies and procedures, addressing the types of services the facility has the ability to provide during an emergency. Failure to address the available services the facility can provide during an emergency, has the potential to hinder	E 006		
E 007 SS=F		E 007	E 007 What corrective action will be accomplished for those residents found to have been affected by the deficient practice. There were no residents identified. How will you identify other residents who have the potential to be affected by the deficient Practice and what corrective action will be taken. There were no residents identified. Residents at the facility have the potential to be affected by this deficient practice. Measures in place and what systemic changes will be made to ensure that the deficient practice does not recur. Policy and procedures have been established including list of resources and abilities facility can provide within scope of practice. How the facility plans to monitor performance to ensure the corrective actions are effective and compliance is sustained. Policy and Procedures and resources facility is able to provide will be in serviced to staff on-going and results reported in QAPI monthly X 3 For educational and corrective opportunities. Person responsible for compliance Maintenance Director or designee will be responsible for compliance. Date of compliance, 12/23/2018	

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E 007	Continued From page 3 continuity of care and emergency management response. This deficient practice affected 69 residents, staff and visitors on the date of the survey. Findings Include: On October 23, 2018 from 9:00 AM TO 10:00 AM, review of provided emergency plan, policies and procedures, revealed the plan failed to define what types of services the facility had the ability to provide during an emergency. Reference: 42 CFR 483.73 (a) (3)	E 007			
E 023 88-D	Policies/Procedures for Medical Documentation CFR(s): 483.73(b)(5) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (5) A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. [(5) or (3),(4),(6)] A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records.	E 023			

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NAME OF PROVIDER OR SUPPLIER IVY COURT			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 IRONWOOD PLACE COEUR D'ALENE, ID 83814		
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E 023	<p>Continued From page 4</p> <p>*[For RNHCs at §403.748(b):] Policies and procedures. (5) A system of care documentation that does the following: (i) Preserves patient information. (ii) Protects confidentiality of patient information. (iii) Secures and maintains the availability of records.</p> <p>*[For OPOs at §486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to develop and implement policies and procedures in conjunction with the emergency plan that ensures preservation and confidentiality of medical records and information of residents during a disaster. Failure to provide policies, procedures and a plan which preserves and protects information and medical records has the potential to hinder continuity of care during a disaster for the 69 residents on the date of the survey.</p> <p>Findings include: On October 23, 2018 from 9:00 AM to 12:00 PM, review of policies, procedures and the emergency plan revealed the facility failed to demonstrate how medical records and information were to be protected to ensure confidentiality during a disaster.</p> <p>Upon further evaluation of the Emergency Plan, it was determined the facility did not have a method</p>	E 023	<p>E 023</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice. There were no residents were identified.</p> <p>How will you identify other residents who have the potential to be affected by the deficient Practice and what corrective action will be taken.</p> <p>There were no residents identified. Residents at the facility have the potential to be affected by this deficient practice. The medical information at Ivy Court is maintained Hard copy in off site storage with retrieval processes and electronically via electronic medical record utilizing Point Click Care which has connect ability with other healthcare providers.</p> <p>Measures in place and what systemic changes will be made to ensure that the deficient practice does not recur. Facility will ensure through annual assessment that the record management system is in place and effective.</p> <p>How the facility plans to monitor performance to ensure the corrective actions are effective and compliance is sustained. Record management assessment will be reviewed in QAPI annually for corrective action and or Educational opportunities.</p> <p>Person responsible for compliance Maintenance Director will responsible for compliance.</p> <p>Date of compliance. 12/23/2018</p>		

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E 023	Continued From page 5 for sharing information and medical documentation.	E 023			
E 024 SS=D	Reference: 42 CFR 483.73 (b) (5) Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(8) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (8) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCs at §403.748(b):] Policies and procedures. (8) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for	E 024			

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E 024	Continued From page 6 Integration of State and Federally designated health care professionals to address surge needs during an emergency. This REQUIREMENT is not met as evidenced by: Based on record review, it was determined the facility failed to develop emergency plan, policies and procedures addressing the use of volunteers during an emergency. Lack of a plan, policy and procedure specific to the use of volunteers, potentially hinders the facility's ability to provide continuity of care during a disaster. This deficient practice has the potential to affect the 69 residents, staff and visitors in the facility on the date of the survey. Findings include: Review of provided emergency plan, policies and procedures conducted on October 23, 2018 from 9:00 AM to 12:00 PM, failed to demonstrate a plan, policy or procedure on the use of volunteers. Reference: 42 CFR 483.73 (b) (6) Emergency Officials Contact Information CFR(s): 483.73(c)(2) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local	E 024	E 024 What corrective action will be accomplished for those residents found to have been affected by the deficient practice. No residents were identified. How will you identify other residents who have the potential to be affected by the deficient Practice and what corrective action will be taken. No residents were identified. Residents at the Facility may be affected by this deficient practice. Measures in place and what systemic changes will be made to ensure that the deficient practice does not recur. Policy & Procedure has been established regarding the non use of volunteers at the facility in a emergency/disaster situation. education regarding P&P will be provided. How the facility plans to monitor performance to ensure the corrective actions are effective and compliance is sustained. Results of education and in serviced will be reported in QAPI monthly X 3 for assessment and corrective action if necessary. Person responsible for compliance Maintenance Director or designee will be Responsible for compliance. Date of compliance. 12/23/2018		
E 031 SS=F		E 031			

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

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E 031	<p>Continued From page 7 emergency preparedness staff. (ii) Other sources of assistance.</p> <p>*[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, or local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance.</p> <p>*[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to ensure contact information for emergency management officials and other resources of assistance was provided in the emergency communication plan. Failure to provide information for resources available to the facility has the potential to hinder facility response and continuity of care for the 69 residents, staff and visitors in the facility on the date of the survey.</p> <p>Findings include: On October 23, 2018 from 9:00 AM to 12:00 PM, review of the emergency plan, policies and procedures, revealed the plan did not include contact information for Federal, State, and County emergency management, as well as State Licensing and Certification Agency and the State</p>	E 031	<p>E 031</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice. There were no residents identified.</p> <p>How will you identify other residents who have the potential to be affected by the deficient Practice and what corrective action will be taken. There are not residents identified. Residents at The facility have the potential to be affected by This deficient practice.</p> <p>Measures in place and what systemic changes will be made to ensure that the deficient practice does not recur. Ivy Court will schedule collaborative efforts With local, state, and tribal entities.</p> <p>How the facility plans to monitor performance to ensure the corrective actions are effective and compliance is sustained. The emergency plan will be reviewed annually To ensure compliance through QAPI meetings And findings assessed for corrective actions if necessary.</p> <p>Person responsible for compliance Maintenance Director or designee is Responsible for compliance.</p> <p>Date of compliance. 12/23/2018</p>	

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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 _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/23/2018
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
E 031	Continued From page 8 Ombudsman.	E 031		
E 034 SS=E	<p>Reference: 42 CFR 483.73 (c) (2)</p> <p>Information on Occupancy/Needs CFR(s): 483.73(c)(7)</p> <p>[(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following:</p> <p>(7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.</p> <p>*[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.</p> <p>*[For Inpatient Hospice at §418.113:] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to document a current plan for sharing information on needs, occupancy and its ability to provide assistance</p>	E 034	<p>E 034</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice. No residents were identified.</p> <p>How will you identify other residents who have the potential to be affected by the deficient practice and what corrective action will be taken. No residents were identified. All residents may be affected by this deficient practice. Ivy Court shall establish methods of communicating both internally and externally during a crisis or disaster situation.</p> <p>Measures in place and what systemic changes will be made to ensure that the deficient practice does not recur. Staff Education/in servicing will be conducted routinely as needed to ensure systems are in place to needs and supportive ability.</p> <p>How the facility plans to monitor performance to ensure the corrective actions are effective and compliance is sustained. Results of in services and education will be reported in QAPI monthly X 3 for corrective action or additional education opportunities.</p> <p>Person responsible for compliance Maintenance Director or designee will be Responsible for compliance.</p> <p>Date of compliance. 12/23/2018</p>	

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E 034	Continued From page 9 with emergency management officials. Lack of a current plan for providing information to emergency personnel on the facility's needs and abilities to provide assistance during an emergency has the potential to hinder response assistance and continuation of care of residents. This deficient practice affected 89 residents, staff and visitors on the date of the survey. Findings include: On October 23, 2018 from 9:00 AM to 12:00 PM, review of provided policies, procedures and emergency plans revealed no method the facility would use to share information on its needs or capabilities with emergency management officials. Reference: 42 CFR 483.73 (c) (7) LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8) [(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by:	E 034		
E 035 SS=F		E 035		

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E 035	Continued From page 10 Based on record review, it was determined the facility failed to provide policies, procedure or plan identifying the method of sharing information on the emergency plan with residents, families, or representatives. Failure to share the emergency plan and its contents with residents, families, or representatives, has the potential to create confusion and lack of understanding of the facility's response during a disaster. This deficient practice potentially affected 89 residents, staff and visitors on the date of the survey. Findings include: On October 23, 2018 from 9:00 AM to 12:00 PM, during review of provided emergency plan, policies and procedures, no documentation was provided demonstrating the facility policy and method for sharing information with residents, their families or representatives on the contents of the emergency plan, or the facility's procedures during such events. Reference: 42 CFR 483.73 (c) (8) EP Training and Testing CFR(s): 483.73(d) (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.	E 035	E 035 What corrective action will be accomplished for those residents found to have been affected by the deficient practice. There were no residents identified. How will you identify other residents who have the potential to be affected by the deficient Practice and what corrective action will be taken. There are no residents identified. Residents at the Facility have the potential to be affected by this deficient practice. Measures in place and what systemic changes will be made to ensure that the deficient practice does not recur. Community meeting will be held to include Residents, families, guardians, POAs and vendors to extend the opportunity for education and Collaboration in emergency preparedness Process. This meeting will be held annually. How the facility plans to monitor performance to ensure the corrective actions are effective and compliance is sustained. Annual meeting will be reported in QAPI for Assessment and educational opportunities. Person responsible for compliance Maintenance Director or designee will be responsible for compliance. Date of compliance. 12/23/2018		
E 038 SS-F		E 038			

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E 036	Continued From page 11 *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to provide an emergency prep training and testing program. Lack of a facility emergency training and testing program covering the emergency preparedness plan, policies and procedures, has the potential to hinder staff response during a disaster. This deficient practice affected 69 residents, staff and visitors on the date of the survey.	E 036	E 036 What corrective action will be accomplished for those residents found to have been affected by the deficient practice. There were no residents were identified. How will you identify other residents who have the potential to be affected by the deficient Practice and what corrective action will be taken. There are no residents identified. All residents at the facility have the potential to be affected by this deficient practice. Emergency Preparedness training will required for Every employee in the facility upon hire and then Annually. Such training is part of the New Employee Orientation/Acknowledgement and Signed copy of this document will be retained in Personnel file for 5 years. Measures in place and what systemic changes will be made to ensure that the deficient practice does not recur. The annual Emergency Preparedness and testing program will be entered in TELS to ensure that process is completed timely. How the facility plans to monitor performance to ensure the corrective actions are effective and compliance is sustained. Results of annual training and testing will be reported to QAPI for educational and or training opportunities. Person responsible for compliance Maintenance Director or designee will Be responsible for compliance. Date of compliance. 12/23/2018	

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E 036	Continued From page 12 Findings include: On October 23, 2018 from 9:00 AM to 12:00 PM, review of provided emergency plan, policies and procedures, along with associated in-services, found no documentation demonstrating the facility had a current testing program for staff based on training conducted over the contents of the emergency plan (EP).	E 036			
E 037 SS=F	Reference: 42 CFR 483.73 (d) EP Training Program CFR(s): 483.73(d)(1) (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at	E 037			

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E 037	Continued From page 13 least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least annually. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. *[For PACE at §460.84(d):] (1) The PACE	E 037	E 037 What corrective action will be accomplished for those residents found to have been affected by the deficient practice. There are no residents identified. How will you identify other residents who have the potential to be affected by the deficient Practice and what corrective action will be taken. There are not residents identified. All residents at the facility have the potential to be affected by this deficient practice. Emergency preparedness training program will be provided to all existing staff and new hires Ongoing. Training to include HVA and disaster Code responses. Measures in place and what systemic changes will be made to ensure that the deficient practice does not recur. Emergency preparedness training will occur annually per requirement and entered in TELS compliance follow up. How the facility plans to monitor performance to ensure the corrective actions are effective and compliance is sustained. Results of annual training will be reported to QAPI for assessment and educational opportunities. Person responsible for compliance Maintenance Director or designee will be responsible for compliance. Date of compliance. 12/23/2018		

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E 037	<p>Continued From page 14</p> <p>organization must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.</p> <p>(ii) Provide emergency preparedness training at least annually.</p> <p>(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.</p> <p>(iv) Maintain documentation of all training.</p> <p>*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:</p> <p>(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.</p> <p>(ii) Provide emergency preparedness training at least annually.</p> <p>(iii) Maintain documentation of the training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.</p> <p>*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection,</p>	E 037		

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E 037	<p>Continued From page 15</p> <p>and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.</p> <p>(ii) Provide emergency preparedness training at least annually.</p> <p>(iii) Maintain documentation of the training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures.</p> <p>*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to provide an emergency preparedness training program. Lack of a training program on the emergency preparedness plan and policies for the facility, has the potential to hinder staff response during a disaster. This deficient practice affected 69 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p>	E 037			

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E 037	Continued From page 16 On October 23, 2018 from 9:00 AM to 12:00 PM, review of provided emergency plan, policy and procedures, revealed no substantiating documentation demonstrating the facility had a training program for staff based on the plan. Reference: 42 CFR 483.73 (d) (1)	E 037			