



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE- Governor
DAVE JEPPESEN- Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P. O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
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February 8, 2019

Joan Martellucci, Administrator
Ivy Court
2200 Ironwood Place
Coeur D'Alene, ID 83814-2610

Provider #: 135053

Dear Ms. Martellucci:

On **January 10, 2019**, we conducted an on-site revisit and a complaint investigation to verify that your facility had achieved and maintained compliance. We presumed, based on your allegation of compliance, that your facility was in substantial compliance as of **December 14, 2018**. However, based on our on-site revisit we found that your facility is not in substantial compliance with the following participation requirements:

-
- **F0677 -- S/S: E -- 483.24(a)(2) -- Adl Care Provided For Dependent Residents**
- **F0684 -- S/S: G -- 483.25 -- Quality Of Care**
- **F0725 -- S/S: F -- 483.35(a)(1)(2) -- Sufficient Nursing Staff**
- **F0835 -- S/S: F -- 483.70 -- Administration**
- **F0600 -- S/S: G -- 483.12(a)(1) -- Free From Abuse And Neglect**
- **F0607 -- S/S: -- 483.12(b)(1)-(3) -- Develop/implement Abuse/neglect Policies**
- **F0609 -- S/S: D -- 483.12(c)(1)(4) -- Reporting Of Alleged Violations**
- **F0610 -- S/S: G -- 483.12(c)(2)-(4) -- Investigate/prevent/correct Alleged Violation**
- **F0622 -- S/S: D -- 483.15(c)(1)(i)(ii)(2)(i)-(iii) -- Transfer And Discharge Requirements**
- **F0655 -- S/S: D -- 483.21(a)(1)-(3) -- Baseline Care Plan**
- **F0657 -- S/S: D -- 483.21(b)(2)(i)-(iii) -- Care Plan Timing And Revision**
- **F0689 -- S/S: E -- 483.25(d)(1)(2) -- Free Of Accident Hazards/supervision/devices**
- **F0837 -- S/S: F -- 483.70(d)(1)(2) -- Governing Body**

- **C0762 -- S/S: -- 02.200,02,c,ii -- When Average Census 60-89 Residents**

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.) **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 **February 18, 2019**.

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.
- 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).

Joan Martellucci, Administrator
February 8, 2019
Page 3 of 4

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

As noted in the Bureau of Facility Standards' letter of **November 29, 2018**, following the survey of **November 9, 2018**, we have already made the recommendation to the Centers for Medicare and Medicaid Services (CMS) for a Civil Money Penalty, Denial of Payment for New Admissions and termination of the provider agreement on **May 9, 2019**, if substantial compliance is not achieved by that time. The findings of non-compliance on **January 10, 2019**, has resulted in our recommendation of continuance of the remedy(ies) previously identified in our letter of November 29, 2018.

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 the deficiencies have been corrected, you may contact please 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.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. 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

Joan Martellucci, Administrator
February 8, 2019
Page 4 of 4

This request must be received by **February 18, 2019**. If your request for informal dispute resolution is received after **February 18, 2019**, 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,

A handwritten signature in black ink that reads "Debby Ransom". The signature is written in a cursive style and is centered below the "Sincerely," text.

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

dr/lj
Enclosures

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

PRINTED: 02/22/2019
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 R 01/10/2019
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	
{F 000}	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the follow-up and complaint survey conducted at the facility on January 8, 2019 through January 10, 2019.</p> <p>The surveyors conducting the survey were:</p> <p>Jenny Walker, RN, Team Coordinator Teresa Kobza, RDN, LD Presie Billington, RN</p> <p>Survey Abbreviations:</p> <p>ADL = Activity of Daily Living CNA = Certified Nursing Assistant COO = Chief Operating Officer DNS = Director of Nursing Services I&A = Incident and Accident LPN = Licensed Practical Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment mg = milligram mg/dl = milligram per deciliter MRR = Medication Regime Review PRN = as needed RCD = Regional Clinical Director RN = Registered Nurse ROM = Range of motion TAR = Treatment Administration Record WNL = Within normal limits</p> <p>F 600 Free from Abuse and Neglect SS=G CFR(s): 483.12(a)(1)</p> <p>§483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property,</p>	{F 000}			
F 600		F 600		3/4/19	

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

TITLE

(X6) DATE

Electronically Signed

02/18/2019

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 600	<p>Continued From page 1 and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.</p> <p>§483.12(a) The facility must-</p> <p>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on staff interview, I&A report review, policy review, and record review, it was determined the facility failed to ensure residents were not subjected to verbal and physical abuse by staff. This was true for 1 of 1 resident (Resident #27) who was reviewed for abuse/neglect. This resulted in harm to Resident #27 when he experienced verbal and physical abuse by a staff member during cares. Findings include:</p> <p>The facility's Abuse policy, dated February 2018, documented residents had the right to be free from abuse and neglect. The policy documented staff members would not verbally or physically abuse residents. The policy documented any allegation of abuse or neglect should be reported immediately. The policy documented verbal abuse included using disparaging and derogatory terms towards residents and physical abuse included being rough with residents. The policy documented staff members were instructed to report all incidents of abuse immediately to the Executive Director, "without fear of retribution."</p>	F 600	<p>Resident #27 re-assessed by IDT for any remaining physical or psychological issues related to incident. Care Plan updated as necessary.</p> <p>Accidents and Incidents, resident grievances, and interviews reviewed for any indication of possible situations not addressed with follow-up as indicated.</p> <p>CNA #2 received formal education from DNS/designee re: role and responsibility of mandated reporter and timeframes for reporting.</p> <p>DNS/designee to conduct 15 staff interviews per week for 4 weeks then monthly for 3 months. Regional Clinical Director to conduct random staff interviews monthly for 3 months. DNS and RCD to report monthly to QAPI with compliance rates and recommendations for ongoing compliance.</p>		

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F 600	<p>Continued From page 2</p> <p>Resident #27 was admitted to the facility on 9/6/18, with multiple diagnoses including dementia without behavioral disturbances.</p> <p>A quarterly MDS assessment, dated 12/1/18, documented Resident #27 had severe cognitive impairment with no behavioral disturbances and required extensive assistance of two staff members with transfers, bed mobility, and toileting.</p> <p>The ADL care plan, dated 9/10/18, documented Resident #27 required two person staff assistance with toilet use, transfers, and bed mobility. The care plan documented staff were to utilize a mechanical lift for transfers.</p> <p>An I&A Report, dated 12/16/18, documented Resident #27 sustained two skin tears of unknown source, one on the top his right hand between the 1st and 2nd fingers by the knuckles and one at the base of his thumb. The report documented Resident #27 was self-propelling his wheelchair in the lobby and his hand was bleeding. The report documented Resident #27 had confusion and impaired memory and no witnesses were found.</p> <p>The IDT follow-up note for the 12/16/18 skin tears, dated 12/26/18 (10 days later), documented Resident #27 was transferred "incorrectly and sustained two skin tears." The report documented Resident #27 was transferred by a "CNA lifting him up and placing him in his wheelchair. (Resident #27) was not transferred by the mechanical lift like he should have been." The follow-up note documented abuse was substantiated, and CNA #1's employment was</p>	F 600			

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F 600	<p>Continued From page 3 terminated.</p> <p>An I&A Report, dated 12/20/18, documented, "it was discovered that a Staff member has caused multiple skin tears to various residents (this Resident included) from being rough during cares." CNA #2 witnessed CNA #1 yelling, "Fuck you! Fuck you! Fuck you!" in Resident #27's face because he had a bowel movement at the change of shift. The report also documented Resident #27 sustained a skin tear to his front left forearm. The report did not document the size or extent of the skin tear. The report documented Resident #27 was unable to recall the incident.</p> <p>On 1/10/19 at 11:29 AM, the Acting DNS stated CNA #2 witnessed CNA #1 verbally abuse Resident #27 on 12/20/18, but CNA #2 did not report the incident to the Acting DNS or the Administrator Designee until 12/21/18. The Acting DNS stated CNA #2 was afraid of CNA #1 and did not want to report him for fear of retaliation by CNA #1. The Acting DNS stated although CNA #2 did not report the abuse until 12/21/18, he back dated the I&A report to 12/20/18, to reflect the date the abuse occurred.</p> <p>The IDT follow-up note for the 12/20/18 verbal abuse and skin tear to the left forearm incident, dated 12/26/18, also included documentation of Resident #27's two skin tears which were identified on 12/16/18 and it was "discovered that the cause of the skin tears" were from CNA #1 handling Resident #27 "roughly." The follow up documented CNA #1 was also accused of swearing profanity in Resident #27's face and transferred him "incorrectly and sustained two skin tears on 12/16/18." The report documented</p>	F 600			

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F 600	Continued From page 4 Resident #27 was transferred by CNA #1 by lifting him up and placing him in his wheelchair. Resident #27 "was not lifted by the mechanical lift like he should have been." The report documented CNA #1's employment was terminated for verbal and physical abuse. On 1/7/19 at 2:00 PM, the Acting DNS and the Administrator Designee stated CNA #2 was not comfortable reporting the witnessed abuse to the charge nurse at the time of the 12/20/18 incident while CNA #1 was in the building. The Acting DNS stated the facility educated CNA #2 on reporting allegations of abuse immediately, however, they did not document the education provided to CNA #2. The Administrator Designee stated the facility's I&A reports were incomplete. The Acting DNS stated the facility should have completed and documented witness statements from staff and residents. The Administrator Designee stated the investigation should have included documentation of the education provided to CNA #2 about reporting allegations of abuse immediately. The Administrator Designee stated the investigative process was not followed for the I&As dated 12/16/18 and 12/20/18.	F 600			
F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and	F 607		3/4/19	

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F 607	Continued From page 5 §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on review of personnel files and staff interview, it was determined the facility failed to ensure reference checks were completed prior to potential employees starting work in the facility. This was true for 1 of 5 new employees (Staff A) whose personnel files were reviewed. This failure placed 14 of 14 sample residents (#24, #27, #31, #34, #38, #40, #218, #219, #220, #221, #222, #223, ##224 and #225) residing in the facility, as well as the other 54 residents residing in the facility, at increased risk of adverse events. Findings include: On 1/10/19 at 2:15 PM, five new employee personnel files were reviewed for reference checks as follows: * Staff A was hired on 11/27/18. Staff A's files did not contain reference checks at the time of review. On 1/10/19 at 2:55 PM, Human Resources Payroll Personnel #1 stated she did not get the reference checks for Staff A completed because it was a busy week due to the holiday.	F 607	Staff "A"'s references were completed without negative findings. Human Resource Manager reviewed all employee files to assure appropriate reference and credentialing documentation is present and complete. Hiring Managers educated re: the requirements for documentation of vetting process prior to employees working with residents. Human Resources Manager will conduct approval process on all new hires to assure all aspects of vetting process is completed and will report monthly to the QAPI Committee on rate of compliance and recommendations for ongoing compliance.		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations	F 609		3/4/19	

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F 609	<p>Continued From page 6</p> <p>involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.</p> <p>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, I&A report review, policy review, review of the State Survey Agency's reporting portal, and staff interviews, it was determined the facility failed to ensure physical and verbal abuse was reported to the Administrator and the State Survey Agency within 2 hours. These deficient practices were true for 1 of 1 resident (Resident #27) whose abuse investigation was reviewed. This deficient practice placed residents at increased risk of undetected abuse/neglect. Findings include:</p> <p>The facility's Abuse Policy, dated February 2018,</p>	F 609	<p>Event occurred in the past and does not allow for correction at this time for resident#27. Resident#27 was reassessed for residual psychosocial harm resulting from untimely abuse reporting. No negative findings were noted.</p> <p>DNS/Designee retrained CNA #2 regarding reporting requirements and timeframes.</p> <p>DNS/Designee retrained all staff</p>		

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F 609	<p>Continued From page 7</p> <p>documented residents had the right to be free from abuse and neglect. The policy documented verbal abuse included using disparaging and derogatory terms towards residents and physical abuse included being rough with residents. The policy documented alleged violations were to be reported immediately to the Administrator and State Survey Agency, but no later than 2 hours if the events that cause the allegation involve abuse or serious bodily injury, and not later than 24 hours if the events that cause the allegations do not involve abuse or result in serious bodily injury.</p> <p>Resident #27 was admitted to the facility on 9/6/18, with multiple diagnoses including dementia without behavioral disturbances.</p> <p>A quarterly MDS assessment, dated 12/1/18, documented Resident #27 had severe cognitive impairment with no behavioral disturbances and required extensive assistance of two staff members with transfers, bed mobility, and toileting.</p> <p>The ADL care plan, dated 9/10/18, documented Resident #27 required two person staff assistance with toilet use, transfers, and bed mobility. The care plan documented staff were to utilize a mechanical lift for transfers.</p> <p>The I&A Report, dated 12/20/18, documented, "it was discovered that a Staff member had caused multiple skin tears to various residents (this Resident included) from being rough during cares." CNA #2 witnessed CNA #1 yelling, "Fuck you! Fuck you! Fuck you!" in Resident #27's face because he had a bowel movement at the</p>	F 609	<p>regarding reporting requirements and timeframes.</p> <p>DNS/designee will conduct staff interviews of 15 staff members weekly a 4 weeks then monthly for 3 months. DNS/designee to report monthly for 3 months to QAPI for recommendations for ongoing compliance.</p>		

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F 609	Continued From page 8 change of shift. The report also documented Resident #27 sustained a skin tear on the front of his left forearm. The report documented Resident #27 was unable to recall the incident. On 1/10/19 at 11:29 AM, the Acting DNS stated CNA #2 witnessed CNA #1 verbally abusing Resident #27 on 12/20/18, but CNA #2 did not report the incident to the Acting DNS or the Administrator Designee until 12/21/18. The Acting DNS stated CNA #2 was afraid of CNA #1 and did not want to report him for fear of retaliation by CNA #1. The Acting DNS stated an I&A was completed on 12/21/18, however, he back dated the I&A to 12/20/18, to reflect the date the abuse occurred. CNA #2 observed CNA #1 verbally abuse Resident #27 on 12/20/18, however did not report the abuse as required by the facility's Abuse Policy. The State Survey Agency's reporting portal was reviewed. The information submitted by the facility through the portal documented the abuse incident occurred on 12/20/18 at 8:00 PM and the facility reported the abuse through the portal on 12/21/18 at 5:10 PM. The 12/20/18 verbal and physical abuse of Resident #27 was not reported to the Administrator and State Survey Agency within 2 hours of the incident.	F 609			
F 610 SS=G	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged	F 610		3/4/19	

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 R 01/10/2019
NAME OF PROVIDER OR SUPPLIER IVY COURT			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 IRONWOOD PLACE COEUR D'ALENE, ID 83814		
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F 610	<p>Continued From page 9 violations are thoroughly investigated.</p> <p>§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.</p> <p>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, I&A report review, policy review, and record review, it was determined the facility failed to ensure injuries of unknown source and verbal and physical abuse were thoroughly investigated. This was true for 2 of 2 residents (#27 and #225) who were reviewed for abuse/neglect. Resident #27 was harmed when he was verbally and physically abused by a CNA, and Resident #225 had the potential to experience harm from physical, and possible verbal, abuse by a CNA. The deficient practice also placed the other 66 residents residing in the facility who received care from CNA #1 during his employment, at risk of undetected physical and/or verbal abuse. Findings include: The facility's Abuse policy, dated February 2018, documented residents had the right to be free from abuse and neglect. The policy stated all alleged violations were thoroughly investigated and documents were retained showing all alleged violations were thoroughly investigated. The policy also documented the facility prevented</p>	F 610	<p>Event is in the past and unable to correct for resident #27 and #225.</p> <p>IDT reviewed Accidents and Incidents for last 30 days to assure investigation and documentation is complete within 5 day timeframe, with special focus on those of unknown origin.</p> <p>IDT and Licensed Nurses education re: thorough investigation and documentation related to Accidents and Incidents and timeframes for completion by the DNS/designee.</p> <p>The Regional Clinical Director/Designee will conduct weekly review of all Accidents and Incidents for 12 weeks to assure investigation complete and thorough and completed timely. The RCD/Designee will report to the QAPI Committee for recommendations and ongoing compliance.</p>		

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F 610	<p>Continued From page 10</p> <p>further potential abuse and/or neglect while the investigation was in process. The policy documented verbal abuse included using disparaging and derogatory terms towards residents and physical abuse included being rough with residents.</p> <p>1. Resident #27 was admitted to the facility on 9/6/18, with multiple diagnoses including dementia without behavioral disturbances.</p> <p>A quarterly MDS assessment, dated 12/1/18, documented Resident #27 was severely cognitively impaired with no behavioral disturbances and required extensive assistance of two staff members with transfers, bed mobility, and toileting.</p> <p>The ADL care plan, dated 9/10/18, documented Resident #27 required two-person staff assistance with toilet use, transfers, and bed mobility. The care plan documented staff were to utilize a mechanical lift for transfers.</p> <p>Resident #27 had two incidences which were not thoroughly investigated as follows:</p> <p>a. An I&A Report, dated 12/16/18, documented Resident #27 sustained two skin tears of unknown source, one on the top his right hand between the 1st and 2nd fingers by the knuckles and one at the base of his thumb. The report documented Resident #27 was self-propelling his wheelchair in the lobby and his hand was bleeding. The report documented Resident #27 had confusion and impaired memory and no witnesses were found.</p>	F 610			

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F 610	<p>Continued From page 11</p> <p>There was no documented evidence the facility completed a thorough investigation of Resident #27's 12/16/18 skin tears as potential physical abuse. The investigation did not include an assessment of Resident #27's right hand skin tears, staff or resident interviews to determine the origin of the skin tears, progress notes identifying the progression of the skin tears, and/or witness statements. Resident #27's record did not document implementation of preventative measure to protect him from further injury while the investigation was in progress.</p> <p>The IDT follow-up note for the 12/16/18 skin tears, dated 12/26/18 (10 days later), documented Resident #27 was transferred "incorrectly and sustained two skin tears." The report documented Resident #27 was transferred by a "CNA lifting him up and placing him in his wheelchair. He was not lifted in the mechanical lift like he should have been." The follow-up note documented abuse was substantiated, and CNA #1's employment was terminated.</p> <p>b. On 1/10/19 at 11:29 AM, the Acting DNS stated CNA #2 witnessed CNA #1 verbally abusing Resident #27 on 12/20/18, but CNA #2 did not report the incident to the Acting DNS or the Administrator Designee until 12/21/18. The Acting DNS stated CNA #2 was afraid of CNA #1 and did not want to report him for fear of retaliation by CNA #1. The Acting DNS stated an I&A was completed on 12/21/18, however, he back dated the I&A to 12/20/18, to reflect the date the abuse occurred.</p> <p>The I&A Report, dated 12/20/18, documented, "it was discovered that a Staff member had caused</p>	F 610			

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

PRINTED: 02/22/2019
FORM APPROVED
OMB NO. 0938-0391

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F 610	<p>Continued From page 12</p> <p>multiple skin tears to various residents (this Resident included) from being rough during cares." CNA #2 witnessed CNA #1 yelling, "Fuck you! Fuck you! Fuck you!" in Resident #27's face because he had a bowel movement at the change of shift. The report also documented Resident #27 sustained a skin tear on the front of his left forearm. The report documented Resident #27 was unable to recall the incident.</p> <p>There was no documented evidence the facility completed a thorough investigation of the physical and verbal abuse which occurred on 12/20/18. The physical abuse investigation lacked documentation of the size or extent of the skin tear to Resident #27's left forearm, staff or resident interviews to determine the origin of the skin tear, or progress notes identifying the progression of the skin tear. The verbal abuse investigation did not document potential verbal abuse was ruled out for other residents. The investigation did not include witness statements regarding the physical or verbal abuse.</p> <p>The IDT follow-up note for the 12/20/18 verbal abuse and skin tear to the left forearm, dated 12/26/18, documented Resident #27 sustained two skin tears on 12/16/18 and it was "discovered that the cause of the skin tears" were from CNA #1 handling Resident #27 "roughly." The follow up note documented CNA #1 was also accused of swearing profanities in Resident #27's face and transferred him "incorrectly and sustained two skin tears on 12/16/18." The report documented Resident #27 was transferred by CNA #1 lifting him up and placing him in his wheelchair. Resident #27 "was not lifted in the mechanical lift like he should have been." The</p>	F 610			

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NAME OF PROVIDER OR SUPPLIER IVY COURT			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 IRONWOOD PLACE COEUR D'ALENE, ID 83814		
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F 610	<p>Continued From page 13</p> <p>IDT 12/26/18 follow-up note did not document how and when it was determined Resident #27 was incorrectly transferred by CNA #1. The report documented CNA #1's employment was terminated for verbal and physical abuse.</p> <p>On 1/7/19 at 2:00 PM, the Acting DNS and the Administrator Designee stated CNA #2 was not comfortable reporting the witnessed abuse to the charge nurse at the time of the incident while CNA #1 was in the building. The Acting DNS stated the facility educated CNA #2 on reporting allegations of abuse immediately, however, they did not document the education provided to CNA #2. The Administrator Designee stated the facility's I&A reports were incomplete. The Acting DNS stated the facility should have documented witness statements from all staff and residents. The Administrator Designee stated the investigation should include documentation of the education provided to CNA #2 about reporting allegations of abuse immediately. The Administrator Designee stated this process was not completed for the 12/16/18 and 12/20/18 I&A reports. The Administrator Designee stated the facility investigated injuries of unknown source as potential abuse.</p> <p>2. Resident #225 was admitted to the facility on 2/1/12, with multiple diagnoses, including dementia.</p> <p>Resident #225 experienced an incident which was not thoroughly investigated as follows:</p> <p>An I&A Report, dated 12/1/18, documented Resident #225 sustained a 2.0 cm by 2.0 cm skin tear to the back of her right calf. The report</p>	F 610			

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

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NAME OF PROVIDER OR SUPPLIER IVY COURT			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 IRONWOOD PLACE COEUR D'ALENE, ID 83814		
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F 610	Continued From page 14 documented there were no witnesses found. There was no documented evidence the facility completed a thorough investigation of the injury of unknown source which occurred on 12/1/18. The injury of unknown source investigation did not include an assessment of Resident #225's right calf, staff or resident interviews to determine the origin of the skin tears, progress notes identifying the progression of the skin tears, and/or witness statements. Resident #225's record did not document implementation of preventative measure to protect her from further injury. The IDT follow-up note for the 12/1/18 skin tears, dated 12/4/18, documented Resident #225 was transferred with a mechanical lift and the sling was removed forcefully causing a skin tear to the back of her right calf. On 1/10/19 at 11:29 AM, RCM #2 stated Resident #225's skin tear was thought to be caused by CNA #1 when he provided cares roughly. On 1/10/19 at 11:45 AM, the Administrator Designee and the Acting DNS stated CNA #1 was rough during cares with multiple residents and it was determined he physically abused residents. The Administrator Designee stated the facility had not thought to investigate verbal abuse for other residents who received cares from CNA #1 during his employment at the facility.	F 610			
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii)	F 622			3/4/19

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

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F 622	Continued From page 15 §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 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 (F) The facility ceases to operate. (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	F 622			

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F 622	Continued From page 16 facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. 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. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c) (1)(i) of this section. (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 needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c) (2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate.	F 622			

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F 622	<p>Continued From page 17</p> <p>(E) Comprehensive care plan goals; (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. 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 information was provided to the receiving hospital for an emergent situation for 2 of 2 residents (#34 and #220) who were reviewed for hospital transfers. This deficient practice had the potential to cause harm if the resident was not treated in a timely manner due to lack of information provided to the hospital. Findings include:</p> <p>1. Resident #34 was readmitted to the facility on 1/3/19, with multiple diagnoses including viral pneumonia.</p> <p>A discharge MDS assessment, dated 1/1/19, documented Resident #34 was discharged to a hospital.</p> <p>A nurses' note, dated 1/1/19 at 9:03 PM, documented Resident #34 was unable to keep his eyes open and rhonchi (crackling in lungs) was heard in his upper lobes and Resident #34 was coughing. The nurses' note documented Resident #34's wife requested he go to the hospital.</p> <p>Resident #34's record did not include documentation a verbal report was given to the hospital or information regarding Resident #34's status was sent with him to the hospital.</p>	F 622	<p>Event is in the past and unable to correct for residents #34 and #220.</p> <p>DNS/Designee retrained all Licensed Nurses regarding transfer/discharge documentation requirements.</p> <p>DNS/Designee will review discharge/transfers daily in clinical meeting and assure documentation is complete and accurate.</p> <p>DNS will report findings and compliance monthly for 3 months to the QAPI Committee for recommendations.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 622	<p>Continued From page 18</p> <p>On 1/9/19 at 5:45 PM, the Acting DNS stated Resident #34's record did not have documentation the Transfer/Discharge Form and paperwork were provided to the hospital or paramedics. The Acting DNS also stated there was not a physician's order to transport Resident #34 to the hospital and no documentation regarding the reason Resident #34 was transferred to the hospital.</p> <p>On 1/10/19 at 11:45 AM, the Administrator Designee stated Resident #34 was transferred to the hospital due to a change of condition and there was no transfer form completed.</p> <p>2. Resident #220 was admitted on 12/12/18 and readmitted to the facility on 1/1/19, with multiple diagnoses including pneumonia and Parkinson's Disease.</p> <p>A discharge MDS assessment, dated 12/27/18, documented Resident #220 was discharged to a hospital.</p> <p>A nurses' note, dated 12/28/18 at 12:08 PM, documented Resident #220 was admitted to the hospital in the cardiac critical unit.</p> <p>Resident #220's record did not include documentation his physician was notified and ordered the transfer to the hospital, a verbal report was given to the hospital, or information regarding Resident #220 and his status was sent with him to the hospital.</p> <p>On 1/10/19 at 11:40 AM, the Administrator Designee stated Resident #220's record did not</p>	F 622			

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

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F 622	Continued From page 19 include documentation he was transferred to the hospital.	F 622			
F 655 SS=D	<p>There was no documentation in Resident #220's record the receiving hospital was provided information regarding his transfer.</p> <p>Baseline Care Plan CFR(s): 483.21(a)(1)-(3)</p> <p>§483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-</p> <ul style="list-style-type: none"> (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- <ul style="list-style-type: none"> (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. <p>§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-</p> <ul style="list-style-type: none"> (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). 	F 655		3/4/19	

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F 655	Continued From page 20 §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, review of I&A reports, and staff interview, it was determined the facility failed to ensure baseline care plans were developed and implemented within 48 hours of admission to the facility and baseline care plans included all information necessary to properly care for the resident. This was true for 2 of 2 residents (#219 and #220) whose baseline care plans were reviewed. This deficient practice placed residents at risk of fractures and other serious injuries from falls and unmet health and care needs. Findings include: 1. Resident #220 was admitted to the facility on 12/12/18, with multiple diagnoses including Parkinson's Disease. A Hospital History and Physical, dated 11/23/18, documented Resident #220 was admitted to the hospital from home after falling. An I&A report, dated 12/14/18 at 4:17 AM, documented Resident #220 was standing when	F 655	Care Plans for residents #219 and #220 have been reviewed. Health Information Manager/Designee conducted audit of all current residents to assure care plan have been reviewed by residents or responsible party. IDT retrained by DNS/Designee regarding requirement for review of baseline care plan within 48 hour timeframe. DNS/designee will review requirement in daily clinical meeting and assure compliance and report to QAPI Committee for 3 months for ongoing compliance.		

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F 655	<p>Continued From page 21</p> <p>he experienced a witnessed fall. The I&A report documented a staff member was standing next to him and the staff member fell over with him into a chair and no injuries were noted. Resident #220's medical record did not include a baseline care plan at the time of his fall on 12/14/18.</p> <p>An I&A report, dated 12/17/18 at 6:20 PM, documented Resident #220 experienced a witnessed fall while visiting with a family member in a visiting lounge area. The I&A report documented he was found on his knees with his back facing his wheelchair and calling for help. The I&A report documented his right knee had an abrasion.</p> <p>Resident #220's record did not contain a baseline care plan. Resident #220's comprehensive care plan was initiated on 12/17/18, 5 days after admission to the facility. The comprehensive care plan included goals and interventions addressing Resident #220's fall risk and falls.</p> <p>On 1/10/19 at 9:52 AM, RCM #1 stated RCM #1 stated when a resident was admitted to the facility the RCMs should complete a baseline care plan within 48 hours. RCM #1 stated the baseline care plans had not been completed due to a lack of staff, requiring RCMs to work as nurses or CNAs on the floor.</p> <p>2. Resident #219 was admitted to the facility on 12/21/18, with multiple diagnoses including dementia and hypertension.</p> <p>A Hospital History and Physical, dated 11/10/18, documented Resident #219 was admitted to the hospital from home after falling and experienced</p>	F 655			

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F 655	Continued From page 22 increased confusion. A nurses' note, dated 12/21/18 at 9:45 PM, documented Resident #219 was a high fall risk and had alarms on his wheelchair to alert staff of the "numerous times he tried to get up without assistance." Resident #219's baseline care plan initiated on 2/21/18 did not address his high risk for falls. An I&A report, dated 12/27/18 at 9:34 PM, documented Resident #219 experienced an unwitnessed fall in his room and sustained a bruise to his left eye, an injury to the top of his scalp, and a skin tear to his left elbow. Goals and interventions addressing Resident #219's high risk for falls were added to his care plan on 12/27/18, 6 days after his admission to the facility on 12/21/18. On 1/10/19 at 9:52 AM, RCM #1 stated Resident #219 was considered a high fall risk from admission. RCM #1 stated Resident #219's baseline care plan completed on 12/21/18 did not address his risk for falls.	F 655			
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician.	F 657			3/4/19

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F 657	<p>Continued From page 23</p> <p>(B) A registered nurse with responsibility for the resident.</p> <p>(C) A nurse aide with responsibility for the resident.</p> <p>(D) A member of food and nutrition services staff.</p> <p>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.</p> <p>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</p> <p>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview, review of I&A reports, review of facility protocols, and record review, it was determined the facility failed ensure residents' care plans were regularly reviewed and revised, to include interventions necessary to prevent falls. This was true for 2 of 14 residents (#220 and #221) reviewed for care plan revisions. This failure resulted in the potential for harm if residents experienced falls resulting in fractures or other serious injuries. Findings include:</p> <p>The facility's Falls Protocol, undated, directed staff to update the interventions on the resident's fall care plan when a resident experienced a fall.</p> <p>a. Resident #221 was admitted to the facility on</p>	F 657	<p>Resident #220 and #221 care plans were re-assessed to assure accurate and updated.</p> <p>DNS/designee reviewed Accident and Incident reports for last 30 days to assure care plan accurate and updated.</p> <p>DNS/designee retrained all Licensed Nurses to assure care plan is updated with new intervention after fall/incidents as identified.</p> <p>DNS/designee to review daily in clinical meeting and assure updated timely. DNS to report monthly to QAPI for recommendations and ongoing</p>		

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F 657	<p>Continued From page 24</p> <p>10/30/18, with multiple diagnoses including a fall with a femur (thighbone) fracture and dementia.</p> <p>Resident #221's Admission Fall Risk Assessment, dated 10/30/18 at 4:58 PM, documented she had a history of multiple falls within the last 6 months.</p> <p>An admission MDS assessment, dated 11/6/18, documented Resident #221 had severe cognitive impaired and required extensive assistance of two staff members with transfers, bed mobility, and toileting.</p> <p>Resident #221's at risk for falls care plan, dated 11/1/18, included the following interventions:</p> <ul style="list-style-type: none"> *Staff were to anticipate and meet her needs and encourage Resident #221 to use her call light. *Staff were to educate Resident #221 and her family of her safety reminders and what to do if a fall occurred. *Staff were to complete neurological assessments as needed. *Resident #221 was to wear non-skid socks or shoes when she was ambulating or mobilizing in her wheelchair. *Resident #221's bed was to be in the low position at night. <p>Resident #221 experienced the following falls between 11/5/18 and 1/5/19 and her care plan was not updated after each fall:</p> <ul style="list-style-type: none"> * An I&A report, dated 11/5/18 at 8:00 PM, documented Resident #221 experienced an unwitnessed fall in her room. The I&A report documented a staff member found Resident 	F 657	compliance.		

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F 657	<p>Continued From page 25</p> <p>#221 lying on her right side on the floor parallel to her reclined wheelchair. The I&A report documented Resident #221 received x-rays of her right hip. Resident #221's at risk for falls care plan was updated to include increased supervision on 11/7/18. The care plan did not define what the increased supervision consisted of.</p> <p>The IDT follow-up note for the 11/5/18 fall, was completed on 11/12/18, 7 days after the fall. The follow-up note documented, "Nursing will increase supervision when needed by having either 1:1 staffing or every 15 minute checks when Resident is restless."</p> <p>* An I&A report, dated 12/5/18 at 4:45 AM, documented Resident #221 experienced an unwitnessed fall in her room. The I&A report documented Resident #221 was sitting on the floor with her back up against her bed.</p> <p>The IDT follow-up note for the 12/5/18 fall, was completed on 12/10/18, 5 days after the fall. The follow-up note documented Resident #221 hit her head resulting in an intact 2.2 cm by 2.0 cm red mark on her upper right scalp. The follow-up note documented Resident #221 was reminded to activate her call light for help with transfers and for assistance. The note documented Resident #221 was non-verbal. The note documented Resident #221 was placed on 15 minute checks for the duration the day. Resident #221's at risk for falls care plan was updated to include a concave mattress (bolsters on each side) on 12/10/18. The reason for the concave mattress was not documented.</p>	F 657			

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F 657	<p>Continued From page 26</p> <p>* An I&A report, dated 12/7/18 at 2:08 PM, documented Resident #221 experienced an unwitnessed fall in her room. The I&A report documented Resident #221 sustained a goose egg bump on her head and her call light was pulled out of the wall. The I&A report documented she was to remain in the hall in line of sight while up.</p> <p>The IDT follow-up note for the 12/7/18 fall, was completed on 12/11/18, 4 days later. The follow-up note documented Resident #221 was found after she attempted to self-transfer from her bed to her chair. The note documented she was incontinent of bowel. The note documented Resident #221 was non-verbal and had advanced dementia which impaired her safety awareness. The note documented Resident #221 was to remain in the hall in line of sight while up. The note documented a concave mattress was to be installed to replace her standard mattress. Resident #221's at risk for falls care plan was previously updated to include a concave mattress on 12/10/18 and no new intervention was developed following the 12/7/18 fall.</p> <p>* An I&A report, dated 12/29/18 at 11:30 PM, documented Resident #221 experienced an unwitnessed fall in her room. The I&A report documented Resident #221 was found on the floor on her right side next to her bed. The I&A report documented Resident #221's bed was in the lowest position and her adult briefs were dry and down around her ankles. There was no documentation if the concave mattress was in place prior to the fall.</p> <p>The IDT follow-up note for the 12/29/18 fall, was</p>	F 657			

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F 657	<p>Continued From page 27</p> <p>completed on 1/8/19, 10 days later. The follow-up note documented staff were to continue to anticipate Resident #221's needs and "remind to make safe and effective decisions and demonstrate/remind how to effectively use her call light." Resident #221's at risk for falls care plan was not updated following the 12/29/18 fall.</p> <p>On 1/10/19 at 9:52 AM, RCM #1 stated residents' care plans should be updated within 1-2 days following a fall.</p> <p>b. Resident #220 was admitted to the facility on 12/12/18, with multiple diagnoses including Parkinson's Disease.</p> <p>A Hospital History and Physical, dated 11/23/18, documented Resident #220 was admitted to the hospital from home after falling and sustaining a rib fracture and developing rhabdomyolysis (a serious syndrome due to a direct or indirect muscle injury. It results from the death of muscle fibers and release of their contents into the bloodstream.) due to the fall.</p> <p>Resident #220's Admission Fall Risk Assessment, dated 12/12/18 at 1:30 PM, documented he had a history of 1-2 falls within the last 6 months. The assessment was signed on 12/13/18.</p> <p>An I&A report, dated 12/14/18 at 4:17 AM, documented Resident #220 experienced a witnessed fall from a standing position. The I&A report documented a staff member was next to him and the staff member fell over with him into a chair and no injuries were noted.</p>	F 657			

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F 657	<p>Continued From page 28</p> <p>An I&A report, dated 12/17/18 at 6:20 PM, documented Resident #220 experienced a witnessed fall while visiting with a family member in a visiting lounge area. The I&A report documented he was found on his knees with his back facing his wheelchair and calling for help. The I&A report documented his right knee had an abrasion.</p> <p>Resident #220's at risk for falls care plan, initiated 12/17/18, documented interventions as follows:</p> <ul style="list-style-type: none"> *Staff were to anticipate and meet his needs and encourage Resident #220 to use his call light. *Staff were to educate Resident #220 and his family of his safety reminders and what to do if a fall occurred. *Staff were to complete neurological assessments as needed. *Resident #220 was to wear non-skid socks or shoes when he was ambulating or mobilizing in his wheelchair. *Resident #220's bed was to be in the low position at night. <p>An I&A report, dated 1/8/19 at 10:27 AM, documented Resident #220 experienced an unwitnessed fall in his room. The I&A report documented he was found in a sitting position with his back against the wall and his wheelchair was positioned in front of him without the brakes locked. The I&A report documented Resident #220 was trying to get into bed. The I&A report documented he sustained skin tears to his right and left elbows. Resident #220's care plan was not updated following the fall on 1/8/19.</p>	F 657			

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F 657	Continued From page 29 On 1/10/19 at 9:45 AM, the Administrator Designee stated the care plans were not consistently updated after Resident #220's and Resident #221's falls. The Administrator Designee stated the RCMs were tasked with updating care plans following falls and due to staffing issues, they had been working on the floor as nurses or CNAs and the care plans had not been updated.	F 657			
{F 677} SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interview, and policy review, it was determined the facility failed to ensure residents were provided with bathing care consistent with their needs. This was true for 6 of 8 (#27, #31, #34, #219, #220, and #221) residents reviewed for bathing. This failure created the potential for residents to experience embarrassment, isolation, decreased sense of self-worth, skin impairment, and compromised physical and psychosocial well-being. Findings include: The facility's Bathing policy and procedure, dated June 2018, documented staff were to provide residents with bathing services. The ADL Bathing documentation key included: - RR = Resident Refused - NA = Not Applicable	{F 677}	Residents #27, #31, #34, #219, #220, #221 have documented showers. DNS/designee reviewed all other residents for similar issues and showers have been documented. CNA's re-trained on accurately documenting showers given to reflect appropriately in record. DNS/designee to conduct daily audits M-F in clinical meeting and address documentation/provision issues daily. Daily/designee will provide monthly report to QAPI with compliance rate. QAPI will review and make recommendations for ongoing compliance.	3/4/19	

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{F 677}	<p>Continued From page 30</p> <ul style="list-style-type: none"> - XA = Resident Not Available - C = Center Staff (facility staff members) - NC = Non-Center Staff <p>"(family/hospice/ambulance/student/etc)"</p> <p>On 1/9/19 at 2:16 PM, CNA #15 stated the Daily Assignment sheets assigned CNAs who were responsible for completing residents' showers on the day and evening shifts. CNA #15 stated when one to two aides were assigned to a hall it was difficult to complete showers and not all residents received their assigned showers. CNA #15 stated if a resident refused a shower or it was not offered due to time constraints the resident was not always re-offered a shower the next day or next shift due to the assigned shower schedule. CNA #15 stated there was not a make-up day for missed or incomplete showers. CNA #15 stated when she documented the showers as "NA" it meant the shower did not occur and when "RR" was documented it meant the resident refused, and if the shower was completed she documented what type of bathing occurred and how much assistance the resident required. CNA #15 stated if she did not have time to complete a resident's shower she documented "NA" and did not leave it "blank" because it was not the resident's fault a shower was not offered or completed.</p> <p>On 1/9/19 at 4:07 PM, RCM #2 stated residents received two showers a week unless the care plan specified differently. RCM #2 stated the shower documentation of "NA" and incomplete/blank documentation meant the shower did not occur. RCM #2 stated she received alerts when showers did not occur, and she had not received alerts recently. RCM #2</p>	{F 677}			

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{F 677}	<p>Continued From page 31</p> <p>stated she was unaware residents' showers were not completed per the assigned schedule. RCM #2 stated "center staff" (facility staff) and "non-center staff" (non-facility staff), such as hospice aides, therapy, or nursing students completed residents' showers. RCM #2 stated if the center staff or non-center staff documented "NA" or "RR" the shower did not occur.</p> <p>Showers were not completed consistently as scheduled twice weekly for the following residents:</p> <p>a. Resident #27 was admitted to the facility on 9/6/18, with multiple diagnoses, including dementia without behavioral disturbances.</p> <p>A quarterly MDS assessment, dated 12/1/18, documented Resident #27 was severely cognitively impaired and was dependent on two staff members for bathing.</p> <p>The care plan area addressing bathing, dated 9/10/18, documented Resident #27 required the assistance of one staff member for bathing twice weekly.</p> <p>Resident #27's ADL Bathing Record, dated 12/14/18 through 1/8/19, documented the staff were to complete showers twice weekly on Tuesdays and Saturdays on the evening shift. Resident #27's record documented he was not provided a bath or shower between 12/15/18 and 12/29/18 (14 days) and 1/2/19 and 1/9/19 (7 days). The record documented Resident #27's shower was "NA" on 12/19/18, 12/26/18 and 1/8/19. The record was blank on 12/22/18 and 1/5/19.</p>	{F 677}			

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{F 677}	Continued From page 32 On 1/9/19 at 12:50 PM, Resident #27 was observed in his wheelchair near the fireplace with greasy looking hair. b. Resident #31 was admitted to the facility on 3/24/18, with diagnoses including dementia. A quarterly MDS assessment, dated 12/13/18, documented Resident #31 was moderately cognitively impaired and required physical assistance of one staff member with bathing. Resident #31's ADL Bathing Record, dated 12/14/18 through 1/8/19, documented the staff were to complete showers twice weekly on Sundays and Wednesdays on the day shift. Resident #31's record documented she was not provided a bath or shower between 12/8/18 and 1/9/19 (32 days). The record documented Resident #31 refused showers on 12/12/18, 12/15/18, and 12/26/18. The record documented Resident #31 shower was "NA" on 12/22/18, 12/29/18 and 1/2/19. The record was blank on 12/19/18 and 1/5/19. c. Resident #34 was admitted to the facility on 3/31/17, with multiple diagnoses including viral pneumonia. An annual MDS assessment, dated 12/16/18, documented Resident #34 was rarely/never understood and required physical assistance with two staff members for bathing. The care plan area addressing Resident #34's bathing, revised on 1/4/18, documented staff were to assist him with bathing twice weekly.	{F 677}			

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

PRINTED: 02/22/2019
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 R 01/10/2019
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{F 677}	Continued From page 33 Resident #34's ADL Bathing Record, dated 12/14/18 through 1/8/19, documented the staff were to complete showers twice weekly on Sundays and Wednesdays on the evening shift. Resident #34's record documented he was not provided a bath or shower between 12/12/18 and 12/19/18 (7 days) and 12/19/18 and 12/26/18 (7 days). Resident #34 was discharged to the hospital on 1/1/19 and readmitted on 1/3/19. Resident #34's record documented he did not receive a shower from 1/3/19 and 1/10/19 (7 days). The record documented Resident #34 refused showers on 12/30/18. The record documented Resident #34 shower was "NA" on 12/23/18 and 1/6/19. The record was blank on 1/9/19. The record documented "XA" on 12/16/18. On 1/10/19 at 10:00 AM, Resident #34 was observed in bed and his skin appear dry and flaky and he was unable to communicate when he received his last shower. d. Resident #219 was admitted to the facility on 12/21/18, with multiple diagnoses including dementia and hypertension. An admission MDS assessment, dated 12/28/18, documented Resident #219 was severely cognitively impaired and was dependent on one staff member for bathing. The care plan area addressing bathing, dated 12/21/18, documented Resident #219 required one staff member assistance with bathing twice weekly.	{F 677}			

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{F 677}	<p>Continued From page 34</p> <p>Resident #219's ADL Bathing Record, dated 12/21/18 through 1/8/19, documented the staff were to complete showers twice weekly on Sundays and Wednesdays on the day shift. Resident #219's record documented he was not provided a bath or shower between 12/23/18 and 12/30/18 (7 days) and 12/30/18 and 1/9/19 (10 days). Resident #219's bathing frequency was documented as needed from 12/21/18 through 12/31/18. Resident #219's 1/1/19 through 1/9/19 ADL Bathing Record did not contain documentation of bathing by center or non-center staff.</p> <p>On 1/10/19 at 9:46 AM, Resident #219 was observed lying in bed with a faint urine odor in the room and was unable to communicate when he received his last shower.</p> <p>e. Resident #220 was admitted to the facility on 12/12/18, with multiple diagnoses including Parkinson's Disease</p> <p>An admission MDS assessment, dated 12/19/18, documented Resident #220 was rarely/never understood and the bathing section documented "bathing activity did not occur the entire period," and he required two staff members assistance with bathing.</p> <p>The care plan area addressing bathing, dated 12/17/18, documented Resident #220 required the assistance of one staff with bathing twice weekly.</p> <p>Resident #220's ADL Bathing Record, dated 12/14/18 through 1/8/19, documented the staff were to complete showers twice weekly on</p>	{F 677}			

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{F 677}	<p>Continued From page 35</p> <p>Tuesdays and Saturdays on the day shift. Resident #220's record documented he was not provided a bath or shower between 12/12/18 and 1/8/19 (27 days). Resident #220 was discharged to the hospital on 12/27/18 and readmitted on 1/1/19. Resident #220's December 2018 ADL Bathing Record did not contain documentation of bathing by center or non-center staff. Resident #220's bathing frequency was documented as needed from 1/1/19 through 1/9/19.</p> <p>f. Resident #221 was admitted to the facility on 10/30/18, with multiple diagnoses including a fall with a femur (thigh bone) fracture and dementia.</p> <p>An admission MDS assessment, dated 11/6/18, documented Resident #221 had a severe cognitive impairment and the bathing section documented "bathing activity did not occur the entire period." The assessment stated she required two staff members assistance with bathing.</p> <p>The care plan area addressing bathing, dated 10/31/18, documented Resident #221 required one staff assistance with bathing twice weekly.</p> <p>Resident #221's ADL Bathing Record, dated 12/14/18 through 1/8/19, documented the staff were to complete showers twice weekly on Sundays and Fridays on the day shift. Resident #221's record documented she was not provided a bath or shower between 12/16/18 and 12/23/18 (7 days), 12/23/18 and 12/30/18 (7 days), and 1/2/19 and 1/9/19 (7 days). Resident #221's bathing frequency was documented as needed from 12/1/18 through 1/9/19.</p>	{F 677}			

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{F 677}	<p>Continued From page 36</p> <p>On 1/8/19 at 11:15 AM, Resident #221 was observed with greasy hair while sitting in her Broda chair. Resident #221 was observed again on 1/8/19 at 4:22 PM and 1/9/19 at 10:52 AM with her hair greasy and stringy.</p> <p>On 1/19/19 at 4:20 PM, RCM #2 was unaware of why Resident #221's showers were scheduled for Fridays and Sundays with five days between the scheduled days.</p> <p>On 1/9/19 at 4:37 PM, RCM #2 stated the shower frequency was entered into the system as needed and not per the residents' scheduled days. RCM #2 stated she was not aware of this until surveyors brought this concern to light. RCM #2 stated she would not receive alerts for incomplete showers if the showers were entered into the system as needed and not per scheduled. RCM #2 stated she would correct the shower frequency for all residents in the system.</p> <p>On 1/10/19 at 3:07 PM, the RCD stated she had been in the facility on 12/13/18, 12/19/18 and 1/7/19, assisting with the plan of correction for skin issues, care plans related to skin, and assisting with the implementation of the electronic MARs/TARs. The RCD stated she showed management how to review the dash board (a system that flags when showers were not completed per the schedule) to check for incomplete showers. The RCD stated residents should receive showers minimally once per week or by resident preference.</p> <p>On 1/10/19 at 4:30 PM, the Administrator Designee stated residents should receive showers minimally twice weekly. The</p>	{F 677}			

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{F 677}	Continued From page 37 Administrator Designee stated "Center staff" meant a residents' shower was completed. The Administrator Designee could not explain what "RR" and "NA" meant with the center staff documentation.	{F 677}			
{F 684} SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, review of I&A reports, record review, and policy review, it was determined the facility failed to ensure professional standards of practice were followed for 3 of 4 residents (#219, #220, and #221) who were reviewed for standards of practice. Resident #219, #220 and #221 had the potential for harm when neurological assessments were incomplete following unwitnessed falls and Resident #220's progress notes were incomplete prior to a change in condition and was discharged to the hospital. These failed practices had the potential to adversely affect or harm other residents whose care and services were not delivered according to accepted standards of clinical practices. Findings include: The facility's Neurological Assessment Flowsheet documented staff were to monitor residents'	{F 684}	Event occurred in the past and unable to correct Resident #219, #220 and #221. Through review of residents records and interviews, no negative findings were noted from not receiving neuro checks. DNS/Designee retrained all licensed staff of requirements for resident with an unwitnessed falls and/or falls with head injury will have neuro checks completed per policy and procedure. DNS/designee to review daily in clinical meeting for ongoing compliance and report monthly to the QAPI Committee for recommendations and ongoing compliance.	3/4/19	

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{F 684}	<p>Continued From page 38</p> <p>neurological status every 15 minutes for one hour, every 30 minutes for two hours, every hour for four hours, every four hours for 16 hours, and every eight hours until the flowsheet was completed or the resident was stable.</p> <p>1. Resident #219 was admitted to the facility on 12/21/18, with multiple diagnoses including dementia and hypertension.</p> <p>A Hospital History and Physical, dated 11/10/18, documented Resident #219 was admitted to the hospital from home after falling and experienced increased confusion.</p> <p>The care plan area addressing ADL, dated 12/21/18, documented Resident #219 had dementia and he required extensive assistance of one staff member for transfers and bed mobility.</p> <p>An I&A report, dated 12/27/18 at 9:34 PM, documented Resident #219 experienced an unwitnessed fall in his room and sustained a bruise to his left eye, an injury to the top of his scalp, and a skin tear to his left elbow. The I&A report documented after the staff assessed him, he was brought out into the hall.</p> <p>Resident #219's clinical record did not contain documentation neurological assessments were completed following the 12/27/18 fall.</p> <p>On 1/10/19 at 9:46 AM, Resident #219 was observed lying in bed with the bed in the lowest position, approximately 1 and 1/2 feet off the floor.</p>	{F 684}			

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{F 684}	<p>Continued From page 39</p> <p>On 1/10/19 at 9:52 AM, RCM #1 stated she was unable to provide Resident #219's neurological assessments following his fall on 12/27/18.</p> <p>2. Resident #220 was admitted to the facility on 12/12/18, with multiple diagnoses including Parkinson's Disease.</p> <p>A Hospital History and Physical, dated 11/23/18, documented Resident #220 was admitted to the hospital from home after falling.</p> <p>Resident #220's Admission Fall Risk Assessment, dated 12/12/18 at 1:30 PM, documented he had a history of 1-2 falls within the last 6 months. The assessment was signed on 12/13/18.</p> <p>The care plan area addressing ADLs, dated 12/17/18, documented Resident #220 was dependent on two staff members for assistance with transfers and repositioning in bed.</p> <p>Resident #220 experienced a fall on 1/8/19 and neurological assessments were not consistently completed.</p> <p>An I&A report, dated 1/8/19 at 10:27 AM, documented Resident #220 experienced an unwitnessed fall in his room. The I&A report documented he was found in a sitting position with his back against the wall and his wheelchair was positioned in front of him without the brakes locked. The I&A report documented he was trying to get into bed. The I&A report documented he sustained skin tears to his right and left elbows.</p> <p>Resident #220's Neurological Assessment</p>	{F 684}			

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{F 684}	<p>Continued From page 40</p> <p>Flowsheet, dated 1/9/19, did not include entries for pupil assessment, motor function, level of consciousness, and pain on 1/8/19 at 2:15 PM, 3:15 PM, 4:15 PM, and 8:15 PM were left blank. On 1/9/19 at 8:15 AM, 4:15 PM and 12:15 AM the neurological assessments were not completed.</p> <p>3. Resident #221 was admitted to the facility on 10/30/18, with multiple diagnoses including a fall with a femur (thigh bone) fracture and dementia.</p> <p>Resident #221's Admission Fall Risk Assessment, dated 10/30/18 at 4:58 PM, documented she had a history of multiple falls within the last 6 months.</p> <p>An admission MDS assessment, dated 11/6/18, documented Resident #221 had severe cognitive impairment and required extensive assistance of two staff members with transfers, bed mobility, and toileting.</p> <p>An I&A report, dated 12/29/18 at 11:30 PM, documented Resident #221 experienced an unwitnessed fall in her room. The I&A report documented Resident #221 was found on the floor on her right side next to her bed. The I&A report documented Resident #221's bed was in the lowest position and her adult briefs were dry and down around her ankles.</p> <p>Resident #221's Neurological Assessment Flowsheet, dated 12/29/18, did not include entries for pupil assessment, motor function, level of consciousness, and pain on 12/30/18 at 2:15 PM and 6:15 PM were left blank. On 12/30/18 at 6:15 AM, 2:15 AM, and on 12/21/18 at 6:15 PM neurological assessments were not</p>	{F 684}			

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{F 684}	Continued From page 41 completed. On 1/10/19 at 9:45 AM, the Administrator Designee stated Resident #220 and #221's neurological assessments were not completed. On 1/10/19 at 9:52 AM, RCM #1 stated neurological assessments should be completed per the facility's protocol as written on the neurological assessment flowsheet.	{F 684}			
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interview, policy review, and record review, it was determined the facility failed to ensure adequate supervision of residents for 4 of 4 residents (#38, #219, #220, and #221) who were reviewed for falls. This failure placed the residents at risk for harm and injury from falling. Findings include: The facility's policy and procedure for Risk Reduction Falls and Injuries Program, undated, documented its purpose was to reduce the risks for falls and injuries by providing supervision and assistance devices to each resident to prevent avoidable accidents. The policy documented the fall response team included a licensed nurse,	F 689	Events were in the past so unable to correct for residents #38, #219, #220, #221. Each identified resident's fall risk assessment and care plan reviewed by IDT to assure current accuracy and assure appropriate supervision as outlined in plan. DNS/designee reviewed fall prevention components with the IDT members. Facility initiated weekly fall prevention committee to review falls and fall risks and assure preventative measures are in place.	3/4/19	

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F 689	<p>Continued From page 42</p> <p>CNA, and 1-2 other team members. The policy documented adequate supervision was defined by the type and frequency of supervision based on the individual residents' assessed needs. The policy documented facility staff assessed residents for their risk of falls and determined causality of falls if they occurred. The policy documented the IDT reviewed and evaluated the resident for falls as well.</p> <p>The facility's Falls Protocol, undated, directed staff to follow these steps when a resident fell:</p> <ul style="list-style-type: none"> - Ensure the resident was safe - Obtain medical treatments as needed - Notify the administrator of major injury - Notify the DNS of major injury - Staff to assess the risk of all residents involved - Notify the MD - Notify the family - Make a note in the chart - Complete a head to toe skin assessment - Complete a pain assessment - Update the fall care plan with interventions - Make therapy referrals - Initiate neurological assessments for unwitnessed falls or if the resident hit their head - Obtain resident and staff witness statements - Complete a fall scene investigation report <p>The facility's policy and procedure for Resident Supervision, effective July 2015, documented the assigned staff member must stay within close proximity, one to two arms length, of the resident at all times and have the resident in sight at all times.</p> <p>These policies were not followed. Examples</p>	F 689	<p>DNS/designee conducted training with all licensed nurses on assuring care plans are followed as indicated with special focus accident prevention and falls as well as the components of the facility fall protocol.</p> <p>DNS/designee to conduct daily, random (10% of residents at high risk for falls)resident audit, to assure ongoing compliance with accident and fall prevention care plans for 30 days then weekly for 8 weeks and report to the QAPI Committee monthly for recommendations and ongoing compliance.</p>		

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F 689	<p>Continued From page 43 include:</p> <p>1. Resident #221 was admitted to the facility on 10/30/18, with multiple diagnoses including a fall with a femur fracture and dementia.</p> <p>Resident #221's Admission Fall Risk Assessment, dated 10/30/18 at 4:58 PM, documented she had a history of multiple falls within the last 6 months.</p> <p>An admission MDS assessment, dated 11/6/18, documented Resident #221 had a severe cognitive impairment and required extensive assistance of two staff members with transfers, bed mobility, and toileting.</p> <p>Resident #221's care plan, dated 11/1/18, identified she was at risk for falls and the documented interventions included wearing non-skid socks or shoes when she was ambulating or mobilizing in her wheelchair and the bed was to be in the low position at night. The care plan also included the following interventions:</p> <ul style="list-style-type: none"> - Staff were to anticipate and meet her needs - Staff were to encourage Resident #221 to use her call light - Staff were to educate Resident #221 and her family of her safety reminders and what to do if a fall occurred - Staff were to complete neurological assessments as needed <p>I&A reports and IDT progress notes documented Resident #221 had four falls between 11/5/18 and 1/5/19. Examples include:</p>	F 689			

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F 689	<p>Continued From page 44</p> <p>- An I&A report, dated 11/5/18 at 8:00 PM, documented Resident #221 had an unwitnessed fall in her room. The I&A report documented a staff member found Resident #221 lying on her right side on the floor parallel to her reclined wheelchair. Resident #221 received x-rays of her right hip. Resident #221's care plan was updated to include increased supervision on 11/7/18. The care plan did not define what the increased supervision consisted of.</p> <p>An IDT follow-up note for the 11/5/18 fall, was completed on 11/12/18, 7 days later. The note documented, "Nursing will increase supervision when needed by having either 1:1 staffing or every 15 minute checks when Resident is restless."</p> <p>- An I&A report, dated 12/5/18 at 4:45 AM, documented Resident #221 had an unwitnessed fall in her room. The I&A report documented Resident #221 was sitting on the floor with her back up against her bed. The I&A report documented no injuries were noted.</p> <p>An IDT follow-up note for the 12/5/18 fall, was completed on 12/10/18, 5 days later. The follow-up note documented Resident #221 hit her head resulting in a 2.2 cm by 2.0 cm red mark on her upper right scalp. The note documented Resident #221 was non-verbal and 15-minute checks were implemented for the duration of the day. Resident #221's care plan was updated to include a concave mattress (lipped) on 12/10/18, 5 days after her fall.</p> <p>- An I&A report, dated 12/7/18 at 2:08 PM,</p>	F 689			

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

PRINTED: 02/22/2019
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 R 01/10/2019
NAME OF PROVIDER OR SUPPLIER IVY COURT			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 IRONWOOD PLACE COEUR D'ALENE, ID 83814		
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F 689	<p>Continued From page 45</p> <p>documented Resident #221 had an unwitnessed fall in her room. The I&A report documented Resident #221 sustained a "goose egg" on her head and her call light was pulled out of the wall. The I&A report documented she was to remain within line of sight of staff while she was awake.</p> <p>An IDT follow-up note for the 12/7/18 fall, was completed on 12/11/18, 4 days later. The follow-up note documented Resident #221 was found after she attempted to self-transfer from her bed to her chair. The note documented Resident #221 was non-verbal and had advanced dementia which impaired her safety awareness.</p> <p>- An I&A report, dated 12/29/18 at 11:30 PM, documented Resident #221 had an unwitnessed fall in her room. The I&A report documented Resident #221 was found on the floor on her right side next to her bed. The I&A report also documented Resident #221's bed was in the lowest position and her adult briefs were dry and down around her ankles. There was no documentation if the concave mattress was in place.</p> <p>The IDT follow-up note for the 12/29/18 fall, was completed on 1/8/19, 10 days later. The follow-up note documented staff were to continue to anticipate her needs and "remind to make safe and effective decisions and demonstrate/remind how to effectively use her call light." Resident #221's care plan was not updated following the 12/29/18 fall.</p> <p>Resident #221's record included four assessments of her risk of falling, between</p>	F 689			

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

PRINTED: 02/22/2019
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 R 01/10/2019
NAME OF PROVIDER OR SUPPLIER IVY COURT			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 IRONWOOD PLACE COEUR D'ALENE, ID 83814		
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F 689	<p>Continued From page 46</p> <p>11/5/18 and 1/5/19. A Fall Risk Assessment, dated 11/5/18 at 8:26 PM, documented Resident #221 had a history of 1-2 falls within the last 6 months. The assessment was inconsistent with her admission assessment for falls, dated 10/30/18, which documented she had multiple falls within the last 6 months. A Fall Risk Assessment, dated 12/10/18 at 7:45 AM, documented Resident #221 had a history of zero falls within the last 6 months. This assessment did not reflect the three falls she had experienced in the facility. Subsequent Fall Risk Assessments, dated 12/12/18 at 5:08 PM and 1/5/19 at 9:30 AM, documented Resident #221 had a history of multiple falls within the last 6 months.</p> <p>On 1/8/19 at 11:20 AM, Resident #221 was observed in the visiting room with a family member watching TV in her Broda chair (reclining chair). Resident #221's visitor stated Resident #221 was admitted because of falls and Resident #221 was to remain in line of sight at all times with staff or family.</p> <p>On 1/8/19 at 4:22 PM, Resident #221 was observed in the hallway without staff present.</p> <p>On 1/9/19 at 10:52 AM, Resident #221 was observed in the hallway with her legs positioned over the right side of her Broda chair and she was lifting her bottom off of her chair.</p> <p>On 1/10/19 at 9:45 AM, the Acting Administrator stated Resident #221's care plan was not updated after each fall because the RCM's have been working the floor and did not have time to update her care plan. The Acting Administrator</p>	F 689			

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 R 01/10/2019
NAME OF PROVIDER OR SUPPLIER IVY COURT			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 IRONWOOD PLACE COEUR D'ALENE, ID 83814		
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F 689	<p>Continued From page 47</p> <p>stated Resident #221 was to be in line of sight by staff by positioning her in the hallway during the day until it was time for Resident #221 to go to bed.</p> <p>2. Resident #220 was admitted to the facility on 12/12/18, with multiple diagnoses including Parkinson's Disease.</p> <p>A Hospital History and Physical, dated 11/23/18, documented Resident #220 was admitted to the hospital from home after falling.</p> <p>Resident #220's Admission Fall Risk Assessment, dated 12/12/18 at 1:30 PM, documented he had a history of 1-2 falls within the last 6 months.</p> <p>The care plan area addressing ADLs, dated 12/17/18, documented Resident #220 was dependent on two staff members for assistance with transfers and repositioning in bed. The care plan also identified he was at risk for falls. The interventions for falls included the following:</p> <ul style="list-style-type: none"> - Staff were to anticipate and meet his needs - Staff were to encourage Resident #220 to use his call light - Staff were to educate Resident #220 and his family of his safety reminders and what to do if a fall occurred - Resident #220 was to wear non-skid socks or shoes when he was "ambulating or mobilizing in w/c (wheelchair)" - Resident #220's bed was to be in a low position at night <p>I&A reports and IDT progress notes documented</p>	F 689			

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

PRINTED: 02/22/2019
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 R 01/10/2019
NAME OF PROVIDER OR SUPPLIER IVY COURT			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 IRONWOOD PLACE COEUR D'ALENE, ID 83814		
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F 689	<p>Continued From page 48</p> <p>Resident #220 experienced three falls between 12/14/18 and 1/8/19. Examples include:</p> <ul style="list-style-type: none"> - An I&A report, dated 12/14/18 at 4:17 AM, documented Resident #220 had a witnessed fall. The I&A report documented a staff member was next to him and the staff member fell over with him into a chair and no injuries were noted. The I&A report did not include documentation of where the fall occurred. - An IDT follow-up note for the 12/14/18 fall, was completed on 12/20/18, 6 days later. The follow-up note documented staff were to increase supervision due to Resident #220's impaired safety awareness. - An I&A report, dated 12/17/18 at 6:20 PM, documented Resident #220 had a witnessed fall while visiting with a family member in a lounge area. The I&A report documented he was found on his knees with his back facing his wheelchair and calling for help. The I&A documented his right knee had an abrasion, there was no documentation of the size or extent of the abrasion to his right knee. - The IDT follow-up note for the 12/17/18 fall, was completed on 1/7/19, 21 days later. The follow-up note documented Resident #220 had three falls since admission and he needed to have a 1:1 care giver until he had better safety awareness. It was unclear when Resident #220 experienced a third fall between 12/14/18 and 1/7/19. - The care plan did not include the added intervention of Resident #220's need for a 1:1 following his 12/17/18 fall. 	F 689			

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 R 01/10/2019
NAME OF PROVIDER OR SUPPLIER IVY COURT			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 IRONWOOD PLACE COEUR D'ALENE, ID 83814		
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F 689	Continued From page 49 - An I&A report, dated 1/8/19 at 10:27 AM, documented Resident #220 had an unwitnessed fall in his room. The I&A report documented he was found in a sitting position with his back against the wall and his wheelchair was positioned in front of him without the brakes locked. The I&A report documented he was trying to get into bed. The I&A report documented he sustained skin tears to his right and left elbows. The report did not include documentation of the size or extent of the skin tears to his right and left elbow. On 1/9/19 at 2:00 AM, Resident #220 was observed sitting in his wheelchair near the nurses' station approximately 15 feet from the nearest staff member. RN #2 and CNA #10 were observed in the charting area of the nurses' station. On 1/9/19 at 2:25 AM, Resident #220 was observed attempting to stand by placing his hands onto the armrest and raising his bottom. RN #1 was notified by the surveyor of Resident #220's attempt to stand. RN #1 was observed attending to his needs. On 1/9/19 at 2:40 AM Resident #220 was observed leaning forward in his wheelchair to move his foot pedals to stand. Resident #220 was unable to remove the foot pedals and attempted to stand by placing his hands onto the armrest and raising his bottom off the seat of his chair. RN #1 was notified by the surveyor of Resident #220's attempt to stand. RN #1 asked CNA #10 to sit near Resident #220 and ensure he did not attempt to stand again.	F 689			

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

PRINTED: 02/22/2019
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 R 01/10/2019
NAME OF PROVIDER OR SUPPLIER IVY COURT			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 IRONWOOD PLACE COEUR D'ALENE, ID 83814		
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F 689	Continued From page 50 On 1/9/19 from 2:40 AM through 3:20 AM, Resident #220 was observed in the same position at the nurses' station. Resident #220 had a staff member near him periodically throughout the observation. On 1/9/19 from 10:52 AM through 11:20 AM, Resident #220 was observed in the same position at the nurses' station and periodically attempted to stand without 1:1 supervision. On 1/9/19 at 12:00 PM, Resident #220 was observed self propelling his wheelchair down the hall towards his room. Resident #220 stated he was going to his room. On 1/9/18 at 4:15 PM, Resident #220 was observed sitting in his wheelchair near the nurses' station and attempted to stand while two nurses were sitting at the nurses' station and were unaware of his attempts to stand. On 1/10/19 at 11:00 AM, the Acting DNS stated Resident #220 was placed at the nurse's station so he was in line of sight of the staff. The Acting DNS stated Resident #220 should have had 1:1 supervision due to his recent falls. 3. Resident #219 was admitted to the facility on 12/21/18, with multiple diagnoses including dementia and hypertension. A Hospital History and Physical, dated 11/10/18, documented Resident #219 was admitted to the hospital from home for falling and increased confusion.	F 689			

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

PRINTED: 02/22/2019
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 R 01/10/2019
NAME OF PROVIDER OR SUPPLIER IVY COURT			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 IRONWOOD PLACE COEUR D'ALENE, ID 83814		
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F 689	<p>Continued From page 51</p> <p>The care plan area addressing ADLs, dated 12/21/18, documented Resident #219 had dementia and he required extensive assistance of one staff member for transfers and bed mobility. The care plan did not identify his risk for falls or include interventions related to falls.</p> <p>Resident #219's Admission Fall Risk Assessment, initiated on 12/21/18 at 9:55 AM, documented he had no history of falls within the last 6 months and was signed on 12/27/18. This was not consistent with the History and Physical from the hospital.</p> <p>Resident #219's Progress Notes documented he had poor safety awareness and multiple attempts to self-transfer as follows:</p> <ul style="list-style-type: none"> - A Progress Note, dated 12/21/18 at 9:45 PM, documented Resident #219 was a high fall risk and had alarms on his wheelchair to alert staff of the "numerous times he tried to get up without assistance." - A Progress Note, dated 12/22/18 at 5:04 AM, documented Resident #219 was attempting to get out of bed without staff assistance. - A Progress Note, dated 12/24/18 at 12:25 AM, documented Resident #219 was in his wheelchair at the nurses' station for safety. - A Progress Note, dated 12/24/18 at 8:25 AM, documented Resident #219 had poor safety awareness and was kept in line of sight of staff at all times. - A Progress Note, dated 12/24/18 at 4:38 PM, documented Resident #219 had no safety awareness and needed frequent checks by staff. <p>An I&A report, dated 12/27/18 at 9:34 PM,</p>	F 689			

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

PRINTED: 02/22/2019
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 R 01/10/2019
NAME OF PROVIDER OR SUPPLIER IVY COURT			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 IRONWOOD PLACE COEUR D'ALENE, ID 83814		
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F 689	<p>Continued From page 52</p> <p>documented Resident #219 had an unwitnessed fall in his room and sustained a bruise to his left eye, an injury to the top of his scalp, and a skin tear to his left elbow. The I&A report documented after the staff assessed him, he was brought out into the hall within sight of staff.</p> <p>On 1/10/19 at 9:46 AM, Resident #219 was observed lying in bed. Resident #219's bed was observed in a low position and approximately 1 and 1/2 feet off the floor.</p> <p>On 1/10/19 at 9:52 AM, RCM #1 stated Resident #219 was considered a high fall risk from admission. RCM #1 stated she did not know if Resident #219 required the need to be in the line of sight of staff and/or frequent checks. RCM #1 stated Resident #219's bed was in the lowest position possible currently and she had not evaluated the height for appropriate positioning.</p> <p>4. Resident #38 was admitted to the facility on 6/30/16, with multiple diagnoses including diabetes mellitus and repeated falls.</p> <p>A quarterly MDS assessment, dated 12/18/18, documented Resident #38 was severely cognitively impaired and had no falls prior to the quarterly MDS assessment.</p> <p>Resident #38's care plan, revised on 10/15/18, documented he was at risk for falls and injury. The care plan directed staff to anticipate and meet his needs and provide 1:1 supervision while awake and asleep.</p> <p>On 1/9/19 at 12:50 PM, Resident #38 was observed in bed sleeping. The staff person</p>	F 689			

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

PRINTED: 02/22/2019
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 R 01/10/2019
NAME OF PROVIDER OR SUPPLIER IVY COURT			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 IRONWOOD PLACE COEUR D'ALENE, ID 83814		
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F 689	<p>Continued From page 53</p> <p>providing his 1:1 supervision was not in the room. At 12:57 PM, CNA #12 said she needed to go to the restroom and asked CNA #13 who was in the hallway outside of Resident #38's room, with CNA #14 and a student CNA, to look after him while she was away.</p> <p>On 1/9/19 at 1:03 PM, Resident #38 was observed in his wheelchair being assisted by CNA #12 to the lobby. The facility's driver arrived and assisted Resident #38 to get into the van in his wheelchair. CNA #12 stayed in the lobby.</p> <p>On 1/9/19 at 1:15 PM, Resident #38 was observed leaving the facility in the van with the driver. The staff person providing him with 1:1 supervision did not go with him.</p> <p>On 1/9/19 at 1:25 PM, LPN #1 said Resident #38's appointment usually took about 2-3 hours and CNA #12 did not want to stay longer for the appointment because CNA #12's shift was finishing at 2:00 PM. LPN #1 said none of the day shift staff were willing to stay longer to provide 1:1 supervision to Resident #38 during his appointment. LPN #1 also said the evening shift staff had not arrived yet and she had no one to send with Resident #38. LPN #1 said Resident #38's care plan documented he was to have 1:1 supervision at all times and she was not comfortable sending him to his appointment without 1:1 supervision but the Administrator Designee told her to send Resident #38 to his appointment and the van driver would provide him with 1:1 supervision.</p> <p>On 1/9/19 at 1:45 PM, CNA #13 said she was outside Resident #38's room with CNA #14 and a</p>	F 689			

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

PRINTED: 02/22/2019
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 R 01/10/2019
NAME OF PROVIDER OR SUPPLIER IVY COURT			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 IRONWOOD PLACE COEUR D'ALENE, ID 83814		
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F 689	<p>Continued From page 54</p> <p>student CNA, when CNA #12 asked them to watch Resident #38 because CNA #12 needed to use the restroom. CNA #13 said CNA #12 did not specifically ask them to stay with Resident #38, although she was aware Resident #38 needed 1:1 supervision. CNA #13 said she then answered Room #27's call light who needed to be changed. CNA #13 asked the student CNA to help her and she said she did not tell CNA #14, who was charting nearby, to watch Resident #38.</p> <p>On 1/9/19 at 1:55 PM, CNA #14 said she was doing her charting in the computer, which was attached on the wall in the hallway next to Resident #38's room, when CNA #13 answered the call light in Room #27. CNA #14 said she had checked Resident #38 once and he was asleep. CNA #14 said she then answered the call light in Room #36 whose oxygen tank needed to be refilled. CNA #14 stated she should have checked first to see if CNA #12 was back before she left the hallway to refill the oxygen tank of the resident in Room #36, or ask another CNA to refill the oxygen tank.</p> <p>On 1/9/19 at 2:15 PM, RCM #1 said Resident #38 should have 1:1 supervision at all times, 24 hours a day, 7 days a week. LPN #2 also stated Resident #38 should not have gone to his appointment without 1:1 supervision.</p> <p>On 1/9/19 at 2:20 PM, the Administrator Designee said she called the hospital and was told the hospital had staff to look after Resident #38 and it was alright for them to send Resident #38 to the hospital without a facility staff person to provide 1:1 supervision. The Administrator Designee said the facility van driver would not go</p>	F 689			

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

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FORM APPROVED
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F 689	<p>Continued From page 55</p> <p>anywhere and he would stay with Resident #38 to provide 1:1 supervision until Resident #38's appointment was finished. When asked how the van driver could provide 1:1 supervision to Resident #38 when he was driving, the Administrator Designee said Resident #38 had a seat belt and would not be able to stand on his own. The Administrator Designee stated she was aware Resident #38 was to have 1:1 supervision because of his history of falls and that was because he got up off his bed. The Administrator Designee also said in her opinion it was safe to send Resident #38 to his appointment without a CNA to provide 1:1 supervision.</p> <p>On 1/10/19 at 9:52 AM, RCM #1 stated the process for nurses to follow after a resident falls included assessing the resident for injury, pain, vital signs, and neurological assessments were initiated as needed. She stated after the resident was safe, the nurse documented in the nurses' notes about the fall, initiated an I&A report, completed a fall assessment, notified the physician, family, and DNS. RCM #1 stated nurses wrote orders if needed and monitored, assessed, and documented for 72 hours after the fall. RCM #1 stated the care plan should be updated within 1-2 days following a fall. RCM #1 stated the fall incident investigation report needed to be completed within 5 days post fall. RCM #1 stated when a resident was considered a high fall risk, staff moved the resident closer to the nurses' station and ensured their beds were in the lowest position. RCM #1 stated if a resident needed to be within line of sight of the staff, the residents were placed in common areas for staff to visualize. RCM #1 stated if a resident required frequent checks, staff observed every</p>	F 689			

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

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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 R 01/10/2019
NAME OF PROVIDER OR SUPPLIER IVY COURT			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 IRONWOOD PLACE COEUR D'ALENE, ID 83814		
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F 689 {F 725} SS=F	Continued From page 56 15-30 minutes. RCM #1 stated if residents required these interventions staff should notify the RCM so the care plan and Kardex were updated and the physician was notified. 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 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). §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: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, review of I&A reports, review of Nurse Staffing information,	F 689 {F 725}	Facility has reviewed and identified staffing patterns and categories of staff	3/4/19	

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{F 725}	<p>Continued From page 57</p> <p>review of Daily Assignment sheets, policy review, and review of the Facility Assessment, it was determined the facility failed to ensure sufficient numbers of staff were provided to meet the supervision, bathing, and nursing oversight needs of residents. This deficient practice directly impacted 7 of 14 residents (#27, #31, #34, #38, #219, #220, and #221) reviewed for sufficient staffing and had the potential to negatively impact the other 61 residents residing in the facility. The deficient practice placed residents at a) at risk of isolation, embarrassment, and health declines due to lack of consistent baths/showers, b) at risk of falls due to lack of required 1:1 staff supervision and the lack of, and delayed revision of, baseline care plans and comprehensive care plans for residents at risk of falls. Findings include:</p> <p>The Facility Assessment, dated November 2017, directed staff:</p> <ul style="list-style-type: none"> * To ensure staffing needs were based on individualized needs. * To rely on more than ranges and fixed staffing models, staff to resident ratios, or prescribed patient formulas. * To review acuity-based staffing levels and to adjust accordingly. <p>a. Residents were not provided staff supervision consistent with their needs.</p> <p>The facility's policy for Resident Supervision, effective July 2015, under the area of Close Visual Supervision, documented the assigned staff member must stay within close proximity "one to two arms lengths" of the resident at all</p>	{F 725}	<p>needed to assure residents showers are given, supervision is provided as outlined in the resident's care plans and oversight provided to assure professional standards are met for residents identified in this deficiency.</p> <p>Executive Director/DNS/Clinical Team and staffing person meet daily M-F to review staffing patterns and adjust according to current resident population. Facility committed to continue hiring qualified staff. Recruited staff from out of state. Advertising on Indeed and Glass Door with frequent upgrades. Facility will submit waiver for Medication Aides-Certified as defined by the Idaho Board of Nursing. Sponsoring employees through the North Idaho College Certified Nursing Program (10 currently enrolled to graduate by mid-April. Sandwich board advertising on corner of Ironwood Place and Ironwood to capture drive-by candidates. Offering flexible schedules and competitive wages. Utilizing company float pool staff to fill open shifts, developed on-call schedule for nursing managers.</p> <p>DNS/Clinical Team and staffing manager retrained by Executive Director on staffing requirements and communication of staffing levels which indicate critical levels and reporting processes and recommended actions for these levels. Executive Director or designee will report critical levels to governing body for determination of admissions status until</p>		

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{F 725}	<p>Continued From page 58</p> <p>times and be able to see the resident at all times.</p> <p>Resident #38 was admitted to the facility on 6/30/16, with multiple diagnoses including diabetes mellitus and repeated falls.</p> <p>A quarterly MDS assessment, dated 12/18/18, documented Resident #38 was severely cognitively impaired and had no falls prior to the quarterly MDS assessment.</p> <p>Resident #38's care plan, revised on 10/15/18, documented he was at risk for falls and injury. The care plan directed staff to anticipate and meet his needs and provide 1:1 supervision while awake and asleep.</p> <p>On 1/9/19 at 12:50 PM, Resident #38 was observed in bed sleeping. The staff person providing his 1:1 supervision was not in the room. At 12:57 PM, CNA #12 said she needed to go to the restroom and asked CNA #13 who was in the hallway outside of Resident #38's room, with CNA #14 and a student CNA, to look after him while she was away.</p> <p>On 1/9/19 at 1:03 PM, Resident #38 was observed in his wheelchair being assisted by CNA #12 to the lobby. The facility's driver arrived and assisted Resident #38 to get into the van in his wheelchair. CNA #12 stayed in the lobby.</p> <p>On 1/9/19 at 1:15 PM, Resident #38 was observed leaving the facility in the van with the driver. The staff person providing him with 1:1 supervision did not go with him.</p> <p>On 1/9/19 at 1:25 PM, LPN #1 said Resident</p>	{F 725}	<p>resolved.</p> <p>Executive Director will report monthly to the QAPI and governing body for recommendations and ongoing compliance.</p>		

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{F 725}	<p>Continued From page 59</p> <p>#38's appointment usually took about 2-3 hours and CNA #12 did not want to stay longer for the appointment because CNA #12's shift was finishing at 2:00 PM. LPN #1 said none of the day shift staff were willing to stay longer to provide 1:1 supervision to Resident #38 during his appointment. LPN #1 also said the evening shift staff had not arrived yet and she had no one to send with Resident #38. LPN #1 said Resident #38's care plan documented he was to have 1:1 supervision at all times and she was not comfortable sending him to his appointment without 1:1 supervision but the Administrator Designee told her to send Resident #38 to his appointment and the van driver would provide him with 1:1 supervision.</p> <p>On 1/9/19 at 1:45 PM, CNA #13 said she was outside Resident #38's room with CNA #14 and a student CNA, when CNA #12 asked them to watch Resident #38 because CNA #12 needed to use the restroom. CNA #13 said CNA #12 did not specifically ask them to stay with Resident #38, although she was aware Resident #38 needed 1:1 supervision. CNA #13 said she then answered Room #27's call light who needed to be changed. CNA #13 asked the student CNA to help her and she said she did not tell CNA #14, who was charting nearby, to watch Resident #38.</p> <p>On 1/9/19 at 1:55 PM, CNA #14 said she was doing her charting in the computer, which was attached on the wall in the hallway next to Resident #38's room, when CNA #13 answered the call light in Room #27. CNA #14 said she had checked Resident #38 once and he was asleep. CNA #14 said she then answered the call light in Room #36 whose oxygen tank needed to be</p>	{F 725}			

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{F 725}	<p>Continued From page 60</p> <p>refilled. CNA #14 stated she should have checked first to see if CNA #12 was back before she left the hallway to refill the oxygen tank of the resident in Room #36, or ask another CNA to refill the oxygen tank.</p> <p>On 1/9/19 at 2:15 PM, RCM #1 said Resident #38 should have 1:1 supervision at all times, 24 hours a day, 7 days a week. LPN #2 also stated Resident #38 should not have gone to his appointment without 1:1 supervision.</p> <p>On 1/9/19 at 2:20 PM, the Administrator Designee said she called the hospital and was told the hospital had staff to look after Resident #38 and it was alright for them to send Resident #38 to the hospital without a facility staff person to provide 1:1 supervision. The Administrator Designee said the facility van driver would not go anywhere and he would stay with Resident #38 to provide 1:1 supervision until Resident #38's appointment was finished. When asked how the van driver could provide 1:1 supervision to Resident #38 when he was driving, the Administrator Designee said Resident #38 had a seat belt and would not be able to stand on his own. The Administrator Designee stated she was aware Resident #38 was to have 1:1 supervision because of his history of falls and that was because he got up off his bed. The Administrator Designee also said in her opinion it was safe to send Resident #38 to his appointment without a CNA to provide 1:1 supervision.</p> <p>b. The facility's policy and procedure for Risk Reduction Falls and Injuries Program, undated, documented its purpose was to reduce the risks for falls and injuries by providing supervision and</p>	{F 725}			

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{F 725}	<p>Continued From page 61</p> <p>assistance devices to each resident to prevent avoidable accidents. The policy documented the fall response team included a licensed nurse, CNA, and 1-2 other team members. The policy documented adequate supervision was defined by the type and frequency of supervision based on the individual residents' assessed needs. The policy documented facility staff would assess residents for their risk of falls and would determine causality for falls if falls occurred. The policy documented the IDT would review and evaluate the resident for falls as well.</p> <p>On 1/10/19 at 9:52 AM, RCM #1 stated the fall incident investigation report needed to be completed within 5 days post fall and this was not always possible to complete due to staffing shortages and the RCMs having to work the floor as nurses or CNAs.</p> <p>Investigations into residents' falls were not completed within 5 days due to lack of staff as follows:</p> <p>i. Resident #219 was admitted to the facility on 12/21/18, with multiple diagnoses including dementia and hypertension.</p> <p>An I&A report, dated 12/27/18 at 9:34 PM. documented Resident #219 experienced an unwitnessed fall in his room and sustained a bruise to his left eye, an injury to the top of his scalp, and a skin tear to his left elbow. The IDT follow-up note for the 12/27/18 fall with injuries, was completed on 1/8/19, 12 days later.</p> <p>ii. Resident #220 was admitted to the facility on 12/12/18, with multiple diagnoses including</p>	{F 725}			

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{F 725}	<p>Continued From page 62 Parkinson's Disease.</p> <p>An I&A report, dated 12/14/18 at 4:17 AM, documented Resident #220 experienced a witnessed fall from a standing position. The IDT follow-up note for the 12/14/18 fall, was completed on 12/20/18, 6 days later.</p> <p>An I&A report, dated 12/17/18 at 6:20 PM, documented Resident #220 experienced a witnessed fall while visiting with a family member in a visiting lounge area. The IDT follow-up note for the 12/17/18 fall, was completed on 1/7/19, 21 days later.</p> <p>iii. Resident #221 was admitted to the facility on 10/30/18, with multiple diagnoses including a fall with a femur (thighbone) fracture and dementia.</p> <p>An I&A report, dated 11/5/18 at 8:00 PM, documented Resident #221 experienced an unwitnessed fall in her room. The IDT follow-up note for the 11/5/18 fall, was completed on 11/12/18, 7 days later.</p> <p>An I&A report, dated 12/29/18 at 11:30 PM, documented Resident #221 experienced an unwitnessed fall in her room. The IDT follow-up note for the 12/29/18 fall, was completed on 1/8/19, 10 days later.</p> <p>c. Residents' care plans were not initiated and or revised timely due to staffing concerns as follows:</p> <p>On 1/10/19 at 9:52 AM, RCM #1 stated the baseline care plan should be completed within 48 hours of admission and this was not always possible due to staffing shortages and the RCMs</p>	{F 725}			

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{F 725}	<p>Continued From page 63 having to work the floor as nurses or CNAs. RCM #1 stated care plans were not always revised due to the same staffing concerns.</p> <p>Refer to F655 and F657 as it relates to the facility's failure to ensure sufficient staff were available to develop and revise baseline care plans and comprehensive care plans to meet residents' needs.</p> <p>d. Residents did not receive baths/showers consistent with their needs and bathing schedules.</p> <p>The facility's Bathing policy and procedure, dated June 2018, documented staff were to provide residents with bathing services.</p> <p>The ADL Bathing documentation key included:</p> <ul style="list-style-type: none"> - RR = Resident Refused - NA = Not Applicable - XA = Resident Not Available - C = Center Staff (facility staff members) - NC = Non-Center Staff <p>"(family/hospice/ambulance/student/etc)"</p> <p>On 1/9/19 at 2:16 PM, CNA #15 stated the Daily Assignment sheets assigned CNAs who were responsible for completing residents' showers on the day and evening shifts. CNA #15 stated when one to two aides were assigned to a hall and it was difficult to complete showers and not all residents received their assigned showers. CNA #15 stated if a resident refused a shower or it was not offered due to time constraints the resident was not always re-offered a shower the next day or next shift due to the assigned shower</p>	{F 725}			

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{F 725}	<p>Continued From page 64</p> <p>schedule. CNA #15 stated there was not a make-up day for missed or incomplete showers. CNA #15 stated when she documented the showers as "NA" it meant the shower did not occur and when "RR" was documented it meant the resident refused, and if the shower was completed she documented what type of bathing occurred and how much assistance the resident required. CNA #15 stated if she did not have time to complete a resident's shower she documented "NA" and did not leave it "blank" because it was not the resident's fault a shower was not offered or completed.</p> <p>On 1/9/19 at 4:07 PM, RCM #2 stated residents received two showers a week unless the care plan specified differently. RCM #2 stated the shower documentation of "NA" and incomplete/blank documentation meant the shower did not occur. RCM #2 stated she received alerts when showers did not occur, and she had not received alerts recently. RCM #2 stated she was unaware residents' showers were not completed per the assigned schedule. RCM #2 stated "center staff" (facility staff) and "non-center staff" (non-facility staff), such as hospice aides, therapy, or nursing students completed residents' showers. RCM #2 stated if the center staff or non-center staff documented "NA" or "RR" the shower did not occur.</p> <p>Showers were not completed consistently as scheduled twice weekly for the following residents:</p> <p>i. Resident #27 was admitted to the facility on 9/6/18, with multiple diagnoses, including dementia without behavioral disturbances.</p>	{F 725}			

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{F 725}	Continued From page 65 A quarterly MDS assessment, dated 12/1/18, documented Resident #27 was severely cognitively impaired and was dependent on two staff members for bathing. The care plan area addressing bathing, dated 9/10/18, documented Resident #27 required the assistance of one staff member for bathing twice weekly. Resident #27's ADL Bathing Record, dated 12/14/18 through 1/8/19, documented the staff were to complete showers twice weekly on Tuesdays and Saturdays on the evening shift. Resident #27's record documented he was not provided a bath or shower between 12/15/18 and 12/29/18 (14 days) and 1/2/19 and 1/9/19 (7 days). The record documented Resident #27's shower was "NA" on 12/19/18, 12/26/18 and 1/8/19. The record was blank on 12/22/18 and 1/5/19. On 1/9/19 at 12:50 PM, Resident #27 was observed in his wheelchair near the fireplace with greasy looking hair. ii. Resident #31 was admitted to the facility on 3/24/18, with diagnoses including dementia. A quarterly MDS assessment, dated 12/13/18, documented Resident #31 was moderately cognitively impaired and required physical assistance of one staff member with bathing. Resident #31's ADL Bathing Record, dated 12/14/18 through 1/8/19, documented the staff were to complete showers twice weekly on	{F 725}			

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{F 725}	<p>Continued From page 66</p> <p>Sundays and Wednesdays on the day shift. Resident #31's record documented she was not provided a bath or shower between 12/8/18 and 1/9/19 (32 days). The record documented Resident #31 refused showers on 12/12/18, 12/15/18, and 12/26/18. The record documented Resident #31 shower was "NA" on 12/22/18, 12/29/18 and 1/2/19. The record was blank on 12/19/18 and 1/5/19.</p> <p>iii. Resident #34 was admitted to the facility on 3/31/17, with multiple diagnoses including viral pneumonia.</p> <p>An annual MDS assessment, dated 12/16/18, documented Resident #34 was rarely/never understood and required physical assistance with two staff members for bathing.</p> <p>The care plan area addressing Resident #34's bathing, revised on 1/4/18, documented staff were to assist him with bathing twice weekly.</p> <p>Resident #34's ADL Bathing Record, dated 12/14/18 through 1/8/19, documented the staff were to complete showers twice weekly on Sundays and Wednesdays on the evening shift. Resident #34's record documented he was not provided a bath or shower between 12/12/18 and 12/19/18 (7 days) and 12/19/18 and 12/26/18 (7 days). Resident #34 was discharged to the hospital on 1/1/19 and readmitted on 1/3/19. Resident #34's record documented he did not receive a shower from 1/3/19 and 1/10/19 (7 days). The record documented Resident #34 refused showers on 12/30/18. The record documented Resident #34 shower was "NA" on 12/23/18 and 1/6/19. The record was blank on</p>	{F 725}			

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{F 725}	<p>Continued From page 67</p> <p>1/9/19. The record documented "XA" on 12/16/18.</p> <p>On 1/10/19 at 10:00 AM, Resident #34 was observed in bed and his skin appear dry and flaky and he was unable to communicate when he received his last shower.</p> <p>iv. Resident #219 was admitted to the facility on 12/21/18, with multiple diagnoses including dementia and hypertension.</p> <p>An admission MDS assessment, dated 12/28/18, documented Resident #219 was severely cognitively impaired and was dependent on one staff member for bathing.</p> <p>The care plan area addressing bathing, dated 12/21/18, documented Resident #219 required one staff member assistance with bathing twice weekly.</p> <p>Resident #219's ADL Bathing Record, dated 12/21/18 through 1/8/19, documented the staff were to complete showers twice weekly on Sundays and Wednesdays on the day shift. Resident #219's record documented he was not provided a bath or shower between 12/23/18 and 12/30/18 (7 days) and 12/30/18 and 1/9/19 (10 days). Resident #219's bathing frequency was documented as needed from 12/21/18 through 12/31/18. Resident #219's 1/1/19 through 1/9/19 ADL Bathing Record did not contain documentation of bathing by center or non-center staff.</p> <p>On 1/10/19 at 9:46 AM, Resident #219 was observed lying in bed with a faint urine odor in</p>	{F 725}			

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

PRINTED: 02/22/2019
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 R 01/10/2019
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{F 725}	<p>Continued From page 68</p> <p>the room and was unable to communicate when he received his last shower.</p> <p>v. Resident #220 was admitted to the facility on 12/12/18, with multiple diagnoses including Parkinson's Disease</p> <p>An admission MDS assessment, dated 12/19/18, documented Resident #220 was rarely/never understood and the bathing section documented "bathing activity did not occur the entire period," and he required two staff members assistance with bathing.</p> <p>The care plan area addressing bathing, dated 12/17/18, documented Resident #220 required the assistance of one staff with bathing twice weekly.</p> <p>Resident #220's ADL Bathing Record, dated 12/14/18 through 1/8/19, documented the staff were to complete showers twice weekly on Tuesdays and Saturdays on the day shift. Resident #220's record documented he was not provided a bath or shower between 12/12/18 and 1/8/19 (27 days). Resident #220 was discharged to the hospital on 12/27/18 and readmitted on 1/1/19. Resident #220's December 2018 ADL Bathing Record did not contain documentation of bathing by center or non-center staff. Resident #220's bathing frequency was documented as needed from 1/1/19 through 1/9/19.</p> <p>vi. Resident #221 was admitted to the facility on 10/30/18, with multiple diagnoses including a fall with a femur (thigh bone) fracture and dementia.</p> <p>An admission MDS assessment, dated 11/6/18,</p>	{F 725}			

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

PRINTED: 02/22/2019
FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER IVY COURT			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 IRONWOOD PLACE COEUR D'ALENE, ID 83814		
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{F 725}	<p>Continued From page 69</p> <p>documented Resident #221 had a severe cognitive impairment and the bathing section documented "bathing activity did not occur the entire period." The assessment stated she required two staff members assistance with bathing.</p> <p>The care plan area addressing bathing, dated 10/31/18, documented Resident #221 required one staff assistance with bathing twice weekly.</p> <p>Resident #221's ADL Bathing Record, dated 12/14/18 through 1/8/19, documented the staff were to complete showers twice weekly on Sundays and Fridays on the day shift. Resident #221's record documented she was not provided a bath or shower between 12/16/18 and 12/23/18 (7 days), 12/23/18 and 12/30/18 (7 days), and 1/2/19 and 1/9/19 (7 days). Resident #221's bathing frequency was documented as needed from 12/1/18 through 1/9/19.</p> <p>On 1/8/19 at 11:15 AM, Resident #221 was observed with greasy hair while sitting in her Broda chair. Resident #221 was observed again on 1/8/19 at 4:22 PM and 1/9/19 at 10:52 AM with her hair greasy and stringy.</p> <p>e. Staff Interviews:</p> <p>On 1/8/19 at 11:30 AM, the Administrator Designee stated the facility was still having staffing concerns and worked as a CNA a few times in the past week. The Administrator Designee stated the RCMs and the Acting DNS had been working the floor as CNAs and floor nurses, as well, for the past 2-3 weeks. The Administrator Designee stated they had been</p>	{F 725}			

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

PRINTED: 02/22/2019
FORM APPROVED
OMB NO. 0938-0391

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{F 725}	<p>Continued From page 70</p> <p>advertising and hired new employees and had to let them go due to failed background checks, staff abusing residents, and poor work ethics. The Administrator Designee stated the Acting Administrator had been in the facility as "support" and she had been referred to the Administrator in a sister facility under the same ownership for guidance. The Administrator Designee provided the paperwork with her credentials as an Administrator Designee. The Administrator Designee stated the acting Administrator applied for his Idaho license and was pending completion.</p> <p>On 1/8/19 at 12:00 PM, the Scheduler stated she mentioned the lack of staff from 12/15/18 to current to the Acting Administrator daily and was instructed to continue to offer bonuses by increasing the hourly pay, cash incentives, and to display the shifts needing staff in the breakroom. The Scheduler stated as of January 2019, she was instructed to not offer the cash incentives but to continue with the hourly increase for extra shifts. The Scheduler stated the Acting DNS and the Administrator Designee had been working the floor as CNAs due to the lack of staff the weekend of 1/4/19 to 1/6/19. The Scheduler stated the nursing staff were tired due to working extra shifts and working short staffed and some had quit or were "no call no shows."</p> <p>On 1/8/19 at 11:46 AM, CNA #3 was observed on one of the halls and stated she was one of two CNAs working the hall, when there should have been 3 CNAs.</p> <p>On 1/8/19 at 12:00 PM, CNA #5 stated there was not enough staff to care for the residents' needs.</p>	{F 725}			

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

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{F 725}	<p>Continued From page 71</p> <p>CNA #5 stated, on 1/7/19, there was one CNA scheduled to work one hall on the evening shift and the facility expected to have the residents cared for including shower completed. CNA #5 stated the residents that were scheduled to receive a shower did not always receive their showers. CNA #5 stated the facility was scheduled short staffed on all shifts, but evening shift seemed to be the worst.</p> <p>On 1/8/19 at 4:26 PM, CNA #4 stated she worked for the activities program one day a week and also worked as a CNA four days a week. CNA #4 stated the hall she worked had several residents requiring Hoyer lift transfers which required 2 people to complete and there was only one or two CNAs working the hall when there should be three CNAs. CNA #4 stated the residents were not receiving their showers as scheduled. CNA #4 stated on 1/4/19 for the evening shift there was only one CNA working one of the halls.</p> <p>On 1/8/19 at 4:42 PM, CNA #7 stated the residents were not receiving their showers as scheduled due to the facility being short staffed. CNA #7 stated the halls were consistently short staffed on the evening shift. CNA #7 stated each hall was to have 3 CNAs, however, each hall averaged one to two CNAs for each shift.</p> <p>On 1/8/19 at 4:49 PM, LPN #2 said in the last 3-4 weeks she noticed they were short of CNAs. LPN #2 said when a CNA asked for assistance with a resident she had to stop what she was doing. LPN #2 also stated sometimes she could not perform wound dressings and had to pass the task on to the next shift.</p>	{F 725}			

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

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FORM APPROVED
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{F 725}	<p>Continued From page 72</p> <p>On 1/8/19 at 5:03 PM, CNA #16 said in the last 3-4 months that she was the only CNA working in one hall during the evening shift. CNA #16 said she was asked by the facility to work extra hours but told them she could not do it.</p> <p>On 1/8/19 at 5:18 PM, CNA #8 stated each hall had several residents who required Hoyer lift and sit to stand transfers that required two people, and most of the time each hall only had two CNAs scheduled to work. CNA #8 stated the residents were not receiving the care they deserved due to not enough staff to meet the residents' needs.</p> <p>On 1/8/19 at 5:20 PM, LPN #3 said they had a meeting recently and were told to pick up extra days of work due lack of staff. LPN #3 said twice she had worked sixteen hours straight and also worked an additional eight hour to help provide staff coverage.</p> <p>On 1/9/19 at 2:10 AM, CNA #9 stated when there were only two CNAs scheduled for the night shift it was difficult to get all the work completed.</p> <p>On 1/9/19 at 2:15 AM, CNA #10 stated on 1/5/19 and on 1/6/19 the 1:1 caregiver was reassigned to work the floor as a CNA and Resident #38 was not provided with 1:1 supervision.</p> <p>On 1/9/19 at 2:20 AM, RN #1 stated she worked as a charge nurse for the day and evening shifts. RN #1 stated each shift was short staffed, more often evening shift. RN #1 said CNAs sent with residents to appointments during the day, which left fewer CNAs to work the floor. RN #1 stated residents were not receiving showers and other</p>	{F 725}			

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

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{F 725}	<p>Continued From page 73</p> <p>personal hygiene care due to lack of staff. RN #1 stated the hospitality aides had work the floor, but the hospitality aides were not allowed to provide personal cares for the residents. RN #1 stated the nurses and CNAs were asked by administration to work extra shifts. RN #1 stated staff members were getting burnt out.</p> <p>On 1/9/19 at 2:25 AM, RN #2 stated when the night shift was fully staffed residents were repositioned and provided personal cares every two hours. RN #2 stated when they were understaffed it was difficult to complete the tasks.</p> <p>On 1/9/19 at 10:45 AM, CNA #5 said there were times when she was the only CNA on the hall because the other CNA had to accompany a resident to a medical appointment and it was not easy to be working by yourself.</p> <p>On 1/9/19 at 10:50 AM, CNA #14 stated when the residents require assistance to go on appointments, a CNA was pulled from the hall to leave with the resident, which left the hall short staffed.</p> <p>On 1/9/19 at 10:56 AM, LPN #4 stated residents were not receiving their showers due to lack of staff.</p> <p>On 1/10/19 at 2:00 PM, the COO stated the facility utilized their internal float pool, advertised for all nursing positions, and weekly phone calls with the administration of the facility to improve staffing. The COO stated the Per Patient Day (PPD) staffing numbers were provided by the facility weekly and the PPD numbers indicated adequate staffing. The COO said he did not take</p>	{F 725}			

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{F 725}	<p>Continued From page 74</p> <p>in account the acuity of the residents requiring 2 person assistance, accompanied residents to appointments, and staff in other departments working as CNAs.</p> <p>On 1/10/19 at 2:55 PM, the Staffing Coordinator said she was aware of the facility's short staffing issues and was made aware of the RN coverage requirements from the last survey. The Staffing Coordinator said the administration did not allow her to enlist agency nurses or CNAs to work in the facility. The Staffing Coordinator said the facility had a float pool of facility employees, but sometimes no staff were available from the float pool. She also said some of the RCMs worked the floor.</p> <p>f. On 1/8/19 at 12:00 PM, the Scheduler stated full staffing coverage of RNs, LPNs, CNAs, and 1:1 caregiver supervision for the day and evening shifts required one charge nurse, 3 licensed nurses, 9 CNAs, and one 1:1 caregiver supervision for the three halls. The night shift required 2 licensed nurses, 3 CNAs, and one staff to provide 1:1 caregiver.</p> <p>The facility's shift assignment sheets documented the following days coverage was not complete for residents needs.</p> <p>* The facility's Shift Assignment sheet for the evening shift of 12/14/18, documented 8 CNAs were scheduled.</p> <p>* The facility's Shift Assignment sheet for the day and evening shifts of 12/16/18, documented 6 CNAs were scheduled. The night shift documented 2 CNAs were scheduled.</p>	{F 725}			

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{F 725}	Continued From page 75 * The facility's Shift Assignment sheet for the day and evening shifts of 12/17/18, 7 CNAs were scheduled. * The facility's Shift Assignment sheet for the day shift of 12/18/18, documented 8 CNAs were scheduled. The night shift documented no 1:1 caregiver supervision was scheduled. * The facility's Shift Assignment sheet for the day shift of 12/19/18, documented 6 CNAs were scheduled. * The facility's Shift Assignment sheet for the day shift of 12/20/18, documented 7 CNAs were scheduled. * The facility's Shift Assignment sheet for the day shift of 12/21/18, documented 6 CNAs were scheduled. The evening shift documented 7 CNAs were scheduled. * The facility's Shift Assignment sheet for the day shift of 12/22/18, documented 7 CNAs were scheduled. The evening shift documented 8 CNAs were scheduled. * The facility's Shift Assignment sheet for the day shift of 12/23/18, documented 6 CNAs were scheduled. The evening shift documented 7 CNAs were scheduled. * The facility's Shift Assignment sheet for the day shift of 12/24/18, documented 8 CNAs were scheduled. The evening shift documented 8 CNAs were scheduled. The night shift documented 2 CNAs were scheduled.	{F 725}			

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

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{F 725}	Continued From page 76 * The facility's Shift Assignment sheet for the day shift of 12/25/18, documented 7 CNAs were scheduled. The evening shift documented 7 CNAs were scheduled. The night shift documented 1 nurse and 2 CNAs were scheduled. * The facility's Shift Assignment sheet for the day shift of 12/26/18, documented 8 CNAs were scheduled. The evening shift documented 7 CNAs were scheduled. * The facility's Shift Assignment sheet for the evening shift of 12/27/18, documented 8 CNAs were scheduled. The night shift documented 1:1 caregiver supervision called in. * The facility's Shift Assignment sheet for the day shift of 12/28/18, documented 7 CNAs were scheduled. The evening shift documented 2 nurses and 6 CNAs were scheduled. * The facility's Shift Assignment sheet for the day shift of 12/29/18, documented 6 CNAs were scheduled. The night shift documented 2 CNAs were scheduled. * The facility's Shift Assignment sheet for the day shift of 12/30/18, documented 6 CNAs were scheduled. The night shift documented 2 CNAs were scheduled. * The facility's Shift Assignment sheet for the day shift of 12/31/18, documented 7 CNAs were scheduled. The evening shift documented 7 CNAs were scheduled. The night shift documented 2 CNAs and 1:1 caregiver	{F 725}			

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{F 725}	<p>Continued From page 77 supervision called in.</p> <p>* The facility's Shift Assignment sheet for the day shift of 1/1/19, documented 8 CNAs were scheduled. The evening shift documented 7 CNAs were scheduled.</p> <p>* The facility's Shift Assignment sheet for the day shift of 1/2/19, documented 8 CNAs were scheduled. The evening shift documented 6 CNAs were scheduled. The night shift documented 2 CNAs were scheduled.</p> <p>* The facility's Shift Assignment sheet for the day shift of 1/3/19, documented 7 CNAs were scheduled. The evening shift documented 7 CNAs were scheduled. The night shift documented 2 CNAs were scheduled.</p> <p>* The facility's Shift Assignment sheet for the day shift of 1/4/19, documented 2 nurses and 1 charge nurse and 8 CNAs were scheduled. The evening shift documented 2 nurses, 1 charge nurse, and 6 CNAs were scheduled. One of the scheduled CNAs worked from 4:00 PM to 7:00 PM and the acting DNS worked as a CNA. The night shift documented 2 CNAs.</p> <p>* The facility's Shift Assignment sheet for the day shift of 1/5/19, documented 6 CNAs were scheduled. The evening shift documented 5 CNAs were scheduled. The night shift documented no 1:1 caregiver supervision was scheduled.</p> <p>* The facility's Shift Assignment sheet for the day shift of 1/6/19, documented 7 CNAs with 2 CNAs as "no call no show" were scheduled. The</p>	{F 725}			

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

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{F 725}	Continued From page 78 evening shift documented 2 nurses, 1 charge nurse, and 6 CNAs were scheduled. The night shift documented 2 CNAs with the acting DNS as one of the CNAs were scheduled. * The facility's Shift Assignment sheet for the day shift of 1/7/19, documented 2 nurses, 1 charge nurse, and 7 CNAs were scheduled. The evening shift documented 5 CNAs were scheduled. * The facility's Shift Assignment sheet for the day shift of 1/8/19, documented 8 CNAs were scheduled. The evening shift documented 6 CNAs were scheduled. * The facility's Shift Assignment sheet for the evening shift of 1/9/19, documented 5 CNAs were scheduled. The night shift documented 2 CNAs were scheduled. * The facility's Shift Assignment sheet for the day shift of 1/10/19, documented 8 CNAs were scheduled. The night shift documented 2 CNAs were scheduled. On 1/10/19 at 11:15 AM, the Administrator Designee provided documentation that 37 out of 69 residents required two person assistance in the facility.	{F 725}			
{F 835} SS=F	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	{F 835}			3/4/19

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 R 01/10/2019
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{F 835}	<p>Continued From page 79</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the Administration failed to ensure available resources were utilized in an effective manner. This deficient practice directly impacted 8 of 14 sampled residents (#27, #31, #34, #38, #219, #220, #221, and #225) and had the potential to negatively impact the other 61 residents residing in the facility. This failure created the potential for harm if residents' cares and safety needs were not met. Findings include:</p> <p>Facility and staff members were not aware who served as the leadership of the facility.</p> <p>On 1/8/19 at 11:30 AM, the Administrator Designee stated the facility was still having staffing concerns and she had worked as a CNA a few times in the past week. The Administrator Designee stated the RCMs, the Acting DNS, and the nurses worked the floor as CNAs for the past 2-3 weeks. The Administrator Designee stated they had been advertising and hired new employees and had to let them go due to failed background checks, staff abusing residents, and poor work ethics. The Administrator Designee stated the Acting Administrator had been in the facility as "support" and she had been referred to another Administrator of a sister facility under common ownership for guidance. The Administrator Designee provided the paperwork with her credentials as an Administrator Designee. The Administrator Designee stated the acting Administrator applied for his Idaho license and was pending completion.</p> <p>On 1/8/19 at 12:50 PM, the Administrator stated</p>	{F 835}	<p>Governing Body hired administrator License # 1085 on 1/21/2019.</p> <p>New administrator to conduct meetings to assure current staff and residents are aware of her presence and how best to contact her with questions and concerns.</p> <p>Administrator to monitor efforts of this 2567 to assure overall compliance.</p> <p>Administrator will report monthly for 3 months to the QAPI and governing body on status of plan of correction and recommendations for ongoing compliance.</p>		

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

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{F 835}	<p>Continued From page 80</p> <p>he was not the Acting Administrator and he was at the facility to support the Administrator Designee (a woman).</p> <p>On 1/8/19 at 4:26 PM, CNA #4 stated the Administrator was a man.</p> <p>On 1/8/19 at 4:42 PM, CNA #7 stated the Administrator was a man.</p> <p>On 1/8/19 at 5:18 PM, CNA #8 stated the Administrator Designee was the Administrator.</p> <p>On 1/8/19 at 5:20 PM, LPN #3 stated the Administrator Designee was the Administrator.</p> <p>On 1/9/19 at 2:10 AM, CNA #9 stated there were two Administrators, the Administrator Designee and a man whose name she did not recall.</p> <p>On 1/9/19 at 2:15 AM, CNA #10 stated the Administrator was a man and the Administrator Designee was the DNS.</p> <p>On 1/9/19 at 2:20 AM, RN #1 stated there were two Administrators, the Administrator Designee and an Administrator from another state.</p> <p>On 1/10/19 at 2:00 PM, the COO said he hired an Administrator in December 2018. The Administrator applied for his Idaho license and his license was pending completion. The COO stated he found out 1/10/19 that the Administrator's license would not be valid until 1/18/19.</p> <p>The COO stated the facility utilized its internal float pool, advertised for all nursing positions,</p>	{F 835}			

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{F 835}	<p>Continued From page 81</p> <p>and completed weekly phone calls with the administration of the facility regarding staffing needs. The COO stated the Patient Per Day (PPD) staffing numbers were provided by the facility weekly and the PPD staff numbers indicated adequate staffing. When asked, the COO said he did not take into account the acuity of residents requiring 2 person assistance, residents needing accompaniment to appointments, or other personnel classified as CNA in their system, but actually worked in other positions in the facility and not as direct care staff. The COO stated he learned of the staffing concerns a week prior to surveyors entering the facility. The COO stated there were weekly clinical report meetings regarding facility concerns. The COO stated the RCD visited the facility one to two times a week to assist with the facility's plan of correction for the 11/9/18 recertification survey and work to attain regulatory compliance.</p> <p>The COO said he was unaware of the continued noncompliance with staffing, bathing not being provided, neurological assessments not completed, and documentation not provided to the hospital for resident transfers. The COO also said he was unaware of the physical and verbal abuse by a CNA, the lack of investigating and reporting the abuse, employee reference checks not being completed, care plans not being implemented and/or revised.</p> <p>On 1/8/19 at 12:00 PM, The Scheduler stated she told the acting Administrator daily about the lack of staff from 12/15/18 to present and was instructed to continue to offer bonuses by increasing their hourly pay, cash incentives and</p>	{F 835}			

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{F 835}	<p>Continued From page 82</p> <p>display the "needed shifts" in the breakroom. The Scheduler stated as of January 2019, she was instructed to no longer offer the cash incentives, but to continue with the hourly increase for extra shifts staff worked. The Scheduler stated the Acting DNS and the Administrator Designee had been working the floor as CNAs due to the lack of staff the weekend of 1/4/19 to 1/6/19. The Scheduler stated the nursing staff had worked extra shifts and worked short staffed, so they quit or do not come to work when scheduled.</p> <p>The facility was previously cited at F725 on 2/26/18, during a complaint investigation survey, and on 11/9/18 during a recertification and complaint survey, related to staffing concerns.</p> <p>Also refer to:</p> <ul style="list-style-type: none"> * F600 as it relates to the facility's failure to protect residents from abuse. * F607 as it relates to the failure of the facility to complete employee reference checks. * F609 as it relates to the facility's failure to ensure abuse was reported to the Administrator and State Survey Agency within 2 hours. * F610 as it relates to the failure of the facility to thoroughly investigation injuries of unknown origin and abuse allegations. * F655 and F657 as it relates to the facility's failure to ensure sufficient staff were available to develop and revise baseline care plans and comprehensive care plans to meet residents' needs. * F677 as it relates to the facility's failure to ensure residents received consistent baths/showers. * F725 as it relates to the facility's failure to 	{F 835}			

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{F 835}	Continued From page 83 ensure sufficient staff were available to meet residents' needs.	{F 835}			
F 837 SS=F	Governing Body CFR(s): 483.70(d)(1)(2) §483.70(d) Governing body. §483.70(d)(1) The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and §483.70(d)(2) The governing body appoints the administrator who is- (i) Licensed by the State, where licensing is required; (ii) Responsible for management of the facility; and (iii) Reports to and is accountable to the governing body. This REQUIREMENT is not met as evidenced by: Based on record review and interview with staff and members of the Governing Body, it was determined the Governing Body was not actively engaged and involved in the management of the facility. This was true for 8 of 14 residents (#27, #31, #34, #38, #219, #220, #221, and #225) who were reviewed, and had the potential to negatively impact the other 60 residents residing in the facility. These deficient practices had the potential to harm residents, when residents were verbally and physically abused, fell, did not receive showers, 1:1 supervision not consistently provided, and care plans not completed or updated resulting in residents not receiving appropriate supervision and cares. Findings include:	F 837	Governing Body hired administrator Llicense#1085 on 1/21/2019. The Governing Body has weekly calls with the facility to review recruitment and retention efforts, labor management to include staffing levels, quality concerns to include but not limited to in-house pressure sores, falls, plan of correction plans and status and other quality assurance performance improvement measures. The governing body will visit the facility monthly and as needed. Findings of these visits will be forwarded to the CEO and CNO for review.	3/4/19	

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F 837	<p>Continued From page 84</p> <p>Harm to residents' health and safety was identified during the survey as follows:</p> <ul style="list-style-type: none"> - Refer to F600 as it related to the failure of the facility to ensure a resident was free from physical and verbal abuse. On 12/21/18 CNA #2 reported CNA #1 abused Resident #27. CNA #2 witnessed CNA #1 physically and verbally abusing Resident #27. CNA #2 was fearful of retaliation from CNA #1 and did not report it timely. This failure placed the health and safety of all residents in the facility at risk of abuse when the facility did not report abuse timely. - Refer to F610 as it related to the failure of the facility to ensure residents were free from physical and verbal abuse. On 12/21/18, the facility investigated CNA #1 for physical and verbal abuse to Resident #27. The facility did not thoroughly investigate other residents for verbal and physical abuse. This failure placed the health and safety of all residents in the facility at risk of abuse when the facility did not thoroughly investigate physical and verbal abuse. <p>The facility remained out of compliance with federal regulations cited during the 11/9/18 recertification survey as follows:</p> <ul style="list-style-type: none"> - F677 as it related to the failure of the facility to provide residents with consistent showers. - F684 as it related to the failure of the facility to complete neurological assessments following unwitnessed falls and provide documentation for residents transferred to the hospital. 	F 837	<p>The ED and DNS have been educated by the RDCO on the notification process to the governing body for events that occur in the center. Staffing reports will be reviewed weekly by the COO to monitor appropriate levels within the facility and will communicate with the CEO and CNO as needed for additional resources to ensure appropriate staffing levels at the center.</p> <p>The governing body will attend at a minimum quarterly the center's QAPI Committee meeting to assist and monitor quality improvement initiatives within the center. The governing body will review all audits and initiatives of the plan of correction monthly for 3 months and report findings to the center's QAPI committee.</p>		

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F 837	<p>Continued From page 85</p> <ul style="list-style-type: none"> - F725 as it related to the failure of the facility to ensure sufficient numbers of staff were provided to meet the supervision, bathing, and nursing oversight needs of residents. - F835 as it related to the failure of the facility to ensure Administration utilized available resources in an effective manner. <p>New citations included the following:</p> <ul style="list-style-type: none"> - F607 as it relates to the failure of the facility to complete reference checks on new employees. - F609 as it relates to the failure of the facility to report abuse timely. - F622 as it relates to the failure of the facility to complete documentation for residents transferred to the hospital. - F655 as it relates to the failure of the facility to complete baseline care plans. - F657 as it relates to the failure of the facility to revise residents' comprehensive care plans. - F689 as it relates to the failure of the facility to ensure there was adequate supervision of residents. <p>On 1/10/19 at 2:00 PM, the COO stated the facility utilized its internal float pool, advertised for all nursing positions, and had weekly phone calls with the administration of the facility to improve staffing needs. The COO stated the PPD was provided by the facility weekly and the PPD numbers indicated adequate staffing. The COO</p>	F 837			

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F 837	<p>Continued From page 86</p> <p>said he did not take into account the acuity of the residents requiring 2 person assistance, residents needing accompaniment to appointments, or other personnel classified working as CNAs in their system, but working in other positions and not as direct care staff. The COO stated he learned of the staffing concerns a week prior to surveyors entering the facility. The COO stated there were weekly clinical report meetings regarding concerns with the facility. The COO stated the RCD visited the facility one to two times a week to assist with the plan of correction in order to meet regulatory compliance. The COO said he hired an Administrator from another state to oversee the facility and provide support for the Administrator Designee. The COO said he was unaware of the continued non-compliance with staffing, bathing not provided, neurological assessments not being completed, and documentation not provided to the hospital for resident transfers. The COO also said he was unaware of the physical and verbal abuse by a CNA, the lack of investigating and reporting of the abuse, employee reference checks not being completed, care plans not being implemented or revised, or residents who were a high fall risk needing 1:1 supervision in the facility.</p> <p>On 1/10/19 at 3:07 PM, the RCD stated she was in the facility on 12/13/18, 12/19/18, and 1/7/19, after the completion of the recertification survey. The RCD stated she assisted with the plan of correction for skin issues, care plans related to skin, and assisted with the implementation of the electronic MARs/TARs. The RCD stated she was informed of the continued staffing concerns a week prior to the surveyors entering the facility.</p>	F 837			

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F 837	Continued From page 87 The RCD stated she did not discuss the staffing concerns with the Administrator Designee, on 1/7/19, because she thought the facility was in compliance with the staffing citation by recruiting and advertising to hire nursing staff. The RCD stated if the facility did not have available staff to meet the residents' needs, her expectation were for the current staff to pick up extra shifts, not to call off, and to stay into the next shift. The RCD stated she showed management how to review the dash board (a system that flags when showers were not completed per the schedule) to check for incomplete showers. The RCD stated residents should receive showers minimally once per week or by resident preference. The RCD was unaware of bathing concerns. The RCD stated she was unaware of the physical and verbal abuse by CNA #1. The RCD stated she did not participate in the weekly meetings with the COO and the facility, unless requested. The RCD stated she was unaware the facility had to meet the federal regulations to be in compliance.	F 837			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001150	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 01/10/2019
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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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{C 000}	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the follow-up and complaint survey conducted at the facility on January 8, 2019 through January 10, 2019.</p> <p>The surveyors conducting the survey were:</p> <p>Jenny Walker, RN, Team Coordinator Teresa Kobza, RDN, LD Presie Billington, RN</p> <p>Survey Abbreviations:</p> <p>ADL = Activity of Daily Living CNA = Certified Nursing Assistant COO = Chief Operating Officer DNS = Director of Nursing Services I&A = Incident and Accident LPN = Licensed Practical Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment mg = milligram mg/dl = milligram per deciliter MRR = Medication Regime Review PRN = as needed RCD = Regional Clinical Director RN = Registered Nurse ROM = Range of motion TAR = Treatment Administration Record WNL = Within normal limits</p>	{C 000}		
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Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 02/18/19
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IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
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June 24, 2019

Joan Martellucci, Administrator
Ivy Court
2200 Ironwood Place,
Coeur D'Alene, ID 83814-2610

Provider #: 135053

Dear Ms. Martellucci:

On **January 10, 2019**, an unannounced on-site complaint survey was conducted at Ivy Court. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00008005

ALLEGATION #1:

The facility was understaffed.

FINDINGS #1:

An unannounced onsite complaint investigation and follow-up to a recertification survey was conducted on 1/8/19 to 1/10/19.

During the survey, all residents were observed for quality of care and staffing concerns. Resident Council meeting minutes and facility grievances were reviewed. Multiple residents and family members were interviewed regarding staffing.

Facility grievances documented concerns with staffing.

During observations of interactions between residents and staff members, concerns were identified. The residents' halls were observed with 1-2 Certified Nursing Assistants (CNAs) working. The nursing schedule documented multiple days where open shifts for CNAs were unfilled. Residents appeared to be unclean and smelled of odors due to lack of assistance with activities of daily living (ADLs) such as showers, toileting, and other cares. One resident, who required a 1:1 caregiver, was observed to not have a 1:1 caregiver multiple times throughout the survey.

Several residents said the facility needed more staff and their needs were not met. Residents stated showers were infrequent, call light response times were long, and assistance with ADLs was hard to come by.

Multiple CNAs and nurses said the facility could use more staff to ensure residents' needs were met.

The Administrator Designee stated the facility had continued staffing concerns and she had worked as a CNA a few times in the prior week. The Administrator Designee stated the RCMs and the Acting Director of Nursing Services (DNS) had been working the floor as CNAs and as floor nurses the prior 2-3 weeks. The Administrator Designee stated they had advertised for and hired new employees, and subsequently let them go due to failed background checks, resident abuse, and poor work ethics.

The Scheduler stated she had mentioned daily to the Acting Administrator the lack of staff from 12/15/18 to current. She stated she had been instructed to offer bonuses to staff by increasing the hourly pay, provide cash incentives, and to display the shifts needing staff in the breakroom. The Scheduler stated as of January 2019, she was instructed to discontinue offering the cash incentives but to continue with the hourly increase in pay for extra shifts. The Scheduler stated the Acting DNS and the Administrator Designee had been working the floor as CNAs due to the lack of staff the weekend of 1/4/19 to 1/6/19. The Scheduler stated the nursing staff was tired due to working extra shifts and working short staffed; and some had quit or were "no call, no shows."

CONCLUSIONS:

Based on the investigative findings, the allegation was substantiated, and deficiencies were cited at F677, F689, and F725 as they related to the failure of the facility to provide adequate staff to meet the residents' needs.

ALLEGATION #2:

The residents did not receive showers.

FINDINGS #2

Observations were conducted during the survey, eight resident records were reviewed, and interviews were conducted with residents, family members, and staff members.

Eight residents' records were reviewed for quality of care and assistance with ADLs, specifically bathing and hygiene assistance, as well as appropriate nail care. Six of the eight records documented showers and oral hygiene were not provided consistently.

Observations of residents were made during the survey, in their rooms, in the common areas, and dining rooms. Residents appeared ungroomed, smelled of odors, and had unclean teeth, and their hair appeared to be unwashed.

Staff interviews were conducted regarding showers and ADL care. The interviews included multiple CNAs and nurses, and the interim DNS. The staff stated residents were not consistently provided their showers twice weekly due to staffing issues. Staff members stated the shower aide was pulled to work the floors often.

The Administrator Designee stated residents should receive showers at least two times per week. The Administrator Designee stated she could not explain the issues with the shower documentation and prove the residents did receive showers consistently.

CONCLUSIONS:

Based on the investigative findings, the allegation was substantiated. Deficiencies were cited at F677 and F725 as it related to the failure of the facility to ensure residents received adequate assistance with ADLs.

ALLEGATION #3:

The Administration was not correcting the staffing issues.

FINDINGS #3

During the investigation, fourteen residents were observed and fourteen residents' records, which included two closed records, were reviewed for administration and governing body issues related to staffing. Interviews were conducted with residents and family members. Staff members were interviewed about administration and governing body related to staffing.

The residents' records included documentation of staffing issues which contributed to missed showering opportunities for residents, incomplete neurological assessments following falls, and

verbal and physical abuse.

Multiple staff interviews identified two different individuals as the facility's current Administrator. The staff did not know which person to report issues to. The staff stated when they did report issues, it fell upon deaf ears and no changes occurred.

CONCLUSIONS:

Based on the results of the investigation, the allegation was substantiated. Deficiencies were cited at F835 and F837 as it related to the failure of the facility to provide adequate staffing numbers to prevent harm from abuse, and potential harm from lack of consistent ADL assistance.

ALLEGATION #4:

Residents were not repositioned timely.

FINDINGS #4:

During the investigation, all residents were observed for quality of care and repositioning. Resident Council meeting minutes and facility grievances were reviewed. Residents and family members were interviewed regarding staffing.

Facility grievances did not document concerns with positioning.

During observations of interactions between residents and staff members, concerns were identified. The residents' halls were observed with 1-2 CNAs working. The nursing schedule documented multiple days where open shifts for CNAs were unfilled. Residents were observed to sit in wheelchairs for extended periods of time and staff were unable to assist with repositioning due to the lack of staff.

Several residents said the facility needed more staff and their needs were currently not being met. Residents stated assistance with positioning did not occur when the facility was under staffed.

Multiple CNAs and nurses said the facility could use more staff to ensure residents' needs were met. CNAs and nurses stated rounding was supposed to occur every two hours. Due to the staffing numbers they stated they were lucky to get one good rounding in where they were able to assist residents with repositioning and other needs.

The Administrator Designee stated the facility had continued staffing concerns and she had worked as a CNA a few times in the prior week. The Administrator Designee stated the RCMs and the Acting DNS had been working the floor as CNAs and floor nurses, as well, for the prior

2-3 weeks. The Administrator Designee stated they had advertised for and hired new employees and subsequently had to let them go due to failed background checks, resident abuse, and poor work ethics. The Administrator Designee stated the Acting Administrator had been in the facility as "support" and she had been referred to the Administrator in a sister facility under the same ownership for guidance. The Administrator Designee provided the paperwork with her credentials as an Administrator Designee. The Administrator Designee stated the acting Administrator applied for his Idaho license and was pending completion.

The Scheduler stated she daily mentioned to the Acting Administrator the lack of staff from 12/15/18 to current. She stated she was instructed to continue to offer bonuses by increasing the hourly pay, cash incentives, and to display the shifts needing staff in the breakroom. The Scheduler stated as of January 2019, she was instructed to discontinue the cash incentives but to continue with the hourly increase for extra shifts. The Scheduler stated the Acting DNS and the Administrator Designee had been working the floor as CNAs due to the lack of staff the weekend of 1/4/19 to 1/6/19. The Scheduler stated the nursing staff were tired due to working extra shifts and working short staffed and some had quit or were "no call, no shows."

CONCLUSIONS:

Based on the investigative findings, the allegation was substantiated, and a deficiency was cited at F725 as it related to the failure of the facility to provide adequate staff to meet the residents' needs and reposition residents.

ALLEGATION #5:

Residents were not provided range of motion (ROM) services.

FINDINGS #5:

Six resident records were reviewed for restorative services. Facility grievances and Resident Council meeting minutes were reviewed. Residents and staff were interviewed.

Six residents denied having concerns with receiving restorative services. Resident Council minutes and grievances did not document issues with residents not receiving restorative services. The records for the six residents included documentation they received their restorative services as ordered.

Two of the residents said they had no concerns with their restorative services. One family member said they had no concerns with residents' restorative services.

Multiple staff interviews stated the restorative aides were not reassigned to the floor anymore

Joan Martellucci, Administrator
June 24, 2019
Page 6

after the last survey and the residents were receiving their restorative services.

CONCLUSIONS:

Based on the investigative findings the allegation was unsubstantiated due to lack of evidence regarding restorative services not being provided.

CONCLUSIONS:

Substantiated. Federal and State deficiencies related to the allegation are cited.

Thank you for the courtesies and assistance extended to us during our visit. 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,



LAURA THOMPSON, RN, Supervisor
Long Term Care Program

LT/slj