



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

.BRAD LITTLE – Governor  
DAVE JEPPESEN – Director

TAMARA PRISOCK – ADMINISTRATOR  
DIVISION OF LICENSING & CERTIFICATION  
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March 9, 2020

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

Provider #: 135053

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

Dear Ms. Martellucci:

On **February 25, 2020**, a Facility Fire Safety and Construction survey was conducted at **Ivy Court** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed.

Joan Martellucci, Administrator  
March 9, 2020  
Page 2 of 4

Please provide ONLY ONE completion date for each federal and state tag in column (X5) Completion Date to signify when you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office. If a State Form with deficiencies was issued, it should be signed, dated and returned along with the CMS-2567 Form.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **March 22, 2020**. Failure to submit an acceptable PoC by **March 22, 2020**, may result in the imposition of civil monetary penalties by **April 13, 2020**.

Your PoC must contain the following:

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

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

Remedies may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **March 31, 2020**, (Opportunity to Correct). Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **May 25, 2020**. A change in the seriousness of the deficiencies on **April 10, 2020**, may result in a change in the remedy.

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 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  02/25/2020
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NAME OF PROVIDER OR SUPPLIER  IVY COURT	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 IRONWOOD PLACE COEUR D'ALENE, ID 83814
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K 000	INITIAL COMMENTS  The facility is a single story, Type V (111) construction built in 1973. The facility has a complete automatic fire suppression and fire alarm system with smoke detection in the corridors and open areas. The Essential Electrical System (EES) is supplied by a natural gas powered, on-site automatic generator. The facility is currently licensed for 80 SNF/NF beds and had a census of 72 on the dates of the survey.  The following deficiencies were cited during the annual Fire/Life Safety survey conducted on February 24 - 25, 2020. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy in accordance with 42 CFR 483.70.  The Survey was conducted by:  Linda Chaney Health Facility Surveyor Facility Fire Safety & Construction	K 000		
K 222 SS=F	Egress Doors CFR(s): NFPA 101  Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the	K 222		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE, *Jean B. Martellus* TITLE *Executive Director* (X6) DATE *3/23/20*

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that their 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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K 222	<p>Continued From page 1</p> <p>rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times.</p> <p>18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6</p> <p><b>SPECIAL NEEDS LOCKING ARRANGEMENTS</b> Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation.</p> <p>18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4</p> <p><b>DELAYED-EGRESS LOCKING ARRANGEMENTS</b> Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system.</p> <p>18.2.2.2.4, 19.2.2.2.4</p> <p><b>ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS</b> Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted.</p> <p>18.2.2.2.4, 19.2.2.2.4</p> <p><b>ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS</b></p>	K 222	<p>K 222</p> <p>East door and service door were repaired on 2/26/20. South exit door is scheduled for repair.</p> <p>All other doors were checked to assure operating properly.</p> <p>Maintenance Director will monitor doors weekly and record reviews.</p> <p>Maintenance Director will report Monthly to the QAPI for the next 3 months to assure ongoing compliance.</p>	3/31/20
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K 222	<p>Continued From page 2</p> <p>Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview, observation and operational testing, the facility failed to ensure special locking arrangements were in accordance with NFPA 101. Failure to provide operational delayed egress locking arrangements for magnetically controlled means of egress could hinder the safe evacuation of residents during a fire or other emergency. This deficient practice affected 55 residents and staff on the dates of the survey.</p> <p>Findings include:</p> <p>During the facility tour on February 24, 2020, from approximately 3:10 PM to 5:00 PM, observation of the exit doors in the south corridor, east corridor and service entrance, revealed they were equipped with magnetic locks, keypad override and delayed egress capability/signage. When tested, delayed egress, the irreversible process to release the magnetic locking mechanisms, was non-operational. Interview of the Maintenance Supervisor at approximately 3:30 PM, revealed the facility was unaware the delayed egress component was not working on these exit doors.</p> <p>Actual NFPA standard:</p> <p>7.2.1.6* Special Locking Arrangements. 7.2.1.6.1 Delayed-Egress Locking Systems. 7.2.1.6.1.1 Approved, listed, delayed-egress</p>	K 222		

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K 222	Continued From page 3 locking systems shall be permitted to be installed on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6 or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 11 through 43, provided that all of the following criteria are met: (1) The door leaves shall unlock in the direction of egress upon actuation of one of the following: (a) Approved, supervised automatic sprinkler system in accordance with Section 9.7 (b) Not more than one heat detector of an approved, supervised automatic fire detection system in accordance with Section 9.6 (c) Not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6 (2) The door leaves shall unlock in the direction of egress upon loss of power controlling the lock or locking mechanism. (3)*An irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions: (a) The force shall not be required to exceed 15 lbf (67 N). (b) The force shall not be required to be continuously applied for more than 3 seconds. (c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening. (d) Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only.	K 222			

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K 222	Continued From page 4 (4)*A readily visible, durable sign in letters not less than 1 in. (25 mm) high and not less than 1/8 in. (3.2 mm) in stroke width on a contrasting background that reads as follows shall be located on the door leaf adjacent to the release device in the direction of egress: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS (5) The egress side of doors equipped with delayed-egress locks shall be provided with emergency lighting in accordance with Section 7.9.	K 222		
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101  Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure testing for battery powered emergency lighting was conducted in accordance with NFPA 101. Failure to test emergency lighting for 30 seconds monthly, has the potential to hinder resident evacuation during an emergency. This deficient practice affected 72 residents and staff on the dates of the survey.  Findings include:  During review of facility maintenance and inspection testing logs on February 24, 2020, from approximately 9:00 AM - 3:00 PM, records were provided for 30 second monthly emergency light testing from September 2019 to present. However, the facility could not produce	K 291		

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K 291	Continued From page 5 documentation for 30 second monthly testing of the emergency lighting prior to September 2019. When asked, at approximately 11:30 AM, the Maintenance Supervisor stated he was new to his position in September 2019. He had attempted to locate testing documentation from the previous Maintenance Supervisor but had not been able to find any.  Actual NFPA standard:  NFPA 101  19.2 Means of Egress Requirements. 19.2.1 General. Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7, unless otherwise modified by 19.2.2 through 19.2.11.  7.9 Emergency Lighting. 7.9.3 Periodic Testing of Emergency Lighting Equipment. 7.9.3.1.1 Testing of required emergency lighting systems shall be permitted to be conducted as follows: (1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, except as otherwise permitted by 7.9.3.1.1(2). (2) The test interval shall be permitted to be extended beyond 30 days with the approval of the authority having jurisdiction. (3) Functional testing shall be conducted annually for a minimum of 1-1/2 hours if the emergency lighting system is battery powered. (4) The emergency lighting equipment shall be fully operational for the duration of the tests required by 7.9.3.1.1(1) and (3).	K 291	K 291  Emergency lighting was tested throughout the building and was found operational within the 30 second time frame.  Maintenance department reviewed the statutory requirement to assure understanding.  Maintenance Director/designee will conduct and record monthly checks of emergency lighting as required.  Maintenance Director will submit completed records to the QAPI committee monthly for 3 months to assure ongoing compliance.	3/31/20	

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K 291	Continued From page 6 (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. 7.9.3.1.2 Testing of required emergency lighting systems shall be permitted to be conducted as follows: (1) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall be provided. (2) Not less than once every 30 days, self-testing/self-diagnostic battery-operated emergency lighting equipment shall automatically perform a test with a duration of a minimum of 30 seconds and a diagnostic routine. (3) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall indicate failures by a status indicator. (4) A visual inspection shall be performed at intervals not exceeding 30 days. (5) Functional testing shall be conducted annually for a minimum of 1-1/2 hours. (6) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall be fully operational for the duration of the 1-1/2-hour test. (7) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. 7.9.3.1.3 Testing of required emergency lighting systems shall be permitted to be conducted as follows: (1) Computer-based, self-testing/self-diagnostic battery-operated emergency lighting equipment shall be provided. (2) Not less than once every 30 days, emergency lighting equipment shall automatically perform a test with a duration of a minimum of 30 seconds and a diagnostic routine. (3) The emergency lighting equipment shall automatically perform annually a test for a	K 291			

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K 291	Continued From page 7 minimum of 1-1/2 hours. (4) The emergency lighting equipment shall be fully operational for the duration of the tests required by 7.9.3.1.3(2) and (3). (5) The computer-based system shall be capable of providing a report of the history of tests and failures at all times. 2.) 7.9.2.1* Emergency illumination shall be provided for a minimum of 1-1/2 hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10.8 lux) and, at any point, not less than 0.1 ft-candle (1.1 lux), measured along the path of egress at floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6 ft-candle (6.5 lux) and, at any point, not less than 0.06 ft-candle (0.65 lux) at the end of 1-1/2 hours. A maximum-to-minimum illumination uniformity ratio of 40 to 1 shall not be exceeded. 7.9.2.6* Existing battery-operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70, National Electrical Code.	K 291			
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101  Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily	K 345			

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K 345	<p>Continued From page 8 available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure fire alarm systems were maintained in accordance with NFPA 72. Failure to conduct sensitivity testing on non-addressable fire alarm systems at required intervals, could hinder system response during a fire event. This deficient practice affected 29 of 72 residents and staff on the dates of the survey.</p> <p>During review of facility fire alarm inspection records conducted on February 24, 2020, from approximately 9:00 AM to 3:00 PM, review of the annual fire alarm inspection revealed the five (5) year sensitivity testing of the smoke detectors had been conducted on May 7, 2018. At the time of the test, three (3) of the smoke detectors in the south corridor failed and were replaced. No documentation could be produced to indicate sensitivity testing of the new smoke detectors was conducted at one year as required. Interview of the Maintenance Supervisor at approximately 11:15 AM, revealed the facility was not aware a sensitivity test was required for new smoke detectors at one year from installation.</p> <p>Actual NFPA standard:  NFPA 101 19.3.4 Detection, Alarm, and Communications Systems. 19.3.4.1 General. Health care occupancies shall be provided with a fire alarm system in accordance with Section 9.6. 9.6.1.3 A fire alarm system required for life safety shall be installed, tested, and maintained in</p>	K 345	<p>K 345</p> <p>The three smoke detectors were retested and found operational.</p> <p>The Maintenance Department reviewed the statutory requirement for understanding.</p> <p>The Maintenance Director will assure the Fire Alarm system checks are completed timely and review reports with the Executive Director for accuracy and full completion.</p> <p>The Maintenance Director will review any reports with QAPI over the next 3 months for recommendations for ongoing compliance.</p>	3/31/20	

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K 345	Continued From page 9 accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm and Signaling Code, unless it is an approved existing installation, which shall be permitted to be continued in use.  NFPA 72 14.4 Testing. 14.4.5.3.1 Sensitivity shall be checked within 1 year after installation. 14.4.5.3.2 Sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with 14.4.5.3.3. 14.4.5.3.3 After the second required calibration test, if sensitivity tests indicate that the device has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years.	K 345		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101  Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____	K 353		

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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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K 353	<p>Continued From page 10 c) Water system supply source</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure that fire suppression systems were maintained in accordance with NFPA 25. Failure to inspect suppression system components has the potential to hinder system performance during a fire event and/or render the facility not fully sprinklered after an activation or repair. This deficient practice affected 72 residents and staff on the dates of the survey.</p> <p>Findings include:</p> <p>During review of provided facility inspection and testing records on February 24, 2020, from approximately 9:00 AM to 3:00 PM, no documentation could be produced to indicate the dry sprinkler system gauge(s) were visually inspected weekly, or monthly visual inspections of the wet sprinkler system gauge(s) and control valves had been completed. Interview of the Maintenance Supervisor at approximately 1:00 PM, revealed the facility was not aware of the requirement to visually inspect gauges and control valves on the fire sprinkler system(s).</p> <p>Actual NFPA standard:</p> <p>NFPA 25</p> <p>5.2.4 Gauges. 5.2.4.1* Gauges on wet pipe sprinkler systems</p>	K 353	<p>K 353</p> <p>All gauges and control valves on the sprinkler system were visually inspected and found operational.</p> <p>The Maintenance Department reviewed the statutory requirement for understanding.</p> <p>A system to review and record the inspection has been developed for ongoing compliance.</p> <p>The Maintenance Director will submit a monthly report for 3 months to the QAPI committee for ongoing compliance.</p>	3/31/20.

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K 353	Continued From page 11 shall be inspected monthly to ensure that they are in good condition and that normal water supply pressure is being maintained. 5.2.4.2 Gauges on dry, preaction, and deluge systems shall be inspected weekly to ensure that normal air and water pressures are being maintained.  Chapter 13 Valves, Valve Components, and Trim 13.3.2 Inspection. 13.3.2.1 All valves shall be inspected weekly. 13.3.2.1.1 Valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly.	K 353		
K 511 SS=E	Utilities - Gas and Electric CFR(s): NFPA 101  Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2  This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure safe electrical installations in accordance with their listed assemblies and those requirements under NFPA 70. Failure to ensure proper electrical installations could result in electrocution or fire. This deficient practice affected 29 of 72	K 511		

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K 511	<p>Continued From page 12 residents and staff on the dates of the survey.</p> <p>Findings include:</p> <p>During the facility tour on February 24, 2020 from approximately 3:00 PM to 5:00 PM, observation of installed electrical systems revealed the following:</p> <p>1.) The staff break room was using a Relocatable Power Tap (RPT) to supply power to a full-sized refrigerator/freezer, and another RPT to power a toaster and coffee pot. A third RPT below the TV was suspended above the floor by the power cords plugged into it.</p> <p>2.) Room number 10 was using a multiple plug adapter and also had a refrigerator powered by a RPT.</p> <p>3.) The Director of Nursing's office had two RPTs connected in series (daisy-chained).</p> <p>Actual NFPA standard:</p> <p>NFPA 70</p> <p>110.2 Approval. The conductors and equipment required or permitted by this Code shall be acceptable only if approved.</p> <p>Informational Note: See 90.7, Examination of Equipment for Safety, and 110.3, Examination, Identification, Installation, and Use of Equipment. See definitions of Approved, Identified, Labeled, and Listed.</p> <p>110.3 Examination, Identification, Installation, and Use of Equipment.</p> <p>(A) Examination. In judging equipment, considerations such as the following shall be evaluated:</p> <p>(1) Suitability for installation and use in conformity</p>	K 511	<p>K 511</p> <p>Building was toured and all inappropriate power strip usage was corrected.</p> <p>Maintenance department reviewed statutory requirement and in serviced managers and front line staff on the appropriate use of power strips.</p> <p>Maintenance Department will conduct regular rounds to assure on a weekly basis to assure ongoing compliance.</p> <p>Maintenance Director will report to QAPI monthly for 3 months to assure ongoing and sustained compliance.</p>	3/31/20	

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K 511	Continued From page 13 with the provisions of this Code Informational Note: Suitability of equipment use may be identified by a description marked on or provided with a product to identify the suitability of the product for a specific purpose, environment, or application. Special conditions of use or other limitations and other pertinent information. Suitability of equipment may be evidenced by listing or labeling. (2) Mechanical strength and durability, including, for parts designed to enclose and protect other equipment, the adequacy of the protection thus provided (3) Wire-bending and connection space (4) Electrical insulation (5) Heating effects under normal conditions of use and also under abnormal conditions likely to arise in service (6) Arcing effects (7) Classification by type, size, voltage, current capacity, and specific use (8) Other factors that contribute to the practical safeguarding of persons using or likely to come in contact with the equipment (B) Installation and Use. Listed or labeled equipment shall be installed and used in accordance with any instructions included in the listing or labeling.	K 511			
K 918 SS=F	Electrical Systems - Essential Electric System CFR(s): NFPA 101  Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this	K 918			

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K 918	Continued From page 14 capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure the generator for the EES (Essential Electrical System) was maintained in accordance with NFPA 110. Failure to inspect and test EES generators could result in a lack of system reliability during a power loss. This deficient practice affected 72 residents and staff on the dates of the survey.  Findings include:	K 918	K 918  The generator service and load bank testing completed on 3/10/20.  The Maintenance Department will review the statutory requirement for understanding.  The Maintenance Director will schedule the test within the appropriate time frame.  The Maintenance Director will report monthly to the QAPI committee the status of required tests for ongoing compliance.	3/31/20	

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K 918	<p>Continued From page 15</p> <p>During review of the facility generator inspection and testing records on February 24, 2020, from approximately 9:00 AM to 3:00 PM, the facility failed to provide weekly generator inspection logs for the following time frames: July 7 - 20, 2019; July 28 - August 3, 2019; September 1 - 14, 2019; and all of August 2019. The facility was also missing a 30-minute load test for August 2019, annual maintenance/inspection (last known January 29, 2019) and the three-year, four-hour load test was due. (last known February 8, 2017). When asked, at approximately 12:15 PM, the Maintenance Supervisor stated there had been turnover of maintenance staff during this time frame and the facility was unaware the inspections and load tests were overlooked.</p> <p>Actual NFPA standard:</p> <p>NFPA 110 8.4 Operational Inspection and Testing. 8.4.1* EPSSs, including all appurtenant components, shall be inspected weekly and exercised under load at least monthly. 8.4.2* Diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS nameplate kW rating 8.4.9* Level 1 EPSS shall be tested at least once within every 36 months. 8.4.9.1 Level 1 EPSS shall be tested continuously for the duration of its assigned class (see Section 4.2).</p>	K 918		
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K 918	<p>Continued From page 16</p> <p>8.4.9.2 Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 continuous hours.</p> <p>8.4.9.3 The test shall be initiated by operating at least one transfer switch test function and then by operating the test function of all remaining ATSS, or initiated by opening all switches or breakers supplying normal power to all ATSS that are part of the EPSS being tested.</p> <p>8.4.9.4 A power interruption to non-EPSS loads shall not be required.</p> <p>8.4.9.5 The minimum load for this test shall be as specified in 8.4.9.5.1, 8.4.9.5.2, or 8.4.9.5.3.</p> <p>8.4.9.5.3 For spark-ignited EPSs, loading shall be the available EPSS load.</p> <p>8.4.9.6 The test required in 8.4.9 shall be permitted to be combined with one of the monthly tests required by 8.4.2 and one of the annual tests required by 8.4.2.3 as a single test.</p> <p>8.4.9.7 Where the test required in 8.4.9 is combined with the annual load bank test, the first 3 hours shall be at not less than the minimum loading required by 8.4.9.5 and the remaining hour shall be at not less than 75 percent of the nameplate kW rating of the EPS.</p>	K 918		
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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MDS001150	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  02/25/2020
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C 000	<p>INITIAL COMMENTS</p> <p>The facility is a single story, Type V (111) construction built in 1973. The facility has a complete automatic fire suppression and fire alarm system with smoke detection in the corridors and open areas. The Essential Electrical System (EES) is supplied by a natural gas powered, on-site automatic generator. The facility is currently licensed for 80 SNF/NF beds and had a census of 72 on the date of the survey.</p> <p>The following deficiency was cited during the annual Fire/Life Safety survey conducted on February 24 - 25, 2020. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70 and IDAPA 16.03.02, Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities.</p> <p>The survey was conducted by:</p> <p>Linda Chaney Health Facility Surveyor Facility Fire Safety and Construction</p>	C 000		
C 442	<p>02.120,12,b Prohibited Use of Personal Comfort Heating</p> <p>b. Portable comfort heating devices shall not be used. This Rule is not met as evidenced by: Based on observation, the facility failed to ensure portable heating devices, which are historically linked to facility fires, were not used as a supplemental heat source. Failure to ensure portable heaters are not used for supplemental heat, potentially increases the risk of facility fires from these devices. This deficient practice affected staff on the date of the survey.</p>	C 442		

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MDS001150	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  02/25/2020
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C 442	Continued From page 1  Findings include:  During the facility tour on February 24, 2020 from approximately 3:10 - 5:00 PM, observation of the Social Services office and Physical Therapy office, revealed each had a portable space heater in use.  Actual State IDAPA requirements:  16.03.02.120 120. EXISTING BUILDINGS. These standards shall be applied to all currently licensed health care facilities. Any minor alterations, repairs, and maintenance shall meet these standards. In the event of a change in ownership of a facility, the entire facility shall meet these standards prior to issuance of a new license. 12. Heating. A heating system shall be provided for the facility that is capable of maintaining a temperature of seventy-five degrees (75F) to eighty degrees (80F) Fahrenheit in all weather conditions. b. Portable comfort heating devices shall not be used.	C 442	C 442  The two unauthorized heating devices were immediately removed. The Maintenance Department completed facility rounds to assure no other devices were found.  The Maintenance Department has reviewed the statutory requirement and reviewed the requirement with the managers.  The Maintenance Department will complete regular rounds to assure ongoing compliance.  The Maintenance Director will report monthly for 3 months to the QAPI committee for ongoing compliance.	3/31/20



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

BRAD LITTLE -- Governor  
DAVE JEPPESEN -- Director

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

March 9, 2020

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

Provider #: 135053

**RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER**

Dear Ms. Martellucci:

On **February 25, 2020**, an Emergency Preparedness survey was conducted at **Ivy Court** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. Please provide **ONLY ONE** completion date for each federal and state tag in column (X5) Completion Date to signify when you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **March 23, 2020**. Failure to submit an acceptable PoC by **March 23, 2020**, may result in the imposition of civil monetary penalties by **April 13, 2020**.

Your PoC must contain the following:

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

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

Remedies may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **March 31, 2020**, (Opportunity to Correct). Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on . A change in the seriousness of the deficiencies on **April 23, 2020**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **March 31, 2020**, includes the following:

Denial of payment for new admissions effective **May 25, 2020**.  
42 CFR §488.417(a)

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **August 25, 2020**, if substantial compliance is not achieved by that time.

**Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.**

If you believe these deficiencies have been corrected, you may contact Nate Elkins, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, option 3; Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **February 25, 2020**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

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

BFS Letters (06/30/11)

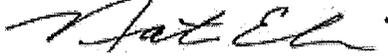
2001-10 Long Term Care Informal Dispute Resolution Process  
2001-10 IDR Request Form

Joan Martellucci, Administrator  
March 9, 2020  
Page 4 of 4

This request must be received by **March 23, 2020**. If your request for informal dispute resolution is received after **March 23, 2020**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



Nate Elkins, Supervisor  
Facility Fire Safety and Construction

NE/lj  
Enclosures

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

PRINTED: 03/06/2020  
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  02/25/2020
NAME OF PROVIDER OR SUPPLIER  IVY COURT			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 IRONWOOD PLACE COEUR D'ALENE, ID 83814		
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E 000	Initial Comments  The facility is a single story, Type V (111) construction built in 1973. The facility has a complete automatic fire suppression and fire alarm system with smoke detection in the corridors and open areas. The Essential Electrical System (EES) is supplied by a natural gas powered, on-site automatic generator. The facility is currently licensed for 80 SNF/NF beds and had a census of 72 on the dates of the survey.  The following deficiencies were cited during the annual Emergency Preparedness Survey conducted on February 24 - 25, 2020. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73.  The Survey was conducted by:  Linda Chaney Health Facility Surveyor Facility Fire Safety & Construction	E 000			
E 007 SS=F	EP Program Patient Population CFR(s): 483.73(a)(3)  [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:]  (3) Address [patient/client] population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.**	E 007			

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

TITLE

(X6) DATE

*Jan B. Martellus* Executive Director 3/23/20

Deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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 following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued participation.

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E 007	<p>Continued From page 1</p> <p>*[For LTC facilities at §483.73(a)(3):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually.</p> <p>(3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.</p> <p>*NOTE: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to provide current policies/procedures outlining services the facility has the ability to provide in an emergency, to include continuity of operations with staff succession planning. Failure to provide updated policies, procedures and succession plan, potentially hinders continuation of resident care during an emergency. This deficient practice affected 72 residents and staff on the dates of the survey.</p> <p>Findings include:</p> <p>On February 25, 2020, from approximately 7:00 AM to 8:30 AM, review of provided emergency preparedness policies and procedures revealed the facility had not addressed the types of _____ services it would have the ability to provide in an emergency, to include delegation of authority and succession planning. When asked, the Administrator and Maintenance Supervisor stated they were both fairly new to their positions and</p>	E 007	<p>E 007</p> <p>No specific resident is identified.</p> <p>All residents have the potential to be affected by the deficient practice.</p> <p>The facility will develop a policy and Procedure to address the types of services the facility would be able to provide in an emergency, to include continuity of staff and succession planning. Facility staff will be trained on the new policy and procedure.</p> <p>New policy and procedure will be Reviewed and approved by QAPI committee.</p>	3/31/20	

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E 007	Continued From page 2 were still working on updating the emergency preparedness plan.	E 007			
E 018 SS=F	Reference: 42 CFR 483.73 (a) (3) Procedures for Tracking of Staff and Patients CFR(s): 483.73(b)(2)  [[b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years (annually for LTC).] At a minimum, the policies and procedures must address the following:]  [(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location.  *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location.	E 018			

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E 018	<p>Continued From page 3</p> <p>*[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures.</p> <p>(ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance.</p> <p>(v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location.</p> <p>*[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.</p> <p>*[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records.</p> <p>*[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	E 018	<p>E 018</p> <p>No specific resident is identified.</p> <p>All residents have the potential to be affected by the deficient practice.</p> <p>Facility will develop policy and Procedure to utilize to track the location of on-duty staff and sheltered patients in the facility's care during an emergency. Facility staff will be trained in the process of the new policy and procedure.</p> <p>New policy and procedure will be reviewed and approved by the QAPI committee.</p>	3.31.20

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E 018	Continued From page 4 Based on record review and interview, it was determined the facility failed to provide a policy/procedure for tracking of staff and residents during an emergency, or if relocated, a policy for documentation of the receiving facility or other location for those relocated individuals. Lack of a tracking policy has the potential to hinder the facility's ability to provide care and continuation of services during an emergency. This deficient practice affected 72 residents and staff on the dates of the survey.  Findings include:  On February 25, 2020, from approximately 7:00 AM to 8:30 AM, review of provided records, policies and procedures failed to demonstrate the facility had in place a system to track the location of on-duty staff and residents during an emergency. When asked, the Administrator and Maintenance Supervisor stated they were both fairly new to their positions and were still working on updating the emergency preparedness plan.  Reference:  42 CFR 483.73 (b) (2)	E 018			
E 036 SS=F	EP Training and Testing CFR(s): 483.73(d)  *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must	E 036			

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E 036	Continued From page 5 develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years.  *[For LTC at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.  *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i).  *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must	E 036	E 036  No specific resident is identified.  All residents have the potential to be affected by the deficient practice.  Facility will develop a written training and testing policy and procedure and train management team on the new policy and procedure.  The new policy and procedure will be reviewed and approved by the QAPI committee.	3.31.20	

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E 036	<p>Continued From page 6</p> <p>develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, it was determined the facility failed to provide a policy/procedure for an emergency preparedness training and testing program. Lack of a training and testing program covering the emergency preparedness plan, has the potential to hinder staff knowledge and response during a disaster. This deficient practice affected 72 residents and staff on the dates of the survey.</p> <p>Findings include:</p> <p>On February 25, 2020, from approximately 7:00 AM to 8:30 AM, review of provided emergency policies/procedures, revealed the facility had not developed a written training and testing policy/procedure for their emergency preparedness plan. When asked, the Administrator and Maintenance Supervisor stated they were both fairly new to their positions and were still working on updating the emergency preparedness plan.</p> <p>Reference:</p> <p>42 CFR 483.73 (d)</p>	E 036			