



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE- Governor
DAVE JEPPESEN- Director

TAMARA PRISOCK—ADMINISTRATOR
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April 25, 2019

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

Provider #: 135053

Dear Ms. Martellucci:

On **April 18, 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 **March 18, 2019**. However, based on our on-site revisit we found that your facility is not in substantial compliance with the following participation requirements:

- F0000 -- S/S: -- -- Initial Comments**
- F0657 -- S/S: D -- 483.21(b)(2)(i)-(iii) -- Care Plan Timing And Revision**
- F0684 -- S/S: D -- 483.25 -- Quality Of Care**
- F0880 -- S/S: D -- 483.80(a)(1)(2)(4)(e)(f) -- Infection Prevention & Control**

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 **May 1, 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).

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' letters of **November 29, 2018** and **February 8, 2019**, following the survey of **November 9, 2018** and **January 10, 2019**, we have already made the recommendation to the Centers for Medicare and Medicaid Services (CMS) for imposition of 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 **April 18, 2019**, has resulted in a continuance of the remedy(ies) previously mentioned to you by the CMS. On **March 7, 2019**, CMS notified the facility of the intent to impose the following remedies:

- DPNA made on or after **March 22, 2019**

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 Laura Thompson, RN, or Belinda Day, RN, Supervisors LTC, Bureau of Facility Standards, 3232 Elder Street, Post Office

Joan Martellucci, Administrator
April 25, 2019
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Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 2; 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. The facility must allege to be in substantial compliance later than **May 4, 2019** to allow for a revisit to be completed before the termination date of **May 9, 2019**.

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

This request must be received by **May 5, 2019**. If your request for informal dispute resolution is received after **May 5, 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 Belinda Day, RN, or Laura Thompson, RN, Supervisors at (208)334-6626, option #2.

Sincerely,



Laura Thompson, RN, Supervisor
Long Term Care Program

lt/dr
Enclosures

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

PRINTED: 05/01/2019
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 04/18/2019
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}	INITIAL COMMENTS The following deficiencies were cited during the federal follow-up and complaint survey conducted at the facility from April 15, 2019 through April 18, 2019. The surveyors conducting the survey were: Cecilia Stockdill, RN, Team Coordinator Presie Billington, RN Monica Meister, QIDP, MEd DON = Director of Nursing LPN = Licensed Practical Nurse MRSA = Methicillin Resistant Staphylococcus Aureus RN = Registered Nurse	{F 000}			
{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. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (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	{F 657}		4/30/19	

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

TITLE

(X6) DATE

Electronically Signed

04/28/2019

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 657}	<p>Continued From page 1 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 observation, staff interview, policy review, and record review, it was determined the facility failed to ensure residents' care plans were revised as their needs changed. This was true for 2 of 12 residents (#228 and #231) whose care plans were reviewed. This failure created the potential for harm if care was not provided or decisions were made based on inaccurate information. Findings include:</p> <p>The facility's policy for Care Plans, undated, documented "The care plan must be reviewed and revised according to the RAI (Resident Assessment Instrument) process, and services provided or arranged must be consistent with each resident's written Care Plan." The policy documented the care plan was re-evaluated at prescribed intervals (quarterly, annually, or if there was a significant change in status) using the RAI process, and then the care plan was modified as appropriate and necessary.</p> <p>1. Resident #228 was readmitted to the facility on 10/23/17, with multiple diagnoses including Parkinson's disease, skin cancer of the scalp and neck, and flushing.</p> <p>a. Resident #228's physician orders documented</p>	{F 657}	<p>Resident #228 care plan has been updated to include MRSA, contact precautions, episodes of skin discoloration and related interventions for staff to follow. Resident #231 no longer resides in the facility.</p> <p>All other residents have the potential to be affected. A review of current resident care plans was completed to assure comprehensive status with any updates made as warranted.</p> <p>Education conducted regarding the comprehensive care plan with licensed nurses which include care plan timing, revision, and implementation.</p> <p>DNS/designee to review new orders and nursing communications daily (M-F) to assure care plan is updated accordingly. DNS/designee to conduct monthly audits of 10% of facility population, for 3 months to assure comprehensive status is maintained and report monthly o the QAPI Committee for ongoing review and compliance.</p>		

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{F 657}	<p>Continued From page 2 the following:</p> <p>* Orders on 4/3/19 for dermatitis (red, swollen skin). Bacterial culture performed, results pending. Apply Mupirocin (topical antibiotic) to scalp 2-3 times per day, and Keflex (antibiotic) 500 mg (milligrams) 3 times a day for 10 days.</p> <p>* Doxycycline (antibiotic) 100 mg twice a day for 10 days, ordered on 4/9/19.</p> <p>Resident #228's Progress Note, dated 4/11/19 at 5:05 PM, documented he was on an antibiotic for an MRSA (bacteria) infection in a wound to his head.</p> <p>A Progress Note, dated 4/13/19 at 2:30 AM, documented Resident #228 had no adverse side effects to the antibiotic, and MRSA precautions were in place.</p> <p>Resident #228's care plan did not include documentation he had MRSA, was being treated for the infection, or was on precautions for MRSA.</p> <p>On 4/15/19 at 2:54 PM, an isolation cart was outside of Resident #228's door, and a sign was posted on his door that stated contact precautions were needed. RN #1 said Resident #228 had a head wound with an MRSA infection, and contact precautions were needed.</p> <p>On 4/15/19 at 3:02 PM, Resident #228 said he had treatment for cancer on his scalp, and it became infected with MRSA. Resident #228 said staff were supposed to put cream on his scalp wound, and he was taking an antibiotic.</p>	{F 657}			

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{F 657}	<p>Continued From page 3</p> <p>On 4/17/19 at 10:00 AM, LPN #2 applied Mupirocin ointment to Resident #228's scalp using contact precautions which included wearing gloves and a gown.</p> <p>On 4/17/19 at 2:00 PM, RN #3 said Resident #228 had MRSA in a scalp wound that started as skin cancer. RN #3 said the MRSA infection was diagnosed on 4/9/19.</p> <p>On 4/17/19 at 3:00 PM, the DON said she did not see MRSA documented on Resident #228's care plan. She said there was a recent change in staff for the Resident Care Manager (RCM) of Resident #228's hall, and the RCM was "catching up" on updating residents' care plans.</p> <p>b. Resident #228's physician orders documented the following:</p> <ul style="list-style-type: none"> * Check fasting blood sugar and full vital signs if Resident #228 complained of sweats/flushing, and report the results to the physician, dated 2/14/19. * Check CBC (complete blood count), CMP (comprehensive metabolic panel), and TSH (thyroid stimulating hormone) for abnormal flushing and sweating, dated 2/21/19 . * Obtain full vital signs with each episode of flushing and a fasting blood sugar to rule out hypoglycemia (low blood sugar), dated 2/21/19. <p>Resident #228's care plan did not include documentation of his episodes of flushing or the interventions to be followed if he experienced</p>	{F 657}			

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{F 657}	<p>Continued From page 4 flushing, as ordered by his physician.</p> <p>On 4/16/19 at 10:17 AM, Resident #228 said he last had an episode of flushing a few days ago, and he did not remember if he told any staff.</p> <p>On 4/16/19 at 4:29 PM, RN #3 said she was aware Resident #228 had flushing episodes, and if he had one she checked his blood sugar and vital signs.</p> <p>On 4/17/19 at 3:00 PM, the DON said there was no documentation on Resident #228's care plan regarding his flushing episodes. The DON said it was best to look at the physician orders regarding Resident #228's flushing episodes and the directions to be followed if he experienced flushing.</p> <p>c. Resident #228's care plan, initiated on 9/25/17 and revised on 3/13/19, documented he had a history of a pressure ulcer to the right heel related to Parkinson's, fragile skin, and decreased mobility. Interventions included an intervention for him to wear protective boots to offload pressure during the day, dated 8/28/18.</p> <p>On 4/15/19 at 3:02 PM, Resident #228 was sitting in a wheelchair in his room and he was not wearing protective boots.</p> <p>On 4/16/19 at 10:17 AM, Resident #228 was sitting in his wheelchair in his room and he was not wearing protective boots. Resident #228 said he had not worn the boots for awhile and the pressure ulcer on his right heel was healed.</p> <p>On 4/17/19 at 3:00 PM, the DON said the</p>	{F 657}			

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{F 657}	Continued From page 5 interventions on Resident #228's care plan should have been updated. 2. Resident #231 was admitted to the facility on 6/17/14, with multiple diagnoses including hypertension (high blood pressure), repeated falls, and protein-calorie malnutrition. Resident #231's physician orders included knee high TED hose (compression stockings) every morning and remove at bedtime for edema (swelling), dated 12/31/18. There was also an order for Sage boots (boots that protect the heels from skin breakdown) while in bed every shift for fragile skin, dated 12/31/18. Resident #231's care plan did not include the TED hose or Sage boots. On 4/17/19 at 4:25 PM, the DON said she did not see TED hose or Sage boots on Resident #231's care plan. The DON said it could have been missed from the physician orders.	{F 657}			
{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 record review, resident interview, and	{F 684}	Resident #228 interviewed and he	4/30/19	

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{F 684}	<p>Continued From page 6</p> <p>staff interview, it was determined the facility failed to ensure adequately trained staff assisted a resident when transferring from his wheelchair. This was true for 1 of 12 residents (Resident #228) reviewed for professional standards of practice. This failure created the potential for harm should residents experience injury from inappropriate transfers. Findings include:</p> <p>Resident #228 was readmitted to the facility on 10/23/17, with multiple diagnoses including Parkinson's disease, muscle weakness, abnormalities of gait and mobility, and dementia.</p> <p>Resident #228's care plan documented he required assistance of one person for transfers.</p> <p>An Appointment and Transportation Request, dated 12/28/18, documented Resident #228 had an eye doctor appointment scheduled on 3/14/19 at 12:45 PM. There was no documentation in the request whether an attendant was needed for the appointment.</p> <p>An Incident and Accident (I and A) Summary, undated, documented Resident #228 complained of rib pain on 3/21/19 at 1:40 AM. Resident #228 said the rib pain was from an occurrence a couple of weeks earlier, when he was at an eye doctor appointment and was lifted up by the van driver "like a big bear and put in my chair and broke my rib." The summary did not document bruising or apparent trauma to the area, and an x-ray did not show a fractured rib. The I and A summary documented the eye doctor appointment was on 3/14/19, and the van driver described how he transferred Resident #228 during the appointment. The van driver reported</p>	{F 684}	<p>reports no negative outcomes from being assisted by the van driver and is comfortable with facility providing transportation.</p> <p>All other residents utilizing facility transportation are at risk. Facility policy updated to clarify that only properly trained employees will attend residents on appointments/outings managed by the facility. Properly trained employees are those trained by virtue of their certification or licensure.</p> <p>Training conducted with individuals responsible for managing/scheduling/staffing appointments that only properly trained employees will accompany residents on facility managed appointments and outings.</p> <p>HIM to review transports on a daily basis (M-F) to assure a properly trained employee is scheduled to accompany residents on facility managed appointments/outings. HIM will report monthly for 3 months to the QAPI Committee any issues, concerns or recommendations for ongoing compliance.</p>		

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{F 684}	<p>Continued From page 7</p> <p>he did not receive formal training on transfers. There were no other staff members present to assist Resident #228 during his eye doctor appointment.</p> <p>A statement signed by the van driver, dated 3/21/19, documented he accompanied Resident #228 to an eye doctor appointment on 3/14/19, and "Due to lack of staff/improper assigning I was sent with him instead of a CNA (Certified Nursing Assistant)." The eye doctor's clinic staff insisted Resident #228 needed to be transferred from his wheelchair into an examination chair, and the van driver assisted Resident #228 to transfer into the clinic's examination chair. The van driver placed his arms under Resident #228's arms and held him "in a hug type fashion" to help him transfer.</p> <p>The facility's Position Description for a Transportation Assistant (Van Driver), dated 7/1/15, documented "All employees of nursing homes may be required to provide lifting and transfer assistance to residents..." The Position Description was signed by the van driver.</p> <p>On 4/15/19 at 3:02 PM, Resident #228 said he had a couple of cracked ribs from when the van driver lifted him approximately four weeks ago. Resident #228 said a CNA was not available to go to his appointment with him, so the van driver lifted him and he did not know how to lift people.</p> <p>On 4/17/19 at 3:00 PM, the DON said Resident #228 was accompanied by the van driver to an appointment. The DON said in the past, it was not necessary to transfer residents during their appointment at this particular clinic. The DON</p>	{F 684}			

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{F 684}	Continued From page 8 said the van driver did not have training to transfer residents and he should not have done the transfer. The DON said usually when an appointment was scheduled it determined whether a CNA was needed to accompany the resident to the appointment, and she could not say if that was done in this case. The DON said the facility typically sent a CNA with the resident to an appointment if there was any indication a transfer was needed during the appointment. The DON said the facility did not anticipate Resident #228 needed to be transferred during the previously mentioned appointment. On 4/18/19 at 7:55 AM, the van driver said he accompanied Resident #228 to an eye doctor appointment because there were no CNAs available to go with him. The van driver said the staff at the eye doctor's office insisted Resident #228 needed to be transferred to their examination chair, and he knew it was not right for him to transfer Resident #228 but he wanted to help. The van driver said it was "pretty well known" a CNA should accompany residents to appointments, and that was the first time he transferred a resident. The van driver said he had since received "a little hands on training" from an employee in Social Services, who was also a CNA. The van driver said he had no other prior training in transferring residents.	{F 684}			
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the	F 880			4/30/19

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F 880	<p>Continued From page 9</p> <p>development and transmission of communicable diseases and infections.</p> <p>§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <ul style="list-style-type: none"> (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: <ul style="list-style-type: none"> (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the 	F 880			

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F 880	<p>Continued From page 10</p> <p>least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and staff interview, it was determined the facility failed to ensure appropriate infection control practices were followed. This was true for 2 of 12 residents (#27 and #226) observed for infection control practices, and had the potential to affect all residents in the facility. These failures created the potential for harm should residents acquire an infection from cross contamination. Findings include:</p> <p>The facility's policy for Hand Hygiene, undated, documented it was required for staff to perform hand hygiene using alcohol based hand rub</p>	F 880	<p>Resident #226 and #27 wounds were re-assessed without any negative changes as a result of the deficient practice.</p> <p>All other residents with wounds are at risk with this deficient practice.</p> <p>Licensed Nurses educated by the DSN/ICN on professional standards of practice, including but not limited to, infection prevention, wound care, dressing changes, glove use, and hand hygiene.</p>		

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F 880	<p>Continued From page 11</p> <p>before having direct contact with residents, after contact with a resident's intact skin, after contact with body fluids or excretions, mucous membranes, non-intact skin and wound dressings, after contact with inanimate objects (including medical equipment), and after removing gloves.</p> <p>The facility's policy for MRSA (a bacteria that is resistant to some common antibiotics), undated, documented use of non-critical items (items that come into contact with skin but not mucous membranes) was dedicated to a single resident. Staff were directed to wear gloves when caring for a resident who has MRSA when providing direct care to the resident, when expecting to contact the source of the infection, and when handling potentially contaminated items. Staff were directed to change gloves after contact with material that may contain MRSA.</p> <p>1. Resident #226 was admitted to the facility on 11/2/13, with multiple diagnoses including peripheral vascular disease (a disease that causes restricted blood flow to the extremities or other body parts) and atherosclerosis (a narrowing of the arteries due to plaque build-up) of the arteries of the right leg with ulceration (an open sore) of the calf.</p> <p>Resident #226's care plan documented she had an infection in her right leg related to stasis ulcers (ulcers caused by poor circulation) and there was MRSA in the wound. Contact precautions were initiated on 6/20/18 related to MRSA in the wound.</p> <p>On 4/15/19 at 3:25 PM, Resident #226 was</p>	F 880	<p>DNS/designee will conduct weekly audit/observations for 12 weeks then monthly of Licensed Staff performing wound care/dressing changes to assure on-going compliance and report findings to the QAPI committee monthly for ongoing compliance.</p>		

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F 880	<p>Continued From page 12</p> <p>sitting in the hallway in her wheelchair near her room. Her right lower leg was wrapped in a brown/tan bandage material. An isolation cart was in the hall outside Resident #226's door, and a sign was posted on the door directing visitors to check at the nurse's station before entering the room. RN #1 said Resident #226 had MRSA in her right leg, and it was contained by the bandage material on her leg.</p> <p>On 4/16/19 beginning at 1:30 PM, RN #2 was observed changing the dressing on Resident #226's right lower leg. RN #2 removed two brown wrap bandages from Resident #226's right lower leg and placed them on a paper towel on the floor. RN #2 removed her gloves, did not perform hand hygiene, applied new gloves, then removed white gauze wrap and dressings from Resident #226's right lower leg. RN #2 removed Resident #226's shoe, then removed her gloves and did not perform hand hygiene before applying new gloves. She opened packages of new dressing material, cut a piece of new dressing material, and applied the dressing to an open wound on Resident #226's shin area.</p> <p>RN #2 removed her gloves, did not perform hand hygiene, applied new gloves, and cut additional pieces of dressing material, and applied dressings to two separate open wounds on Resident #226's right lower leg. RN #2 opened a roll of gauze wrap, removed her gloves, did not perform hand hygiene, applied new gloves, and applied the gauze wrap to Resident #226's right lower leg. RN #2 applied a second roll of gauze wrap to Resident #226's right lower leg, opened another roll of gauze wrap, removed her gloves, did not perform hand hygiene, applied new</p>	F 880			

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F 880	<p>Continued From page 13</p> <p>gloves, cut a piece of dressing material and applied it to Resident #226's ankle area, and applied more gauze wrap.</p> <p>RN #2 opened another roll of gauze wrap and applied it to Resident #226's right lower leg. RN #2 picked up a roll of the brown bandage material from the paper towel on the floor and applied it to Resident #226's right lower leg. RN #2 said she was going to throw out the other roll of brown/tan bandage material that was on the paper towel on the floor because it was wet.</p> <p>RN #2 discarded the brown bandage material, picked up the scissors from the overbed table in a paper towel, and placed it on a ledge over the sink in Resident #226's room. There was an orange, a small bottle of baby power, and a small bottle of deodorant on the ledge over the sink next to where the bandage scissors were sitting in the paper towel. RN #2 removed her gown and gloves, washed her hands, and left Resident #226's room.</p> <p>On 4/16/19 at 2:15 PM, RN #2 said Resident #226 had MRSA in her right leg wound. RN #2 said she should wash her hands before starting a procedure and after the procedure. When asked about performing hand hygiene after removing gloves, RN #2 said she did not know about that. RN #2 said she did not perform hand hygiene between changing gloves while performing the dressing change for Resident #226. A pair of scissors were wrapped in a tissue on the medication cart in the South hall across from Resident #226's room. RN #2 said the scissors on the medication cart were the ones used during Resident #226's dressing change. When asked</p>	F 880			

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

PRINTED: 05/01/2019
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OMB NO. 0938-0391

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F 880	<p>Continued From page 14</p> <p>about the scissors, RN #2 said she cleaned them with a Sani Cloth (a disinfectant wipe) and she should probably clean them some more and put them away. RN #2 then picked up the scissors, walked with them to the isolation cart outside Resident #226's room, obtained a Sani Cloth from the isolation cart and cleaned the scissors without wearing gloves, placed the scissors in a Sani Cloth, returned to the medication cart and laid the scissors, wrapped in a Sani Cloth, on top of the medication cart. RN #2 did not perform hand hygiene after cleaning the scissors. She then prepared medications at the medication cart by crushing them and placing them in applesauce. RN #2 administered oral medications in applesauce to Resident #235.</p> <p>RN #2 changed her gloves five times during the observation, and did not perform hand hygiene after removing her gloves.</p> <p>On 4/16/19 at 3:00 PM, RN #3 said Resident #226 had MRSA in her leg wound. RN #3 said the brown/tan bandage material should not be placed on the floor, and the scissors used during the dressing change should not be placed on the ledge over the sink in Resident #226's room. RN #3 said hand hygiene should be performed prior to applying gloves and anytime gloves were removed. RN #3 said each resident on transmission based precautions should have their own supplies which should not leave their room.</p> <p>On 4/16/19 at 3:37 PM, the DON said hand hygiene should be performed between dirty to clean glove changes. The DON said equipment, including scissors, should be only used for that</p>	F 880			

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F 880	<p>Continued From page 15</p> <p>particular resident who is on precautions for MRSA, and the scissors should be dedicated to that room and not brought out to the medication cart.</p> <p>2. Resident #27 was admitted to the facility on 9/6/18, with multiple diagnoses including Type 2 diabetes mellitus, stroke, urinary tract infection, dementia, and difficulty walking.</p> <p>Resident #27's care plan documented he had pressure ulcers of the left heel related to decreased mobility and fragile skin, initiated on 11/30/18 and revised on 2/20/19.</p> <p>On 4/17/19 at 10:03 AM, LPN #1 performed wound care to Resident #27's left heel pressure ulcer. LPN #1 performed hand hygiene, applied clean gloves, and removed Resident #27's sock and the dressing from his left heel. LPN #2 took a gauze soaked in normal saline and wiped Resident #37's wound using the same gloves she used to remove Resident #37's socks and soiled dressing. LPN #2 then removed her gloves and applied new gloves without performing hand hygiene. LPN #2 applied Cellerate gel (a type of dressing containing material to accelerate wound healing) to Resident #37's wound, covered the area with a new dressing, and wrote the date on the dressing.</p> <p>On 4/17/19 at 4:15 PM, LPN #2 said hand hygiene should be performed in between residents' care, and before and after changing gloves. LPN #2 said she did not perform hand hygiene in between changing her gloves when she performed wound care to Resident #37.</p>	F 880			

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 04/18/2019
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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>A follow-up to the state licensure survey was conducted on 04/18/19, and the facility was found to be in compliance with state regulatory requirements.</p> <p>Cecilia Stockdill, RN, Team Coordinator Presie Billington, RN Monica Meister, QIDP</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 04/28/19
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IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
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July 24, 2019

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

Provider #: 135053

Dear Ms. Martellucci:

On **April 18, 2019**, an unannounced on-site complaint survey was conducted at Ivy Court. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00008043

ALLEGATION #1:

The facility was not providing laboratory services to meet resident needs.

FINDINGS #1:

An unannounced complaint investigation was conducted from 4/15/19 - 4/18/19. During the investigation, resident records were reviewed, and interviews were conducted with residents.

Thirteen residents' records were reviewed. One resident's record was reviewed for Physician Orders and did not include orders to provide or obtain laboratory values.

However, one resident's record documented the resident was admitted to the facility on 12/2018 and required skilled nursing services from recent rectal cancer resection and diverting ileostomy. The resident's admitting Physician Orders included Potassium Chloride (a metal halide salt composed of potassium and chlorine) 20 meq (milliequivalent is used to express the concentration or strength of certain pharmaceutical products) twice a day with meals.

A Progress Note documented the resident had an appointment with his oncologist and shortly after the appointment, the oncologist called the facility and reported the resident had a critically high potassium level and to discontinue the ordered Potassium Chloride. The Progress Note documented the oncologist ordered the resident be immediately sent to the local emergency room and the resident was transported to the hospital via an ambulance. The Progress Note also documented the resident had no signs or symptoms of distress and no complaint of nausea, vomiting, or pain prior to sending the resident to the hospital.

A subsequent Progress Note documented the resident was going to return home after the resident was released from the hospital and already had a planned discharge date from the facility. The Progress Note documented the resident's physician reported the resident may return to the facility if the home was not safe due to the resident's health concerns.

During the complaint investigation, four residents agreed to be interviewed and were asked about the services provided to them. All the residents stated they had no concerns and were pleased with the facility's services.

Based on the investigative findings, the allegation was unsubstantiated and no deficient practice was identified.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The facility did not ensure each resident was offered sufficient fluid intake to maintain proper hydration and health.

FINDINGS #2:

During the investigation, observations and interviews were conducted, and resident records were

Joan Martellucci, Administrator
July 24, 2019
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reviewed.

Observations were conducted in the facility from 4/15/19 - 4/17/19. During the observations, Certified Nursing Assistants (CNAs) were noted to consistently deliver ice water to resident rooms and during meal observations, residents were offered apple, orange, mango, and cranberry juices, water, coffee, tea, and hot cocoa.

Thirteen residents' records were selected for review and no concerns related to hydration needs were identified.

Four residents agreed to be interviewed and were asked about their hydration needs and the facility's response to meet those needs. All the residents stated they had no concerns and were pleased with the facility's services. One resident stated pitchers of ice water were delivered to resident rooms at least three times a day.

Based on the investigative findings, the allegation was unsubstantiated and no deficient practice was identified.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The facility did not ensure each resident was provided with a nourishing, palatable, well-balanced diet that met his or her daily nutritional and special dietary needs.

FINDINGS #3:

During the investigation, observations and interviews were conducted, and resident records were reviewed.

One breakfast and two lunch meal observations were conducted in the facility from 4/15/19 - 4/17/19. The food was noted to be nourishing, palatable and well balanced. The lunch menu for 4/15/19 was Beef Tips Au Jus, noodles, sliced zucchini, a roll, and baked apples. The alternative meal was pork roast, garlic buttered rice, and mixed vegetables. Residents were also offered apple, orange, mango, and cranberry juices, water, coffee, tea, and hot cocoa.

During the meal observations, residents were noted to be served their choice of meal items and were

observed to be assisted as needed. Two residents required food to be mechanically altered (i.e., pureed food and thickened liquids) to meet their dietary needs and they were assisted by one-to-one staff to eat. During the 4/15/19 lunch observation, a resident stated he was not hungry and did not want to eat lunch. Staff were noted to offer him several alternative food items to which he declined. During the 4/16/19 lunch observation, a resident stated he preferred a grilled cheese sandwich and staff were noted to obtain the sandwich for him in a timely manner.

The facility also had an Always Available menu, undated, which was posted next to the daily menu and documented food items were always available if menu or alternative menu food items were not desired. The Always Available menu listed the following foods: grilled cheese sandwich and soup of the day, cheeseburger and fries, chef salad, deli sandwich and side salad, peanut butter and jelly sandwich with chips, egg salad sandwich with chips, pizza and salad, and cold cereal and yogurt.

Thirteen residents' records were selected for review and no concerns related to nutritional and special dietary needs were identified.

Four residents were interviewed and were asked about their nutritional and special dietary needs and the facility's response to meet those needs. All the residents stated they had no concerns and were pleased with the facility's services.

Based on the investigative findings, the allegation was unsubstantiated and no deficient practice was identified.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The facility did not ensure each resident had the right to choose activities and schedules (including sleeping and waking times) consistent with his or her interests.

FINDINGS #4:

During the investigation, observations and interviews were conducted, and 13 resident records were reviewed.

Observations were conducted in the facility from 4/15/19 - 4/17/19. Residents were observed to be offered activities and schedules, including sleeping and waking times, consistent with their interests. No concerns related to activities and schedules were noted.

Joan Martellucci, Administrator
July 24, 2019
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Thirteen residents' records were selected for review and no concerns related to choosing activities and schedules, including sleeping and waking times, consistent with his or her interests were identified.

Four residents were interviewed and were asked about their activities and schedules and the facility's response to choices. All the residents stated they had no concerns and their choices were honored by the facility.

Based on the investigative findings, the allegation was unsubstantiated and no deficient practice was identified.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

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



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July 24, 2019

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

Provider #: 135053

Dear Ms. Martellucci:

On **April 18, 2019**, an unannounced on-site complaint survey was conducted at Ivy Court. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00008053

ALLEGATION #1:

The facility is not assuring each resident receives care to prevent pressure ulcers.

FINDINGS #1:

An unannounced on-site complaint investigation was conducted from 4/15/19 - 4/18/19. During that time, resident records were reviewed and interviews were conducted with the following results:

Observations were conducted in the facility from 4/15/19 - 4/17/19. During that time, residents were observed to be repositioned and pressure relieving devices were noted to be present and in use, based on their needs. Concerns related to receiving care to prevent pressure ulcers were not noted.

Thirteen residents' records were selected for review. Two of the 13 residents' records documented history of pressure ulcers and both records documented appropriate care and treatment to aid healing and resolution.

During the complaint investigation, four residents agreed to be interviewed and were asked about appropriate care and treatment. All the residents stated they had no concerns and were pleased with the facility's services.

It could not be determined the facility was not assuring each resident received care to prevent pressure ulcers. Therefore, the allegation was unsubstantiated due to lack of sufficient evidence and no deficient practice was identified.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The facility is not assuring each resident receives food prepared in a form designed to meet individual needs.

FINDINGS #2:

One breakfast and two lunch meal observations were conducted in the facility from 4/15/19 - 4/17/19. During the meal observations, residents were noted to be served their choice of meal items and were observed to be assisted as needed. For example, two residents required food to be mechanically altered (i.e., pureed food and thickened liquids) to meet their dietary needs and they were assisted by one-to-one staff to eat.

Thirteen residents' records were selected for review and no concerns related to nutritional and special dietary needs were identified.

During the complaint investigation, four residents agreed to be interviewed and were asked about their nutritional and special dietary needs and the facility's response to meet those needs. All the residents stated they had no concerns and were pleased with the facility's services.

It could not be determined the facility was not assuring residents received food prepared in a form designed to meet individual needs. Therefore, the allegation was unsubstantiated due to lack of

Joan Martellucci, Administrator
July 24, 2019
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sufficient evidence and no deficient practice was identified.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The facility is not assuring each resident has the right to choose activities and schedules (including sleeping and waking times) consistent with his or her interests.

FINDINGS #3:

Observations were conducted in the facility from 4/15/19 - 4/17/19. Residents were observed to be offered activities and schedules, including sleeping and waking times, consistent with their interests. No concerns related to activities and schedules were noted.

Thirteen residents' records were selected for review and no concerns related to choosing activities and schedules, including sleeping and waking times, consistent with his or her interests were identified.

During the complaint investigation, four residents agreed to be interviewed and were asked about their activities and schedules and the facility's response to making choices. All the residents stated they had no concerns and their choices were honored by the facility.

It could not be determined the facility was not assuring each resident had the right to choose activities and schedules consistent with his or her interests. Therefore, the allegation was unsubstantiated due to lack of sufficient evidence and no deficient practice was identified.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The facility is not providing a sanitary and comfortable environment for residents, staff, and the public.

FINDINGS #4:

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Observations were conducted in the facility from 4/15/19 - 4/17/19. The facility was observed to be clean and comfortable and no concerns were identified.

Four residents agreed to be interviewed and were asked about the facility's environment. All the residents stated they had no concerns and were pleased with the facility's services.

It could not be determined the facility was not assuring a sanitary and comfortable environment for residents, staff, and the public. Therefore, the allegation was unsubstantiated due to lack of sufficient evidence and no deficient practice was identified.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

The facility does not have sufficient nursing staff to provide nursing and related services to each resident, as determined by resident assessments and individual plans of care.

FINDINGS #5:

Observations were conducted in the facility from 4/15/19 - 4/17/19. Sufficient nursing staff were observed to be present and provide nursing and related services to each resident. No concerns with sufficient nursing staff were identified.

Four residents agreed to be interviewed and were asked about sufficient nursing staff. All the residents stated they had no concerns and were pleased with the facility's services.

Nine Certified Nursing Assistants (CNAs), who worked various shifts, were asked about sufficient numbers of nursing staff. All staff reported there were sufficient numbers of staff to meet the residents' needs.

Thirteen residents' records were selected for review and no concerns related to sufficient nursing staff were identified.

It could not be determined the facility did not have sufficient nursing staff to provide nursing and related services to each resident. Therefore, the allegation was unsubstantiated due to lack of sufficient evidence and no deficient practice was identified.

Joan Martellucci, Administrator
July 24, 2019
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CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

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,

A handwritten signature in black ink, appearing to read "Belinda Day".

BELINDA DAY, RN, Supervisor
Long Term Care Program

BD/slj



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
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August 29, 2019

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

Provider #: 135053

Dear Ms. Martellucci:

On **April 18, 2019**, an unannounced on-site complaint survey was conducted at Ivy Court. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00008080

ALLEGATION #1:

The facility does not have sufficient nursing staff to provide nursing and related services to each resident in a timely manner.

FINDINGS #1:

During the survey, observations were conducted, resident records were reviewed, and resident and staff were interviewed. The facility's nursing schedule and daily assignments were reviewed. Grievances and Incident and Accident reports were also reviewed.

Call light response times were observed throughout the survey, including day shift, evening shift, and night shift. Residents were observed receiving assistance from staff members throughout the survey on each shift. Call lights were answered within an acceptable period of time, often within five minutes or less.

The three week nursing schedule and actual hours worked documented the facility provided a sufficient number of staff to meet the needs of the residents. The residents were appropriately groomed, dressed, and assisted with activities of daily living in a timely manner during observations. Residents were also assisted with dining as needed at meals and were appropriately assisted to bed at night.

Staff members said they were able to complete their tasks and meet the residents' needs during their shift. Residents stated they received the care and assistance they needed.

Based on the investigative findings, the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The facility is not maintaining appropriate infection control practices.

FINDINGS #2:

During the survey, observations were conducted, facility policies were reviewed and staff were interviewed.

Three residents on contact precautions were observed as staff provided care to them, including wound care. Dressing changes were observed for two residents, including one resident who was on contact precautions. The laundry facilities and procedures were observed for appropriate infection control practices.

During observation of a dressing change for a resident who was on contact precautions, a nurse did not perform appropriate hand hygiene after removing her gloves during the dressing change and did not ensure a piece of equipment that was used during the resident's dressing change was dedicated only to that resident per the facility's policies. The nurse also did not wear gloves while disinfecting the scissors used during the dressing change, then she did not perform hand hygiene and immediately prepared and administered medications to another resident.

During a dressing change for another resident, a nurse did not perform hand hygiene after removing her gloves during the dressing change.

Both nurses were interviewed after the observations and both stated they should have performed hand hygiene after removing their gloves.

Joan Martellucci, Administrator
August 29, 2019
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Based on the investigative findings, the allegation was substantiated and the facility was cited at F880 as it related to the facility's failure to ensure appropriate infection control practices were followed.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #3:

The facility did not provide care in a manner that maintained residents' dignity.

FINDINGS #3:

During the survey, residents were observed for dignity, the nursing schedule and daily assignments were reviewed, Grievances and Incident and Accident reports were reviewed, and staff and residents were interviewed.

Call light response times were observed throughout the survey, including day shift, evening shift, and night shift. Residents were observed receiving assistance from staff members throughout the survey on each shift. Residents were observed receiving assistance with toileting and having their catheter bags and urinals emptied.

One resident was interviewed and said staff members emptied his urinal in a timely manner. He said he did not recall a time when his urinal was full and left sitting near his bed. He said he had no issues or concerns with being assisted with toileting or his personal needs. Upon multiple observations, the resident's urinal was empty or was promptly emptied by staff after he used it.

There were no concerns expressed or observed by other residents regarding staff not assisting them with their toileting needs in a timely manner to preserve their dignity.

Based on the investigative findings, the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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.

Joan Martellucci, Administrator
August 29, 2019
Page 4 of 4

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,

A handwritten signature in cursive script, appearing to read "Laura Thompson".

Laura Thompson, RN, Supervisor
Long Term Care Program

LT/lj



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
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October 25, 2019

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

Provider #: 135053

Dear Ms. Martellucci:

On **April 14, 2019** through **April 18, 2019**, an unannounced on-site complaint and follow up survey was conducted at Ivy Court. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00008073

ALLEGATION #1:

The facility failed to provide sufficient staff to meet the residents' needs.

FINDINGS #1:

During the investigation 12 residents were observed and their records were reviewed for Quality of Care. The Three-Week Nursing Schedule and Daily Staff Assignment Sheets and Incidents and Accidents reports were reviewed. Call light response times were observed. Residents and staff on different shifts were interviewed.

The facility's Three-Week Nursing Schedule dated 3/24/19 through 4/13/19, and the Daily Staffing Assignment sheets were reviewed and there were no concerns noted.

In an interview, the Staffing Coordinator said the facility hired a patient companion for one resident who needed 1:1 supervision. The Staffing Coordinator also stated she has not received any complaints from residents or staff about not having sufficient staff to care for residents.

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October 25, 2019
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The Director of Nursing (DON) said during an interview if someone called off, they would ask another off duty staff member to fill in. She also stated there were Unit Managers on call who would also fill in if needed. The DON said the facility utilized their float pool staff and she also covered if needed.

Certified Nursing Assistants (CNA) and Licensed Nurses who worked at different shifts were interviewed and said they were able to meet the residents' needs.

Residents were interviewed at various times during the survey and there were no concerns voiced regarding the number of staff working in the facility. Residents said their needs were being met by the staff.

Based on the investigative findings, the allegation could not be substantiated.

CONCLUSION:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The facility did not provide shower/baths and oral care to the residents.

FINDINGS #2:

Resident records were reviewed, observations made, and residents, resident representatives, and staff were interviewed.

Twelve residents' records were reviewed for showers and other activities of daily living, and there were no concerns noted.

Eleven residents were interviewed and said their showers were being done as scheduled. Residents who needed assistance with their oral care said they had no concern with the quality of care they received from the facility.

A resident's representative was interviewed and said she had no concerns with the facility's care of her resident.

Residents were observed appropriately groomed and dressed. There were no unpleasant odors noted in the facility.

Certified Nursing Assistants and Licensed Nurses on different shifts were interviewed and said they were able to meet residents' needs.

Based on the investigative findings, the allegation could not be substantiated.

CONCLUSION:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

Staff were asked to falsify residents' shower records.

FINDINGS #3:

During the investigation, Daily Shower records of 12 residents' were reviewed and there were no concerns noted.

A CNA said if she was unable to provide a shower to a resident during her shift due to the resident's refusal or other reasons, such as having an appointment, she would pass it on to the next shift. If the next shift was unable to provide a shower due to a resident's refusal, then it would be reported to the nurse. The CNA said she would not document anything on the shower record. The CNA also stated the facility recently had a training regarding resident shower documentation and they were directed to refer the resident to the nurse when the resident continuously refused their shower.

A Licensed Nurse said resident shower/bath refusals were documented in the residents' nursing notes.

The DON said the CNAs were educated to inform the nurse of a resident's refusal and the nurse should document in their nurse's notes. The DON said she received a report every morning of residents who did not have their shower/baths the previous day and she made sure residents' showers were rescheduled according to resident preferences. The DON also said the facility holds morning meetings daily to discuss any concerns related to a resident.

Based on investigative findings, the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The facility failed to respond to call lights. Call lights take more than 30 minutes to be answered.

FINDINGS #4:

Joan Martellucci, Administrator
October 25, 2019
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During the investigation call light response time was observed on all shifts (day, evening and night).

Staff were observed answering call lights in a timely manner and there was no concern noted.

The Resident Council Minutes dated 3/5/19, 3/12/19, 3/19/19 and 3/26/19 were reviewed, and there were no concerns with call light response time noted.

Residents were interviewed at different times and there were no concerns voiced regarding delayed call light response time.

Based on investigative findings, the allegation could not be substantiated.

CONCLUSION:

Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

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

Sincerely,



Belinda Day, RN, Supervisor
Long Term Care Program

BD/lj