

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
Western Division of Survey and Certification  
Seattle Regional Office  
701 Fifth Avenue, Suite 1600  
Seattle, WA 98104



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

May 21, 2019

Re: CMS Certification Number: 135053  
Back in Compliance

Dear Administrator:

In our letter dated March 7, 2019, we advised you that a mandatory three month denial of new admissions was effective March 22, 2019. Findings from the January 10, 2019; April 18, 2019; May 9, 2019, revisit survey by a survey team from the Bureau Of Facility Standards (State survey agency) indicate that Ivy Court is now in substantial compliance with federal requirements for nursing homes participating in the Medicare and/or Medicaid programs, as of April 30, 2019.

Based on these findings, please recall the denial of payments for new admissions against Ivy Court is from March 7, 2019 through April 29, 2019 at midnight. You may contact me by telephone at (206) 615-2313 or by e-mail to [CMS\\_RO10\\_CEB@cms.hhs.gov](mailto:CMS_RO10_CEB@cms.hhs.gov). Attention: Ivy Court.

Sincerely,

Certification & Enforcement Branch  
Centers for Medicare & Medicaid Services

cc: Bureau Of Facility Standards

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

PRINTED: 05/31/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135053</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/09/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>IVY COURT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2200 IRONWOOD PLACE</b> <b>COEUR D'ALENE, ID 83814</b>		
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{F 000}	<p><b>INITIAL COMMENTS</b></p> <p>No deficiencies were cited during the federal follow-up conducted at the facility from May 7, 2019 through May 9, 2019.</p> <p>The surveyors conducting the survey were: Cecilia Stockdill, RN, Team Coordinator Teresa Kobza, RDN, LD Kate Johnsrud, RN</p>	{F 000}			

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

TITLE

(X6) DATE

Electronically Signed

05/21/2019

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.



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

BRAD LITTLE- Governor  
DAVE JEPPESEN- Director

TAMARA PRISOCK—ADMINISTRATOR  
LICENSING & CERTIFICATION  
DEBBY RANSOM, R.N., R.H.I.T – Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P. O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: (208) 334-6626  
FAX: (208) 364-1888  
E-mail: [fsb@dhw.idaho.gov](mailto:fsb@dhw.idaho.gov)

May 23, 2019

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

Provider #: 135053

Dear Ms. Martellucci:

On **May 9, 2019**, a survey was conducted at Ivy Court by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3.) **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 **June 3, 2019**. Failure to submit an acceptable PoC by **June 3, 2019**, may result in the imposition of civil monetary penalties by

**June 25, 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; and
- Include dates when corrective action will be completed in column (X5).

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

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

We are recommending that Centers for Medicare & Medicaid Services (CMS) Region X impose the following remedy(ies):

- **Denial of payment for new admissions effective as soon as notice requirements can be met.**
- **A civil money penalty**

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **November 9, 2019**, if substantial compliance is not achieved by that time. **Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, CMS will provide you with a separate formal notification of that determination.**

Joan Martellucci, Administrator  
May 23, 2019  
Page 3

If you believe these deficiencies have been corrected, you may contact Laura Thompson, RN or Belinda Day, RN, Supervisors LTC, Bureau of Facility Standards, 3232 Elder Street, Post Office 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. 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.

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

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

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

- BFS Letters (06/30/11)

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

This request must be received by **June 3, 2019**. If your request for informal dispute resolution is received after **June 3, 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, Long Term Care Program 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

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OMB NO. 0938-0391

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F 000	INITIAL COMMENTS  The following deficiencies were cited during a complaint investigation conducted at the facility from May 7, 2019 through May 9, 2019.  The surveyors conducting the survey were: Cecilia Stockdill, RN, Team Coordinator Teresa Kobza, RDN, LD Kate Johnsrud, RN  Survey Abbreviations:  ADL = Activities of daily Living BID = Twice a day cm = centimeters CNA = Certified Nursing Assistant D/C = Discontinue DON = Director of Nursing LPN = Licensed Practical Nurse MAR = Medication Administration Record MDS = Minimum Data Set mg = milligram RCM = Resident Care Manager RN = Registered Nurse TID = Three times a day	F 000			
F 580 SS=G	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15)  §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical,	F 580			6/3/19

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

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(X6) DATE

Electronically Signed

05/28/2019

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F 580	<p>Continued From page 1</p> <p>mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);</p> <p>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or</p> <p>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).</p> <p>(ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.</p> <p>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-</p> <p>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or</p> <p>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.</p> <p>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).</p> <p>§483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).</p>	F 580			

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F 580	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff and physician interview, policy review, review of Incident and Accident Reports, and record review, it was determined the facility failed to ensure the physician was notified in a timely manner of a resident's accident which resulted in a leg injury. This was true for 1 of 8 residents (Resident #239) whose records were reviewed. This failed practice resulted in a lack of information being provided to the physician on which to base treatment decisions, causing harm to Resident #239 due to a 9 day delay in sufficient treatment for a leg injury/fracture. Findings include:</p> <p>Resident #239 was admitted to the facility on 11/29/16, with diagnoses which included repeat falls, muscle weakness, dementia without behavioral issues, right knee replacement, and osteoporosis (disease effecting the structure and strength of bones and may cause them to break more easily) without pathological fractures.</p> <p>A quarterly MDS assessment, dated 2/18/19, documented Resident #239 had a severe cognitive impairment and sometimes understood others and was understood. The MDS assessment documented Resident #239 required extensive assistance of two staff members with bed mobility, transfers, dressing, and hygiene. The MDS documented she was dependent on two staff members for bathing and toileting. The MDS documented Resident #239 experienced one fall without injury since the prior assessment.</p> <p>A Nurse's Progress Note, dated 4/16/19 at 4:34 PM, documented Resident #239's son reported a</p>	F 580	<p>Resident no longer at the facility.</p> <p>Residents residing in the facility have the potential to be affected by this deficient practice. The past 14 days of incident reports and 24 hour reports were reviewed to ensure timely physician notification and identify potential changes in condition warranting physician notification.</p> <p>Daily monitoring of the 24 hour report, risk management, clinical dashboard, and missed medication reports will occur to identify resident changes that need to be reported to the MD and to ensure timely notification.</p> <p>Nurses have been educated to facilities policy/procedure on accidents/incidents including, but not limited to, timely physician notification and ensuring physician is provided comprehensive information on resident's status.</p> <p>Audits of the 24 hour report, risk management, clinical dashboard and missed medication report will done by the DNS/RCM's daily Monday thru Friday x 12 weeks to ensure compliance. Findings will be reviewed by QAPI monthly for 3 months for further educational opportunities. DON/Designee is responsible for compliance.</p>		

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F 580	<p>Continued From page 3</p> <p>possible injury that occurred on 4/7/19 while he was with Resident #239. The note documented Resident #239's son reported the injury on 4/7/19 to the floor nurse. The note documented Resident #239's right lower extremity was dragging on the ground and bent backwards under her wheelchair. The note documented Resident #239 cried out, "Ouch!" at the time of the incident.</p> <p>The Facility's Accidents and Incidents: Report, Investigate, Review and Analysis policy, dated February 2018, defined an accident as "Any unexpected or unintentional incident that resulted in injury or illness." The policy documented steps to be taken which included the following:</p> <ul style="list-style-type: none"> <li>* "Instruct staff, resident/resident representative, family, visitor, etc. to report immediately, without fear of reprisal, any accident/incident."</li> <li>* "Complete an electronic accident/incident report." The policy stated the electronic accident/incident report was to be initiated "...immediately upon identification of an accident/incident ..."</li> </ul> <p>A 4/7/19 accident/incident report could not be found which should have documented Resident #239's right leg injury. There was no documentation found the physician was notified of the injury.</p> <p>On 5/8/19 at 9:47 AM, RN #1 stated she first learned about the possible injury during a care conference with Resident #239's son and daughter on 4/16/19. RN #1 stated during the care conference, Resident #239's son stated on</p>	F 580			

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F 580	<p>Continued From page 4</p> <p>4/7/19 when he assisted his mother by pushing her wheelchair, her right leg was dragging on the ground and was caught twisted or bent backwards under her wheelchair. RN #1 stated Resident #239's son stated he heard a loud popping sound and Resident #239 cried out, "Ouch!". RN #1 stated Resident #239's son reported the injury to LPN #3 when he brought Resident #239 back to the facility on 4/7/19. RN #1 stated LPN #3, who was notified on 4/7/19 by the son, should have notified the physician.</p> <p>The facility's February 2018 Accidents and Incidents: Report, Investigate, Review and Analysis policy did not include information related to floor staff reporting directly to the physician. The procedure stated, "Report all accident/incidents to the Executive Director." The policy stated injuries involving a medical device were to be immediately reported to the Executive Director and allegations of abuse, neglect, mistreatment, injuries of unknown source, and misappropriation were to be immediately reported to the Executive Director and the DON/designee. Timeframes for reporting other types of accidents and incidents was not included in the policy.</p> <p>The facility failed to ensure policies and procedures were developed, implemented, and monitored necessary to ensure Resident #239's accident and resulting right leg injury, which had the potential to require physician intervention, was immediately reported to the physician.</p> <p>On 5/8/19 at 11:20 AM, the DON and the Administrator stated Resident #239's son reported an injury to LPN #3 on 4/7/19 and she</p>	F 580			

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F 580	<p>Continued From page 5</p> <p>(LPN #3) assessed the injury and felt it was not far from Resident #239's baseline. The Administrator stated Resident #239 normally had swelling to her right knee from a history of MRSA (Methicillin-resistant Staphylococcus aureus - a bacterial infection) and a knee replacement. The DON stated the facility received a phone call on 4/9/19 from Resident #239's daughter requesting additional pain medications and to ensure the facility knew about the swelling to her right knee.</p> <p>A faxed Physician Notification, dated 4/9/19 at 7:00 PM, documented Resident #239's daughter called and was worried about Resident #239's knee pain. "With recent weight loss her knee brace does [not] (sic) fit anymore." The fax documented the daughter made an appointment with an orthopedic physician for a new brace. The fax documented Resident #239's daughter was worried about increased pain and if Resident #239's scheduled Tylenol could be increased from twice a day to three times a day "just temporarily until she gets a new brace?" The Physician Notification did not include information related to the accident and resulting right leg injury reported by Resident #239's son on 4/7/19.</p> <p>A handwritten note on the top of the 4/9/19 Physician Notification stated "4/10/19 Forward to [physician's name] to address." A handwritten note at the bottom of the form documented "Tylenol 500 mg po TID (D/C current Tylenol BID)."</p> <p>On 5/9/19 at 11:46 AM, the physician stated she received a notification by fax from the facility regarding Resident #239's pain issue and need for additional medications. She stated the facility</p>	F 580			

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F 580	<p>Continued From page 6</p> <p>may have sent it on 4/9/19. However, when the information was faxed she likely did not see the notification right away. The physician stated she received multiple faxes on a daily basis. The physician stated if the fax was documented with her signature on 4/11/19 she most likely did not receive the fax right away. The physician stated she did not recall receiving another notification regarding what happened to Resident #239's right leg. She stated she may have received another fax and it was easiest to call her to get a hold of her immediately.</p> <p>The facility failed to ensure the physician was provided with complete information on which to base treatment decisions and the physician was contacted in a manner which allowed for more timely care to be provided.</p> <p>A Nurse's Progress Note, dated 4/11/19 at 8:23 PM, documented Resident #239's daughter called the facility to see if LPN #4 knew about Resident #239's swollen right leg. The note documented LPN #4 did not know about the injury and she was going to assess Resident #239's leg. The note documented Resident #239's right knee "appears 2x [two times] larger than the other knee." The note documented an ice pack was placed and helped decrease the swelling. The note documented another staff member was aware of the injury to Resident #239's right knee when it was reported by Resident #239's son on Sunday (4/7/19), that her right knee "might" have bent too far back and was stuck under her wheelchair. The note documented Resident #239's son spoke with the evening shift nurse about the injury on 4/7/19. The note documented the physician was notified</p>	F 580			

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F 580	<p>Continued From page 7 about the knee swelling.</p> <p>A faxed Physician Notification, dated 4/11/19 at 9:24 PM, documented Resident #239's right knee was swollen with no signs and symptoms of pain. The fax documented ice was applied to her knee which was effective in decreasing the swelling. The fax documented "...after speaking with staff and residents [sic] son it appeared that her swelling was due to a transfer on Sunday [4/7/19] by her son when she was out with him ..." The fax documented Resident #239 was placed on alert charting and staff were going to monitor her for pain and swelling in her right knee.</p> <p>The notification to the physician did not include complete information regarding Resident #239's leg being caught under her wheelchair and bending too far back as documented in the 4/11/19 Nurse's Progress Note.</p> <p>During an interview with the DON and the Administrator, on 5/8/19 at 11:20 AM, the DON stated after the physician's notification note and the previous note written by LPN #4 on 4/11/19 were read to her, the notes did not contain the same information regarding the incident.</p> <p>The facility failed to ensure the physician was provided with complete information on which to base treatment decisions.</p> <p>The physician responded to the faxed notification on 4/12/19 at an unknown time. The physician documented agreement with the actions that the LPN had taken and documented "Elevate as much as possible. Notify MD if not improving." The facility noted the order on 4/12/19 and input</p>	F 580			

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F 580	<p>Continued From page 8</p> <p>the order on 4/13/19. Resident #239's Physician Orders included instructions to notify the physician if the swelling to her right knee worsens, ice the knee as needed during meal times, and elevate the right leg as much as possible, ordered 4/13/19.</p> <p>Nursing Progress Notes, dated 4/12/19 at 1:56 AM and at 11:25 PM, 4/13/19 at 11:43 PM, 4/15/19 at 2:50 PM, and 4/16/19 at 2:05 AM, documented Resident #239's right knee was swollen. There was no documentation the physician was notified of the continued swelling to the right knee on 4/13/19 and 4/15/19.</p> <p>An Incident and Accident report, dated 4/16/19 at 3:26 PM and revised on 4/21/19 at 9:21 PM, documented the physician was notified of Resident #239's injury at 4:00 PM on 4/16/19, 9 days after the injury occurred.</p> <p>On 5/8/19 at 9:47 AM, RN #1 stated when she first learned about the possible injury during a care conference with Resident #239's son and daughter on 4/16/19, she immediately evaluated Resident #239's right knee and found a large 36 cm by 9 cm yellow faded bruise extending from her right upper thigh to the lower portion of her shin and she notified the physician of what happened.</p> <p>On 4/17/19, an x-ray order was received and a subsequent Radiology Report, dated 4/17/19, documented there was an acute fracture to Resident #239's right distal femur (thigh bone).</p> <p>The facility failed to ensure the physician was provided with timely, comprehensive information</p>	F 580			

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F 580	Continued From page 9 regarding the circumstances under which Resident #239's right leg injury occurred. This failed practice resulted in a lack of information being provided to the physician on which to base treatment decisions for a period of 9 days.	F 580			
F 684 SS=G	<p>Quality of Care CFR(s): 483.25</p> <p>§ 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 staff interview, record review, review of Incident and Accident Reports, and policy review, it was determined the facility failed to ensure professional standards of nursing practice were followed for 1 of 4 residents (Resident #239) who was reviewed for nursing standards of practice. The failed practice resulted in harm to Resident #239 when she sustained a femur (thigh bone) fracture, resulting in increased swelling and pain, which was not recognized and treated for 9 days. Findings include:</p> <p>The facility's Accidents and Incidents: Report, Investigate, Review and Analysis policy, dated February 2018, defined an accident as any unexpected or unintentional incident that resulted in injury. The procedure outlined the following steps when an incident occurred:</p>	F 684	<p>Resident #239 no longer resides at the facility.</p> <p>Residents residing in the facility have the potential to be affected by this deficient practice. The past 14 days of incident reports and 24 hour reports were reviewed to ensure timely physician notification and to identify potential changes in condition warranting physician notification.</p> <p>Daily monitoring of the 24 hour report, risk management, clinical dashboard and the missed medication report to review for any accident or incident that needs to be reported, investigated or placed on alert charting for continued documentation. Licensed nurses have been in-serviced</p>	6/3/19	

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F 684	<p>Continued From page 10</p> <ul style="list-style-type: none"> <li>* Staff, residents, residents' families, and visitors report any accidents/incidents immediately.</li> <li>* Facility staff were to complete an electronic incident and accident report.</li> <li>* Protect the resident from further harm.</li> <li>* Staff were to complete a physical assessment related to the incident.</li> <li>* Staff were to initiate an Incident and Accident Report immediately upon knowledge of the incident to include falls, skin issues, alleged abuse, and injuries of unknown origin.</li> <li>* Staff were to complete, review, and submit the Incident and Accident Report.</li> <li>* Staff were to report the incident and accident to the Administrator.</li> <li>* Staff were to document in the resident's chart for 72 hours following the incident and accident (alert charting).</li> </ul> <p>This policy was not followed.</p> <p>Resident #239 was admitted to the facility on 11/29/16, with diagnoses which included repeat falls, muscle weakness, dementia without behavioral issues, right knee replacement, and osteoporosis (disease effecting the structure and strength of bones and may cause them to break more easily) without pathological fractures.</p> <p>Resident #239's care plan included areas for limited physical mobility related to osteoarthritis, revised on 9/13/17, and acute pain, revised on 8/28/18. Interventions for her limited physical mobility included the assistance of two staff and monitoring/documentation/reporting to the physician, as needed, signs and symptoms of immobility and fall related injury. Interventions for acute pain included to complete a pain</p>	F 684	<p>by the DNS on the policy for reporting accidents and incidents, initiating accident and incident reports, documenting in the resident's chart, and protecting residents from further harm. Nurses educated on professional standards of nursing practice including resident assessment timely and effective communication to the physician.</p> <p>Audits of the 24 hour report, risk management, clinical dashboard and the missed medication report will be done by the DNS/RCM's daily Monday- Friday x 12 weeks to ensure compliance. Findings will be reviewed at QAPI monthly for 3 months for further educational opportunities. DNS/designee is responsible for compliance.</p>		

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F 684	<p>Continued From page 11</p> <p>assessment for new complaints of pain, upon changes in condition, and as needed. The ADL section of the care plan initiated 11/10/17 and revised on 2/11/19, instructed staff to use a mechanical aid, "Sit to Stand" and 2 staff for transfers.</p> <p>A physician visit report, dated 1/24/19, stated Resident #239 was non-verbal and it was difficult to interpret her response to questions asked by the physician. The physician documented Resident #239 " ...shakes her head side to side to all answers." A subsequent physician visit report, dated 3/21/19, stated Resident #239 was non-verbal and had minimal interactions.</p> <p>A quarterly MDS assessment, dated 2/18/19, documented Resident #239 had severe cognitive impairment and sometimes understood others and was sometimes understood, and her speech was unclear with slurred or mumbled words. The MDS assessment documented Resident #239 required extensive assistance of two staff with bed mobility, transfers, dressing, and hygiene. The MDS also documented she was dependent on two staff for bathing and toileting. The MDS documented Resident #239 experienced one fall without injury since the prior assessment.</p> <p>A Physical Therapy Evaluation and Plan of Treatment, dated 2/6/19, documented Resident #239's was referred to physical therapy for a fall from her wheelchair when bending to pick up an item. The short-term goal was to demonstrate an improved sitting position in her wheelchair to reduce fall risk and allow for improved functional mobility. The long-term goal was for Resident #239 to maintain an upright position with a</p>	F 684			

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F 684	<p>Continued From page 12</p> <p>wedge seat in the wheelchair allowing her to tolerate being in the wheelchair for long periods and perform short distances of self-propulsion without an increased risk for falling.</p> <p>A Physical Therapy progress note, dated 3/21/19, documented Resident #239 demonstrated improved postural alignment with a new Vicair cushion (a cushion which provides support and pressure distribution) which was modified to simulate a wedge cushion, with fewer air pockets in the back and more in the front. The progress note documented Resident #239 was able to self-propel for short distances using her legs.</p> <p>Resident #239's Physical Therapy Discharge Summary, dated 3/26/19, documented she could move her wheelchair using both legs. The discharge recommendations requested staff to continue to monitor Resident #239's alignment with her new wheelchair cushion.</p> <p>Progress notes for Resident #239 included documentation she experienced an injury to her leg involving her wheelchair on 4/7/19. The progress notes were documented as follows:</p> <p>A Nurse's Progress Note signed by LPN #4, dated 4/11/19 at 8:23 PM, stated Resident #239's daughter called and asked if nursing staff were aware of her swollen leg. LPN #4 documented she told Resident #239's daughter nursing staff did not know about the swelling to her leg and she was going to assess her. LPN #4 documented Resident #239's right knee had swelling and appeared " ...2x larger then [sic] the other knee." LPN #4 documented she placed an ice pack on the right knee. LPN #4 documented</p>	F 684			

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F 684	<p>Continued From page 13</p> <p>other staff were aware of the swelling to Resident #239's right knee because it was reported on Sunday 4/7/19, 4 days earlier. LPN #4 documented she contacted Resident #239's son via phone and he informed her on Sunday, 4/7/19, he was attempting to transfer Resident #239 and " ...her knee might have got bent to [sic] far and got stuck under her w/c [wheelchair]." Resident #239's son told LPN #4 he had talked to the nurse on the evening shift on 4/7/19, about her knee. LPN #4 documented she was going to let the physician know about the swelling to the right knee and the DON was notified.</p> <p>Resident #239's record did not include a progress note from nursing staff regarding the conversation with her son on 4/7/19. There was no documentation in Resident #239's Nurse's Progress Notes from 4/7/19 through 4/10/19 related to assessment and monitoring of Resident #239's pain level or knee following a reported injury on 4/7/19. The family asked on 4/11/19, if staff were aware of the resident 239's right knee injury with increased swelling and pain. The documented response on 4/11/19 at 8:23 PM in a nursing progress note was no. The care plan instructed staff to assess pain using the Wong Baker pain scale. The scale shows a series of faces ranging from a happy face at 0, or "no hurt", to a crying face at 10, which represents "hurts like the worst pain imaginable". This scale requires the resident to select the face which best represent the level of pain they are experiencing. The quarterly MDS dated 2/18/19, documented Resident #239 had severe cognitive impairment and sometimes understood others and was sometimes understood, and her speech</p>	F 684			

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F 684	<p>Continued From page 14</p> <p>was unclear with slurred or mumbled words. Additionally, the physician visit report, dated 1/24/19, stated Resident #239 was non-verbal and it was difficult to interpret her response to questions asked by the physician. The physician documented Resident #239 "...shakes her head side to side to all answers." There was no documentation of Resident #239's pain level using the Wong Baker pain scale faces, in the progress notes or TAR, or other documentation describing how staff determined Resident #239, with increased swelling due to a leg injury, was or was not in pain.</p> <p>Subsequent Nurse's Progress Notes documented Resident #239's right knee was swollen on 4/12/19 at 1:56 AM and 11:25 PM, 4/13/19 at 11:43 PM, and 4/16/19 at 2:05 AM. There was no documentation in the progress notes, dated 4/12/19 to 4/15/19, a physician was notified of the continued swelling to Resident #239's right knee.</p> <p>A Nurse's Progress Note signed by RN #1, dated 4/16/19 at 4:34 PM, documented Resident #239's son reported a possible injury that occurred on 4/7/19, while he was helping her. The note stated per Resident #239's son her right foot was dragging on the ground and bent backwards under her wheelchair. The note documented Resident #239's son stated she cried out "Ouch!" at the time of the incident. RN #1 documented she assisted Resident #239 into bed to have her adult brief changed and RN #1 assessed her right knee due to the recent swelling and notification of the incident that day. RN #1 documented Resident #239 had swelling to her right knee and "Tenderness noted upon</p>	F 684			

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F 684	<p>Continued From page 15</p> <p>movement of right leg." The note also documented Resident #239's right leg had a yellow, faded bruise extending from her right upper thigh to the lower portion of her shin and the bruise was approximately 36 cm by 9 cm (14.5 inches by 3.5 inches).</p> <p>Resident #239's record did not include documentation of a bruise to her right leg prior to the 4/16/19 Nurse's Progress Note.</p> <p>Resident #239's record included Physician Notifications, which were faxed on 4/9/19 and 4/11/19, and written as follows:</p> <ul style="list-style-type: none"> <li>- A Physician Notification, dated 4/9/19 at 7:00 PM, documented Resident #239's daughter called and was worried about her knee pain. The fax documented Resident #239's daughter made an appointment with an orthopedic physician for a new brace because she believed the current one did not fit well anymore. The fax documented Resident #239's daughter requested her scheduled Tylenol be increased from twice a day to three times a day. The physician responded on 4/11/19, two days later, to the request and included an order to increase Tylenol to 500 mg three times a day. There were no Nurse's Progress Notes in Resident #239's record which included documentation of the phone call from her daughter or the contact with the physician about knee pain.</li> <li>- A Physician Notification, dated 4/11/19 at 9:24 PM, stated Resident #239 had swelling to her right knee with no signs and symptoms of pain. The fax stated ice was applied to her knee and the knee was elevated in her wheelchair, which</li> </ul>	F 684			

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F 684	<p>Continued From page 16</p> <p>was effective in decreasing the swelling. The fax stated Resident #239's son reported the swelling "...was due to a transfer on Sunday [4/7/19] by her son when she was out with him." The fax stated Resident #239 was placed on alert charting to monitor for pain and swelling and to "Please advise." The notification to the physician did not include a description from the son that Resident #239's leg was caught under her wheelchair and was bent back. The physician responded to the faxed notification the following day on 4/12/19, which documented "Agree [with] above" and to elevate the right knee as much as possible, and to notify the physician if the knee was not improving.</p> <p>A care conference was held 9 days after facility staff were notified by family of the potential injury to Resident #239's right leg. The Care Conference Note, dated 4/16/19 at 3:30 PM, documented Resident #239, her children, a social service assistant, and RN #1 were in attendance. The note stated topics discussed were Resident #239's plan of care, recent medication/order changes, upcoming appointments, and recent weights. The note stated the family reported at the conference Resident #239's "...leg getting caught under her wheelchair while son was assisting her around building two weekends previous." The Care Conference Note stated RN #1 was going to request an x-ray for the right knee prior to her orthopedic appointment which was scheduled on 5/6/19.</p> <p>Resident #239's ADL reports for 3/1/19 through 4/17/19, documented her skin was assessed by CNAs every shift. The CNAs were to document</p>	F 684			

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F 684	<p>Continued From page 17</p> <p>"yes" if the resident had new skin impairments or "no" if new skin impairments were not identified. Resident #239's ADL reports documented "no" for all shifts from 3/1/19 through 4/17/19. Resident #239's 36 cm by 9 cm bruise to her right leg was identified by nursing staff on 4/16/19. The CNA's documentation of no new skin impairments was inconsistent with the discovery of the bruise on her right leg on 4/16/19.</p> <p>A verbal Physician Order, dated 4/17/19 at 12:57 PM, documented the facility requested a stat (urgent/rush) x-ray for Resident #239's right thigh, right knee, and right shin. A Nurse's Progress Note, dated 4/17/19 at 4:00 PM, documented Resident #239 was awaiting a stat mobile x-ray of her right leg, 3 hours after the stat order was received. At 9:17 PM on 4/17/19, a Nurse's Progress Note stated a physician order was received to send Resident #239 to the local emergency department for evaluation and treatment of a right femur fracture. Resident #239 was transported via ambulance to the hospital and was accompanied by her son.</p> <p>A Radiology Report signed by a radiologist on 4/17/19 at 7:11 PM, documented Resident #239 had a fracture to her right femur. The x-ray was ordered and completed 10 days following the initial report of the incident by Resident #239's son to facility staff on 4/7/19.</p> <p>The incident with Resident #239's right leg was not documented in an Incident and Accident Report prior to 4/16/19, 9 days after her son informed facility nursing staff of the injury.</p>	F 684			

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F 684	<p>Continued From page 18</p> <p>An Incident and Accident Report, dated 4/16/19 at 3:26 PM, documented during the care conference Resident #239's son stated on 4/7/19, her right foot dragged on the ground and bent backwards while he was pushing her wheelchair. The report documented Resident #239 said, "Ouch!" at the time of the incident. The report documented a faded yellow bruise which measured 36 cm by 9 cm was identified on Resident #239's right leg. The Incident and Accident Report stated the physician was called and informed about the incident and the bruise and monitoring of the bruise was started and added to the TAR, adjustable foot and leg rests were placed on Resident #239's wheelchair, and her care plan was updated.</p> <p>A follow-up note on the Incident and Accident Report, dated 4/19/19, documented on 4/17/19 an order was received for a stat x-ray of Resident #239's right thigh, knee, and shin. The note stated the x-ray showed a fracture of the right femur and the physician was notified of Resident #239's fractured femur and she was transferred to the hospital for further evaluation and treatment. The follow-up note further documented Resident #239 was transferred from the local hospital to another hospital out of state for further treatment of the fractured femur.</p> <p>A subsequent follow-up note to the Incident and Accident report, dated 4/21/19, documented LPN #3, who received the injury report from the son on 4/7/19, stated she assessed Resident #239 on that day and her right leg appeared swollen but not different from its normal appearance. The report documented Resident #239 had a right knee arthroplasty (knee replacement) and utilized</p>	F 684			

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F 684	<p>Continued From page 19</p> <p>a knee brace constantly. The report documented Resident #239's right knee brace was loose fitting due to weight loss and nursing staff did not believe the swelling to the right knee was due to an injury but related to the brace not fitting properly. The report documented Resident #239 did not appear to have increased pain and she was successfully medicated for pain.</p> <p>The Incident and Accident Report, dated 4/16/19 at 3:26 PM, included a section for witness statements. This section included statements from Resident #239's son, LPN #3, CNA #6, CNA #7, and CNA #8. The statements from staff were documented as follows:</p> <ul style="list-style-type: none"> <li>- CNA #6 stated "The bruise first showed up on 04/08/19, the day after the incident with her son."</li> <li>- LPN #3 stated Resident #239's son told her that he either bumped her leg, or her leg did not lift while he was pushing her in the wheelchair and Resident #239 yelled out "Ouch" when it happened. LPN #3 stated she looked at the right knee and there was swelling but no warmth, redness, or bruising and Resident #239 did not complain of pain.</li> <li>- CNA #7 stated "During the time resident was having knee swelling she did not seem to be having any pain during transfers. She seemed like her normal self."</li> <li>- CNA #8 stated "When resident had her knee swelling, she did seem like she was in more pain. We reported this to the nurse when she complained of pain."</li> </ul> <p>On 5/8/19 at 8:48 AM, CNA #1 stated approximately three weeks prior to Resident #239 leaving the facility she recalled Resident</p>	F 684			

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F 684	<p>Continued From page 20</p> <p>#239's leg was dragging on the ground more and she required a foot rest on her wheelchair at times.</p> <p>On 5/8/19 at 9:14 AM, CNA #3 stated she filled out a witness statement for Resident #239's injury a week after she was discharged from the facility. CNA #3 stated she did not have many contacts with Resident #239 and did not know how she fractured her leg.</p> <p>On 5/8/19 at 9:29 AM, LPN #1 stated she was not working when Resident #239's injury was first reported by the son. LPN #1 stated it was reported to her the son heard a loud popping sound and Resident #239 cried out, "Ouch!" LPN #1 stated she was monitoring the swelling, utilizing ice packs, and elevating her leg to assist with decreasing the swelling. LPN #1 stated she began monitoring the bruise prior to Resident #239 leaving the facility and a fractured femur was discovered. LPN #1 stated she did not recall Resident #239 appearing to be in more pain. LPN #1 stated the daughter asked for increased pain medications for Resident #239's knee.</p> <p>On 5/8/19 beginning at 9:47 AM, RN #1 stated she first learned about the possible injury during a care conference with the son and daughter on 4/16/19. RN #1 stated during the care conference the son stated on 4/7/19, when he assisted his mother by pushing her wheelchair, her right leg was dragging on the ground and was caught twisted or bent backwards under her wheelchair. RN #1 stated the son stated he heard a loud popping sound and Resident #239 cried out, "Ouch!". RN #1 stated the son reported the injury to LPN #3 when he brought Resident #239 back</p>	F 684			

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F 684	<p>Continued From page 21</p> <p>to the facility the same day. RN #1 stated, on 4/16/19, she immediately evaluated Resident #239's right knee and found a large 36 cm by 9 cm yellow faded bruise extending from her right upper thigh to her shin. RN #1 stated Resident #239's knee was swollen as well. RN #1 stated she called the physician to obtain an x-ray of the right leg. RN #1 stated she was unsure when the bruise was sustained and the bruise "came out of nowhere" on either 4/16/19 or 4/17/19. RN #1 stated a faded bruise was indicative of an older injury and she was unsure how the staff did not identify the bruise sooner than 4/16/19, and why staff documented there were no skin impairments on the skin assessments.</p> <p>During the same interview RN #1 stated she then initiated an Incident and Accident investigation on 4/16/19, and through the findings she stated LPN #3, who evaluated Resident #239's leg on 4/7/19, did not note any bruising or increased pain. LPN #3 did note swelling to her right knee with the brace in place. RN #1 stated LPN # 3 did not complete an incident report, initiate alert charting, or notify the RCM, the DON, or the physician. RN #1 stated the family called the facility a couple of times to discuss the increased pain and swelling to the right knee. RN #1 stated after one of the phone calls, on 4/11/19, Resident #239 was placed on alert charting for the injury. RN #1 stated LPN #4 did not initiate an incident report on 4/11/19. RN #1 stated the nurses on 4/7/19 and 4/11/19 both should have initiated an investigation into Resident #239's leg injury.</p> <p>RN #1 stated she obtained four staff members witness statements about the incident that occurred with Resident #239 on 4/7/19,</p>	F 684			

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F 684	<p>Continued From page 22</p> <p>beginning on 4/16/19 and ending on 4/21/19. RN #1 stated she obtained these interviews per direction from the DON. RN #1 stated on 4/25/19, the facility was notified by a hospital that Resident #239 had a fractured humerus (long bone in the upper arm) in addition to the femur fracture. RN #1 stated when the facility was notified of the humerus fracture, she then obtained witness statements from 54 staff members in the building regarding the incident on 4/7/19.</p> <p>Answers to the Witness Statements documented one staff member heard Resident #239 fell prior to discharge from the facility, two staff members identified a bruise on her right leg, four staff members documented concerns with increased pain, one staff member identified an issue with transferring Resident #239, eight staff members heard about an incident involving the family and her right leg, and one staff member documented an increased need for assistance with dressing and transfers.</p> <p>A Witness Statement, dated 4/24/19, documented CNA #6 who identified the bruise on 4/8/19, documented he did not recall the exact date he saw the bruise to her right leg. The statement documented Resident #239's right leg had slight discoloration directly at the swelling sight and at the knee on 4/8/19, and the large bruise down her thigh and shin did not appear until closer to 4/15/19.</p> <p>A Witness Statement, dated 5/3/19, from CNA #5 who provided a shower to Resident #239 on 4/7/19, following the outing with her son, documented the son stated Resident #239's leg</p>	F 684			

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F 684	<p>Continued From page 23</p> <p>was caught "deep under" her wheelchair. The statement documented the son reported Resident #239's right leg needed to be assessed and CNA #5 stated "I could tell something was very wrong. Her leg looked broken or dislocated at the knee." CNA #5 stated she informed LPN #3 right away asking for her to look at Resident #239 in the shower room. The statement documented when CNA #5 and another CNA later laid Resident #239 down in bed her leg did not lay flat on the bed. CNA #5 stated she asked LPN #3 to assess Resident #239's right leg again, which she did.</p> <p>An untitled document, dated 5/4/19, documented an unknown staff member met with CNA #5 to discuss Resident #239's incident on 4/7/19. The document stated CNA #5 related what happened to Resident #239's leg from speaking with the son and she alerted LPN #3 twice of an issue with Resident #239's leg. The document stated LPN #3 assessed Resident #239 both times. The document stated CNA #5 did not complete a Stop and Watch (A report used to identify concerns for residents) or document the concerns on her shower sheet. The document stated CNA #5 thought LPN #3 would address the concerns in her notes.</p> <p>On 5/8/19 at 11:20 AM, the DON and the Administrator stated Resident #239's son reported an injury to LPN #3 on 4/7/19, and she assessed the injury and felt it was not far from Resident #239's baseline status. The DON stated the facility received a phone call on 4/9/19, from Resident #239's daughter requesting additional pain medications and to ensure the facility knew about the swelling to her right knee. The DON</p>	F 684			

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F 684	<p>Continued From page 24</p> <p>stated on 4/11/19, the daughter called again to ensure the staff were aware of Resident #239's right knee injury. The Administrator stated Resident #239 normally had swelling to her right knee from a history of MRSA (Methicillin-resistant Staphylococcus aureus - a bacterial infection) and a knee replacement. The DON stated the facility educated LPN #3, the nurse Resident #239's son the reported the injury to on 4/7/19. The education included the need to complete an investigation, write a brief note, and place the resident on alert charting for injury monitoring. The DON stated she was not aware the physician was provided minimal information regarding what happened to Resident #239's right leg as reported by her son. The DON stated she was unaware how staff could not see a large bruise on her right leg when completing skin assessments every shift between 4/7/19 through 4/17/19. The DON stated she was not made aware of the extent of the injury to Resident #239's right leg until 4/16/19. The DON stated on 4/11/19, LPN #4 told her Resident #239's right leg brace was "ill fitting" and the family had made an appointment to address the concern. After the physician notification fax and the progress note written by LPN #4 were read to the DON, she stated they did not include the same information. The DON stated based on LPN #4's progress note she would have completed an Incident and Accident Report and an investigation. The DON stated the facility had a process to identify concerns that need investigation through a daily review of all residents' alert charting notes. The DON stated this process was not completed.</p> <p>On 5/8/19 at 3:40 PM, the DON and the Administrator stated through examination of</p>	F 684			

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F 684	<p>Continued From page 25</p> <p>Resident #239's first investigation into the injury, the facility identified a lack of thoroughness. The DON stated RN #1 was new to her position and was learning the correct procedures.</p> <p>On 5/9/19 at 11:46 AM, the physician stated she received a notification by fax from the facility regarding Resident #239's pain issue and need for additional medications. She stated the facility may have sent it on 4/9/19. However, when the information was faxed she likely did not see the notification right away. The physician stated she received multiple faxes on a daily basis. The physician stated if the fax was documented with her signature on 4/11/19 she most likely did not receive the fax right away. The physician stated she did not recall receiving another notification regarding what happened to Resident #239's right leg. She stated she may have received another fax and it was easiest to call her to contact her immediately.</p> <p>Professional standards of nursing practice were not followed when the facility failed to:</p> <ul style="list-style-type: none"> <li>* Ensure nursing staff followed the facility's policy for reporting and investigating accidents when Resident #239's son reported and described her leg injury to nursing staff.</li> <li>* Ensure nursing staff responsible for Resident #239's care and accident investigations were competent to do so.</li> <li>* Ensure Resident #239's pain level was effectively assessed using a process consistent with her impaired cognition and limited communication abilities.</li> <li>* Ensure staff responded correctly to Resident #239's injury by identifying and assessing her leg</li> </ul>	F 684			

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F 684	Continued From page 26 injury and immediately reporting the increased swelling and bruising to her physician. * Ensure effective communication among staff regarding the full-extent of Resident #239's accident/leg injury as reported by her son.	F 684			



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HEALTH & WELFARE

BRAD LITTLE – Governor  
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR  
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August 26, 2019

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

Provider #: 135053

Dear Ms. Martellucci:

On May 7, 2019 through **May 9, 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 #ID00008089**

ALLEGATION:

The facility failed to investigate an injury resulting in a delay in treatment.

FINDINGS:

During the investigation four residents were observed and five resident's records, which included one closed record, were reviewed for accidents and incidents. Interviews were conducted with residents and family members. Staff members were interviewed regarding accidents and incidents and the investigation process. Facility grievances and incident and accident files were reviewed.

The facility abuse investigations and grievances documented concerns with injuries of unknown origin.

Three of five residents' records documented issues with investigations into injuries of unknown origin or injuries not associated with falls and their causes.

Joan Martellucci, Administrator  
August 26, 2019  
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Review of the records for one resident documented the resident experienced an injury with a family member present, and the facility did not investigate, fully assess the resident, and/or notify the physician of a possible injury, which resulted in a fractured femur going unidentified for 10 days. The nursing progress notes did not identify the injury the resident sustained for 4 days following the injury.

The resident's record did not include documentation of a thorough investigation, to include, assessment of a swollen knee, complete staff and resident interviews, and preventative measure to protect the resident from further injury.

Several residents and family members stated they had concerns with the facility's investigation into injuries and the facility did not taking appropriate action.

Based on the results of the investigation, the allegation was substantiated. A deficiency was cited at F580 and F684 as they related to the failure of the facility to ensure residents' injuries were investigated and appropriate interventions were added to include timely physician notification and timely treatment orders.

#### CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

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

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

Sincerely,



Belinda Day, RN, Supervisor  
Long Term Care Program

BD/lj