

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

PRINTED: 09/03/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135053	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 08/06/2020
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 an onsite Focused Infection Control follow-up and complaint survey which was conducted from August 5, 2020 to August 6, 2020. Surveyors conducting the survey: Laura Thompson RN, BSN - Team Lead Molly Lorden RN, BSN 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, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (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 (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (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.	{F 000}			
F 580 SS=D		F 580		9/1/20	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 08/14/2020
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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 580	<p>Continued From page 1</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). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the resident's family and/or representative was notified when the resident died for 1 of 5 residents (Resident #1) whose records were reviewed for end-of-life care. This had the potential to cause psychosocial harm and distress when a resident's family and close relations were not made aware of their death. Findings include:</p> <p>Resident #1 was admitted to the facility on 6/15/15, with diagnoses of atrial fibrillation (an irregular heartbeat), high blood pressure, and hemiplegia and hemiparesis (weakness and paralysis) of the left side following a stroke. The</p>	F 580	<p>This plan of correction constitutes the facility's written allegation of compliance for the deficiencies cited. The submission of this plan of correction is not an admission of, or agreement with, the deficiencies or conclusions contained in the department's inspection report.</p> <p>Deficiencies related to: F580 Notify of changes</p> <p>1. Correction/s as it relates to the resident/s:</p>		

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F 580	<p>Continued From page 2</p> <p>resident was also diagnosed with COVID-19.</p> <p>A progress note, dated 7/29/20 at 10:10 AM, stated Resident #1's spouse was updated on his status. The progress note stated Resident #1 continued to be unresponsive and the spouse declined to visit at that time.</p> <p>A progress note, dated 8/1/20 at 11:00 AM, stated Resident #1's daughter asked to be called with any changes in his condition.</p> <p>A progress note, dated 8/2/20 at 2:20 PM, stated Resident #1 died at 1:55 PM that day. The note stated "Spouse notified prior when patient was assessed as actively dying. She stated she did not need to be called back as this was 'a long time coming.'"</p> <p>Resident #1's spouse was not notified by the facility when he died on 8/2/20 at 1:55 PM.</p> <p>On 8/6/20 at 3:45 PM, the Resident Care Manager (RCM) stated she did not call Resident #1's spouse when he died. She stated Resident #1's spouse told her when she spoke with her the previous day, 8/1/20, she did not need to call her back. The RCM stated she was "surprised" the spouse of Resident #1 did not want to be called with further status updates. The RCM stated she also believed the spouse was stating she did not want to be called when he died.</p>	F 580	<p>Resident #1 no longer resides at facility</p> <p>2. Action/s taken to protect residents in similar situations: Residents experiencing end of life care and/or changes in condition were reviewed for need to update families/POA/Guardian of status with no negative findings.</p> <p>3. Measures taken or systems altered to ensure that solutions are sustained: Education to nursing staff on requirements to F-580 including, but not limited to: Informing resident, consulting with resident physician, and notifying resident representative for significant changes in resident status.</p> <p>4. Plans to monitor performance to ensure solutions are sustained and person responsible: Resident changes in condition will be monitored through review of 24 hour report and daily clinical meeting. DON/ED will be informed of residents at end of life to ensure processes are being followed related to notification. Any identified concerns will be immediately corrected with licensed nurse education. Future auditing will be determined by the Quality Assurance and Performance Improvement Committee.</p> <p>5. Who will be responsible for ensuring compliance: ED/DON</p>		

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{F 880} SS=L	<p>Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)</p> <p>§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 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> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p>	{F 880}		9/1/20	

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{F 880}	<p>Continued From page 4</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the 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, review of employee screening logs, review of employee training, and staff interview, it was determined the facility failed to ensure infection prevention practices were implemented and maintained to prevent and contain infection of staff and residents with COVID-19. This failure resulted in the continued likelihood of serious harm, impairment, or death related to cross-contamination and infection to all staff and residents. Findings include:</p>	{F 880}	<p>Deficiencies related to: F880 Infection Control</p> <p>1. Correction/s as it relates to the resident/s:</p> <p>Residents' #10 #16, #19, # 29 no longer reside in facility.</p> <p>Residents' #1, #4 #11 #12,#13 #14,#15 #24 #25 reside in designated units with</p>		

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{F 880}	Continued From page 5 On 8/6/20 at 3:49 PM, the Administrator and Director of Nursing were notified the Immediate Jeopardy found during the survey conducted from 7/28/20 to 7/29/20 was not removed for 42 CFR §483.80 (F880) due to continued likelihood of serious harm, impairment, or death related to the inappropriate use and fit of N95/KN95 respirator masks and staff wearing contaminated PPE into the breakroom of the COVID-19 positive units.	{F 880}	designated staff. Res #12 and #13 had no negative effects from staff crossing between units and improper use of PPE Resident # 1,2,3,4,5,6,7,8,9 20 21, 24 and 25 had no negative effects from improper PPE use by staff Resident #11 had no negative effects from plastic barrier being unzipped exposing negative rooms to positive rooms. Res #9 and #22 are being offered hand hygiene before and after meals Residents currently in facility that tested positive for Covid have recovered with no negative effects. 2. Action/s taken to protect residents in similar situations: Facility has designated Covid positive and Covid negative units with dedicated staff assignments in place. Facility has PPE stations for units with donning/doffing areas as indicated. Upon notification of immediate Jeopardy relating to infection control, the facility immediately educated staff to special droplet precautions including: PPE use, donning/doffing of PPE, proper cleaning and disinfecting of equipment, and hand hygiene. Facility established separate entrances for Covid positive units, Staff logs were updated to include active screening by		

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{F 880}	Continued From page 6	{F 880}	<p>staff member. Plastic barrier/zipper was repaired on North hall and East hall.</p> <p>3. Measures taken or systems altered to ensure that solutions are sustained:</p> <p>Daily monitoring of residents through review of 24* report and clinical meetings will occur to identify infection signs and symptoms that might warrant need for transmission based precautions. Identified issues will be addressed immediately.</p> <p>Facility has designated a new Infection Control Nurse with start date 8/11/10</p> <p>Facility will update orientation program to provide for education and competency testing in transmission based precautions.</p> <p>Staff educated to:</p> <ul style="list-style-type: none"> a) Process of active screening at facility for all employees regarding Covid symptoms and taking of temperature prior to their assigned shift by a designated staff member. b) Proper hand hygiene for staff , Hand hygiene before/after glove use, between residents c) Assisting residents with hand hygiene before/after meals d) Proper use of PPE including donning/doffing of PPE. e) Fit testing for N-95 masks, and use. f) How to enter through plastic barrier on Covid positive unit ensuring zipper closed and no gaps. 		

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{F 880}	Continued From page 7	{F 880}	<p>g) Placing residents on precautions including posting of signage with instructions and setting up PPE station.</p> <p>h) Following precaution signs posted</p> <p>i) Using dedicated medical equipment for Covid + residents, cleaning of medical equipment per manufacturer directions</p> <p>Housekeeping staff educated to proper cleaning/disinfecting of beds and high touch surfaces following manufacturer directions for use and dwell times.</p> <p>4. Plans to monitor performance to ensure solutions are sustained and person responsible: Hand washing audits will be conducted daily x 1 week, then weekly x4 with documented observations by ICN/DON/. Identified errors will be immediately corrected. Future auditing to be determined by QAPI.</p> <p>Donning/Doffing/PPE audits will be conducted daily x 1 week, then weekly x4with documented observations by ICN/DON Identified errors will be immediately corrected. Future auditing to be determined by QAPI.</p> <p>Staff attestation sign in logs will be reviewed daily for compliance by ICN/DON with concerns immediately investigated.</p> <p>A random visual audit of housekeeping procedures to ensure compliance to cleaning/disinfecting of beds/ high touch surfaces will occur daily x 1 week then</p>		

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{F 880}	Continued From page 8	{F 880}	<p>weekly x 4. Future auditing to be determined by QAPI</p> <p>The Quality Assurance and Performance Improvement Committee will meet weekly to discuss findings of audits for any recommendations/ root cause analysis. Any concerns will be followed up with appropriate action plan.</p> <p>5. Who will be responsible for ensuring compliance: ED/DON</p>		