



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

C.L. "BUTCH" OTTER -- Governor  
RICHARD M. ARMSTRONG -- Director

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

FILE COPY

March 27, 2015

Paul McVay, Administrator  
LaCrosse Health & Rehabilitation Center  
210 West LaCrosse Avenue  
Coeur d'Alene, ID 83814-2403

Provider #: 135042

Dear Mr. McVay:

On **March 12, 2015**, we conducted an on-site follow-up revisit to verify that your facility had achieved and maintained compliance. We had presumed, based on your allegation of compliance, that your facility was in substantial compliance as of **February 2, 2015**. However, based on our on-site follow-up revisit conducted **March 12, 2015**, we found that your facility is not in substantial compliance with the following participation requirements:

**F329 -- S/S: D -- 42 CFR §483.25(l) -- Drug Regimen is Free From Unnecessary Drugs**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **Please provide ONLY ONE completion date for each federal tag 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 Form CMS-2567, Statement of Deficiencies and Plan of Correction in the spaces provided and return the original to this office.

Your copy of the Post-Certification Revisit Report, Form CMS-2567B, listing deficiencies that have been corrected is enclosed.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **April 9, 2015**.

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.

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

As noted in the Bureau of Facility Standards' letter of **January 20, 2015**, following the survey of **December 29, 2015**, we have already made the recommendation to the Centers for Medicare and Medicaid Services (CMS) for Denial of Payment for New Admissions and termination of the provider agreement on **June 29, 2015**, if substantial compliance is not achieved by that time. The findings of noncompliance on **December 29, 2015**, has resulted in a continuance of the remedy(ies) previously mentioned to you by the CMS. On **February 2, 2015**, CMS notified the facility of the intent to impose the following remedies:

- DPNA made on or after **March 29, 2015**
- A 'per instance' civil money penalty of \$1700.00

**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.**

Paul McVay, Administrator  
March 27, 2015  
Page 3 of 3

If you believe the deficiencies have been corrected, you may contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, 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.

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 #200I-10. Informational Letter #200I-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:

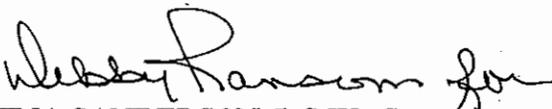
- BFS Letters (06/30/11)

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

This request must be received by **April 2, 2015**. If your request for informal dispute resolution is received after **April 2, 2015**, 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 on-site follow-up revisit survey. If you have any questions, comments or concerns, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, Option 2.

Sincerely,

  
NINA SANDERSON, L.S.W., Supervisor  
Long Term Care

NS/dmj  
Enclosures

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

PRINTED: 03/20/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  R-C 03/12/2015
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NAME OF PROVIDER OR SUPPLIER  LACROSSE HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 210 WEST LACROSSE AVENUE COEUR D'ALENE, ID 83814
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(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
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(F 000)	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiency was cited during the follow up survey of your facility.</p> <p>The survey team entered the facility on Tuesday, 3/10/15, and exited on, Thursday, 3/12/15.</p> <p>The surveyors conducting the survey were:</p> <p>Karen Marshall, MS, RD, LD, Team Coordinator James Troutfelter, QIDP</p> <p><b>F 329 SS=D 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</b></p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p>	{F 000}	<p><i>"This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This 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."</i></p> <p><b>F-329: Drug Regime Is Free From Unnecessary Drugs</b></p> <p><u>Individual Residents</u> Resident #10 has had her antipsychotic medication reviewed by the interdisciplinary team (IDT). A taper and discontinuation has been ordered and is in process.</p> <p><u>Residents in similar situations</u> Residents who have antipsychotic medication treatment have had their medications reviewed for diagnosis, behavior monitoring and clinical indications for use. Care plans and behavior monitoring have been updated as needed and MD notifications as indicated.</p>	
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RECEIVED  
APR - 1 2015  
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Paul McVay</i>	TITLE NHA 3-30-15	(X6) DATE
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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 329	Continued From page 1  This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure each resident's drug regimen had adequate indications for medication use. This was true for 1 of 5 (#10) residents sampled for antipsychotic medications. This created the potential for harm when Resident #10 received an antipsychotic medication without clinical indication. Findings included:  Resident #10 was admitted to the facility on 12/29/14 with diagnoses that included dementia, unspecified without behavioral disturbances, and depressive disorder not elsewhere classified.  Resident #10's record contained a Physicians Telephone Orders, dated 2/16/15, that documented risperidone (an antipsychotic drug) 0.5 mg at bed time was to be discontinued. The diagnosis section of the order documented it had been given for insomnia.  Her record also contained a Physician's Orders, dated 2/17/15, documenting Resident #10 was to receive risperidone 0.5 mg at bed time. The order was also followed by an unsigned or dated, hand written, entry of "BPSD" (Behavioral or Psychological Symptoms of Dementia).  Additionally, Resident #10's record contained a nurse practitioner's progress note dated 2/17/15. The plan section documented, "For her own safety, not getting up on her own, ramming her wheelchair into things and being able to sleep at night, we will again start Risperdal 0.5 and	F 329	<b><u>Measures to prevent reoccurrence/RCA</u></b> Interdisciplinary team was educated by the Regional Director of Operations (MSW, CNHA) on psychoactive medication policy and procedure, behavior monitoring, assessment and "mind over meds" meeting.  RCA: Execution of process - IDT failed to review resident through clinical meeting structure with initiation of antipsychotic medication for clinical indications, diagnosis and behavior monitoring.  <b><u>On-going Monitoring</u></b> Residents with antipsychotic medications will be reviewed quarterly, and as needed with changes, through the clinical meeting process (Mind Over Meds) by the IDT to evaluate necessity and appropriateness. Residents with changes in medication regime related to antipsychotics will be reviewed through the daily clinical meeting structure (M-F) for clinical indications and behavior monitoring.	

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F 329	<p>Continued From page 2</p> <p>nursing will monitor for resolution of her concerning symptoms."</p> <p>During an interview on 3/11/15 from 10:30 - 11:21 a.m., the Director of Nursing [DON] stated Resident #10's behavioral or psychological symptoms of dementia were repetitive movements, restlessness and a "constant urge to move." He also stated some of her additional behaviors included running her wheelchair into things such as doors and walls, not remembering she was a fall risk and obsessive activity (e.g. asking for cookies or pills), and inability to rest. In addition the survey team requested information related to the requirement at F329 for antipsychotic use for residents diagnosed with dementia. Specifically, "Antipsychotic medications may be considered for elderly residents with dementia but only after medical, physical, functional, psychological, emotional psychiatric, social and environmental causes have been identified and addressed."</p> <p>On 3/11/15 at 12:20 p.m., the DON provided a progress note, dated 2/20/15, signed by the facility's Social Worker documenting "Res [resident] had previous behaviors of combativeness and agitation, resisting cares previous to coming to this facility. Research with MD [Medical Doctor], MD feels res [resident] becomes upset and Risperdal is being given to [increase] quality of life. Res is at the lowest dose possible."</p> <p>The facility failed to ensure the use of Risperdal was indicated for Resident #10, a resident diagnosed with dementia, prior to the use of the antipsychotic medication.</p>	F 329	<p>Residents with antipsychotics will be audited monthly for 3 months for appropriateness through the Mind Over Meds meeting by the Director of Nursing. Findings of these audits will be brought to the monthly QAPI meeting for 3 months for identification of further training opportunities.</p> <p><b><u>Individual to Ensure Compliance</u></b> Director of Nursing or designee</p> <p><b><u>Date of Compliance</u></b> 3/27/15</p>	

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F 329	Continued From page 3 The facility did not provide any additional information related to Resident #10's behaviors or diagnoses that would indicate the use of Risperdal, for a resident diagnosed with dementia.	F 329			