



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

April 10, 2015

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

Provider #: 135042

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Mr. McVay:

On **April 1, 2015**, a Facility Fire Safety and Construction survey was conducted at **Lacrosse Health & Rehabilitation Center** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies and a similar State Form 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. Please provide **ONLY ONE** completion date for each federal and state tag in column (X5) Completion Date to signify when you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on

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page 2). After each deficiency has been answered and dated, the administrator should sign both Statement of Deficiencies and Plan of Correction, Form CMS-2567 and State Form, in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **April 23, 2015**. Failure to submit an acceptable PoC by **April 23, 2015**, may result in the imposition of civil monetary penalties by **May 13, 2015**.

Your PoC must contain the following:

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

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **May 6, 2015**, (Opportunity to Correct). Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **May 6, 2015**. A change in the seriousness of the deficiencies on **May 6, 2015**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **May 6, 2015**, includes the following:

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Denial of payment for new admissions effective **July 1, 2015**.
42 CFR §488.417(a)

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **October 1, 2015**, if substantial compliance is not achieved by that time.

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

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

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **April 1, 2015**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

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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 23, 2015**. If your request for informal dispute resolution is received after **April 23, 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 survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,



Mark P. Grimes, Supervisor
Facility Fire Safety and Construction

MPG/lj
Enclosures

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

Printed: 04/09/2015
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 01 - ENTIRE FACILITY BUILDINGS 1 & 2 B. WING _____	(X3) DATE SURVEY COMPLETED 04/01/2015
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NAME OF PROVIDER OR SUPPLIER LAGROSSE HEALTH & REHABILITATION CEN	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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K 000	<p>INITIAL COMMENTS</p> <p>The facility is a single story, Type V(111) construction that includes an ventilator unit wing. It has an automatic fire extinguishment system throughout the facility; The fire alarm system has smoke detectors in corridors and areas that are open to the corridor, with the 300 hall and the 600 hall having smoke detectors in each resident room as well. The facility was built in 1967 and currently is licensed for 100 SNF beds. The ventilator unit was approved in November of 2011 and has a type 1 Emergency Electrical System. Census on the date of the survey was 94.</p> <p>The following deficiencies were cited at the above facility during the annual Life Safety Code survey conducted on April 1, 2015. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, and 42 CFR 483.70.</p> <p>The survey was conducted by:</p> <p>Nathan Elkins Health Facility Surveyor Fire Life Safety & Construction</p>	K 000	<p>Submission of this plan of correction does not constitute an admission of fact of wrong doing on the part of the facility; this plan of correction is being submitted as it is required by law.</p> <p>Please accept this submission of the plan of correction as our allegation of substantial compliance.</p>	
K 047 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1</p> <p>This Standard is not met as evidenced by: Based on observation and interview the facility failed to ensure exit signage was continuously illuminated. This deficient practice could confuse</p>	K 047	<p>K047</p> <p>1.Exit sign at 500 hall near nurses station had the back up battery replaced.</p> <p>2.Facility exits signs audited for proper operation of back up batteries and none were found to be in need of replacement.</p>	<p>4/3/15</p> <p>4-3-15</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Paul M. Gray, N.H.A.* TITLE: _____ (X6) DATE: 4-23-15

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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K 047	Continued From page 1 evacuation in a dark smoke filled corridor affecting 22 residents, staff members, and visitors on the date of survey. The facility is licensed for 100 SNF/NF beds with a census of 94 on the day of survey. Findings include: During the facility tour on April 1, 2015 at approximately 1:30 PM, observation and interview reveled the exit sign in the 500 hallway near the nurses station was not operational. Interview with maintenance supervisor revealed the facility was aware the exit sign was not working properly. Actual NFPA reference: 19.2.10 Marking of Means of Egress. 19.2.10.1 Means of egress shall have signs in accordance with Section 7.10. Exception: Where the path of egress travel is obvious, signs shall not be required in one-story buildings with an occupant load of fewer than 30 persons. 7.10.5 Illumination of Signs. 7.10.5.1* General. Every sign required by 7.10.1.2 or 7.10.1.4, other than where operations or processes require low lighting levels, shall be suitably illuminated by a reliable light source. Externally and internally illuminated signs shall be legible in both the normal and emergency lighting mode.	K 047	3. Facility maintenance director will check all exit signs for proper operation of back up batteries Monday through Friday and replace back up batteries as required. 4. Any issues related to exit signs back up batteries not functioning properly will be corrected immediately and forwarded to the Quality Assurance Committee for further review and systems correction's as necessary.	
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable	K 052	K052 1. Smoke detector D33 was cleaned of dust and placed back into operation. 2. Facility smoke detectors audited and cleaned to ensure proper smoke detector function.	4-1-15 4-3-15

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K 052	Continued From page 2 requirements of NFPA 70 and 72. 9.6.1.4 This Standard is not met as evidenced by: Based upon observation and interview the facility failed to ensure the fire alarm system was maintained in a reliable operating condition. Failure to maintain the fire alarm system could result in the failure to provide early notification to building occupants when a fire occurs. This deficient practice affected one of four smoke compartments, 21 residents, staff and visitors on the day of the survey, the facility is licensed for 100 SNF/NF beds and had a census of 94 on the date of the survey. Findings include: During the facility tour on April 1, 2015 between 9:00 AM to 4:00 PM, observation and interview revealed that smoke detector D33 located in the 300 hallway was activated. Upon further visual investigation of the Fire Alarm Control Panel it was confirmed the fire alarm system was in trouble due to smoke detector D33. Interview with the maintenance supervisor found that this particular smoke detector has been a nuisance in the past. Actual NFPA standard: 9.6.1.4. A fire alarm system required for life safety shall be installed, tested, and maintained in	K 052	3.Facility maintenance Director will monitor all smoke detectors Monday through Friday for proper functioning and cleanliness. 4.Any issues related to proper functioning of smoke detectors and/or cleanliness of smoke detectors will be repaired immediately and forwarded to the Quality Assurance Cokmi9ttee meeting for further reviews and systems corrections as necessary.	

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K 064	<p>Continued From page 4 survey. The facility is licensed for 100 SNF/NF beds with a census of 94 on the day of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour on April 1, 2015 from 1:00 PM to 4:30 PM, observation of the fire extinguishers located throughout the entire facility were installed above the maximum height requirement of 60 inches. The extinguishers were measured and ranged in height between 62 inches and 68 inches to the top of the extinguishers.</p> <p>2) During the facility tour on April 1, 2015 from 1:00 PM to 4:30 PM, observation found the distribution of portable fire extinguishers that were measured from the lounge area between the 500 and 600 hallway of the building did not meet the travel distance of 75 feet or less to any portable fire extinguisher for a class A hazard.</p> <p>3) During the facility tour on April 1, 2015 at approximately 1:00 PM, observation-revealed a window curtain was obstructing/obscuring the view of a fire extinguisher and the fire extinguisher sign located in the lobby area near the business office.</p> <p>Interview with the Maintenance Supervisor found he was not aware of the standard requiring fire extinguishers installation height, travel distance, and location requirements.</p> <p>Actual NFPA standard: NFPA 10 Standard for Portable Fire Extinguishers 1-6.3 Fire extinguishers shall be conspicuously located where they will be readily accessible and</p>	K 064		

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K 064	Continued From page 5 immediately available in the event of fire. Preferably they shall be located along normal paths of travel, including exits from areas. 1-6.6* Fire extinguishers shall not be obstructed or obscured from view. Exception: In large rooms, and in certain locations where visual obstruction cannot be completely avoided, means shall be provided to indicate the location. 1-6.10 Fire extinguishers having a gross weight not exceeding 40 lb (18.14 kg) shall be installed so that the top of the fire extinguisher is not more than 5 ft (1.53 m) above the floor. Fire extinguishers having a gross weight greater than 40 lb (18.14 kg) (except wheeled types) shall be so installed that the top of the fire extinguisher is not more than 3 1/2 ft (1.07 m) above the floor. In no case shall the clearance between the bottom of the fire extinguisher and the floor be less than 4 in. (10.2 cm). See Table 3-2.1 Fire Extinguisher Size and Placement for Class A Hazards = Maximum travel distance to extinguishers is 75 feet	K 064		
K 076 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4	K 076	K076 1. The light switch in the Oxygen storage and transferring room will be raised to 60 inches upon acceptance of this Plan of Correction, POC. 2. Other facility oxygen storage and transferring rooms audited for light switches at 60" and light switches were found to be 60 inches above the floor as required by code. 3. Education provided to Maintenance director regarding light switches in oxygen storage and transferring rooms be at 60 inches above the floor. Maintenance director to audit oxygen rooms weekly to ensure proper conditions for storage and transferring oxygen are maintained.	4/28/15

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K 076	Continued From page 6 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to assure that supplemental oxygen supplies were safely stored. Failure to safely store oxygen supplies could result in electrical damage and cause a fire. This deficient practice affected one of four smoke compartments, 22 residence, staff and visitors on the date of survey. The facility is licensed for 100 SNF/NF beds with a census of 94 on the day of survey Findings include: During the facility tour on April 1, 2015 at approximately 3:00 PM, observation revealed that a light switch in the oxygen transfilling/storage room was installed approximately 48 inches above the floor. Interview with the maintenance supervisor revealed that he was aware of the requirement for all electric wall fixtures, switches, and receptacles in an oxygen transfilling/storage room to be installed at least 60 inches above the floor. Actual NFPA reference: 19.3.2.4 Medical Gas. Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. NFPA 99, 4-3.1.1.2(a)4 Requires that the electric installation in storage locations or manifold enclosures for nonflammable medical gases shall comply with the standards of NFPA 70, National Electrical Code, for ordinary locations. Electric wall fixtures, switches, and receptacles shall be installed in fixed locations not less than 152 cm (5	K 076	4. Any issues regarding the proper storage and transferring of oxygen will be corrected immediately and forwarded to the Quality Assurance Committee for further review and systems corrections as required.	

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K 076	Continued From page 7 ft) above the floor as a precaution against their physical damage	K 076		
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This Standard is not met as evidenced by: Based on observation the facility did not ensure that electrical wiring and equipment usage was in accordance with NFPA 70 and UL listings. Utilizing relocatable power taps improperly can lead to overload wiring and start a fire. The deficient practice affected two of four smoke compartments, 41 residents, staff, and visitors on the date of survey. The facility is licensed for 100 SNF/NF beds with a census of 94 on day of survey. Findings include: 1) During the facility tour on April 1, 2015 at approximately 3:30 PM, observation of room #206 revealed non special purpose Relocatable Power Taps (RPT) being used to power a Nebulizer. 2) During the facility tour on April 1, 2015 at approximately 2:00 PM, observation of room #506 revealed non special purpose Relocatable Power Taps (RPT) being used to power a Nebulizer. 3) During the facility tour on April 1, 2015 at approximately 2:00 PM, observation of room #505 revealed non special purpose Relocatable Power Taps (RPT) being used to power an oxygen concentrator.	K 147	K 147: 1. Rooms # 206, # 506, and # 505 have had their Relocatable Power Taps, RPT's, removed. 2. Audit of facility rooms completed and any RPT's removed. 3. Weekly audits by maintenance director or designee to complete weekly audits to ensure facility does not have any RPT's in use. 4. Any issue related to RPT use will be immediately corrected and forwarded to the Quality Assurance Committee for further review and systems correction.	4-1-15 4-3-15

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K 147	Continued From page 8 Interview with Maintenance Supervisor found the facility was unaware of the relocatable power taps being used to power medical equipment. Actual NFPA Standard: NFPA 70 National Electrical Code 1999 Edition 400-3. Suitability Flexible cords and cables and their associated fittings shall be suitable for the conditions of use and location. 110-3. Examination, Identification, Installation, and Use of Equipment (a) Examination. In judging equipment, considerations such as the following shall be evaluated; 1. Suitability for installation and use in conformity with the provisions of this Code FPN: Suitability of equipment use may be identified by a description marked on or provided with a product to identify the suitability of the product for a specific purpose, environment, or application. Suitability of equipment may be evidenced by listing or labeling. 2. Mechanical strength and durability, including, for parts designed to enclose and protect other equipment, the adequacy of the protection thus provided 3. Wire-bending and connection space 4. Electrical insulation 5. Heating effects under normal conditions of use and also under abnormal conditions likely to arise in service. 6. Arcing effects 7. Classification by type, size, voltage, current capacity, and specific use 8. Other factors that contribute to the practical safeguarding of persons using or likely to come in contact with the equipment	K 147		

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K 147	Continued From page 9 (b) Installation and Use. Listed or labeled equipment shall be installed and used in accordance with any instructions included in the listing or labeling. See UL listings: XBYS Guide information XBZN2 Guide information	K 147		