



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK-- ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
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 7, 2016

Tom De Oro, 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. De Oro:

On **March 30, 2016**, 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. 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. Please provide **ONLY ONE** completion date for each federal and state tag in column (X5) Completion Date to signify when

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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 page 2). After each deficiency has been answered and dated, the administrator should sign the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office. If a State Form with deficiencies was issued, it should be signed, dated and returned along with the CMS-2567 Form.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **April 20, 2016**. Failure to submit an acceptable PoC by **April 20, 2016**, may result in the imposition of civil monetary penalties by **May 10, 2016**.

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 4, 2016**, (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 4, 2016**. A change in the seriousness of the deficiencies on **May 4, 2016**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **May 4, 2016**, includes the following:

- Denial of payment for new admissions effective **June 30, 2016**.
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 **September 30, 2016**, 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 **March 30, 2016**, 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:

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<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 20, 2016**. If your request for informal dispute resolution is received after **April 20, 2016**, 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

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 03/30/2016
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NAME OF PROVIDER OR SUPPLIER LACROSSE 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

INITIAL COMMENTS

K 000

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 is currently is licensed for 100 SNF/NF beds. The ventilator unit was approved in November of 2011 and has a Type 1 Emergency Electrical System with a 96 hour fuel supply in accordance with NFPA 99.

The following deficiencies were cited during the annual Fire/Life Safety survey conducted on March 30, 2016. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy in accordance with 42 CFR 483.70.

The survey was conducted by:

Sam Burbank
Health Facility Surveyor
Facility Fire Safety and Construction

K 012
SS=F

NFPA 101 LIFE SAFETY CODE STANDARD

K 012

Building construction type and height meets one of the following:
19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1
This Standard is not met as evidenced by:
Based on observation and interview, the facility failed to ensure that smoke and fire resistive properties of the structure were maintained. Failure to ensure the smoke and fire resistance of a structure, could allow fire, smoke and dangerous gases to migrate between compartments during a fire event. This deficient

"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."

Deficiencies related to **K012** will be corrected as follows:

- 1) **Correction/s as it relates to the resident/s:**

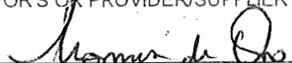
Identified open area in the linen closet and storage are were sealed.
- 2) **Action/s taken to protect residents in similar situations:**

All other areas have been inspected for additional open areas.
- 3) **Measures taken or systems altered to ensure that solutions are sustained:**

All staff has been educated on alerting maintenance if they identify an open area throughout the facility.
- 4) **Plans to monitor performance to ensure solutions are sustained and person responsible:**

Maintenance Director will perform weekly rounds to ensure that the facility is free of open areas. Results will be monitored monthly for three months and presented at QAPI.
- 5) **Date of Compliance:**

RECEIVED
APR 21 2016
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Executive Director	(X6) DATE 4/18/16
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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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K 012	<p>Continued From page 1</p> <p>practice affected 60 residents, staff and visitors in 1 of 4 smoke compartments on the day of the survey. The facility is licensed for 100 SNF/NF beds and had a census of 95 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on March 30, 2016 from approximately 10:30 AM to 1:30 PM, the following unsealed penetrations were noted:</p> <p>1) The interior of the linen closet across from the 200 wing nurse's station revealed an approximately two inch by two inch unsealed hole with an approximately 1/2 inch diameter hole, exposing the interior of the wall cavity.</p> <p>2) The storage area outside of the service corridor revealed an unsealed hole approximately 2 inches in diameter was drilled through the wall from the exterior of the building to the interior of the space.</p> <p>When asked about the unsealed penetrations, the Maintenance Director stated he had not been aware of these prior to the survey.</p> <p>Actual NFPA standard:</p> <p>19.1.6.2 Health care occupancies shall be limited to the types of building construction shown in Table 19.1.6.2. (See 8.2.1.) Exception*: Any building of Type I(443), Type I(332), Type II(222), or Type II(111) construction shall be permitted to include roofing systems involving combustible supports, decking, or roofing, provided that the following criteria are met:</p>	K 012	<p>5/4/16</p> <p>6) Person's Responsible Maintenance Director</p>	

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K 012	Continued From page 2 (a) The roof covering meets Class C requirements in accordance with NFPA 256, Standard Methods of Fire Tests of Roof Coverings. (b) The roof is separated from all occupied portions of the building by a noncombustible floor assembly that includes not less than 2 1/2 in. (6.4 cm) of concrete or gypsum fill. (c) The attic or other space is either unoccupied or protected throughout by an approved automatic sprinkler system. 8.2.1* Construction. Buildings or structures occupied or used in accordance with the individual occupancy chapters (Chapters 12 through 42) shall meet the minimum construction requirements of those chapters. NFPA 220, Standard on Types of Building Construction, shall be used to determine the requirements for the construction classification. Where the building or facility includes additions or connected structures of different construction types, the rating and classification of the structure shall be based on either of the following: (1) Separate buildings if a 2-hour or greater vertically-aligned fire barrier wall in accordance with NFPA 221, Standard for Fire Walls and Fire Barrier Walls, exists between the portions of the building Exception: The requirement of 8.2.1(1) shall not apply to previously approved separations between buildings. (2) The least fire-resistive type of construction of the connected portions, if no such separation is provided	K 012		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating	K 062		

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K 062	<p>Continued From page 3</p> <p>condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This Standard is not met as evidenced by: Based on observation, the facility failed to ensure fire suppression system pendants were maintained free of impairments such as corrosion in accordance with NFPA 25. Failure to keep fire suppression systems free of corrosion could inhibit system response during a fire event. This deficient practice affected 60 residents, staff and visitors in 2 of 4 smoke compartments on the date of the survey. The facility is licensed for 100 SNF/NF beds and had a census of 95 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on March 30, 2016 from approximately 10:00 AM to 1:00 PM, observation of the fire suppression system sprinkler heads revealed corroded heads in the following locations:</p> <p>One (1) corroded head at the Oxygen storage/transfill room in the 200 wing One (1) corroded head at the 200 wing tub room adjacent to room 213. One (1) corroded head in the housekeeping storage abutting the boiler room. One (1) corroded head over the dishwashing area in the main Kitchen.</p> <p>Actual NFPA standard:</p> <p>NFPA 25 2-2 Inspection. 2-2.1 Sprinklers. 2-2.1.1* Sprinklers shall be inspected from the floor level</p>	K 062	<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>Deficiencies related to K062 will be corrected as follows:</p> <ol style="list-style-type: none"> Correction/s as it relates to the resident/s: Corroded sprinkler heads in the oxygen storage/transfill room, tub room, housekeeping storage and dishwashing have been replaced. Action/s taken to protect residents in similar situations: All other areas have been inspected for corroded sprinkler heads.. Measures taken or systems altered to ensure that solutions are sustained: Maintenance Director will monitor that all sprinkler heads are free of corrosion. Plans to monitor performance to ensure solutions are sustained and person responsible: Maintenance Director will perform monthly rounds to ensure that the facility is free of open areas. Results will be monitored monthly for three months and presented at QAPI. 	

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K 062	Continued From page 4 annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. Exception No. 1*: Sprinklers installed in concealed spaces such as above suspended ceilings shall not require inspection. Exception No. 2: Sprinklers installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown.	K 062	5) Date of Compliance: 5/4/16 6) Person's Responsible Maintenance Director	
K 064 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6 This Standard is not met as evidenced by: Based on observation, the facility failed to ensure fire extinguishers were installed in accordance with NFPA 10. Failure to install extinguishers at the correct height could result in extinguisher damage or physical injury, hindering response during a fire event. This deficient practice affected 95 residents, staff and visitors in 3 of 4 smoke compartments on the date of the survey. The facility is licensed for 100 SNF/NF beds and had a census of 95 on the day of the survey. Findings include: During the facility tour conducted on March 30, 2016 from approximately 10:00 AM to 2:30 PM, observation of installed portable fire extinguishers revealed the following extinguishers measured over sixty (60) inches in height to the top of the extinguisher:	K 064	<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> Deficiencies related to K064 will be corrected as follows: 1) Correction/s as it relates to the resident/s: Extinguishers outside of room 312, 205, 614 and beauty salon were all adjusted to be below 60 inches in height. Action/s taken to protect residents in similar situations: All other extinguishers were measured to ensure they are below the 60 inch threshold height. 2) Measures taken or systems altered to ensure that solutions are sustained: Maintenance Director will monitor that all extinguishers remain below 60 inches in height.	

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K 064	<p>Continued From page 5</p> <p>The extinguisher installed in the corridor outside room #312 measured approximately 62 inches from the floor to the top of the extinguisher. The extinguisher installed in the smoking area outside room #205 measured approximately 62 inches from the floor to the top of the extinguisher. The extinguisher installed in the corridor outside room #614 measured approximately 62 inches from the floor to the top of the extinguisher. The extinguisher installed in the beauty salon measured approximately 62-1/2 inches from the floor to the top of the extinguisher.</p> <p>Actual NFPA standard:</p> <p>NFPA 10 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).</p>	K 064	<p>3) Plans to monitor performance to ensure solutions are sustained and person responsible:</p> <p>Maintenance Director will perform monthly rounds to ensure that the facility extinguishers do not rise above 60 inches in height. Results will be monitored monthly for three months and presented at QAPI.</p> <p>4) Date of Compliance: 5/4/16</p> <p>5) Person's Responsible Maintenance Director</p>	
K 072 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10. 18.2.1, 19.2.1 This Standard is not met as evidenced by:</p>	K 072		

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K 072	<p>Continued From page 6</p> <p>Based on observation, operational testing and interview the facility failed to ensure that means of egress were maintained free of impediments. Failure to provide means of egress free of impediments could hinder evacuation during an emergency. This deficient practice affected 60 residents, staff and visitors on the date of the survey. The facility is licensed for 100 SNF/NF beds and had a census of 95 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on March 30, 2016 from approximately 10:00 AM to 11:00 AM, observation and operation testing of the doors entering into the water heater access across from the 200 wing nurse's station revealed the doors were equipped with keyed hasp locks which were mounted at approximately 70 inches from the floor and only operable from the corridor side, preventing egress from the interior of the space.</p> <p>When asked, the Maintenance Director stated he was not aware this type of locking arrangement was not allowed.</p> <p>Actual NFPA standard:</p> <p>NFPA 101 Chapter 19</p> <p>19.2.1 General. Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7. Exception: As modified by 19.2.2 through 19.2.11.</p> <p>Chapter 7</p>	K 072	<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>Deficiencies related to K072 will be corrected as follows:</p> <p>1) Correction/s as it relates to the resident/s:</p> <p>The keyed hasp lock to the water heater access next to the 200 wing nurses station has been removed to provide egress from the interior of the space.</p> <p>Action/s taken to protect residents in similar situations:</p> <p>All other similar locks have been removed.</p> <p>2) Measures taken or systems altered to ensure that solutions are sustained:</p> <p>Maintenance Director will monitor that all interior areas are free to egress.</p> <p>Plans to monitor performance to ensure solutions are sustained and person responsible:</p> <p>Maintenance Director will perform monthly rounds to ensure egress from interior areas is provided. Results will be monitored monthly for three months and presented at QAPI.</p>	
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K 072	Continued From page 7 7.2 MEANS OF EGRESS COMPONENTS 7.2.1.5 Locks, Latches, and Alarm Devices. 7.2.1.5.4* A latch or other fastening device on a door shall be provided with a releasing device having an obvious method of operation and that is readily operated under all lighting conditions. The releasing mechanism for any latch shall be located not less than 34 in. (86 cm), and not more than 48 in. (122 cm), above the finished floor. Doors shall be operable with not more than one releasing operation. Exception No. 1*: Egress doors from individual living units and guest rooms of residential occupancies shall be permitted to be provided with devices that require not more than one additional releasing operation, provided that such device is operable from the inside without the use of a key or tool and is mounted at a height not exceeding 48 in. (122 cm) above the finished floor. Existing security devices shall be permitted to have two additional releasing operations. Existing security devices other than automatic latching devices shall not be located more than 60 in. (152 cm) above the finished floor. Automatic latching devices shall not be located more than 48 in. (122 cm) above the finished floor. Exception No. 2: The minimum mounting height for the releasing mechanism shall not be applicable to existing installations.	K 072	3) Date of Compliance: 5/4/16 4) Person's Responsible Maintenance Director	