



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

CERTIFIED MAIL: 7012 1010 0002 0836 3912

April 25, 2014

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 15, 2014**, 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

Paul McVay, Administrator
April 25, 2014
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May 20, 2014, includes the following:

Denial of payment for new admissions effective **July 15, 2014**.
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 15, 2014**, 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 15, 2014**, 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/NursingFa>

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[ilities/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 **May 8, 2014**. If your request for informal dispute resolution is received after **May 8, 2014**, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135042	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01 - ENTIRE FACILITY BUILDING</u> B. WING _____	(X3) DATE SURVEY COMPLETED 04/15/2014
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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
K 000	INITIAL COMMENTS The facility is a single story, Type V(III) 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 130 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. The following deficiencies were cited at the above facility during the annual Life Safety Code survey conducted on April 15, 2014. The facility was surveyed under the LIFE SAFETY CODE, 2000 th Edition, Existing Health Care Occupancy, and 42 CFR 483.70. The survey was conducted by: Dan Holbrook, Fire Health Surveyor Sam Burbank, Fire Health Surveyor Mark P. Grimes, Supervisor Facility Fire Safety and Construction Program	K 000	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. Please accept this submission of the plan of correction as our allegation of substantial compliance.	
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1	K 029	K 029 1. Item # 1 pass-through window to be abandoned and replaced with framing and drywall. Item # 1a. 5 kitchen doors to have automatic door closers installed. Item # 2 Hydro Therapy room door to be replaced with appropriate door for a hazardous area. Maintenance Supervisor to ensure compliance. 2. All house inspection of walls and doors of facility to ensure hazardous areas protected by appropriate doors and walls. Maintenance Supervisor to ensure compliance.	6-20-14

RECEIVED
MAY 12 2014
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Paul McVay, NHA-5-12-14</i>	TITLE	(X5) 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.

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

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 BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 04/15/2014
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K 029	Continued From page 1 This Standard is not met as evidenced by: Based upon observation and interview, the facility failed to safeguard hazardous areas. This potentially exposes all residents, and staff to the effects of fire and smoke. The facility was licensed for 100 beds and had the census of 94 the day of the survey. Findings include: 1. Observation at on April 15, 2014, at 3:20 PM revealed the kitchen pass-through window did not have a self closing, smoke proof door. The findings were acknowledged by the Maintenance Supervisor and the Building Administrator at the exit interview. 1.a. Observation at on April 15, 2014, at 3:25 PM revealed five kitchen exit doors do not have automatic closure devices. Three of the five doors lead to an access hallway and then into the dining room. 2. Observation at on April 15, 2014, at 1:50 PM revealed the Hydro Therapy room had been converted into a storage room containing flammable materials without meeting hazardous area door requirements. The findings were acknowledged by the Maintenance Supervisor and the Building Administrator at the exit interview. The findings were acknowledged by the Maintenance Supervisor and the Building Administrator at the exit interview. NFPA Reference 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic	K 029	3.Periotic inspections by Administrator and maintenance Supervisor to ensure hazardous areas protected by appropriate doors and walls. Administrator to ensure compliance. 4.Any issues related to hazardous areas being protected by appropriate doors and/or walls will be corrected immediately and referred to the Quality Assurance Committee for further evaluation, and corrections as required. Administrator to ensure compliance.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 029	Continued From page 2 extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door. 8.4.1.1* Protection from any area having a degree of hazard greater than that normal to the general occupancy of the building or structure shall be provided by one of the following means: (1) Enclose the area with a fire barrier without windows that has a 1-hour fire resistance rating in accordance with Section 8.2. (2) Protect the area with automatic extinguishing systems in accordance with Section 9.7. (3) Apply both 8.4.1.1(1) and (2) where the	K 029		

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K 029	Continued From page 3 hazard is severe or where otherwise specified by Chapters 12 through 42.	K 029		
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This Standard is not met as evidenced by: Based upon observation, the facility failed to provide protection throughout by an approved, supervised, and maintained automatic sprinkler system. The deficient practice affects one of four smoke compartments and 61 residents, staff and visitors. The facility was licensed for 100 beds and had the census of 94 the day of the survey. Findings include: Observation at on April 15, 2014, at 1:40 PM revealed no sprinkler revealed no sprinkler protection had been installed outside of either exit at the end of the wing 100 leading into the garden area and the street. Interview with the Maintenance Supervisor revealed the facility was not aware overhangs exceeding 4 feet in depth must have fire sprinklers.	K 056	1. Two exterior fire sprinkler heads to be installed at the exterior overhangs at both exits from 100 hall. Maintenance Supervisor to ensure compliance. 2. All facility inspection of exterior to ensure overhangs have appropriate fire sprinkler heads as required by regulations. Maintenance Supervisor to ensure compliance. 3. Periodic exterior inspections by Administrator and maintenance Supervisor to ensure exterior overhangs have appropriate fire sprinkler heads. Administrator to ensure compliance. 4. Any issues related to fire sprinkler heads at exterior overhangs will be corrected immediately and forwarded to the Quality Assurance Committee for further review and correction as required. Administrator to ensure compliance.	6-20-14

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K 056	Continued From page 4 The findings were acknowledged by the Maintenance Supervisor and the Building Administrator at the exit interview. Actual NFPA Standards: NFPA 13, 5-13.8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 ft (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.	K 056		
K 062, SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This Standard is not met as evidenced by: Based upon observation and record review, the facility failed to maintain the sprinkler system. This deficient practice could allow the system to fail when needed. This deficiency affected all residents, staff, and visitors. The facility is licensed for 100 beds and had a census of 94 on the day of the survey. A. Observation on April 15, 2014 between the hours of 9:00 AM and 11:20 AM records review revealed the sprinkler maintenance company had indicated the dry barrel sprinkler assemblies in the walk-in freezer and cooler were out of compliance and had been since 2010. Interview with the Maintenance Supervisor revealed he was aware of the requirement and had taken action to correct the deficiency. B. Observation on April 15, 2014 between the hours of 9:00 AM and 11:20 AM records review	K 062	K062 1.A, Walk in freezer and coolers to have fire sprinkler heads removed and replaced with appropriated fire sprinkler heads. B. First quarter 2014 flow and valve testing report unavailable. C. Fire sprinkler trim ring outside of the 300 wing exit to be install. Maintenance Supervisor to ensure compliance of A, B, & C. 2.A. All facility inspection of fire sprinkler heads to ensure appropriate fire sprinkler heads installed and compliant. B. Audit of flow and valve testing to ensure the only missing flow and valve testing report is the first quarter of 2014. C. All facility inspection of fire sprinkler heads to be completed to ensure appropriate trim rings installed. Maintenance Supervisor to ensure compliance of A, B, & C.	6-20-14

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K 062	Continued From page 5 revealed no documentation of first quarter, 2014 flow and valve testing. C. Observation on April 15, 2014 at about 11:20 AM found the exterior fire sprinkler outside of the exit at the end of the 300 wing is missing a trim ring creating a void around the sprinkler head. This affects 13 patients, all staff, and visitors. Actual Code Reference: LSC 101, 2000 edition 9.7.5 Maintenance and Testing. All automatic sprinkler and standpipe systems required by this Code shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems.	K 062	3.Periotic audits by Administrator and Maintenance Supervisor to ensure: A. appropriate fire sprinkler heads in place and within compliance, B. flow and valve testing completed quarterly, and C. installed fire sprinkler heads have appropriate trim rings installed. Administrator to ensure compliance. 4.Any issues related to A. appropriate fire sprinkler heads in place and within compliance, B. flow and valve testing completed quarterly, and C. installed fire sprinkler heads have appropriate trim rings installed will be corrected immediately and forwarded to the Quality Assurance Committee for further review and correction as required. Administrator to ensure compliance.	
K 147 SS=F	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 upon observation, the facility failed to comply with National Electrical Code in a potentially hazardous area. This affects all residents and staff. The facility was licensed for 100 beds and had the census of 94 the day of the survey. Findings include: Observation at on April 15, 2014, at 3:15 PM revealed the beverage area in the kitchen was using a portable power tap as a substitute for the fixed wiring to operate an air compressor and a refrigeration unit. The air compressor had marking indicating it was drawing 24 amps. The findings were acknowledged by the Maintenance Supervisor and the Building Administrator at the	K 147	K.147 1.Air compressor in the kitchen beverage area will be plugged into an appropriate outlet, and the portable power tap will be eliminated. Maintenance Supervisor to ensure compliance.	6-20-14

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

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K 147	Continued From page 6 exit interview. NFPA 70, 400.8 Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of 368.8. (5) Where concealed by walls, floors, or ceilings or located above suspended or dropped ceilings (6) Where installed in raceways, except as otherwise permitted in this Code	K 147	2.All facility audit of plug in appliance and/or devices will be completed to ensure appropriate connections to electrical power. Maintenance Supervisor to ensure compliance. 3.Periotic audits by Administrator and Maintenance Supervisor to ensure appliance and/or devices have appropriate connections to electrical power. Administrator to ensure compliance. 4.Any issue related to appliance and/or devices having appropriate connections to electrical power will be corrected immediately and forwarded to the Quality Assurance Committee for further review and correction as required. Administrator to ensure compliance.	

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C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2.</p> <p>The facility is a single story, Type V(III) 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 130 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 deficiency was cited at the above facility during the annual Life Safety Code survey conducted on April 15, 2014. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, and 42 CFR 483.70 and IDAPA 16.03.02 Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities.</p> <p>The survey was conducted by:</p> <p>Dan Holbrook, Fire Health Surveyor Sam Burbank, Fire Health Surveyor Mark P. Grimes, Supervisor Facility Fire Safety and Construction Program</p>	C 000		
C 226	<p>02.106 FIRE AND LIFE SAFETY</p> <p>106. FIRE AND LIFE SAFETY. Buildings on the premises used as facilities shall meet all the requirements of local, state and national codes concerning fire and</p>	C 226		

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

TITLE

(X6) DATE

Paul McWay, NHA, 5-13-14

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C 226	Continued From Page 1 life safety standards that are applicable to health care facilities. This RULE: is not met as evidenced by: Refer to CMS form 2567 K029 Hazardous Areas K056 Sprinkler System K062 Sprinkler Maintenance K147 Electrical	C 226	Refer To Federal Form 2567 (MP6)	

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.