



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 2557**

July 3, 2013

Troy L. Thayne, Administrator  
LaCrosse Health & Rehabilitation Center  
210 West LaCrosse Avenue  
Coeur d'Alene, ID 83814-2403

Provider #: 135042

Dear Mr. Thayne:

On **June 21, 2013**, a Recertification and State Licensure 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/or 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. **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 3). **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.** WAIVER RENEWALS MAY BE REQUESTED ON THE PLAN OF CORRECTION. After each deficiency has been answered and dated, the administrator should

Troy L. Thayne, Administrator  
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sign both Form CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **July 16, 2013**. Failure to submit an acceptable PoC by **July 16, 2013**, may result in the imposition of civil monetary penalties by **August 5, 2013**.

The components of a Plan of Correction, as required by CMS include:

- 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 in place or what systemic change 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. This monitoring will be reviewed at the follow-up survey, as part of the process to verify that the facility has corrected the deficient practice. Monitoring must be documented and retained for the follow-up survey. In your Plan of Correction, please be sure to include:
  - a. Specify by job title who will do the monitoring. It is important that the individual doing the monitoring has the appropriate experience and qualifications for the task. The monitoring cannot be completed by the individual(s) whose work is under review.
  - b. Frequency of the monitoring; i.e., weekly x 4, then q 2 weeks x 4, then monthly x 3. A plan for 'random' audits will not be accepted. Initial audits must be more frequent than monthly to meet the requirement for the follow-up.
  - c. Start date of the audits;
- Include dates when corrective action will be completed in column 5.

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.

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- 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 **July 26, 2013 (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 **July 26, 2013**. A change in the seriousness of the deficiencies on **July 26, 2013**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **July 26, 2013** includes the following:

Denial of payment for new admissions effective **September 21, 2013**. [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 **December 21, 2013**, 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 Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0036; phone number: (208) 334-6626; 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. 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.

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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 **June 21, 2013** 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 noncompliance 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>

go to the middle of the page to **Information Letters** section and click on **State** and select the following:

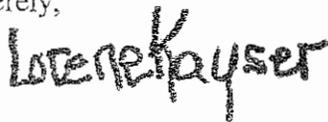
- BFS Letters (06/30/11)

[2001-10 Long Term Care Informal Dispute Resolution Process](#)  
[2001-10 IDR Request Form](#)

This request must be received by **July 16, 2013**. If your request for informal dispute resolution is received after **July 16, 2013**, 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,



LORENE KAYSER, L.S.W., Q.M.R.P., Supervisor  
Long Term Care

LKK/dmj  
Enclosures

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

AH  
"A" FORM

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #  <b>135042</b>	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE:  <b>6/21/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>LACROSSE HEALTH &amp; REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>210 WEST LACROSSE AVENUE COEUR D'ALENE, ID</b>		
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
<b>F 204</b>	<p><b>483.12(a)(7) PREPARATION FOR SAFE/ORDERLY TRANSFER/DISCHRG</b></p> <p>A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to account for a discharged resident's belongings. This created the potential for personal belongings to be lost, misplaced or otherwise unaccounted for. This affected 1 of 3 (#17) closed records reviewed. Findings included:</p> <p>Resident #17 was admitted to the facility on 2/9/13 and passed away at the facility on 4/10/13.</p> <p>Review of the closed record did not provide evidence of an account of the resident's belongings. The record contained a form titled Inventory of Personal Effects (IPE). The IPE documented personal articles of several clothing items, a cell phone, clock, suitcases and pictures. The IPE was signed in the admission section on 2/20/13. The IPE was not signed by a family member or the facility in the section marked "Discharge."</p> <p>On 6/20/13 at 11:55 a.m. Medical Records staff said there was no documentation of disposition of Resident #17's personal possessions.</p> <p>On 6/20/13 the Administrator, DON, and the Medical Records staff were informed of the above concern. The facility provided no further information.</p>		

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

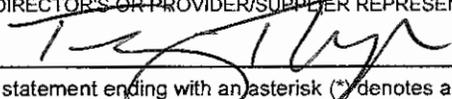
The above isolated deficiencies pose no actual harm to the residents

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

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FORM APPROVED  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135042</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/21/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>LACROSSE HEALTH &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>210 WEST LACROSSE AVENUE COEUR D'ALENE, ID 83814</b>	
(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	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the annual federal recertification survey of your facility.</p> <p>The surveyors conducting the survey were: Brad Perry, BSW, LSW Team Coordinator Sherri Case, BSW, LSW, QMRP Linda Kelly, RN</p> <p>Survey Definitions: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status cm = Centimeters CNA = Certified Nurse Aide DNS/DON = Director of Nursing Services ESRD = End Stage Renal Disease GDR - Gradual Dose Reduction LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment OT = Occupational Therapist PHQ-9 = Patient Health Questionnaire PT = Physical Therapist PRN = As Needed PROM = Passive Range of Motion RCM = Resident Care Manager ROM = Range of Motion S/S or S/SX = Signs and Symptoms TAR = Treatment Administration Record</p>	F 000	<p><i><b>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.</b></i></p> <p><b>RECEIVED</b> <b>JUL 18 2013</b> <b>FACILITY STANDARDS</b></p> <p><b>F-176</b></p> <p><b>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>Resident #21 had a self-medication assessment and has the staff observation needed to ensure safe duoneb delivery.</p>	
F 176 SS=D	<p><b>483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE</b></p> <p>An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.</p>	F 176		

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



TITLE

*Administrator*

(X6) DATE

*7-17-13*

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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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER  <b>LACROSSE HEALTH &amp; REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>210 WEST LACROSSE AVENUE COEUR D'ALENE, ID 83814</b>
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F 176	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure residents were assessed to determine if they were safe to self-administer medication. This was true for 1 random resident (#21) who was left alone during nebulizer breathing treatment during a medication pass observation. The failed practice created the potential for the resident to receive less than the prescribed amount of the nebulizer medication. Findings included:</p> <p>Resident #21's June 2013 recapitulation of physician orders included an order for DuoNeb (a combination of Albuterol and Ipratropium), 1 unit dose 4 times a day via face mask.</p> <p>On 6/19/13 at 11:18 a.m., LN #5 was observed as he set-up Resident #21's DuoNeb nebulizer treatment, placed a face mask on the resident, turned on the nebulizer machine, told the resident he would be back in a few minutes, then left the room. At that time, a student practical nurse (SPN) was in the room with the resident. The SPN stayed in the resident's room after the LN and surveyor left. However, 2 minutes later, the SPN joined LN #5 at the medication cart that was parked in the hallway 2 rooms away from Resident #21's room.</p> <p>At 11:20 a.m., the surveyor accompanied LN #5 and the SPN into another Resident #2's room. A few minutes later, the LN #5 was observed to briefly go into Resident #21's room. Then, at 11:25 a.m., the surveyor accompanied LN #5 and the SPN in to Resident #2's room again.</p>	F 176	<p><b>How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</b></p> <p>Records were reviewed to identify all residents receiving SVN treatments in the facility. Self-medication assessments were completed on these identified residents. Staff assistance is in place as identified, for residents per self-medication assessment to deliver SVN's as per order.</p> <p><b>What measures will be but in place or what systemic change you will make to ensure that the deficient practice does not recur</b></p> <p>LN's were educated on the needed assessments required for independent/supervised use of SVN's for residents with SVN orders.</p>	
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NAME OF PROVIDER OR SUPPLIER  <b>LACROSSE HEALTH &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>210 WEST LACROSSE AVENUE COEUR D'ALENE, ID 83814</b>	
(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 176	Continued From page 2  At about 11:33 a.m., LN #5 returned to Resident #21's room, checked to see if any medication was left, turned off the nebulizer machine, and removed the face mask from the resident's face.  At 11:40 a.m., when asked if Resident #5 had been assessed to self-administer the DuoNeb medication, LN #5 stated, "She can take it off if she decides to. That's why I check on her."  On 6/20/13 at 1:40 p.m., a medication self-administration assessment was not found in Resident #21's chart. At 1:58 p.m., LN #5 was asked again if Resident #21 had been assessed to self-administer the DuoNeb medication. The LN stated, "She would have to set it up and turn it on herself. No!"  On 6/20/13 at about 6:20 p.m., the Administrator and DNS were informed of the issue. No other information or documentation was received from the facility regarding the issue.	F 176	Residents requiring staff assistance for SVN delivery have it in place.  <b>How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place</b>  Resident's utilizing SVN's will be audited daily Monday through Friday to ensure the assessed staff assistance needed is in place X 1month and then 2 times weekly for 1 month and weekly for 2 months. These audits will be reviewed at Performance Improvement monthly for tracking and trending.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.  This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure residents' dignity was maintained. This was true for 1 random resident (#19) whose urinary drainage	F 241	<b>Specify by job title that will do the monitoring.</b> Director of Nursing/Designee.  <b>Date when corrective action will be completed.</b> July 26, 2013	

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F 241	<p>Continued From page 3</p> <p>bag was exposed to other residents in the main dining room. This failure created the potential for a negative affect on the Resident #19's self-esteem. Findings included:</p> <p>On 6/17/13 at 5:45 p.m., just before the evening meal service, Resident #19 was observed reclined in a geri-chair in the assisted area of the main dining room. Resident #19's uncovered urinary drainage bag was noted hanging at the left side of the resident's geri-chair with the bottom of the uncovered bag touching the floor (NOTE: Refer to F441, for additional information). A privacy cover, under the left side of the geri-chair, was about 6 inches away from the drainage bag. The resident was noted to have multiple leg spasms. With each spasm, the resident's right and/or left leg suddenly, but briefly, lifted up 2 or more feet off the geri chair. And, with each left leg spasm, the urinary drainage bag also lifted up briefly then it went back down and drug the floor.</p> <p>At the time, 6 other residents were in the assisted area of the dining room and the resident's uncovered urinary drainage bag was in full view of 3 of those residents.</p> <p>At about 5:50 p.m., the RCM #1 and CNA #6 entered the dining room. They went directly to Resident #19 and moved the resident up in the geri-chair. After that, the RCM placed Resident #19's urinary drainage bag into the privacy bag on the left side of the geri-chair.</p> <p>Immediately afterward, the RCM was informed of the observations regarding Resident #19's uncovered urinary drainage bag. The RCM</p>	F 241	<p><b>F-241</b></p> <p><b>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>Resident #19 has a dignity bag in use for urinary drainage. The drainage bag has been re-located on w/c to promote it staying covered.</p> <p><b>How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</b></p> <p>Residents utilizing Foley catheters have been identified per record review. Drainage bags for urine collection have been assessed by nursing and are all covered for resident dignity.</p>		

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F 241	Continued From page 4 acknowledged the resident's urinary drainage bag had been exposed. She stated the resident frequently had leg spasms and the leg spasms caused the drainage bag to "work its way out" of the privacy cover.  On 6/20/12 at about 6:15 p.m., the Administrator and DNS were informed of the dignity issue. No other information or documentation was received from the facility.	F 241	<b>What measures will be but in place or what systemic change you will make to ensure that the deficient practice does not recur</b>  Licensed Nurses and Aides have been educated on policy and procedure of the use of foley drainage bags to promote resident dignity with the use of foley catheters.	
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record	F 280	<b>How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into action will be completed.</b>  Residents using foley catheters will be observed daily to ensure drainage bags are covered to promote resident dignity X 30 days and then weekly X 2 months. These audits will be reviewed in Performance Improvement monthly	

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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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F 280	<p>Continued From page 5</p> <p>review, it was determined the facility failed to update and revise residents' care plan as their conditions changed. This was true for 4 of 11 residents (#s 1, 3, 4, &amp; 10) whose care plans were reviewed. This had the potential to result in harm if residents did not receive appropriate care due to lack of direction in the care plan. Findings included:</p> <p>1. Resident #3 was admitted to the facility on 6/24/11 with diagnoses including depression, diabetes and pain.</p> <p>Resident #3's medical record included a 5/21/13 physician order to discontinue thickened liquids unless the resident, "wants to use PRN."</p> <p>During the morning meal observation on 6/18/13, at 8:18 a.m., Resident #3 was observed to have apple juice, milk, and water. None of the liquids were thickened.</p> <p>Resident #3's Nutrition Risk Plan of Care (CP) included an intervention for the resident to receive nectar thick liquids.</p> <p>On 6/19/13 at approximately 3:00 p.m. the dietary manager stated the CP had not been revised but the dietary card that the kitchen referred to, identified the resident could have thin liquids.</p> <p>2. Resident #1 was admitted to the facility on 5/12/12 with diagnoses including generalized weakness, urinary tract infection, and dementia.</p> <p>a. Resident #1's Mood and Behavior CP, revised 4/13, included an intervention that the resident was on Lorazepam.</p>	F 280	<p>for 3 months for tracking and trending.</p> <p>Specify by job title that will do the monitoring Director of Nursing /Designee</p> <p>Date when corrective action will be completed July 25, 2013</p> <p>Resident #3 Physician order was corrected to reflect the discontinue of thickened liquid.</p> <p>Resident #3 Dietary card has been revised to indicate thin liquids.</p> <p>Resident# 3 Nutrition Risk Plan of Care corrected to indicate thin liquids</p>	

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NAME OF PROVIDER OR SUPPLIER  <b>LACROSSE HEALTH &amp; REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>210 WEST LACROSSE AVENUE COEUR D'ALENE, ID 83814</b>		
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F 280	<p>Continued From page 6</p> <p>The resident's 6/1/13 recapitulation Physician Orders did not include an order for Lorazepam.</p> <p>On 6/20/13 at 9:30 a.m., RCM #1 said the CP should have been revised to not include the Lorazepam.</p> <p>b. After the initial tour, on 6/17/13 at approximately 3:45 p.m., LN #7 stated Resident #1 was not able to be interviewed.</p> <p>Resident #1's Cognitive Assessment CP included in the "Assessment" section that the resident was "interviewable."</p> <p>On 6/20/13 at 9:30 a.m., RCM #1 said the CP should have been revised as the resident was not able to be interviewed.</p> <p>c. Resident #1's Sensory/Communication CP included an intervention to keep the resident's "glasses clean and in reach."</p> <p>During observations on 6/18/13 and 6/19/13 Resident #1 was not observed to wear glasses.</p> <p>On 6/20/13 at 9:30 a.m., RCM #1 said she had never known the resident to wear glasses.</p> <p>3. Resident #10 was admitted to the facility on 1/27/05 and readmitted on 12/3/12 with diagnoses including malignant neoplasm colon (tumor of colon or rectum), atrial fibrillation and bone and cartilage disease.</p> <p>On 6/19/13 at 8:53 a.m., two staff were observed to use a Sit to Stand mechanical device to assist</p>	F 280	<p>for 3 months for tracking and trending.</p> <p><b>Specify by job title that will do the monitoring.</b> Director of Nursing /Designee</p> <p><b>Date when corrective action will be completed.</b> July 26, 2013</p>	

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F 280	<p>Continued From page 7 Resident #10 to sit on the toilet.</p> <p>The resident's Alteration in Urinary Continence CP documented an intervention for, "Scheduled Check and Change -Residents who cannot sit on a toilet or commode ... "</p> <p>On 6/20/13 at 9:30 a.m., RCM #1 said she had marked the wrong area for Resident #10.</p> <p>4. Resident #4 was admitted to the facility on 2/13/13 and readmitted on 2/27/13, with multiple diagnoses including quadriplegia, chronic respiratory failure, aftercare tracheostomy, ventilator dependence, and multiple pressure ulcers.</p> <p>The resident's quarterly MDS assessment, dated 5/26/13, coded, in part:  <ul style="list-style-type: none"> <li>* Intact cognition with a BIMS score of 15;</li> <li>* No vision, hearing, or speech problems;</li> <li>* No signs or symptoms of delirium and no acute mental status change;</li> <li>* Minimal depression, with a PHQ-9 score of 3; and,</li> <li>* No indicators of psychosis and no behavioral symptoms.</li> </ul> </p> <p>Resident #4's recapitulation of Physician's Orders for June 2013 included diazepam (generic Valium) 5 milligrams (mg) every 6 hours, sertraline (generic Zoloft) 100 mg daily, and Trazadone 50 mg daily at bedtime.</p> <p>The resident's Mood and Behavior Symptom Assessment/Plan of Care, dated "5/13," documented, "At risk for depression as evidenced by: PHQ9 Severity Score." Two different scores,</p>	F 280	<p><b>F-280</b></p> <p><b>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>Resident #1 has had his care plan updated and is correct related to the use of Lorazepam</p> <p>Resident #1 has had his care plan updated to accurately reflect cognition</p> <p>Resident #1 has been assessed and his care plan has been updated to include the use of glasses.</p> <p>Resident #10 has had his care plan updated to accurately reflect urinary status and assistance needed from the staff for toileting.</p> <p>Resident #4 has had her mood and behavior care plan updated to</p>	

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F 280	<p>Continued From page 8</p> <p>"0-4 None" and "5-9 Mild" were both marked.</p> <p>Another Mood and Behavior Symptom Assessment/Plan of Care for Resident #4, dated 2/15/13, documented, "Potential side effects related to psychotropic drug use" with the following medication listed, diazepam for anxiety, and Zoloft and Trazadone, both for depression. However, no interventions were checked or documented in any way.</p> <p>In addition, the care plan for Skin Integrity, dated 5/10/13, documented 3 different Braden Risk Assessment Scores for Resident #4 in the Assessment/Problem column. The scores were, "At Risk (15-18), Moderate Risk (13-14), and Very High Risk (9 or below)."</p> <p>On 6/20/13 at 4:00 p.m., the interim RCM for the 600 Hall was asked about the aforementioned care plans for Resident #4. When asked if interventions should be included in the psychotropic drug use care plan, the RCM stated, "Yeah." The RCM acknowledged that no interventions were checked/checked. She stated, "It's incomplete." Regarding the risk for depression care plan, the RCM reviewed the resident's PHQ-9 assessments in the clinical record then stated, 0-4 was the accurate score. And, regarding the skin integrity care plan, the RCM stated, "Moderate risk is accurate." The RCM stated the care plans needed to be completed and/or revised."</p> <p>On 6/20/13 at about 6:30 p.m., the Administrator and DNS were informed of the care plan issues. However, no other information or documentation was received from the facility that resolved the</p>	F 280	<p>reflect the accurate PHQ9 score, and interventions for depression added.</p> <p>The psychotropic drug use care plan for Resident #4 is completed and current.</p> <p>Resident #4 has had her Braden score redone to reflect accurate assessment and care plan has been updated to reflect appropriate interventions for Braden score.</p> <p><b>How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</b></p> <p>Per record review, residents using psychotropic drugs have been identified and their care plans are current with appropriate interventions in place. Per record review, resident Braden's are current and have appropriate</p>	

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F 280 F 309 SS=D	Continued From page 9 issue. <b>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</b>  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and review of contracts between the facility and dialysis providers, it was determined the facility failed to provide the necessary care and services for 3 of 11 sample residents (#s 4, 12, and 15). Failure to consistently float Resident #4's heels, as care planned, placed the resident at risk for pressure ulcers. And, failure to interchange information between the facility and dialysis providers placed Resident #12 and #15 at risk for complications related to dialysis. Findings included:  1. Resident #4 was admitted to the facility on 2/13/13 and readmitted on 2/27/13, with multiple diagnoses which included quadriplegia, chronic respiratory failure, aftercare tracheostomy, ventilator dependence, and multiple pressure ulcers.  The resident's quarterly MDS assessment, dated 5/26/13, coded, in part: * Intact cognition with a BIMS score of 15;	F 280 F 309	weekly for 3 months and then with admission, quarterly, annual, and change of condition care plan reviews per MDS schedule. Audits will be brought to Performance Improvement meeting for the next 3 months for tracking and trending.  <b>Specify by job title that will do the monitoring.</b> Director of Nursing/Designee  <b>Date when corrective action will be completed.</b> July 26, 2013	07/02/13	



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F 309	<p>Continued From page 11</p> <p>document was received from the facility that resolved the issue.</p> <p>2. Resident #12 was admitted to the facility on 10/10/10 and readmitted on 6/13/13, with multiple diagnoses which included ESRD and hemodialysis.</p> <p>The resident's recapitulation of physician orders for June 2013 included, "Renal dialysis at [name of dialysis provider] 3 [times] weekly..." and "Monitor dialysis site and check for bruit/thrill s/sx [signs and symptoms] of infection every day (right forearm)."</p> <p>The care plan for hemodialysis, dated 6/7/13, documented the resident's access device was an AV (arteriovenous) fistula in the right arm. Interventions included, "Complete Dialysis Center Communication Record [DCCR] prior to transport" and "Send [DCCR] with resident for documentation of weights, medications [meds], laboratory results, vital signs [VS] and special instructions."</p> <p>Review of Resident #12's clinical record revealed there was only one DCCR in the chart. It was dated 2/4/13. No other DCCR documentation was found in the resident's chart.</p> <p>The DCCR included 3 sections: * Top section, labeled "Center Nurse," included instructions for completion by a facility LN prior to dialysis. Information to be completed included access site, any bleeding after the last treatment, s/sx of infection, bruit/thrill present, VS, diet and time of last meal, meds given 6 hours prior to sending the resident to dialysis, any changes or</p>	F 309	<p>identified and there are current and completed DCCR's that correlate to dialysis visits.</p> <p><b>What measures will be but in place or what systemic change you will make to ensure that the deficient practice does not recur.</b></p> <p>Licensed Nurses have been educated on the necessary documentation relating to dialysis and filling out the DCCR in its entirety with each dialysis session. Licensed Nurses have been in serviced on obtaining handoff information from the dialysis provider with each dialysis session to be reviewed post treatment.</p>	

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F 309	<p>Continued From page 12</p> <p>additional information (such as new meds or post treatment complications), the LN on the next shift, the LN's signature, date, and time.</p> <p>NOTE: The information completed were the aspects about the access site, VS, last meal, LN on the next shift, LN's signature, date and time. All other areas were blank.</p> <p>* Middle section, labeled "Dialysis Nurse," included instructions for completion by the dialysis nurse prior to return to the facility. Information to be completed included lab work done, pre and post dialysis VS, any problems with access, meds given during and after treatment, any change in condition or other pertinent information, LNs signature, date, and time.</p> <p>NOTE: This entire section was blank.</p> <p>* Bottom section, labeled "Center Nurse," included instructions for completion by a facility LN "upon return to the center for Post-Dialysis Assessment." Information to be completed included VS, thrill palpated, bruit auscultated, bleeding at site, and areas to check symptoms, such as fatigue, low blood pressure, nausea, chest pain, unsteady gait, electrolyte imbalance, seizures, leg cramps, fluid imbalance, or headache.</p> <p>NOTE: The information completed included only aspects about the access site, VS, the LN's signature, date and time.</p> <p>Other documentation by the dialysis provider included Extended Care Facility Notifications (ECFN) and a MD (physician) Dialysis Encounter Note (MDDEN).</p> <p>The ECFN included information regarding the 5 previous dialysis encounters and the current dialysis treatment, dialysis treatment data, current</p>	F 309	<p><b>How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place</b></p> <p>Audits will be completed 3 X a week Monday through Friday to ensure DCCR's will be done prior to dialysis and information from the dialysis provider is current and present post treatment for 1 month and then weekly X 2 months. Audits will be brought to Performance Improvement meeting for the next 3 months for tracking and trending.</p> <p><b>Specify by job title that will do the monitoring.</b> Director of Nursing/Designee</p> <p><b>Date when corrective action will be completed.</b> July 26, 2013</p>		

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F 309	<p>Continued From page 13</p> <p>dialysis orders and any new orders, current access and any problems, treatment status, faxed and/or verbal contact with the facility, and the dialysis nurse's electronic signature, date and time.</p> <p>The MDDEN included the same information as above as well the dialysis history, laboratory results, assessment and plan, and medications.</p> <p>On 6/20/13, review of the ECFNs and MD Encounter Note for Resident #12 revealed documentation by the dialysis provider on the following dates:</p> <ul style="list-style-type: none"> <li>* 1/28/13 - included data for 1/21/13, 1/23/13, and 1/25/13;</li> <li>* 2/15/13 - included data for 2/4/13, 2/6/13, 2/8/13, 2/11/13, and 2/13/13;</li> <li>NOTE: No ECFN were found for 1/30 or 2/1/13 (2 days).</li> <li>* 3/8/13 - included data for 2/25/13, 2/27/13, 3/1/13, 3/4/13, and 3/6/13;</li> <li>NOTE No ECFN were found for 2/15, 2/18 2/20 or 2/22/13.</li> <li>* 3/15/13 - included data for 3/11/13, and 3/13/13 (2 days);</li> <li>NOTE: A MDDEN, 3/20/13, included data for 3/15/13 and 3/18/13;</li> <li>* 4/15/13 - included data for 4/3/13, 4/5/13, 4/8/13, 4/10/13, and 4/12/13;</li> <li>NOTE: No ECFN were found for 3/22, 3/25, 3/27, 3/29 or 4/1/13 (5 days);</li> <li>* 4/22/13 - included data for 4/17/13, and 4/19/13;</li> <li>* 6/7/13 - included data for 5/27/13, 5/29/13, 5/31/13, 6/3/13, and 6/5/13;</li> <li>NOTE: No ECFN were found for dialysis 3 days a week between 4/24 and 5/24/13 (14 days).</li> <li>* 6/12/13 - included data for 6/10/13;</li> </ul>	F 309		

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F 309	<p>Continued From page 14</p> <p>NOTE: No ECFN were found for 6/14, 6/17 or 6/19/13 (3 days).</p> <p>On 6/20/13 at 4:55 p.m., when asked if she assessed Resident #14 when the resident returned from dialysis, LN #14 stated, "There isn't really a place where we document that." When asked if she checked the resident's AV fistula after dialysis, the LN stated, "No. I check the dressing" and "We do check for thrill and bruit every shift. It's on the treatment sheet." LN #14 was shown the DCCR and asked where other DCCRs were located. The LN stated, "We used to send a sheet with him but they [dialysis provider] didn't do anything with it and they started electronic stuff." The LN added, "I'm not here when he goes [to dialysis]. Noc [night] or day shift used to fill them out. I don't know where they are now."</p> <p>On 6/20/13 at about 6:30 p.m., the Administrator and DNS were informed of the issue and asked to provide the agreement between the facility and Resident #12's dialysis provider.</p> <p>On 6/21/13 at about 11:40 a.m., the Administrator provided the requested agreement. The agreement included the following, "2. The parties agree...c) The mechanisms for the interchange of information that is useful/necessary for the care of the resident will be transmitted using a methodology that is consistent with the parties' current communication system;..."</p> <p>The interchange of information between the facility and the dialysis provider regarding Resident #12 was inconsistent and/or incomplete. No other information was received from the</p>	F 309		
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F 309	<p>Continued From page 15 facility that resolved the issue.</p> <p>3. Resident #15 was admitted to the facility on 6/27/11 and readmitted on 4/23/13 with multiple diagnoses which included ESRD.</p> <p>The resident's recapitulation of physician orders for June 2013 included, "Renal dialysis at [name of dialysis provider] [blank] [times] weekly on Mon[day] Wed[nesday] [and] Fri[day]..." and "Monitor dialysis site and check for bruit/thrill s/sx [signs and symptoms] of infection every day." Both orders were dated 4/30/13.</p> <p>The resident's hemodialysis care plan, dated 5/1/13, documented the access device was a central venous catheter (CVC) in the left chest. Interventions included, "Complete Dialysis Center Communication Record [DCCR] prior to transport" and "Send [DCCR] with resident for documentation of weights, medications [meds], laboratory results, vital signs [VS] and special instructions."</p> <p>The DCCRs in Resident #12's clinical record included 3 sections, as follows: * Top section, labeled "Center Nurse," included instructions for completion by a facility LN prior to dialysis. Information to be completed included access site, any bleeding after the last treatment, s/sx of infection, bruit/thrill present, VS, diet and time of last meal, meds given 6 hours prior to sending the resident to dialysis, any changes or additional information (such as new meds or post treatment complications), the LN on the next shift, the LN's signature, date, and time. * Middle section, labeled "Dialysis Nurse," included instructions for completion by the</p>	F 309			

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F 309	<p>Continued From page 16</p> <p>dialysis nurse prior to return to the facility. Information to be completed included lab work done, pre and post dialysis VS, any problems with access, meds given during and after treatment, any change in condition or other pertinent information, LNs signature, date, and time.</p> <p>* Bottom section, labeled "Center Nurse," included instructions for completion by a facility LN "upon return to the center for Post-Dialysis Assessment." Information to be completed included VS, thrill palpated, bruit auscultated, bleeding at site, and areas to check symptoms, such as fatigue, low blood pressure, nausea, chest pain, unsteady gait, electrolyte imbalance, seizures, leg cramps, fluid imbalance, or headache.</p> <p>Review of Resident #15's DCCRs dated 4/22/13, 5/1/13, 5/6/13, 5/13/13, 5/17/13, 5/20/13, 5/24/13, 5/27/13, 5/29/13, 6/3/13, 6/5/13, 6/7/13, 6/10/13, 6/12/13, 6/14/13, and 6/17/13 revealed:</p> <p>* The status of the access site and/or last meal was not documented by the facility nurse before dialysis on 5/20, 6/7, and 6/17/13;</p> <p>* Whether or not there were access problems was not documented by the dialysis nurse on any of the aforementioned DCCR dates; and,</p> <p>* The entire post-dialysis assessment by the facility nurse was blank on all of the aforementioned DCCR dates.</p> <p>NOTE: There were no DCCRs for 4/24, 4/26 or 4/29, 5/3, 5/8, 5/10, 5/15, 5/22 or 5/31/13.</p> <p>On 6/20/13 at 9:10 a.m., RCM #1 was asked about the care, assessment and monitoring Resident #15 received before and after dialysis treatments. The RCM said the resident's vital signs and blood glucose (BG) were checked</p>	F 309			

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F 309	Continued From page 17 before dialysis. She added, "The BG doesn't go on the dialysis sheet." Regarding after dialysis, the RCM said "We monitor her site. Nothing else. Usually she request something for pain and goes to bed." When asked the type of access device in place for dialysis, the RCM stated, "I'll have to check if she has a Port-a-cath or what." When asked if it was important for staff to know the type of access of device, the RCM stated, "Um huh." When asked if DCCR were kept anywhere other than the resident's chart. the RCM stated, "No."  The interchange of information between the facility and dialysis provider was inconsistent and when there was interchange it was often incomplete.  On 6/20/13 at about 6:30 p.m., the Administrator and DNS were informed of the issue. However, no other information or documentation was received from the facility.	F 309			
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION  Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.  This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to provide ROM services in a timely manner, to a resident who	F 318			



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F 318	<p>Continued From page 19</p> <p>The resident's ADL/Mobility Plan of Care, dated 2/13/13 and 6/6/13, documented the problem, "Potential or Actual ADL/Mobility deficit...[related to]...quadriplegia." The interventions that were marked, or checked, included bed bath, grooming, and transfers using a mechanical lift. However, the intervention, "See Restorative Resident Summary Report," was not marked/checked.</p> <p>Review of the OT records revealed:                      * OT services, started 2/14/13, included contracture and edema management. The resident's current level of function was 60% of normal PROM in both UE.                      * Upon readmission to the facility, OT services started again on 2/27/13, related to increased edema and limited PROM in both UE. The current level of function was still 60% in the UE.                      * OT discontinued on 3/20/13. The long term OT goals included, "The patient will demonstrate 100% of B UE [bilateral upper extremity] PROM to ensure comfort, prevent contractures and decrease edema." Caregiver training included, "Provided education to caregiver staff and restorative aids [sic] regarding restorative program..." The discharge plan included, "Pt [patient] will receive restorative program for PROM to B [both] UE."                      NOTE: Other OT documentation revealed OT services were started again on 4/4/13 for edema management, and was continued on 5/31/13 under Medicare B.</p> <p>Review of the PT records revealed:                      * PT services, started 2/14/13, documented, "Therapy necessary for rom. Without therapy patient at risk for contractures with hypertonic</p>	F 318	<p><b>What measures will be but in place or what systemic change you will make to ensure that the deficient practice does not recur</b></p> <p>Staff (therapy and nursing) responsible for initiating restorative nursing assessment and programs have been educated on the need for starting program in a timely manner consistent with resident need for range of motion programs.</p> <p><b>How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place</b></p> <p>Residents referred to restorative nursing programs for range of motion will be reviewed in stand-up meeting Monday-Friday am to ensure plans are initiated in a timely manner. Restorative nursing plans for range of motion will be audited</p>	

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F 318	<p>Continued From page 20 muscle tone noted in both LE." * Upon readmission to the facility, PT services started again on 2/27/13. Therapy necessity was, "...for ROM program to be established and taught to restorative aides. Without therapy patient at risk for contracture formations." * PT discontinued on 3/21/13. The long term PT goal was, "The patient will achieve PROM of knees...and ankles...with a restorative aide program established...to help his circulation, joint integrity and prevent contracture formations." Caregiver training included, "Home exercise program initiated with cna [sic] focusing on le [lower extremity] rom." The discharge plan was, "Remain in SNF with Functional Maintenance Program."</p> <p>No Restorative Nursing Program documents were found in the resident's chart.</p> <p>On 6/19/13 at 12:40 p.m., Resident #4 was observed in bed on his right side with the head of the bed raised to about 30 degrees. CNA #10 was in attendance as she fed the resident. When asked about ROM, the resident stated, "I haven't had range of motion since PT stopped." The resident added, "My joints are starting to lock up. They hurt like [expletive]." When asked, CNA #10 said she was the resident's CNA that day and the day before. When asked if she provided ROM for the resident, CNA #10 stated, "It's been awhile." When asked to define "awhile," the CNA stated, "For me personally, probably a week ago."</p> <p>On 6/20/13 at about 4:00 p.m., RCM # 2 was asked about restorative services for Resident #4. When the RCM did not find any restorative documents in the resident's chart, she printed a</p>	F 318	<p>for time of referral to time of initiation daily Monday through Friday 3 times a week for 1 month then weekly X 2 months. Audits will be brought to Performance Improvement meeting for the next 3 months for tracking and trending.</p> <p><b>Specify by job title that will do the monitoring.</b> Director of Nursing/Designee</p> <p><b>Date when corrective action will be completed.</b> July 26, 2013</p>		

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F 318	<p>Continued From page 21</p> <p>Restorative Report for June 1 through 20, 2013, from the computer. This report documented the resident received PROM 15 minutes or longer on 15 of the 20 days, including 6/19 and 6/20, and 10 minutes on 6/8/13. When asked for the Restorative Program care plan, the RCM said she would ask the Restorative Nurse for it.</p> <p>On 6/20/13 at 4:15 p.m., RCM #2 informed the surveyor the Restorative Nurse was not available. The RCM reviewed a Restorative Resident Summary Report [RRSR] on the computer for Resident #4 with the surveyor. She said the RRSR was the resident's restorative care plan.</p> <p>The RRSR/care plan documentation included:          * Start Date: 3/27/13 and End Date: 5/10/13;          * Program Name - "Active ROM Program;"          * Program Help Text - "Resident prefers to participate in activities in the evening/NOC [night] shift;"          * Interventions: PROM to: fingers/wrists/elbows in all planes, shoulder flexion/extension, BLE in all planes, monitor pain/intolerance, notify LN of pain/intolerance/frequent refusals;</p> <p>At about 4:20 p.m., CNA #11 joined the conversation. When asked to provide documentation of PROM for the resident in June 2013, the RCM and CNA #11 CNA/RA documentation was in a computer program called CareTracker. The RCM printed a Restorative Detail Report (RDR) for Resident #4 from the computer.</p> <p>The RDR documented PROM was provided 21 times in 20 days (6/1-6/20/13). The RCM was also asked to print the RDR for March 2013. This</p>	F 318	<p><b>F-322</b></p> <p><b>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>LN#3 has been educated and performed a return demonstration of correctly flushing the g-tube related to administering medications via g-tube per policy and procedure</p> <p><b>How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</b></p> <p>Per record review residents utilizing g-tubes for medication administration have been identified. Per return demonstration nurses administering medications to a g-tube are flushing the tube in</p>		

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F 318	<p>Continued From page 22</p> <p>report documented an "Active ROM Program" began 3/28/13. When asked about the "Active ROM Program" documentation, the RCM said the Restorative Nurse would have to explain it. NOTE:: Refer to F514, regarding documentation accuracy, for details.</p> <p>Resident #4, who was at risk for contractures, received OT services until 3/20/13 and PT services until 3/21/13. Discharge plans for both OT and PT included a restorative program for PROM. However, per facility documentation, the restorative program did not start until 3/28/13, 7 days after PT ended and 8 days after OT ended.</p> <p>On 3/20/13 at about 6:30 p.m., the Administrator and DNS were informed in the issue. However, no other information or documentation was received from the facility that resolved the issue.</p>	F 318	<p>accordance with policy and procedure.</p> <p><b>What measures will be but in place or what systemic change you will make to ensure that the deficient practice does not recur</b></p> <p>License Nurses have been educated on facility policy and procedure of administering medications via g-tube, including flushing protocols before, after and between medications.</p>	
F 322 SS=D	<p>483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that --</p> <p>(1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and</p> <p>(2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p>	F 322	<p><b>How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place</b></p> <p>Residents receiving medications via g-tube will be observed by Resident Care Managers/Designees for correct flushing technique and frequency during medication administration 3 times weekly X 30</p>	

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F 322	Continued From page 23  This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure residents who received medications via a gastrostomy tube (g-tube) received the appropriate treatment. This was true for 1 random resident (#20) during medication pass observations. Failure to flush Resident #20's g-tube with water prior to the administration of medications and between each medication created the potential for tube-associated complications. Findings included:  Resident #20's recapitulation (recap) of Physician's Orders for June 2013 included: * "Flush with 30 ml H2O pre/post medications and 5 ml between each medication [Flush g-tube with 30 milliliters of water before and after medications and 5 milliliters [of water] between each medication]." * "Acyclovir 400 mg [milligrams] tablet... 1 tablet via tube 2 times a day." * "Docu [laxative] 50 mg/5 ml liquid: Give 10 ml... via tube 2 times a day..." * "Reglan 5 mg PT [per tube] Q [every] 6 [hours]." * "Mi-acid gas [same as Gas X] 80 mg... 1 tablet... 3 [times] daily..." * "Vitamin C 500 mg... 1 tablet via tube 2 times a day..." And, 6/4/13 Physician's Telephone Orders included Neurontin 300 mg 2 times a day.	F 322	days Monday through Friday then weekly X 2 months. These observations will be reviewed by the Director of Nursing and then brought to Performance Improvement for tracking and trending.  <b>Specify by job title that will do the monitoring. Director of Nursing/Designee</b>  <b>Date when corrective action will be completed. July 26, 2013</b>		

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F 322	Continued From page 24  On 6/18/13 at 5:10 p.m., LN #3 was observed as she poured then crushed Reglan, Neurontin, Acyclovir, Vitamin C, and Gas X for Resident #20. The LN poured the crushed medications (meds) into a single medication cup and she poured the Docu liquid into another med cup. LN #3 took the 2 med cups to Resident #20 and administered the medications in the 2 med cups back to back into Resident #20's g-tube. The LN did not flush the resident's g-tube before she administered the medications; nor, did she flush the g-tube between any of the medications.  At 5:25 p.m., upon return to the medication cart in the hallway, when asked about the omitted water flushes, LN #3 confirmed she had not flushed Resident #20's g-tube before or between administration of the medications. She stated, "No, I did not."  On 6/20/13 at about 6:30 p.m., the Administrator and DNS were informed of the issue. However, no other information or documentation was received from the facility.	F 322	<b>F-328</b>  <b>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</b>  Resident #6 is receiving the ordered amount of oxygen which is 2L per nasal cannula  Resident #5 has had his oxygen orders evaluated by his MD and resident is receiving ordered amount of oxygen with appropriate humidification and delivery apparatus  <b>How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</b>  Per record review residents using oxygen therapy have been identified. Components of oxygen	
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS  The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and	F 328		

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F 328	<p>Continued From page 25 Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure oxygen therapy was accurately administered; and, an order for oxygen via nasal cannula met standards of care. This affected 2 of 15 sampled residents (#5 &amp; 6). This practice created the potential for nasal irritation and possibly harm if the resident developed hyperoxia from being delivered too much oxygen. Findings included:</p> <p>1. Resident #6 was admitted on 10/28/08 and readmitted on 5/24/11 for multiple diagnoses, including C1-C4 spinal cord injury, diabetes mellitus, and muscle weakness.</p> <p>The resident's June 2013 Physician recapitulation orders documented an oxygen order dated 12/23/11, "O2 [oxygen] at 2 liters via nasal cannula continuously for SOB [shortness of breath] to keep sats [saturation] at or above 90%."</p> <p>On 6/18/13 at 8:15 AM during a dining room observation, Resident #6's oxygen canister was set at 2.5 liters per minute (LPM).</p> <p>On 6/20/13 at 9:47 AM, RCM #1 was interviewed regarding the dining room observation. She said the resident's oxygen should be kept at 2 liters and she did not know why it was set to 2.5 liters.</p> <p>On 6/20/13 at 6:15 PM, the Administrator and</p>	F 328	<p>therapy including orders, delivery system and accuracy of flow delivery are accurate and appropriate for diagnosis.</p> <p><b>What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur</b></p> <p>Nursing staff will be and has been in serviced on ensuring the flow rate of oxygen is as per MD order and appropriate delivery system for ordered amount of oxygen when oxygen therapy is being utilized.</p> <p><b>How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place</b></p> <p>Audits will be done daily for 30 days for 1 month 2 times a week for 1 month and then 1 time weekly times 2 months, to ensure accurate</p>	

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F 328	<p>Continued From page 26</p> <p>DNS were informed of the issue. No further information was provided.</p> <p>2. Resident #5 was admitted to the facility on 11/14/12 and had multiple readmissions. The last readmission was on 3/18/13, with multiple diagnoses which included lung cancer, metastatic malignant neoplasm of the liver, and chronic obstructive pulmonary disease (COPD).</p> <p>The resident's recapitulation of Physician's Orders for June 2013 included the order, "O2 at 1-10 liters via nasal cannula as needed...to keep sats at or above 89%."</p> <p>The resident's respiratory plan of care, dated 6/7/13, identified alteration in oxygen exchange as a problem. One of the interventions was, "O2 as ordered."</p> <p>Resident #5 was observed in bed with an O2 nasal cannula (NC) in his nostrils and the O2 concentrator set at 4 LPM as follows: * 6/18/13 at 1:40 p.m. and 4:30 p.m.; and * 6/19/13 at 11:05 a.m.</p> <p>The resident's O2 via NC was observed at 3.5 LPM on 6/19/13 at 12:35 p.m.</p> <p>On 6/20/13 at 2:55 p.m., the Respiratory Therapy Department Manager (RTDM) was asked about an order for O2 1-10 liter per NC. The RTDM stated, "Eight liter or above you need to go to a simple mask." The RTDM added, "If the order is 1-10 liters per nasal cannula, I would recommend order clarification and humidification for anything over 4 liters."</p>	F 328	<p>delivery of flow rate and appropriate delivery system is in place to residents with ordered oxygen therapy.</p> <p><b>Specify by job title that will do the monitoring.</b> Director of Nursing/Designee.</p> <p><b>Date when corrective action will be completed.</b> July 26, 2013</p>		

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F 328	Continued From page 27 NOTE: Regarding oxygen delivery via nasal cannula, the Lippincott Manual of Nursing Practice, ninth edition, states on page 244, "Because a nasal cannula is a low-flow system... Approximate oxygen concentrations delivered are: 1 L [liter] = 24% to 25%, 2 L = 27% to 29%...6 L = 39% to 45%." And on page 245 it states, "Flow rates in excess of 4 L/minute may cause irritation to the nasal and pharyngeal mucosa."  On 6/20/13 at about 6:30 p.m., the Administrator and DNS were informed of the issue regarding the O2 order. The DNS stated that she nor her staff would administer O2 at 10 lpm via NC. She indicated the resident's physician would be contacted for clarification. No other information was received from the facility.	F 328			
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS  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.  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	F 329			

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F 329	<p>Continued From page 28</p> <p>drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to provide physician justification for the continued use of an antidepressant, monitor the effectiveness of a medication for sleep and to monitor for hypoglycemia for a resident receiving insulin. This affected 2 of 7 sampled residents (#3 and #4) whose medications were reviewed and created the potential for harm related to adverse reactions and possible health decline. Findings include:</p> <p>1. Resident #3 was admitted to the facility on 6/24/11 with diagnoses including depression, diabetes and pain.</p> <p>a. Resident #3's 6/2013 recapitulation Physician Order included an order for Sertraline HCL (antidepressant) 100 mg orally once a day.</p> <p>The medical record did not include documentation a dose reduction had been considered by the interdisciplinary team or by the physician for the Sertraline.</p> <p>On 6/21/13 at 11:35 a.m., the DNS said the resident had been on the antidepressant since he was admitted (6/24/11). The DNS said a GDR</p>	F 329		

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F 329	<p>Continued From page 29</p> <p>had not been attempted in the last year as the resident had been discharged to the hospital on 4/5/13. The resident returned on 4/9/13 but because it was a considered to be a "new" admission, the facility did not feel a GDR was required.</p> <p>b. Resident #3's recapitulation Physician Order, dated 6/2013 included a section for "Diabetic Orders." The orders were as follows:</p> <p>Lantus 100 units/ml sub-Q (injection under the skin) daily at bedtime Metformin HCL 850 MG orally every morning Novolog 100 unit/ML sub-Q before meals per sliding scale CBG (capillary blood glucose) before meals. NOTE: There were no further orders related to BG levels in the recapitulation orders.</p> <p>Resident #3's 5/7/13 Progress Notes documented, " FSBS (finger stick blood sugar) at HS (hour of sleep) was 56. I gave resident a Glucerna shake ...BS (blood sugar) was 218, 1 hr (hour) later. "</p> <p>NOTE: The American Diabetic Association's (ADA) Standards of Medical Care in Diabetes, January 2010, defines hypoglycemia as a glucose level less than 70. The ADA recommends 15-20 grams of glucose in the treatment of hypoglycemia. The ADA also recommends checking BG levels 15 minutes after treatment. If the BG level showed continued hypoglycemia, the treatment and BG rechecks should be repeated until the BG level was normal.</p> <p>On 6/19/13 at 2:40 p.m. LN #9 was asked if the</p>	F 329			

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F 329	<p>Continued From page 30</p> <p>BG level should have been checked prior to the documented 1 hour check. He/she stated, "I would have rechecked in 15 minutes as I thought it was Standard of Practice." RCM #1 was present and stated he/she would check for further documentation. RCM #1 was also informed Resident #3's recapitulation orders did not include to notify the physician of low BG levels.</p> <p>On 6/20/13 at 9:00 a.m. the DON said for diabetes care the facility followed the Lippincott Manual of Nursing for standards of care or the physician orders. The DON was informed there was no documentation the blood sugar level had been rechecked in 15 minutes or the resident 's physician had been informed of the low blood sugar on 5/7/13.</p> <p>NOTE: Lippincott Manual of Nursing Practice, ninth edition, 2010, by Lippincott, Williams and Wilkins, page 961, under Preventing Injury Secondary to Hypoglycemia states, "Treat with 15 grams of rapidly absorbed carbohydrates...wait 15 minutes... repeat the blood glucose check."</p> <p>The Administrator and DON were informed of the above concern on 6/20/13 at approximately 6:00 p.m. The facility provided no further information.</p> <p>2. Resident #4 was admitted to the facility on 2/13/13 and readmitted on 2/27/13, with multiple diagnoses including quadriplegia, chronic respiratory failure, aftercare tracheostomy, and ventilator dependence.</p> <p>Resident #4's recapitulation of Physician's Orders for June 2013 included an order for Trazodone 50 milligrams daily at bedtime. The order was dated</p>	F 329	<p><b>F-329</b></p> <p><b>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>Resident #3 has been reviewed by interdisciplinary team (IDT) for GDR of sertraline HCL.</p> <p>Resident #3 orders have been updated to include parameters for MD notification and interventions related to hypoglycemia.</p> <p>Resident #4 sleep monitor has been added for tracking number of hours slept and diagnosis added.</p>		

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F 329	Continued From page 31 2/27/13. However, an indication, or diagnosis, for the medication was not included in the recap.  On 3/12/13, in response to a Consultation Report request, Resident #4's physician documented, "Trazodone is for sleep cycle disturbance."  On 6/18/13 at 8:25 a.m., Resident #4 was interviewed. The resident stated, "I'm a night person. Sometimes I'm up till 9 a.m. then I crash till about lunch time then I go back to sleep."  Review of Resident #4's clinical record, including the MARs and TARs, revealed there was no documented evidence the facility monitored the resident's hours of sleep each shift.  On 6/20/13 at 4:00 p.m., the 600 Hall Interim Resident Care Manager (RCM) was interviewed. When asked about Resident #4's hours of sleep related to the use of Trazodone for sleep, the RCM reviewed the resident's clinical record then stated, "I don't see it."  On 6/20/13 at about 6:15 p.m., the Administrator and DNS were informed of the issue. No other information or documentation was received from the facility that resolved the issue.	F 329	<b>How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</b>  An audit has been performed to ensure that all residents with psychotropic medications have been reviewed for GDR's.  All diabetics have been reviewed to ensure they include parameters and interventions related to hypoglycemia.  All residents who are on medications for sleep have been reviewed to ensure sleep monitoring and diagnosis is in place.		
F 441 SS=F	<b>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</b>  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program	F 441			

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F 441	<p>Continued From page 32</p> <p>The facility must establish an Infection Control Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) 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.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of Infection Control records, it was determined the facility failed to ensure accurate infection control reports were shared with the Infection Control Committee (ICC) in order for the ICC to develop and implement corrective action plans,</p>	F 441	<p><b>What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur</b></p> <p>IDT has been educated to regulation related to psychotropic medications and GDR's.</p> <p>Licensed staffs have been educated to the Lippincott manual of hypoglycemia intervention. Licensed staff has also been educated to necessary orders to be in place with diabetics related to hypoglycemia.</p> <p>IDT and licensed staff have been educated to requirement for diagnosis and sleep monitoring related to psychotropic medications ordered for sleep.</p>	
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F 441	<p>Continued From page 33</p> <p>based upon data collection, which included known diagnoses of active infections; and, that staff adhered to standard infection control measures. This was true for 2 of 11 sample residents (#s 9 and 10), 2 random residents (#s 19 and 20), and had the potential to affect all residents who lived in the facility. Failure to utilize infection control data and to report all infections to the ICC in order for the committee to develop and implement a corrective action plan, placed all the residents in the facility at risk for infections. In addition, failure to perform hand washing/hygiene before and after the administration of medication, before PICC (peripherally inserted central catheter) line flushes and after toileting assistance and, to maintain an uncovered urinary drainage bag off the floor, placed residents #9, 10, 19 and 20 and any residents whom staff cared for after caring for these residents at risk for infections. Findings include:</p> <p>1. On 6/20/13 from 9:15 a.m. to 10:30 a.m., the Infection Control Nurse (ICN) was interviewed about the facility's infection control program. The DNS was present during the interview until 10:15 a.m.</p> <p>a) Review of the Monthly Line Listing Report / Monthly Healthcare Associated Infection Incident Rate (MLLR/MHAIRR) log for May 2013 revealed:</p> <ul style="list-style-type: none"> <li>* Fourteen residents had UTI (urinary tract infection), 9 of which were facility acquired;</li> <li>* Six residents had pneumonia, 4 of which were facility acquired;</li> <li>* Five residents had a skin infection (included cellulitis and wounds), 3 of which were facility acquired;</li> <li>* Two residents had C-diff (Clostridium difficile),</li> </ul>	F 441	<p><b>How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place</b></p> <p>Psychotropic medications will be reviewed for Gradual Dose Reduction admission, quarterly, annual, change of condition and PRN.</p> <p>Diabetic orders related to hypoglycemia will reviewed on admission, quarterly, annual, change of condition and PRN.</p> <p>Psychotropic medications ordered for sleep will be reviewed for diagnosis and appropriate sleep monitoring on admission, quarterly, annual, change of condition and PRN</p> <p>Any trends identified will be brought to performance improvement for review monthly x 3 months and PRN</p>	

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F 441	<p>Continued From page 34</p> <p>both of which were acquired in the facility; * One resident was admitted with sepsis; and, * One resident was admitted with osteomyelitis.</p> <p>Review of the mapping tool revealed only 4 of the aforementioned infections (1 UTI, 1 GI, and 2 respiratory) were tracked on a map of the facility in May 2013.</p> <p>Review of the May 2013 Infection Control report revealed the following documentation, "[Four] infections that met the CDC [Center for Disease Control] guidelines, 1 UTI, 2 respiratory, 1 GI [gastrointestinal][.] Trending[:] 100 [hall]-none 200 [hall] -1-1 respiratory 300 [hall]-1-none 500 [hall]-1-1-respiratory 600-1-GI and 1 UTI[.] No trends noted, 2 respiratory and both residents are on separate wings."</p> <p>When asked about the difference in the number of infections documented in the May 2013 MLLR/MHAIR log and those noted in the infection control report and on the mapping tool, the ICN and the DNS both stated only those infections which met the CDC guidelines for infections, based on McGeer criteria for infections, were included in the report and mapping tool.</p> <p>Infection Surveillance Worksheets (ISW) for the individual residents identified on the May 2013 MLLR/MHAIR log were reviewed with the ICN. Review of these worksheets revealed positive urine cultures for all but 1 of the facility acquired UTI. The review also revealed there were no trends.</p> <p>When asked how the ICC was appraised of the</p>	F 441	<p><b>Specify by job title that will do the monitoring.</b> Director of Nursing/Designee</p> <p><b>Date when corrective action will be completed.</b> July 26, 2013</p>		

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F 441	<p>Continued From page 35</p> <p>true number of infections in the facility, the DNS said she, the ICN, and RCM #7 discussed infections every morning and infections were a topic in the daily standup meetings with the Administrator and department heads. The ICN said infection control reports were presented during monthly Quality Assurance meetings, and, "We talk about it but it's not in the report." After discussion, the ICN stated, "I see what you mean." She agreed the information did not formulate any conclusions to ensure issues and/or trends were addressed.</p> <p>b) When asked how staff were monitored regarding the implementation of infection control measure, such as hand hygiene and the use of PPE (personal protective equipment), the ICN said the Education Nurse monitored staff.</p> <p>On 6/20/13 at 11:05 a.m., the Education Nurse (EN) was interviewed. The EN said she performed medication pass audits of LNs. She stated, "I watch them pass meds. I announce it and they know the observation is being done." She stated the results are discussed and reviewed with the LN who was observed. When asked if other staff were monitored/observed regarding the implementation of infection control measure such as hand hygiene and the use of PPE, the EN stated, "No. There's not a tool like that." The EN added, "The med nurses watch for that." She stated, "Med Pass Competency is the only audit I have."</p> <p>ICN did not include complete information about infections in the facility in the reports provided to the ICC. Per guidance at F441 included under Data Analysis, "It is important that surveillance</p>	F 441	<p><b>F-441</b></p> <p><b>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>All infections have been crossed referenced to map and updated.</p> <p>Resident #19 has a dignity bag in use for urinary drainage. The contaminated drainage bag has been changed and the dignity bag-located on w/c had been relocated to promote it staying covered</p> <p>LN #3, LN #4 and CNA #8 were educated to proper infection control procedures related to hand washing and glove changes.</p>		

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F 441	<p>Continued From page 36</p> <p>reports be shared with appropriate individuals including, but not limited to, the director of nursing and medical director. In addition, it is important that the staff and practitioners receive reports that are relevant to their practices to help them recognize the impact of their care on infection rates and outcome."</p> <p>In addition, the facility did not ensure all disciplines of staff were monitored to ensure infection prevention based on current standards of practice was consistently implemented.</p> <p>On 6/20/13 at about 6:30 p.m., the Administrator was informed about infection control issues. No other information or documentation was received from the facility that resolved the issues.</p> <p>2. On 6/17/13 at 5:45 p.m., just before the evening meal service, Resident #19 was observed reclined in a geri-chair in the assisted area of the main dining room. Resident #19's uncovered urinary drainage bag was observed hanging at the left side of the resident's geri-chair and the bottom of the bag was in contact with the floor. A privacy cover was also noted at the left side of the resident's geri-chair.</p> <p>At about 5:50 p.m., the RCM #1 and CNA #6 entered the dining room. They moved Resident #19 up in the geri-chair. After that, the RCM placed the resident's drainage bag into the privacy bag on the geri-chair.</p> <p>Immediately afterward, when informed Resident #19's uncovered urinary drainage bag was observed in contact with the floor, the RCM stated the resident's leg spasms caused the</p>	F 441	<p><b>How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</b></p> <p>In house audit has been completed to identify any residents on antibiotic that meet criteria for infection control reporting and added as appropriate</p> <p>Audit of all residents with catheters to ensure dignity bag in is place and being utilized</p> <p>Education and skills checks have been completed on nursing staff by education nurse to ensure proper infection control measures are utilized for hand washing the use of PPE.</p>	

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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
F 441	<p>Continued From page 37</p> <p>drainage bag to "work its way out" of the privacy cover. The RCM indicated she would take care of the resident's contaminated urinary drainage bag after lunch.</p> <p>On 6/20/13 at 6:15 p.m., the Administrator and DNS were informed of the infection control issue. No other information or documentation was received from the facility.</p> <p>3. On 6/18/13 at 5:10 p.m., LN #3 was observed as she administered 6 medications into Resident #20's g-tube; then, with the same gloves on, the LN flushed the resident's 3 PICC lines. LN #3 did not remove her gloves, perform hand hygiene, or apply new gloves after she administered the medications via the g-tube and before she flushed the PICC lines.</p> <p>At 5:25 p.m., when asked about hand hygiene after the administration of the g-tube medications and before the PICC line flushes, LN #3 stated, "No, I didn't. I should have, now that you said that."</p> <p>On 6/20/12 at about 6:15 p.m., the Administrator and DNS were informed of the infection control issue. No other information or documentation was received from the facility.</p> <p>4. On 6/19/13 at 11:00 a.m., LN #4 was observed as she removed a bottle of artificial tears from the medication cart and took the bottle to Resident #9. The LN administered one drop of the artificial tears into each of the resident's eyes. Then the LN removed her gloves and left the room. LN #4 did not wash her hands before or after she administered Resident #9's eye drops.</p>	F 441	<p><b>What measures will be but in place or what systemic change you will make to ensure that the deficient practice does not recur</b></p> <p>The infection control nurse has been educated to appropriate tracking, trending and reporting of infections.</p> <p>The education nurse was in serviced by Regional Director of Clinical Operation to the infection control policy and procedures related to hand washing and use of personal protective equipment with subsequent monitoring of staff to ensure compliance</p> <p>Education and skills checks have been completed on nursing staff by education nurse to ensure proper infection control measures are utilized or hand washing the use of PPE.</p>	

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F 441	Continued From page 38  Immediately afterward, when informed of the observation, LN #4 stated, "I should have washed my hands."  On 6/20/12 at about 6:15 p.m., the Administrator and DNS were informed of the infection control issue. No other information or documentation was received from the facility.  5. Resident #10 was admitted to the facility on 1/27/05 and readmitted on 12/3/12 with diagnoses which included malignant neoplasm colon (tumor of colon or rectum), atrial fibrillation and bone and cartilage disease.  Resident #10 's most recent MDS quarterly assessment, dated 4/30/13, documented extensive assistance for bed mobility, transfers, to toilet and personal hygiene.  During an observation, on 6/19/13 at 8:53 a.m., two CNA's were observed to use a sit to stand lift to transfer Resident #10 to the toilet. CNA #8 was observed to carry a wash basin into the toileting area and after a few minutes remove his/her gloves and leave the resident's room without washing his/her hands. CNA #8 returned to the resident's room and put on a clean pair of gloves without washing his/her hands. At that time the surveyor asked CNA about washing his/her hands. CNA #8 stated his/her hands should have been washed prior to leaving the room and when he/she returned.	F 441	<b>How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place.</b>  Audits of the infection control map and log will occur weekly on Wednesdays x 4 weeks then Monthly x 3 months by DNS or designee to ensure compliance. Any trending in infections will be brought to Performance Improvement for follow up  Audits of residents with catheters will be completed on M-W-F x 4 weeks then weekly x 4 weeks to ensure compliance. Any trending will be brought to Performance Improvement for follow up  Direct observations of care of nursing staff will be conducted to ensure proper infection control procedures are followed in relation		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE	F 514			

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

PRINTED: 07/02/2013  
FORM APPROVED  
OMB NO. 0938-0391

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F 514	<p>Continued From page 39</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure ensure the accuracy of medical records. This was true for 5 of 10 resident records reviewed (#1, 4, 6, 9 and 10). Care plans did not reflect the current status of residents, physician recap orders did not include all necessary information and records did not accurately document the delivery of ROM services. The placed residents at risk of having a record that was not reflective of their progress or change in condition. Findings include:</p> <p>1. Resident #6 was admitted on 10/28/08 and readmitted on 5/24/11 with multiple diagnosis including C1-C4 spinal cord injury, diabetes mellitus, and muscle weakness.</p> <p>The resident's hospice Discharge Summary form, documented the resident was discharged from a local hospice agency on 11/5/12.</p> <p>The resident's current Mood and Behavior</p>	F 514	<p>to hand washing and use of PPE. Observations will occur daily X 30 days Monday through Friday then weekly X 2 months. These observations will be reviewed by the Director of Nursing and then brought to Performance Improvement for tracking and trending.</p> <p><b>Specify by job title that will do the monitoring.</b> Director of Nursing/Designee</p> <p><b>Date when corrective action will be completed.</b></p> <p>July 26, 2013</p>		

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F 514	<p>Continued From page 40</p> <p>Symptom Assessment/Plan of Care dated 2/13 with a due date of 8/13, documented as an intervention, "Hospice." NOTE: The word was highlighted, but was not crossed out, dated or initialed.</p> <p>RCM #1 was interviewed on 6/20/13 at 1:25 PM regarding the highlighted word and she stated, "it means they dc'd (discontinued) it." She said the resident was no longer on hospice and there should have been a line through the word.</p> <p>2. Resident #10 was admitted to the facility on 1/27/05 and readmitted on 12/3/12 with diagnoses which included malignant neoplasm colon (tumor of colon or rectum), atrial fibrillation and bone and cartilage disease.</p> <p>a) Resident #10's 6/2013 recapitulation Physician's Order had the following medications without a diagnosis:</p> <p>Furosemide 40 mg tablet 2 times a day Glucosamine 500 mg 1 time a day Levothyroxine 12 mcg 1 time a day Metolazone 5 mg 1 time a day</p> <p>On 6/20/13 at 5:45 p.m., RCM #1 said the pharmacy had dropped the diagnoses off of the recapitulation orders and the facility had not, "caught it."</p> <p>b) Resident #10's "Plan of Care: Pain Management" (CP) was dated 4/24/13. A box in the Problem section had been marked that identified the use of a pain pump.</p> <p>On 6/20/13 at 9:30 a.m., RCM #1 said the date</p>	F 514	<p><b>F-514</b></p> <p><b>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>LN's were educated on the proper procedure for discontinuing orders and on mars, tars and care plans. LN's were instructed how to review physician orders for appropriate follow through.</p> <p><del>#1</del> Resident #<sup>#6</sup> hospice order was discontinued properly on care plan.</p> <p>Resident #10 physician's orders have been reviewed and corrected to reflect proper diagnosis for medications.</p> <p>Resident #10 Physicians order has been reviewed and corrected to reflect appropriate recapitulation and pharmacy notified regarding</p>	

*Res #1 changed to Resident #6 - T780 by facility. Corrected with permission via telephone with Don Julie Weir at 10:45 AM on July 26, 2013*

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F 514	<p>Continued From page 41 should have been crossed out as the resident did not have a pain pump.</p> <p>c) Resident #10's Diabetes CP had been marked to implement the following interventions:</p> <p>Administer hypoglycemic medications per MD order Administer insulin per MD order Assess for symptoms of hypo/hyperglycemic Check blood glucose as needed Document actions taken for hyper/hypoglycemia Encourage client to participate in physical exercise Encourage to avoid foods that are concentrated sweets Follow up with physician as needed Follow with protein snack such as peanut butter or cheese sandwich, diabetic nutrition bar, milk</p> <p>The CP did not identify that the protein snack was to be given after a low blood sugar had returned to an acceptable level.</p> <p>3. Resident #3 was admitted to the facility on 6/24/11 with diagnoses including depression, diabetes and pain.</p> <p>Resident #3's CP for Diabetes had similar interventions as the CP for Resident #10. The CP did not identify that the protein snack was to be given after a low blood sugar had returned to an acceptable level.</p> <p>On 6/20/13 at 9:30 a.m., RCM #1 was informed that the CP's for Residents #3 and #10 did not clarify if the protein snack was for hypoglycemia or hyperglycemia. RCM #1 said the CPs needed</p>	F 514	<p>proper follow through on monthly orders.</p> <p>Resident #10 Plan of Care was corrected to reflect discontinuation of a pain pump.</p> <p>Resident #10 Care plan was corrected to identify a protein snack is to be given after a low blood sugar and returned to an acceptable level.</p> <p>Resident #3 Care plan was corrected to identify a protein snack is to be given after a low blood sugar and returned to an acceptable level.</p> <p>Resident # 1 #3 and #10 Care plan was corrected to reflect whether protein snack was given for hypoglycemia or hyperglycemia.</p> <p>Resident #9 monthly recap orders for Methadone have been reviewed and corrected to reflect current order. Pharmacy has been notified and instructed on proper follow</p>		

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F 514	<p>Continued From page 42</p> <p>to be clarified for hypoglycemia in the intervention section.</p> <p>4. Resident #9 was admitted to the facility on 8/31/10 with severe left hip arthritis unresponsive to conservative measures, osteoporosis, and chronic kidney disease.</p> <p>The resident's most recent quarterly MDS assessment, dated 5/3/13, coded, in part: * Intact cognition with a BIMS score of 14; * Received scheduled pain medication at any time in the last 5 days; and * Frequent pain at a 7 (on a numeric rating scale of 1-10).</p> <p>The resident's pain management care plan, dated 4/22/13, identified the problem, "Persistent Pain (Chronic)." One of the interventions was, "Administer pain medication as ordered."</p> <p>Resident #9's June 2013 MAR included instructions for Methadone 20 milligrams by mouth every morning and 10 milligrams every noon, PM, and bedtime. Both doses of the Methadone were documented as administered as directed.</p> <p>However, the resident's recapitulation (recap) of Physician's Orders for May and June 2013 did not include any orders for Methadone.</p> <p>On 6/20/13 at 11:50 a.m., RCM #1 was asked about Resident #9's Methadone. The DNS and the Education Nurse (EN) were present during the interview. Upon review of the resident's orders, the RCM and DNS acknowledged that Methadone was not on the recap orders. The</p>	F 514	<p>through on monthly physician's orders.</p> <p>Resident #4's Restorative Program reflects corrected Passive range of motion program and restorative nurse educated to provide restorative assessment within a timely manner and to review appropriateness of program selected.</p> <p><b>How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.</b></p> <p>Residents on restorative programs have been identified per record review and will continue to be reviewed along with new potential residents Recap order protocols have been reviewed. Pharmacy has been instructed on proper procedures for follow through on</p>		

*Added #4 to Resident identifier via permission via telephone with Don Sullivan wem at 10:45 AM on July 26, 2013*

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F 514	<p>Continued From page 43</p> <p>RCM said Methadone should be on the recap and the resident would be in severe pain without it. The RCM stated, "The Methadone was dropped off the June recap by pharmacy and I didn't write in on the recap. And, I missed it in May too." The EN stated, "We have a 2 person double check." And, the DNS stated, "Pharmacy generates the recap." The DNS indicated the pharmacy would be contacted about the omitted medication.</p> <p>No other information or documentation was received from the facility that resolved the documentation issue.</p> <p>5. Resident #4 was admitted to the facility on 2/13/13 and readmitted on 2/27/13, with multiple diagnoses including quadriplegia, chronic respiratory failure, aftercare tracheostomy, ventilator dependence, and multiple pressure ulcers.</p> <p>The resident's admission and quarterly MDS assessments, dated 3/6/13 and 5/26/13 respectively, coded, in part:</p> <ul style="list-style-type: none"> <li>* Intact cognition, with a BIMS score of 15;</li> <li>* Required total assistance with bed mobility, dressing, eating, toileting, personal hygiene and bathing; and</li> <li>* Functional limitation in ROM in both upper extremities (UE) and lower extremities (LE).</li> </ul> <p>The two MDS assessments differed, in part, as follows:</p> <p>3/6/13</p> <ul style="list-style-type: none"> <li>* Occupational Therapy (OT) was administered 6 of the last 7 days;</li> <li>* Physical Therapy (PT) was administered 6 of the last 7 days; and,</li> </ul>	F 514	<p>orders and all orders are being reviewed. Medications are being reviewed to reflect diagnosis placement on orders mars and tars. Current diabetic residents as well as new diabetic residents will be reviewed for proper protocols and documentation.</p> <p><b>What measures will be but in place or what systemic change you will make to ensure that the deficient practice does not recur.</b></p> <p>Per record review all residents on restorative programs will be reviewed licensed staff have been educated to proper. iabetics will be reviewed for appropriate procedures and monitoring.</p>	

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F 514	<p>Continued From page 44</p> <p>* No Restorative Nursing Program was performed in the last 7 calendar days. 5/26/13</p> <p>* OT was administered 6 of the last 7 days; and, * Restorative Nursing Program of passive ROM (PROM) was provided 5 of the last 7 calendar days.</p> <p>Review of OT documentation revealed the resident was discharged from OT services on 3/20/13 with plans for a restorative program for PROM to B [both] UE.</p> <p>Review of PT documentation revealed the resident was discharged from PT services on 3/21/13 with the goal for the resident to "achieve PROM of knees...and ankles...with a restorative aide program established...to help his circulation, joint integrity and prevent contracture formations."</p> <p>On 6/20/13 at 4:20 p.m., upon request, RCM #2 printed Resident #4's restorative nursing documentation for March 2013 and June 2013. The March report documented the resident received an "Active ROM Program" from 3/28/13 through 5/9/13 and a "Passive ROM Program" from 5/10/13 through 6/21/13. When asked about documentation of an active, rather than passive, ROM program, the RCM said the Restorative Nurse would have to explain it.</p> <p>On 6/20/13 at about 6:25 p.m., the Administrator and DNS were informed of the issue.</p> <p>On 6/21/13 at approximately 11:30 a.m., the DNS stated the Restorative Nurse had accidentally highlighted the Active ROM Program when she first entered information into the computer for</p>	F 514	<p><b>How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place.</b></p> <p>Monitoring of all diabetic residents, restorative residents, physician order recaps and care plans will be reviewed by audit 3 x a week x 4 weeks, 2 x weekly for 1 month and then monthly x 2 months. Any trends will be identified at performance improvement x 3 months.</p> <p><b>Specify by job title that will do the monitoring.</b> Director of Nursing/Designee.</p> <p><b>Date when corrective action will be completed.</b></p> <p>July 26, 2013</p>	

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F 514	Continued From page 45 Resident #4 and the Restorative Nurse was unable to "go back" in the computer program to correct the problem. The DNS added, however, that the error was later corrected and documentation was under the Passive ROM Program after that.	F 514			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001350</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/21/2013</b>
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C 000	16.03.02 INITIAL COMMENTS  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. The following deficiencies were cited during the State licensure survey of your facility.  The surveyors conducting the survey were: Brad Perry, BSW, LSW Team Coordinator Sherri Case, BSW, LSW, QMRP Linda Kelly, RN	C 000	<b>C125</b>  See F-241  <b>C664</b>  See F-441  <b>C669</b>	
C 125	02.100,03,c,ix Treated with Respect/Dignity  ix. Is treated with consideration, respect and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; This Rule is not met as evidenced by: Refer to F241 as it related to dignity.	C 125	<b>C782</b>  See F-280	
C 644	02.150,01,a,i Handwashing Techniques  a. Methods of maintaining sanitary conditions in the facility such as:  i. Handwashing techniques. This Rule is not met as evidenced by: Refer to F441 as it related to hand hygiene in the facility.	C 644	<b>C784</b>  See F-382 <b>F309/F322</b>	
C 669	02.150,03 PATIENT/RESIDENT PROTECTION  03. Patient/Resident Protection. There is evidence of infection	C 669		

**RECEIVED**  
**JUL 18 2013**  
**FACILITY STANDARDS**

Bureau of Facility Standards

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

STATE FORM

6899

JTY011

TITLE

*Administrator*

(X6) DATE

**7-17-13**

If continuation sheet 1 of 4

*changed F 382 to F 309/322 -  
+ 180 by facility with permission  
via telephone with Don Julie wein  
at 10:45 AM on July 26 2013*

Bureau of Facility Standards

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C 669	Continued From page 1  control, prevention and surveillance in the outcome of care for all patients/residents as demonstrated by: This Rule is not met as evidenced by: Refer to F441 as it related to the infection control program.	C 669	<b>C788</b>  See F-328  <b>C796</b>	
C 782	02.200,03,a,iv Reviewed and Revised  iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Please see F 280 as it pertains to care plan revisions.	C 782	See F-318  <b>C835</b>  See F-176	
C 784	02.200,03,b Resident Needs Identified  b. Patient/resident needs shall be recognized by nursing staff and nursing services shall be provided to assure that each patient/resident receives care necessary to meet his total needs. Care shall include, but is not limited to: This Rule is not met as evidenced by: Refer to F309 as it related to following care planned interventions and the interchange of useful and necessary information between the facility and dialysis providers. Also, refer to F322 as it related to gastrostomy tube care.	C 784	<b>C881</b>  See F-514	
C 788	02.200,03,b,iv Medications, Diet, Treatments as Ordered  iv. Delivery of medications, diet and treatments as ordered by the	C 788		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001350</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/21/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>LACROSSE HEALTH &amp; REHABILITATION CEN1</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>210 WEST LACROSSE AVENUE COEUR D'ALENE, ID 83814</b>		
(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) COMPLETE DATE
C 788	Continued From page 2  attending physician, dentist or nurse practitioner; This Rule is not met as evidenced by: Refer to F328 related to improper liter flow for oxygen therapy.	C 788		
C 796	02.200,03,b,xii Rehabilitative Nursing Standards  xii. Rehabilitative nursing current with acceptable professional practices to assist the patient/resident in promoting or maintaining his physical functioning. This Rule is not met as evidenced by: Refer to F318 as it related to range of motion for a resident.	C 796		
C 835	02.201,02,i Meds in Possession of Resident Limitations  i. No medication shall be in the possession of the patient/resident unless specifically ordered by the physician on the patient's/resident's medical record, and in no case shall exceed two (2) units of dosage. All such medications shall be individually packaged by the pharmacist in units of dose, labeled with the patient's/resident's name, unit of dose, and date of distribution. The charge nurse shall maintain an inventory of these drugs on the patient's/resident's medical record.  This Rule is not met as evidenced by: Refer to F176 as it related to medication self-administration.	C 835		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001350</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>06/21/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>LACROSSE HEALTH &amp; REHABILITATION CEN</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>210 WEST LACROSSE AVENUE COEUR D'ALENE, ID 83814</b>		
(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) COMPLETE DATE
C 881	Continued From page 3	C 881		
C 881	02.203,02 INDIVIDUAL MEDICAL RECORD  02. Individual Medical Record. An individual medical record shall be maintained for each admission with all entries kept current, dated and signed. All records shall be either typewritten or recorded legibly in ink, and shall contain the following: This Rule is not met as evidenced by: Refer to F514 regarding medical record issues.	C 881		



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

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BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0009  
PHONE 208-334-6626  
FAX 208-364-1888

July 3, 2013

Troy L. Thayne, Administrator  
LaCrosse Health & Rehabilitation Center  
210 West LaCrosse Avenue  
Coeur d'Alene, ID 83814-2403

Provider #: 135042

Dear Mr. Thayne:

On June 21, 2013, an on-site follow-up revisit of your facility was conducted to verify correction of deficiencies noted during the Complaint Investigation survey of April 18, 2013. LaCrosse Health & Rehabilitation Center was found to be in substantial compliance with health care requirements as of **May 20, 2013**.

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

Thank you for the courtesies extended to us during our follow-up revisit. If you have any questions, concerns or if we can further assist you, please call this office at (208) 334-6626.

Sincerely,

LORENE KAYSER, L.S.W., Q.M.R.P., Supervisor  
Long Term Care

LKK/dmj  
Enclosures