



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

January 20, 2015

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

FILE COPY

Provider #: 135042

Dear Mr. McVay:

On **December 29, 2014**, a Complaint Investigation survey was conducted at LaCrosse Health & Rehabilitation Center by the Idaho Department of Health and Welfare, Division of Licensing and Certification, 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 an isolated deficiency that constitutes actual 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 sign both the 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 **February 2, 2015**. Failure to submit an acceptable PoC by **February 2, 2015**, may result in the imposition of civil monetary penalties by **February 23, 2015**.

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

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained.
- Include dates when corrective action will be completed in column (X5).

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of 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 **February 2, 2015 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **February 2, 2015**. A change in the seriousness of the deficiencies on **February 2, 2015**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **February 2, 2015** includes the following:

Denial of payment for new admissions effective **March 29, 2015**. [42 CFR §488.417(a)]

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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 **June 29, 2015**, if substantial compliance is not achieved by that time.

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

If you believe these deficiencies have been corrected, you may contact Lorene Kayser, L.S.W., Q.I.D.P. or David Scott, R.N., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, Option #2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **December 29, 2014** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the 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

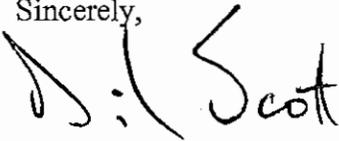
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2001-10 IDR Request Form

This request must be received by **February 2, 2015**. If your request for informal dispute resolution is received after **February 2, 2015**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Lorene Kayser, L.S.W., Q.I.D.P. or David Scott, R.N., Supervisors, Long Term Care at (208) 334-6626, Option #2.

Sincerely,

A handwritten signature in black ink that reads "D. Scott". The signature is written in a cursive style with a large initial "D" and a clear "Scott" following.

DAVID SCOTT, R.N., Supervisor
Long Term Care

DS/dmj
Enclosures

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

PRINTED: 01/20/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/29/2014
NAME OF PROVIDER OR SUPPLIER LACROSSE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 210 WEST LACROSSE AVENUE COEUR D'ALENE, ID 83814	
(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	INITIAL COMMENTS The following deficiencies were cited during the complaint survey of your facility. The survey team entered and exited the facility on December 29, 2014. The surveyors were: Arnold Rosling RN, QIDP Lorraine Hutton RN Judy Atkinson RN Survey Definitions: BIMS = Brief Interview of Mental Status BS, BG, FSBS = Blood Sugar CAA = Care Area Assessment CNA = Certified Nursing Assistant DNS/DON = Director of Nursing IDDM = Insulin Dependent Diabetes Mellitus IDT = Interdisciplinary Team MAR = Medication Administration Record MDS = Minimum Data Set LN = Licensed Nurse LPN = Licensed Practical Nurse mg = milligrams RN = Registered Nurse SSD = Social Services Director TAR = Treatment Administration Record	F 000	POC Lacrosse F280@D F309@G F356@C F514@D "This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. The submission of this plan of correction is not a submission of our agreement of the deficiencies or conclusions contained in the Departments inspection report."	
F 280 SS=D	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	F 280	F-280 <u>Corrective action accomplished for affected residents by the deficient practice:</u> Resident #8 has had her careplan updated and is now reflective of the diabetic protocol.	

RECEIVED
FEB 25 2015
FACILITY STANDARDS

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

TITLE

(X6) DATE

Paul M. Vay N.H.A. 1-30-15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 280	<p>Continued From page 1</p> <p>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.</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 that changes made to the facility and resident specific protocols were care planned. This was true for 1 of 9 (#8) sampled residents. There was a potential for harm when a care plan failed to include complete and accurate information on how to care for a resident. Findings include:</p> <p>Resident #8 was admitted to the facility on 7/14/10 with diagnoses of Type II diabetes without complications, bipolar disorder unspecified, anxiety disorder, and depressive disorder.</p> <p>The facility adopted a hypoglycemic protocol in 12/2014 to be used on all diabetic residents in the facility. The protocols included:</p> <ul style="list-style-type: none"> - Administer 1/2 cup or 4 ounces juice, 1 cup skim milk, 3 glucose tablets, 4 sugar cubes, 5 to 6 pieces of hard candy if resident able to swallow. - Administer glucagon 1 gm subcutaneously of I.M. if resident cannot ingest per physician order. - Administer hypoglycemic measures with 15 to 	F 280	<p><u>How the facility will identify other residents who have the potential to be affected by the same deficient practice:</u></p> <p>Residents with the diagnosis of Diabetes residing at the facility have the potential to be affected by the deficient practice. Residents with the diagnosis of Diabetes have had their diabetic careplans audited and now accurately reflect their diabetic protocol</p> <p><u>Root Cause Analysis and what measures will be put in place to ensure that the deficient practice does not recur:</u></p> <p>RCA- Execution of Process resulting in lack of follow through with care plan reviews.</p> <p>Nurse managers and the CCPR (comprehensive care plan review) IDT team have been in-serviced on careplan requirements for diabetes.</p> <p>Careplans will be evaluated and updated during admission and comprehensive care plan review in accordance with the MDS schedule</p>		

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F 280	Continued From page 2 20 grams of fast acting carbohydrates. The resident's 9/8/14 care plan for "Potential for Alteration/Alteration in Blood Glucose Levels related to Diagnosis of IDDM - adult onset" had the protocols on the preprinted care plan but the facility failed to designate they applied to the resident. The acting director of nursing (ADON) was interviewed on 12/29/14 at 2:00 p.m. and indicated the resident's care plan should have been updated to reflect the protocols. No further information was provided.	F 280	<u>How the facility plans to monitor performance to ensure the corrective action (s) are effective and compliance is sustained:</u> Residents with the diagnosis of diabetes will have their careplans audited weekly X 12 weeks. Audits will be reviewed at monthly QAPI X 3 months for further education and training opportunities. <u>Dates when corrective action will be completed:</u> 2-2-15	
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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 record review, review of facility incident reports and staff interviews, it was determined the facility failed to ensure nursing staff followed residents' hypoglycemic protocol and assessed and responded to episodes of low blood sugar and change in condition. This affected 1 of 6 residents (Resident #1) reviewed for diabetic care. The failure to follow the Resident #1's diabetic	F 309	F-309 <u>Corrective action accomplished for affected residents by the deficient practice:</u> Resident #1 is no longer at the facility. <u>How the facility will identify other residents who have the potential to be affected by the same deficient practice:</u>	

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F 309	<p>Continued From page 3</p> <p>plan of care resulted in harm to the resident when she became severely hypoglycemic, unresponsive, and required emergency care. Findings include:</p> <p>The American Diabetic Association (ADA) documented in the "Standards of Medical Care in Diabetes-2012," page S27, "...Prevention of hypoglycemia is a critical component of diabetes management. ...The stress of illness...frequently aggravates glycemic control... Any condition leading to deterioration in glycemic control necessitates more frequent monitoring of blood glucose..." The ADA defined hypoglycemia as a glucose level less than 70 mg/dL [milligrams per decaliter]. The ADA recommended 15-20 grams of glucose in the treatment of hypoglycemia. The ADA also recommended 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. The ADA further recommended that, "Glucagon should be prescribed for all individuals at significant risk of severe hypoglycemia..."</p> <p>Diabetes Spectrum, Volume 18, Number 1, 2005 stated in Table 4 titled, "Age-Specific Considerations Regarding Hypoglycemia," under the heading, "Geriatric," on page 43, "Elderly individuals may have hypoglycemia unawareness (i.e., they do not experience the early symptoms of hypoglycemia). This is particularly concerning because the blood glucose level continues to drop and may reach very serious levels (< 40 mg/dl) before hypoglycemia is recognized and treated."</p> <p>Resident #1 was last admitted to the facility on 11/25/14 with diagnoses including Diabetes</p>	F 309	<p>Residents with the diagnosis of Diabetes residing at the facility have the potential to be affected by the deficient practice.</p> <p><u>Root Cause Analysis and what measures will be put in place to ensure that the deficient practice does not recur:</u></p> <p><i>RCA- Execution of Process/ Staff Education resulting in lack of communication between C.N.A. and nurse and failure to initiate the hypoglycemic protocol.</i></p> <p>Residents with diabetes have had their blood glucose monitoring and protocol reviewed and combined onto the MAR (medication administration record). At the completion of each meal, C.N.A.'s will communicate in writing to nurse managers and the floor nurse using the STOP AND WATCH early detection tool from interact 3 for residents with diabetes with decreased po intake.</p>		

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F 309	<p>Continued From page 4</p> <p>Mellitus type II, encephalopathy, chronic renal failure and hypertension.</p> <p>The resident's 11/25/14 admission orders documented the resident was to receive 22 units of Lantus Insulin twice a day and provided the following diabetic protocol for episodes of hypoglycemia:</p> <p>* Check resident's BG before meals and at bedtime, notify the physician if BG was less than 50 or more than 400. The orders also documented protocol for treating low blood glucose as;</p> <p>* "If BS below 70 [mg/dl] and resident is able to swallow, administer 15 - 20 grams of fast acting carbohydrate (examples given)"</p> <p>* "If [resident] unable to swallow, give Glucagon 1mg SQ [sub cutaneous] or IM [intramuscular]."</p> <p>* "Re-check BS approximately every 15 minutes after giving carbohydrate until 90 [mg/dl] or above. Notify MD (physician) per orders."</p> <p>* "Follow-up with protein snack such as peanut [butter] or cheese sandwich, diabetic nutrition bar, milk."</p> <p>The resident's 12/2/14 MDS admission assessment coded the resident spoke clearly, had clear comprehension, was moderately cognitively disabled with evidence of acute onset of mental change, required extensive assistance of at least one person with eating, and received insulin 7 days per week.</p> <p>Nursing Notes, Weekly Blood Glucose/Sliding Scale Coverage Monitoring Record (WBG/SS MR) for December 2014, documented a BG of 63 on 12/6/14 at 8:00 am, and 68 on 12/7/14 at 8:00 am. The 12/6 & 12/7-MAR/Nurses Notes</p>	F 309	<p>Licensed nurses have been educated on the facilities hypoglycemic protocol and through the RELIAS learning management system including the following modules on diabetes:</p> <p><u>"About Diabetes", "Diabetes and Controlling Resident Blood Glucose"</u></p> <p><u>How the facility plans to monitor performance to ensure the corrective action (s) are effective and compliance is sustained:</u></p> <p>Facility will audit the MAR daily to ensure compliance with the ordered hypoglycemic protocol. Nurse manager will review residents with decreased po intake for communication to the nurse and nurse manager using the Stop and Watch Monday through Friday X 30 days then twice a week for 8 weeks. Friday, Saturday and Sunday po intakes audits reviewed on Mondays. Audits will be reviewed monthly in QAPI X 3 months for further education and training opportunities.</p> <p><u>Dates when corrective action will be completed:</u></p> <p>2-2-15</p>		

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F 309	<p>Continued From page 5</p> <p>documented no interventions by nursing staff. For example, the resident was not provided a fast acting carbohydrate on either day, and the blood glucose was not rechecked every 15 minutes until above 90. In addition, the resident's BG was only checked once daily on 12/2, 12/4, and 12/5.</p> <p>A Hospital Emergency Room report, dated 12/7/14, documented Resident #1 was transferred by EMS to a local hospital at 4:36 pm with a chief complaint of "unresponsiveness." The report documented EMS found the resident, "... unresponsive with a BS of 21, and administered an ampule of D50." By the time the resident arrived at the ER she was alert and responsive and complaining of being hungry. The ER fed the resident supper and checked her serum glucose which was 106. Resident #1 was discharged back to the facility at 7:30 pm with the assessment of, "Hypoglycemic episode associated with diabetes and renal insufficiency." Nursing staff were instructed to, "Check blood sugar frequently tonight" and "Assure adequate dietary intake." Nursing records documented these orders were followed and the resident had no further episodes of hypoglycemia between 12/8/14 and 12/29/14.</p> <p>An Incident Investigation Reported, dated 12/8/14, documented the events that led up to the resident's 12/7/14 hypoglycemic episode: * LN #1 documented the resident's BG was taken at 7:30 am on 12/7/14. It was 69. No action was documented by LN #1. The resident's BG was not rechecked until 11:30 am and was 80. At 1:45 CNA #3 reported the resident had not eaten breakfast or lunch and was unresponsive. LN #1 immediately assessed the resident. LN #1 stated the resident woke up with calling her name and touch, and was able to move her extremities and</p>	F 309			

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F 309	<p>Continued From page 6</p> <p>follow commands. LN #1 stated there was, "... no diaphoresis."</p> <p>* CNA #3 documented on 12/7/14 at 1:30 pm the resident would not "fully wake up" at 9:00 am, 10:00 am, or 11:30 am. CNA #3 documented, "Around 1:30 pm I asked the other aide [CNA #4] to help reposition [Resident #1]. We checked her and she was dry. We tried asking yes/no questions and she wouldn't reply just opened her eyes, At 1:50 pm - 1:55 pm I told [LN #1] the resident had not eaten, drank, or voided the entire shift."</p> <p>* CNA #4 documented on 12/7/14, "... around 1:15 pm, CNA #3 came to me," and said that she [CNA #3] went into [Resident #1's] room to check on her... and she was unresponsive and she was sweaty, but not wet with urine, at that time we changed her bedding. She [CNA #3] reported to the nurse that [Resident #1] did not eat and did not void all shift."</p> <p>* The evening nurse (LN #2) on 12/7/14 documented, "[Received] information in report that resident was lethargic [and] having unusual behaviors when awake. I was able to get to her and assess her around 4:00 pm - she was alert but totally non-responsive, eyes were fixed, open, and dilated... she was thrashing in bed. I notified the MD and received orders to send her to [local hospital]..." Note: Based on staffing records, the facility nurses work 8 hour shifts. The evening shift change is at 2:00 pm. This indicated the resident was not observed until 2 hours after shift change when the LN received report that Resident #1 was lethargic, exhibiting unusual behaviors, and had not had any oral intake or urinary output.</p> <p>A Resident Concern Report, initiated by Resident #1's family member on 12/8/14</p>	F 309		

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F 309	<p>Continued From page 7</p> <p>documented,"Resident was found shaking and out of it by son at approximately 4:07 pm, dead eyes, shaking, [and] can't get any assistance'... blood sugars were 21. ... no one helped her to eat and she did not eat breakfast or lunch... "</p> <p>On 12/29/14 at 2:05 PM, LN #1 was asked if she provided Resident #1 with a fast acting carbohydrate after the resident's 12/6/14 am BG of 63 or her 12/7/14 am BG of 69 and if she rechecked the resident's blood sugar before the noon meal. LN #1 answered, "No," to both questions. When asked if she had received training on the facility's and resident's diabetic protocol for hypoglycemia, LN #1 said "No." LN #1's stated her hire date was November 2014 and she was not aware of the protocol until after the incident on 12/7/14. LN #1 stated she had since been in-serviced on the protocol and had a copy of it with the steps to follow. LN #1 stated during all of her interactions with the resident on 12/7/14 day shift, the resident was responsive, non-diaphoretic and did not have any concerns. When asked what she reported to the oncoming shift on 12/7/14, LN #1 stated she told LN #2 that the resident had not eaten all day or voided.</p> <p>CNA's #3 & 4 were interviewed on 12/7/14 between 12:10 pm and 12:15 pm. Both substantially repeated what they had written in the 12/8/14 investigative report. CNA #1 stated she did not tell the LN about the poor oral intake or absence of voiding until the end of the shift.</p> <p>LN #2 was no longer working for the facility and was unavailable for interview.</p> <p>The ADON was interviewed at various times throughout the day on 12/29/14, but stated she</p>	F 309			

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

PRINTED: 01/20/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/29/2014
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 309	<p>Continued From page 8</p> <p>was not the DON when the 12/7/14 BG issue occurred.</p> <p>A 12/12/14 IDT review report of the 12/7/14 incident documented, "During the investigation it was discovered that the resident had refused both breakfast and lunch and LN had not been notified. FSBS [fasting blood sugar] at noon was 80, which is [with]in parameters for resident. After MD review of blood sugars bedtime Lantus insulin decreased as resident runs low in the morning. Pharmacy medication review request faxed and returned [,] MD notified of recommendation. Staff educated in regards to resident not eating, notification to the LN, also care plan updated and staff educated that resident [#1] is to eat meals in restorative dining."</p> <p>The 12/12/14 IDT report identified CNA #3's failure to notify the day shift LN in a timely manner of her concerns with the resident, and identified the resident had a history of fluctuating BGs. However, the report did not identify:</p> <ol style="list-style-type: none"> 1. LN #1's failure to follow diabetic protocol for hypoglycemia on the mornings of 12/6 and 12/7 2. LN #2's failure to assess Resident #1 for 2 hours after she had been notified by LN #1 of the potential change in condition. 3. The report addressed education of staff regarding reporting low oral intake to the LN but did not address educating CNA or LN staff on recognizing the signs and symptoms of hypoglycemia in the elderly or how and when to report them. <p>The Administrator and ADON were notified of the identified harm to Resident #1 on 12/29/14 at 3:15 pm.</p>	F 309			

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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 356 F 356 SS=C	Continued From page 9 483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was determined the facility failed to post required staffing information on a daily basis. This had the	F 356 F 356	F-356 <u>Corrective action accomplished for affected residents by the deficient practice:</u> Residents # 1,3,4,5 no longer reside at the facility Residents # 2,6,8,9 have been informed to the posting of the correct daily nurse staffing data <u>How the facility will identify other residents who have the potential to be affected by the same deficient practice:</u> This deficient practice has the potential to affect all residents that reside in the facility. <u>Root Cause Analysis and what measures will be put in place to ensure that the deficient practice does not recur:</u> <i>RCA- Staff Education resulting in staffing coordinator not knowing the expectation of how to fill out the daily nursing staffing data sheet and licensed nurse not knowing the expectation of revising the daily nursing staffing data sheet.</i> Staffing coordinator and licensed nurse completed education on how to complete	

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F 356	Continued From page 10 potential to affect all residents who reside in the facility, including 9 of 9 (#s 1 - 9) sampled residents. Findings include: The facility had a "Daily Nurse Staffing Form" posted on the wall next to the reception desk. The form contained boxes for information relating to "Facility Name," "Date," "Resident Census at the start of the shift," "Licensed" and "Non-Licensed" staff numbers, and "Actual Hours Worked." The form that was posted for 12/29/14 failed to include a completed resident census for the shift and staff hours worked. The forms for the month of December 2014 were requested. These forms also failed to have the resident census and staff hours completed. The Administrator was interviewed on 12/29/14 at 1:25 p.m. about the form and the omitted information. The administrator failed to provide an explanation and indicated that in the future the form will be changed and completed.	F 356	and maintain the form per state and federal guidelines <u>How the facility plans to monitor performance to ensure the corrective action (s) are effective and compliance is sustained:</u> <i>Administrator</i> will verify the posting daily Monday through Friday X 30 days and reviewed at QAPI monthly x 1 month for further education and training opportunities. <i>Friday, Saturday, and Sunday postings audited on Monday's.</i> <u>Dates when corrective action will be completed:</u> 2-2-15		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE 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. 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.	F 514	<u>Corrective action accomplished for affected residents by deficient practice:</u> Resident # 7 has had their blood glucose parameters clarified by the physician and the MAR accurately reflects the current physicians order. <u>How the facility will identify other residents who have the potential to be affected by the same deficient practice:</u> Residents residing at the facility with the diagnosis of diabetes have the potential to be affected by this deficient practice.		

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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 514	<p>Continued From page 11</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, it was determined the facility failed to ensure physician orders for 1 of 9 (# 7) sampled residents were accurate and did not contain contradicting orders. There was a potential for harm when physician orders were unclear regarding items and issues the physician wanted to be notified about. Findings include:</p> <p>Resident #7 was admitted to the facility on 6/24/11, and readmitted on 1/9/14, with diagnoses of late effect cerebrovascular disease, Type II diabetes without complications and depressive disorder.</p> <p>The resident's medical record included a 12/1/14 physician recapitulation order that documented two different values for blood glucose levels that needed to be reported to the physician. The orders documented, "Notify the MD if [blood glucose level] less than 70 [milligrams per decaliter] or above 400 [mg/dl]" and, "Notify MD II (sic) [when resident's BG was] less than 50 [mg/dl] or more than 360 [mg/dl]."</p> <p>The acting director of nursing (ADON) was interviewed on 12/29/14 at 2 p.m. about the two different recapitulation order directives. She stated facility protocols were to report any values less then 70 mg/dl or greater then 400 mg/dl to the physician. The ADON stated she would contact the physician for a clarification order. No further information was provided.</p>	F 514	<p><u>Root Cause Analysis and what measures will be put in place to ensure that the deficient practice does not recur:</u></p> <p><i>RCA- Execution of Process/ Staff Education on proper physician order verification.</i></p> <p>Residents in the facility have had their MD notification parameters reviewed related to blood glucose values and any identified contradicting or duplication of orders have been clarified.</p> <p>Licensed nurses completed education on how to accurately transcribe physician orders and to clarify any contradicting or duplicate orders with the physician.</p> <p><u>How the facility plans to monitor performance to ensure the corrective action (s) are effective and compliance is sustained:</u></p> <p><i>Nurse manager to complete daily audits of new physician orders for changes in diabetic orders Monday through Friday X 30 days then twice a week for 8 weeks. Friday, Saturday, and Sunday physician orders audited on Mondays. Audits will be reviewed monthly in QAPI X 3 months for further education and training opportunities.</i></p> <p><u>Dates when corrective action will be completed:</u></p> <p style="text-align: center;">2-2-15</p>	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001350	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/29/2014
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NAME OF PROVIDER OR SUPPLIER LACROSSE HEALTH & REHABILITATION CEN1	STREET ADDRESS, CITY, STATE, ZIP CODE 210 WEST LACROSSE AVENUE COEUR D'ALENE, ID 83814
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C 000	16.03.02 INITIAL COMMENTS The following deficiencies were cited during the complaint survey of your facility. The survey team entered and the facility on December 29, 2014. The surveyors were: Arnold Rosling RN, QIDP Lorraine Hutton RN Judy Atkinson RN	C 000	POC Lacrosse C 782 C 784 C 886 "This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. The submission of this plan of correction is not a submission of our agreement of the deficiencies or conclusions contained in the Departments inspection report."	2-2-15
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: Refer to F 280 as it relates to care planning.	C 782	C 782: Please see attached F 280	2-2-15
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: Please refer to F 309 as it relates to recognizing residents' needs and providing necessary care.	C 784	C 784: Please see attached F 309	2-2-15
C 886	02.203,02,e Physician Orders e. Physician's order record containing the physician's authorization for required medications, tests, treatments, and	C 886	C 886: Please see attached F-514	2-2-15

RECEIVED
FEB 25 2015
FACILITY STANDARDS

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Paul M. Vay N.H.A.</i>	TITLE 1-30-15	(X6) DATE
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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001350	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/29/2014
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NAME OF PROVIDER OR SUPPLIER LACROSSE HEALTH & REHABILITATION CEN1	STREET ADDRESS, CITY, STATE, ZIP CODE 210 WEST LACROSSE AVENUE COEUR D'ALENE, ID 83814
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C 886	Continued From page 1 diet. Each entry shall be dated and signed, or countersigned, by the physician. This Rule is not met as evidenced by: Refer to F 514 as it relates to physician orders.	C 886		
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IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

FILE COPY

February 5, 2015

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

Provider #: 135042

Dear Mr. McVay:

On **December 29, 2014**, an unannounced on-site complaint survey was conducted at LaCrosse Health & Rehabilitation Center. The complaint allegations, findings and conclusions are as follows:

Complaint #6718

ALLEGATION:

The facility does not post required staffing information on a daily basis.

FINDINGS:

During the investigation observations were conducted, past and current posted information was reviewed and staff were interviewed with the following results:

On December 29, 2014, posted information was observed at the facility. The posted information included a "Daily Nurse Staffing Form" posted on the wall next to the reception desk. The form contained boxes for information relating to "Facility Name," "Date," "Resident Census at the start of the shift," "Licensed" and "Non-Licensed" staff numbers and "Actual Hours Worked." The form that was posted for December 29, 2014, did not include a completed resident census for

Paul McVay, Administrator
February 5, 2015
Page 2 of 2

the shift and staff hours worked.

The forms for the month of December 2014 were requested. The forms did not include resident census and staff hours completed.

The Administrator was interviewed on December 29, 2014, at 1:25 p.m. about the form and the omitted information. The Administrator indicated that the future the form would be changed and completed in the future.

The facility did not ensure complete information had been posted at the facility. Therefore, the allegation was substantiated and deficient practice was identified and cited.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

Based on the findings of the complaint investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this complaint's findings letter as it will be addressed in the provider's Plan of Correction.

If you have questions, comments or concerns regarding our investigation, please contact Lorene Kayser, L.S.W., Q.I.D.P., David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, Option #2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

A handwritten signature in black ink that reads "Lorene Kayser". The signature is written in a cursive, slightly slanted style.

LORENE KAYSER, L.S.W., Q.I.D.P., Supervisor
Long Term Care

LKK/dmj



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

FILE COPY

February 26, 2015

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

Provider #: 135042

Dear Mr. McVay:

On **December 29, 2014**, an unannounced on-site complaint survey was conducted at Lacrosse Health & Rehabilitation Center. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006797

Allegation: Residents do not receive appropriate diabetic care.

Findings: During the investigation the facility's hypoglycemic protocol and resident records were reviewed and staff were interviewed with the following results:

The clinical records of seven residents, who required diabetic care, were reviewed. Of the seven records, three did not include documentation of appropriate, comprehensive diabetic care, as follows:

The facility adopted a hypoglycemic protocol in December 2014, which was to be used for all diabetic residents who experienced low blood sugar. The protocol stated staff were to administer the following:

- 1/2 cup or 4 ounces juice, 1 cup skim milk, 3 glucose tablets, 4 sugar cubes, or 5 to 6 pieces of hard candy if the resident was able to swallow.

Paul McVay, Administrator
February 26, 2015
Page 2 of 3

- Glucagon 1 gm (gram) subcutaneously if the resident could not ingest, per physician order.
- Hypoglycemic measures with 15 to 20 grams of fast-acting carbohydrates.

One resident's 9/8/14 care plan for "Potential for Alteration/Alteration in Blood Glucose ..." had the protocols on the preprinted care plan but the facility failed to designate they applied to the resident.

The Acting Director of Nursing (ADON) was interviewed on 12/29/14 at 2:00 p.m. and indicated the resident's care plan should have been updated to reflect the protocols.

A second resident's medical record included a 12/1/14 physician recapitulation order that documented two different values for blood glucose levels that needed to be reported to the physician. The orders documented, the physician was to be notified if the resident's blood glucose was less than 70 milligrams per (mg/dl) deciliter or above 400 mg/dl and that the physician was to be notified if the resident's blood glucose was less than 50 mg/dl or more than 360 mg/dl.

The ADON was interviewed on 12/29/14 at 2:00 p.m. about the two different recapitulation order directives. She stated facility protocols were to report any values less than 70 mg/dl or greater than 400 mg/dl to the physician.

A third resident's record documented the resident's diabetic care plan was not implemented. The resident's Nursing Notes, Weekly Blood Glucose/Sliding Scale Coverage Monitoring Record for December 2014, documented her blood glucose was 63 on 12/6/14 at 8:00 a.m. and 68 on 12/7/14 at 8:00 a.m. The 12/6 and 12/7 Nurses Notes documented no interventions by nursing staff. For example, the resident was not provided a fast acting carbohydrate on either day, and the blood glucose was not rechecked every 15 minutes until it measured above 90. In addition, the resident's blood glucose was only checked once daily on 12/2, 12/4, and 12/5.

Further, a Hospital Emergency Room report, dated 12/7/14, documented the resident was unresponsive and transferred by Emergency Medical Services (EMS) to a local hospital at 4:36 p.m. The report documented EMS found the resident, "... unresponsive with a BS {blood sugar} of 21, and administered an ampule of D50 {Dextrose 50 mg IV solution}." By the time the resident arrived at the emergency room, she was alert and responsive and complaining of being hungry.

The facility failed to ensure the residents' hypoglycemic protocol and assessed and responded to episodes of low blood sugar and change in condition.

Paul McVay, Administrator
February 26, 2015
Page 3 of 3

The ADON was interviewed at various times throughout the day on 12/29/14, but stated she was not the DON when the 12/7/14 incident occurred.

The facility failed to ensure residents received appropriate diabetic care. Therefore, the allegation was substantiated and deficient practice was identified and cited.

Conclusion: Substantiated. Federal and State deficiencies related to the allegation are cited.

Based on the findings of the complaint investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this complaint's findings letter as it will be addressed in the provider's Plan of Correction.

If you have questions, comments or concerns regarding our investigation, please contact Lorene Kayser, L.S.W., Q.I.D.P., David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, Option #2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

A handwritten signature in black ink that reads "LORENE KAYSER". The letters are somewhat stylized and slanted.

LORENE KAYSER, LSW, QIDP
Co-Supervisor
Long Term Care

LK/pmt