IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T. – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

March 2, 2017

Gary Liesner, Administrator
Lacrosse Health & Rehabilitation Center
210 West Lacrosse Avenue
Coeurd d'Alene, ID 83814-2403

Provider #: 135042

Dear Mr. Liesner:

On **February 10, 2017**, we conducted an on-site revisit and a complaint investigation to verify that your facility had achieved and maintained compliance. We presumed, based on your allegation of compliance, that your facility was in substantial compliance as of **January 17, 2017**. However, based on our on-site revisit we found that your facility is not in substantial compliance with the following participation requirements:

F0166 -- S/S: D -- 483.10(f)(2) -- Right To Prompt Efforts To Resolve Grievances
F0250 -- S/S: E -- 483.15(g)(1) -- Provision Of Medically Related Social Service
F0280 -- S/S: E -- 483.20(d)(3), 483.10(k)(2) -- Right To Participate Planning Care-Revise Cp
F0312 -- S/S: E -- 483.25(a)(3) -- Adl Care Provided For Dependent Residents
F0314 -- S/S: G -- 483.25(c) -- Treatment/svcs To Prevent/heal Pressure Sores
F0323 -- S/S: D -- 483.25(h) -- Free Of Accident Hazards/supervision/devices
F0329 -- S/S: D -- 483.25(l) -- Drug Regimen Is Free From Unnecessary Drugs
F0353 -- S/S: E -- 483.30(a) -- Sufficient 24-Hr Nursing Staff Per Care Plans
F0441 -- S/S: E -- 483.65 -- Infection Control, Prevent Spread, Linens
F0490 -- S/S: F -- 483.75 -- Effective Administration/resident Well-Being
F0252 -- S/S: E -- 483.15(h)(1) -- Safe/clean/comfortable/homelike Environment
F0284 -- S/S: D -- 483.20(l)(3) -- Anticipate Discharge: Post-Discharge Plan
F0520 -- S/S: F -- 483.75(o)(1) -- Qaa Committee-Members/meet Quarterly/plans

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE**: The alleged compliance date must be after the "Date Survey Completed" (located in field X3.) **Please provide ONLY ONE completion date for each federal and state**

tag (if applicable) 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 the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **March 13, 2017**.

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 the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

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

As noted in the Bureau of Facility Standards' letter of **December 14, 2016**, following the survey of **November 7, 2016**, we have already made the recommendation to the Centers for Medicare and Medicaid Services (CMS) for imposition of a Civil Money Penalty, Denial of Payment for New Admissions effective **February 7, 2017** and termination of the provider agreement on **May 7, 2017**, 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 the deficiencies have been corrected, you may contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 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.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. 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 **March 13, 2017**. If your request for informal dispute resolution is received after **March 13, 2017**, 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 David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2.

Sincerely,

David Scott, RN, Supervisor
Long Term Care

DS/lj

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135042		R 02/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LACROSSE HEALTH & REHABILITATION CENTER	210 WEST LACROSSE AVENUE COEUR D'ALENE, ID 83814

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{F 000}	INITIAL COMMENTS The following deficiencies were cited during the on-site follow-up and complaint investigation survey conducted at the facility February 7, 2017 through February 10, 2017. The surveyors conducting the survey were: Jenny Walker, RN, Team Coordinator Nina Sanderson, LSW Susan Costa, RN ABBREVIATIONS: @ = At ADL = Activities of Daily Living CNA = Certified Nursing Assistant DNS = Director of Nursing Services E = Employee HH = Hand Hygiene H&P = History and Physical IDT = Interdisciplinary Team LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set MG = Milligram OT = Occupational Therapy 1:1 = One person supervising one resident only PRN = As Needed PT = Physical Therapy RVP = Regional Vice President TAR = Treatment Administration Record	{F 000}		
{F 166} SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may	{F 166}		3/27/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/10/2017

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 166}	Continued From page 1 have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, record review, and review of facility grievances, it was determined the facility failed to ensure residents' grievances were resolved and residents' felt free to file grievances without fear of retribution. This was true for 2 of 11 residents (#23 and #25) sampled for grievances. The deficient practice created the potential for harm if residents felt too intimidated to file grievances, or felt helpless when grievances were not promptly responded to. Findings include: 1. Resident #23 was admitted to the facility on 3/13/15, with multiple diagnoses including bipolar disorder, major depressive disorder, and borderline personality disorder. Resident #23's Annual MDS assessment, dated 1/2/17, documented she was cognitively intact and had no behavioral issues. Resident #23's care plan did not document special considerations for when she had a concern or grievance. On 2/7/17 at 12:55 pm, Resident #23 was sitting in her wheelchair in her room, wiping tears from the side of her face. She initially agreed to an interview, only to abruptly end the conversation in less than 5 minutes, stating tersely, "Everything's fine. I don't want to say anymore."	{F 166}	"This Plan of correction constitutes this facility's written allegation of compliance for 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" Corrective actions that will be accomplished for those residents found to have been affected by the deficient practice; The grievance for resident #23 is resolved to the resident's satisfaction. Resident #23 has an identified champion she feels comfortable voicing future concerns. The grievance for Resident #25 is resolved to the resident's satisfaction. Adaptive equipment is in place as indicated for Resident #25. Other residents who have the potential to be affected by the same deficient practice and what corrective actions will be taken; Residents residing at the facility who have concerns/grievances could be affected by this deficient practice. Resident concerns/grievances have been reviewed for the last 30 days and are resolved to the satisfaction of individual residents as identified. Measures in place and systemic changes made to ensure that the deficient practice	

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{F 166}	Continued From page 2 On 2/8/17 at 3:30 pm, Resident #23's psychologist stated Resident #23's tendency was to be reluctant to express concerns when they initially presented, but to wait until she felt there was a "crisis" before saying anything. The psychologist stated after Resident #23 expressed a concern, she tended to "minimize" the importance of it and report she did not want anyone to "over-react." On 2/9/17 at 9:10 am, Resident #23 stated she was reluctant to continue the interview on 2/7/17, because she had filed a complaint just before the interview, and was worried the facility would retaliate "as they have in the past." Resident #23 stated she had complained that her roommate was not getting her hair or feet washed during bed baths. Resident #23 stated the lack of thorough bathing was evident in the odors present in the room. Resident #23 stated, "Sure enough, that DNS came in here yesterday and essentially called me a liar and said showers were being documented, and if they were documented they were done. Then she shot me a dirty look and left the room." Resident #23 said she approached the DNS later that afternoon to discuss her feelings further, but the DNS refused to talk to her. Resident #23 stated she did not know the new Administrator well enough to judge whether he would be a safe person to whom she could report concerns. On 2/9/17 at 11:30 am, the Regional Nurse Consultant stated the facility was aware of Resident #23's grievance, and she would investigate the facility's response to Resident #23 . The Regional Nurse Consultant provided a copy of the grievance form, and the facility's	{F 166}	does not recur; Staff employed at the facility have been re-educated on the concern/grievance policy and procedure. Concerns/Grievances will be reviewed during the morning management meeting for investigation and resolution. A concern/grievance log will be maintained by the administrator and reviewed during the morning management meeting for investigation and apprising family/resident of progress towards resolution. Concern and Grievance policy and procedure has been evaluated through the QAPI process to ensure timely satisfaction for residents initiating concerns and grievances at the facility. Monitor performance to ensure the corrective actions are effective and compliance is sustained; The concern/grievance log will be reviewed by the administrator or designee. Investigation, notification, and resolution will be monitored weekly X 12 by the Regional Director of Clinical Services/ Regional Director of Operations to ensure completion. Findings will be corrected as identified and presented at QAPI (quality assurance performance improvement) meeting monthly X 3 for further educational opportunities.	

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{F 166}	Continued From page 3 investigation thus far. 2. Resident #25 was readmitted to the facility on 12/19/16, with a below the knee amputation of his right leg. Resident #25's admission MDS assessment documented he was cognitively intact and required extensive assistance of two staff for bed mobility. On 2/7/17 at 5:30 pm, Resident #25 stated he was admitted to the facility after an acute illness and amputation of his right leg below the knee. Resident #25 stated he used side rails and an overbed trapeze while in the hospital to be able to move around in bed more independently. Resident #25 stated he asked for those devices in the facility and was told he could not have them. Resident #25 stated no explanation for the refusal was offered. Resident #25 stated he had, "complained again and again but nothing ever happens." On 2/8/17 at 5:30 pm, the Administrator stated he was aware of Resident #25's concerns and was working to resolve them. On 2/9/17 at 4:30 pm, Resident #25 was observed in bed. He had half side rails on either side of the bed and a trapeze overhead. Resident #25 stated he was very grateful for the devices, as he was now more independent in his mobility, but was frustrated that it took so long to receive them.	{F 166}		
{F 250} SS=E	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE	{F 250}		3/27/17

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{F 250}	Continued From page 4 The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	{F 250}		
	This REQUIREMENT is not met as evidenced by: Based on observation, resident, family member, and staff interview, and record review, it was determined the facility failed to ensure residents received medically related social services consistent with their needs. This was true for 4 of 11 residents (#8, #23, #29, and #33) sampled for social services. The deficient practice created the potential for residents to experience psychosocial harm when: * Resident #8 experienced a broken tooth and ongoing pain, and barriers to being seen by a dentist were not addressed. * Resident #23 lacked a psychosocial assessment and resident-specific interventions for her multiple mental health diagnoses. * Resident #29 had a physician's order for a 1:1 attendant, which the facility did not provide. The family attempted to provide these services privately, which placed an undue financial burden on them. There was no evidence of social service intervention in this matter. * Resident #33's private information, not pertinent to his/her health status, was shared with a family member without his/her consent. Findings include: 1. Resident #23 was admitted to the facility on		Corrective actions that will be accomplished for those residents found to have been affected by the deficient practice; Facility is collaborating with the local hospital, dentist, MCNA, and primary physician to accomplish Resident #8's tooth extraction. Resident requires a surgical procedure with specialized equipment to accomplish the procedure that the dentist and hospital are attempting to obtain. Resident #23 has had her psychosocial needs evaluated by an LSW and there are resident-specific interventions for her multiple mental health diagnoses. Resident #29 has had supervision by facility staff as per MD order but is now discharged. Staff has been re-educated on policy and procedure for sharing resident information for Resident #33. Other residents who have the potential to be affected by the same deficient practice and what corrective actions will be taken; Residents residing at the facility have the potential to be affected by this deficient practice. Residents residing at the facility have	

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{F 250}	Continued From page 5 3/13/15, with multiple diagnoses including bipolar disorder, major depressive disorder, and borderline personality disorder. On 11/7/16, Resident #23 was identified as having psychosocial harm when the facility failed to provide medically related social services after Resident #23 was sexually assaulted by another resident in the facility. Resident #23's 1/2/17 Annual MDS assessment documented she was cognitively intact, had minimal depression, and no hallucinations, delusions, or other behavioral concerns. Resident #23's Mood and Behavior Symptom Assessment Care Plan, dated 1/10/17, and documented as "rewritten" on 1/14/17, did not include specific care plan interventions for her mental health diagnoses. Behavioral symptoms were documented as increased agitation, self-isolation, tearfulness, sadness, and fixation on different things and/or subjects. On 1/25/17, an SSPN documented Resident #23 was seen regularly by her psychologist, was doing well, and was last seen by the psychologist 1/13/17. Progress notes from the psychologist's visits could not be located in Resident #23's record. On 2/7/17 at 4:20 pm, E #1 stated she filled the social services role in the facility. E #1 stated she had been working at the facility for "about 4 weeks." E #1 stated a psychosocial assessment had not been completed, and she was not sure what Resident #23's care plan goals were.	{F 250}	been evaluated to identify medically-related social service needs. Measures have been taken to ensure identified medically-related social service needs have been met. Measures in place and systemic changes made to ensure that the deficient practice does not recur; Facility has re-educated social services department on the policy and procedures to ensure medically-related social services are provided to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Monitor performance to ensure the corrective actions are effective and compliance is sustained; Medically related social services for individual residents displaying behaviors will be monitored by the administrator or designee weekly for 3 months. Findings will be corrected as identified and forwarded to QAPI for further education opportunities X 3 months. Date corrective action will be complete and who is responsible to maintain compliance; Director of Nursing	

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{F 250}	Continued From page 6 On 2/8/17 at 3:30 pm, Resident #23's psychologist stated due to Resident #23's mental health conditions, she tended to react to situations as a crisis, then minimized the crisis aspect when staff responded. The psychologist stated the most important aspect of managing Resident #23's mental health issues day-to-day in the facility was consistency in approach amongst all staff members. The psychologist stated while he "checked in on" Resident #23 frequently, she was not always receptive to visiting with him. The psychologist stated when Resident #23 was not in "crisis" by her own definition, it was up to the facility to manage her day-to-day needs. Resident #23's Mood and Behavior Symptom Assessment Care Plan, dated 1/10/17, did not include approaches as to how staff to respond should Resident #23 experience feelings of crisis. On 2/9/17 at 9:10 am, Resident # 23 stated the facility had not provided social service visits or interventions for several months, and she had not participated in a psychosocial assessment. Resident #23 stated no one discussed care plan development or goals with her, in terms of her psychosocial needs or mental illness. Resident #23 stated she knew there was a "new person" designated to ensure the provision of social services in the facility, but she had not spoken with that person yet. Resident #23 stated it would be nice to get to know the new person, as she had a difficult time knowing who to trust in the facility when she had a concern, such as one she had voiced two days prior regarding bathing services for her roommate. Resident #23 stated	{F 250}		

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{F 250}	Continued From page 7 she wished she knew who in the facility she could trust to act as her advocate, as she felt the facility retaliated whenever she made a concern known to them. 2. Resident #29 was admitted to the facility on 1/25/17, with diagnoses which included a tibia/fibia fracture to the left leg, mental disability, cerebral palsy, and difficulty communicating. On 1/26/17, Resident #29's Physician's Telephone Orders documented the need for 1:1 supervision at all times. Resident #29's care plan for that date documented his mother had hired a 1:1 attendant for the night shift. A Social Services Progress Note, dated 1/26/17, documented, "...1:1 [Family Member] will be here at night but we don't...[Family Member] can stay at night...[Family Member] offered hospitality aide for evening to go home. After tonight [Family Member] will make arrangements with hospitality aide for private 1:1 herself. [Family Member] agreed..." On 2/8/17 at 9:30 am, Resident #29's Family Member stated the facility had informed her she would have to pay privately for 1:1 supervision for Resident #29, even after she informed the facility neither she nor Resident #29 could afford the expense of that level of care. Resident #29's Family Member stated she had not received any additional feedback or referrals from the facility to access the care Resident #29 required, or to ensure supervision was provided as the physician had ordered. 3. Resident #8 was readmitted to the facility on	{F 250}		

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{F 250}	Continued From page 8 9/22/16 with diagnoses which included C1-C4 fracture with quadriplegia. He had a tracheostomy and was on a ventilator. Resident #8's record included nursing notes from October 2017 to present, with entries related to tooth pain and attempts to secure dental care. Greater than 4 months elapsed without dental care for Resident #8. Nursing note entries below describe attempts to secure dental care: 10/3/16, Called and scheduled pickup with non-emergent ambulance with critical care nurse to stay at dental appoint with resident, non-emergent confirmed 10:45 am pickup with critical care nurse to be at dental office by 11:20 am on 10/4/16. 10/4/16, Appointment for dentist canceled today. Non-emergent transport did not have a nurse available to stay for Resident #8's dental appointment. They suggested Resident #8 be admitted to the hospital for short stay and have his dental care there. They were to return phone call. 10/6/16, Dental office called to check on how to obtain dental x-rays, will call back. 10/19/16, Call to dental office, expressed that Resident #8 was in pain secondary to teeth, controlled with ora-gel and pain pills. Awaiting call back. 10/20/16, Received call that a dentist will do maintenance work. Working on getting an assistant for cleaning, will call back with more information.	{F 250}		

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LACROSSE HEALTH & REHABILITATION CENTER	210 WEST LACROSSE AVENUE COEUR D'ALENE, ID 83814

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{F 250}	Continued From page 9 10/31/16, Placed follow up call to oral surgeon to get update on status of coordination of dental needs, left message. 10/31/16, The General Dentist was waiting for an assistant to help at the hospital. 11/7/16, Contacted dental office to check status of oral surgery/care. [Oral Surgeon] was attempting to coordinate with an assistant that is able to work at the hospital. Will call back when assistant located. 11/19/16, Resident #8 complained of tooth pain. Ora-gel applied. 11/25/16, Resident #8 in bed resting. Complained of dental pain score 8 on scale of 1-10. Applied ora-gel after cleaning teeth, not effective. Oxycodone prn given. 11/30/16, Resident #8 complained of gum pain, relieved by ora-gel. 2/4/17, Resident #8 complained of pain from tooth, given ora-gel and pain medication with adequate relief. On 2/7/17 at 2:10 pm, Resident #8 was observed as he received PT. He was unable to speak, but was able to mouth words which were understood by the Physical Therapist and the CNA who was in the room. Resident #8 opened his mouth wide and with his tongue indicated a tooth on his upper left side, a molar, which was causing him pain. The molar appeared to have a large hole or was broken. Resident #8 responded by mouthing	{F 250}		

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{F 250}	Continued From page 10 the words "big hole" and "needs to come out." When asked if he had pain, he responded by mouthing "Yes." On 2/7/17 at 2:30 pm, the RN Manager of the 600 hall stated she had been working for greater than 4 months to coordinate dental care for Resident #8. She stated it was difficult to have a dentist come in to the facility to perform dental care. The RN Manager stated the oral surgeon was trying to get Resident #8 transferred to a hospital that could manage his medical, as well as, dental care. She reviewed the nursing notes with documentation of attempts to secure dental care. She stated she had written most of the entries, and was facilitating the communication between the medical director, hospital, and oral surgeon. The RN Manager stated she did not include the facility Social Worker when attempting to secure dental care for Resident #8. On 2/9/17 at 1:55 pm, E #1 stated she was unaware of Resident #8's tooth pain and his need for dental care. She responded with the question "What do I do?" and stated she did not know how to get a dentist to the facility for residents' dental needs. 4. Resident #33 was admitted to the facility with multiple diagnoses, including respiratory failure and depression. Resident #33's 12/29/16 MDS assessment documented s/he was cognitively intact, required extensive assistance with transfers, displayed no behavioral symptoms that were distressing or potentially harmful to the resident, other residents, or staff members.	{F 250}		

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{F 250}	Continued From page 11 Resident #33's Mood and Behavior care plan, dated 1/30/17, documented Resident #33 was "socially inappropriate," as evidenced by masturbating in the resident's room. The intervention was to have Resident #33 close the door for privacy. The goal was for Resident #33 to have privacy when needed. Resident #33's ADL/Mobility care plan, dated 1/3/17, documented Resident #33 required assistance with transfers. The social service notes, dated 1/31/17 through 2/2/17, documented Resident #33 was having "socially inappropriate" behaviors and would not shut the door for privacy. A social services note, dated 2/3/17, documented E #1 spoke with a female family member of Resident #33's regarding the "socially inappropriate" behavior, along with the expectation that the female family member encourage Resident #33 to shut the door prior to masturbating. A psychologist note, dated 2/2/17, documented the psychologist was asked to assess Resident #33 due to the socially inappropriate behavior. The note documented Resident #33 had family visitors at the time the Psychologist was meeting with Resident #33 and the Psychologist would come back another day when he and Resident #33 could talk privately. On 2/9/17, Resident #33 stated s/he was embarrassed someone in the facility told a female family member about the "socially inappropriate" behavior.	{F 250}		

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{F 250}	Continued From page 12 On 2/9/17 at 4:45 pm, E #1 stated Resident #33 lived at home with the female family member prior to admission and E #1 wanted to know what the family member had done when the behavior occurred at home. Additionally, E #1 said the female family member was also embarrassed, and stated she had not witnessed this type of behavior in the past, and assumed if it occurred it was done in private. E #1 did not have permission to speak with Resident #33's female family member.	{F 250}		
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation and resident interview, it was determined the facility failed to ensure air vents and blinds were clean, walls were repaired and easily cleanable, and residents were not exposed to lingering unpleasant odors. This was true for 2 of 11 sampled residents (#23 and #25) and all resident living in the 200, 300, 500, or 600 halls. The deficient practice created the potential for residents to become embarrassed or be exposed to substances that may compromise their health. Findings include: 1. On 2/7/17 at 5:30 pm, Resident #25 was laying in his bed. Resident #25 stated he was concerned about the cleanliness of his room, as	F 252	Corrective actions that will be accomplished for those residents found to have been affected by the deficient practice; The unit for resident #25 has been deep cleaned and identified environmental issues are resolved. Resident #23 has been transferred to a private room. The room mate for Resident #23 is receiving bathing as per resident choice and schedule. The unit RCM will audit weekly x3 months for resident cleanliness to ensure bathing is occurring and to ensure odor control in the room.	3/27/17

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F 252	Continued From page 13 he had recently undergone an amputation related to a fairly serious infection. Resident #25 stated the facility's housekeeping services were "piecemeal at best," causing him to be concerned about the air return vent on the ceiling near his closet, and dust and grime build-up on his window blinds. Resident #25 stated, "It's filthy. It's a breeding ground for bacteria." The air return vent was approximately 6 inches square, with another 2 inches of frame on each side where it entered the ceiling. The vent itself had strings of a dusty, hairy substance where the air was trying to move through. The frame had a black splotchy substance around its edges, which trailed onto the textured ceiling for approximately 4 inches on one side. The mini-blinds on Resident #25's window were coated with a dusty/greasy build-up, with raised round brown splotches consistent with the spray pattern of a liquid (coffee or cola beverage). Resident #25 was also concerned about areas of his room he could not see, which may also be difficult for the staff to clean. Upon further inspection, the wall covering on the wall behind Resident #25's bed had 2 gouges, each about 2 feet long by 8 inches wide, consistent with the placement of the lift mechanism for the bed frame. The area was unsightly, and the edges of the gouges had frayed wall paper, and was not an easily cleanable surface. On 2/8/17 at 5:30 pm, the Administrator stated he had been made aware of Resident #25's concerns, and that the identified areas had been cleaned. On 2/9/17 at 4:30 pm, the vent and blinds in Resident #25's room were observed in the same	F 252	Other residents who have the potential to be affected by the same deficient practice and what corrective actions will be taken; Residents residing at the facility have the potential to be affected by the deficient practice. Scheduled cleaning per housekeeping is in place related to findings. Measures in place and systemic changes made to ensure that the deficient practice does not recur; Housekeeping contracts, staffing and cleaning schedules have been evaluated by the Administrator for effectiveness. Re-education to the housekeeping manager has been provided. Facility staff has been re-educated on measures to reduce odor and maintain a safe, clean, comfortable and homelike environment. Monitor performance to ensure the corrective actions are effective and compliance is sustained; Environmental rounds will be monitored through the facility Caring Partners program daily X 30 and then weekly X 8. Findings will be corrected and brought forward to QAPI for further corrective opportunities monthly X 3. Date corrective action will be completed and who is responsible to ensure compliance; Administrator	

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F 252	Continued From page 14 condition as in the 2/7/17 observation. Resident #25 stated they had not been cleaned. 2. Between 2/7/17 and 2/9/17, lingering odors were noted throughout most of the facility, as follows: * 2/7/17 at 9:00 am - stale, musty odor in the lobby and entrance to the 500 hall. * 2/7/17 at 9:15 am - stale, musty odor with strong urine component at the nurse's station across from the Administrator's office, extending down the 200 and 300 hallways. * 2/7/17 at 12:50 pm - strong urine odor in the 200 hallway, strong odor of feces in 300 hallway. * 2/7/17 at 4:10 pm - stale urine and feces odor outside the biohazard room across from the 300 hall nurse's station. * 2/7/17 between 11:10 and 11:30 pm - noticeable urine and feces odor in the 200 hallway, becoming strong to the point of overpowering in the 300 hallway. On 2/9/17 a 9:10 am, Resident #23 stated her roommate was not being bathed properly, and the room frequently had an odor as a result. Resident #23's room was noted to smell of body odor and urine.	F 252		
{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	{F 280}		3/27/17

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{F 280}	Continued From page 15 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.	{F 280}		
	This REQUIREMENT is not met as evidenced by: Based on observation, resident, family member, and staff interview, and record review, it was determined the facility failed to ensure care plans were updated to reflect residents' current needs. This was true for 5 of 11 residents (#8, #23, #28, #29, and #32) sampled for care plan revisions. The deficient practice created the potential for residents to not receive individualized care consistent with their current needs. Findings include: 1. Resident #23 was admitted to the facility on 3/13/15 with multiple diagnoses including bipolar disorder, borderline personality disorder, and major depression. On 2/8/17 at 3:30 pm, Resident #23's psychologist stated staff needed to be aware of specific attributes of her mental illnesses and change their approach with her accordingly to successfully meet her needs. The psychologist		Corrective actions that will be accomplished for those residents found to have been affected by the deficient practice; Resident #23 has individualized approaches related to her diagnoses and Resident #23 has had input into her care plan through a care planning conference. Resident #32 has an updated care plan to reflect residents' mood and behavior interventions. Resident #28 has an updated care plan which reflects her current needs and staus. Resident #8 has his dental care plan updated to reflect resident need. Resident #29 has been discharged. Other residents who have the potential to be affected by the same deficient practice and what corrective actions will be taken; Residents residing at the facility have the	

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{F 280}	Continued From page 16 said Resident #23's mental health issues could impact the way she identified goals and interacted with others from day-to-day, and how she communicated concerns. The psychologist stated it was important for the facility to identify these factors and incorporate them into her care plan so staff were consistent in their interactions with her. Resident #23's Mood and Behavior Symptom Assessment/Care Plan consisted of columns with pre-printed Assessments, Goals, and Interventions. The Assessment columns did not identify major depression or borderline personality disorder. The Goals column had check marks next to pre-printed statements of, "No negative outcomes resulting from use of psychotropic medications," and, "Will maintain adequate rest as evidenced by 6-8 hours of sleep during [night] shift." There was no evidence in the care plan that the facility had sought Resident #23's input in terms of goals or interventions, or provided individualized approaches for her borderline personality disorder, major depression or need for consistency with staff interactions. 2. Resident #32 was admitted to the facility on 8/13/12, with multiple diagnoses including paranoid schizophrenia, anxiety, and Parkinson's disease. The 1/14/17 quarterly MDS assessment documented Resident #32 did not experience hallucinations, delusions, or behaviors. A Nurse's Note, dated 2/4/17, documented Resident #32 had thoughts of cutting her wrist. The facility notified the physician, implemented	{F 280}	potential to be affected by this deficient practice. Residents residing at the facility with mood and behavior needs and dental needs have been evaluated and currently reflect assessment, goals and interventions to meet resident needs. . Measures in place and systemic changes made to ensure that the deficient practice does not recur; Social Services and Nurse Managers have been re-educated on care planning to accurately reflect resident care needs related to mood and behavior and dental needs. Monitor performance to ensure the corrective actions are effective and compliance is sustained; Resident care plans will be evaluated weekly by the RCM'S to ensure mood and behavior and dental needs are current and reflect resident needs X 3 weeks. Findings will be corrected and then presented to QAPI monthly X 3 for further educational opportunities. Date corrective action will be completed and who is responsible to ensure compliance; Director of Nursing	

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{F 280}	Continued From page 17 15 minute checks, and initiated alert charting by the nursing staff. Resident #32's Mood and Behavior Care plan, dated January 2017, was not updated to address Resident #32's thoughts of self-harm on 2/4/17. On 2/7/17 at 4:25 pm, E #1 was unable to provide an updated care plan for Resident #32's incident on 2/4/17. 3. Resident #28 was readmitted to the facility on 11/21/16, with multiple diagnoses including a pressure ulcer to the coccyx, chronic pain, and depression. a. The 11/28/16 admission MDS assessment documented Resident #28 did not experience depression or behaviors. Resident #28's Psychosocial Well-Being Care Plan, dated November 2016, documented Resident #28's mood-severity score showed she was not at risk for depression. A Physician's Recapitulation Orders, dated February 2017, documented Resident #28 was receiving Lexapro [antidepressant] 10 mg daily in the morning, initiated 11/21/16. On 1/24/17, the Lexapro was discontinued and Zoloft 25 mg daily in the morning for depression was initiated. A Physician's Order, dated 1/30/17, documented Resident #28's mood-severity score for depression had increased and included an order for a psychology consult. The Psychosocial Well-Being Care Plan was not	{F 280}		

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{F 280}	Continued From page 18 updated to reflect the increase of Resident #28's mood-severity score for depression, medication changes, and resident-specific interventions. b. A fax to the physician, dated 1/30/17, documented Resident #28's coccyx wound had re-opened. The measurements were 1.2 x 1.2 and staff documented the depth could not be determine due to slough [dead tissue] in the wound bed. Resident #28's physician's order, dated 1/30/17, instructed staff to cleanse the coccyx wound with normal saline, apply skin prep to the peri wound, apply Santyl medication to the wound bed, and change the wound dressing every other day, and as needed. Resident #28's Skin Integrity Assessment Care Plan documented an unstageable coccyx wound, with no date included. The care plan did not include goals. The interventions documented staff was to monitor the wound weekly and PRN, and see the Skin Grid for "pressure/venous insufficiency ulcer/other." The care plan did not include other interventions for pressure ulcer prevention. On 2/9/17 at 9:30 am, RN #7 was unable to provide an explanation for the reason the care plan was not updated. 4. Resident #8 was admitted to the facility on 3/13/13, with multiple diagnoses including quadriplegia, chronic pain, and pressure ulcers; he had a tracheostomy and was ventilator dependent.	{F 280}		

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{F 280}	Continued From page 19 On 1/7/17 at 2:10 pm, Resident #8 was unable to speak, but was clear in "mouthing" his needs. He placed his tongue over a tooth on his upper left side, and mouthed the words "big hole," and "needs to come out." He responded with yes when questioned about tooth pain. The Physician's Recapitulation Orders for February 2017, included Ora-jel dry mouth gel, 1 gram topically to gums 4 times a day as needed for gum pain. The order was initiated on 9/22/16. His MAR did not include specific medication which addressed toothache or dental pain. Nursing notes reviewed from 10/3/16 to 2/4/17, documented Resident #8 had tooth pain for greater than a 4 month period, as well as, the facility's attempts to secure dental care. Additionally, nursing notes included documentation of administering ora-jel and pain medications for the tooth pain. Resident #8's care plan did not address tooth pain, oral care, or other interventions related to his oral discomfort. On 2/7/17 at 2:30 pm, the RN Manager of the 600 hallway stated she had discussed obtaining dental services with the medical director and a dentist. She stated Resident #8 had first complained about tooth pain in September of 2016, and to this date had not received dental care. She reviewed Resident #8's care plans and was unable to find documentation that addressed Resident #8's oral pain, or interventions related to dental care.	{F 280}		

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{F 280}	Continued From page 20 6. Resident #29 was admitted to the facility on 1/25/17, after his discharge from a hospital following repair of lower left leg bone fractures, with additional diagnoses of mental disability, cerebral palsy and difficulty communicating. Resident #29's record included a verbal order dated 1/26/17, which stated "Patient must be one on one at all times, no exceptions." Resident #29's Fall/Injury Assessment: Prevention and Management Care Plan, dated 1/26/17, included documentation Resident #29 required 2 people for assistance. The section of the care plan titled Resident Specific Supervision, documented, "Family hired 1:1 sitter @ noc [night]." On 2/9/17 at 8:55 am, Resident #29's Family Member stated she was informed by the facility Administrator after Resident #29 was admitted that she would be responsible for paying for the 1:1 supervision. She stated the facility representative she spoke with prior to his admission implied that the facility would provide the supervision he required. Resident #29's Family Member said she did not have the financial resources to pay for additional staff to be with Resident #29 at the rate quoted by the Administrator. She said she was thankful of support from her neighbors and friends that contributed cash to provide for the 1:1 supervision. She stated she spent every night with Resident #29 in the facility, and could afford to pay for 8 hours daily. Resident #29's record did not include a care plan which identified financial/family stressors of	{F 280}		

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LACROSSE HEALTH & REHABILITATION CENTER	210 WEST LACROSSE AVENUE COEUR D'ALENE, ID 83814

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{F 280}	Continued From page 21 providing the 1:1 staff. Additionally, there was no care plan which delineated duties of the staff who were providing the additional supervision. On 2/9/17 at 9:50 am, the RN Regional Consultant reviewed Resident #29's record. She was unable to find documentation that his specific supervision needs were identified and interventions were in place to provide for his safety. She stated she was unaware of the fact that Resident #29's Family Member was financially providing for the 1:1 supervision.	{F 280}		
F 284 SS=D	483.20(l)(3) ANTICIPATE DISCHARGE: POST-DISCHARGE PLAN When the facility anticipates discharge a resident must have a discharge summary that includes a post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment. This REQUIREMENT is not met as evidenced by: Based on family member and staff interview, and record review, it was determined the facility failed to ensure the discharge needs of residents were anticipated and related discharge plans were comprehensively developed to meet those needs. This was true for 1 of 11 (#29) residents whose discharge plans were reviewed. The deficient practice placed Resident #29 at risk of harm as he was not evaluated for safety or anticipated needs to ensure a smooth transition from the facility to his home. Findings include: Resident #29 was admitted to the facility on	F 284	Corrective actions that will be accomplished for those residents found to have been affected by the deficient practice; Resident #29 has a plan in place to support safe discharge. He has since been safely discharged home with his mother. Other residents who have the potential to be affected by the same deficient practice and what corrective actions will be taken; Residents admitting to the facility have the potential to be affected by this	3/27/17

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F 284	Continued From page 22 1/25/17, following hospitalization for repair of lower left leg bone fractures. Resident #29's diagnoses included mental disability, cerebral palsy, and difficulty communicating. Resident #29's record included a verbal order dated 1/26/17, which stated, "Patient must be one on one at all times, no exceptions." A Fall/Injury Assessment: Prevention and Management Care Plan, dated 1/26/17, documented Resident #29 required the assistance of 2 staff for transfers and was not to bear weight on his left foot. On 2/8/17 at 9:30 am, Resident #29's Family Member stated he required supervision to ensure he did not get out of bed by himself. She stated he would not be able to bear weight on his left foot until cleared by his Orthopedic Surgeon, which was scheduled for 2/17/17. Resident #29's Family Member stated his insurance would not pay for care at the facility beyond 2/14/17, which was 6 days away, and she did not have the financial resources to pay for the facility without his insurance. She stated she would have to take him home to her house and felt he would not be safe as it had stairs and a narrow hallway. Resident #29's Family Member stated the social worker had not talked with her about preparations for his discharge and needed items, such as a wheelchair or other equipment. Resident #29's record included a Discharge Care Plan. It was signed by the facility MSW, and dated 1/2017. The Problem documented on the care plan was, "Potential for Complications [related to] discharge planning" due to fracture.	F 284	deficient practice. Residents residing at the facility planning to discharge from the facility have a current discharge plan in place. Measures in place and systemic changes made to ensure that the deficient practice does not recur; Social Service department has been re-educated and will assume responsibility for discharge planning at the facility. Discharge plan will include a resident/family conference as to needs and plan. Resident discharge planning will begin upon admission to the facility. Residents discharging from the facility will have their discharge plan reviewed by the management/therapy team to ensure a safe discharge that meets the each residents' unique needs. Monitor performance to ensure the corrective actions are effective and compliance is sustained; Discharge planning for residents will be reviewed weekly X3 months by the DON to ensure/modify effective discharge planning. Findings will be corrected and presented to QAPI monthly X 3 for further corrective actions. Date corrective action will be done and who is responsible to ensure compliance; Administrator	

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F 284	Continued From page 23 The Goal on the care plan included a box that was checked next to the statement, "Will be discharged to least restrictive and safest setting with HH [Home Health] assistance when appropriate." The Interventions section of the care plan documented, "Discuss discharge goals with resident/family...Assess need for DME [Durable Medical Equipment] of home health services prior to discharge...Link to community resources." The due date on the Interventions section was 4/2017. Sections of the Discharge Care Plan which were not completed and remained blank included, "Resident/family education, Home assessment, Plan family meeting as needed, Update resident/family/physician on discharge goals of progress," and "Obtain authorization from insurance company for discharge." On 2/9/17 at 9:50 am, the RN Regional Consultant reviewed Resident #29's record. She confirmed Resident #29's record did not include updated plans for his discharge the following week. She was unable to find documentation of coordination with the PT, OT, and nursing staff related to assessment of his discharge needs and DME requirements.	F 284		
{F 312} SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	{F 312}		3/27/17

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{F 312}	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, and resident record review, it was determined the facility failed to ensure residents were provided assistance with bathing and toenail care consistent with their needs. This was true for 9 of 11 residents (#8, #23, #25, #26, #27, #28, #29, #30, and #32), 1 Random Resident (#34), and a total of 56 of the 85 residents residing in the facility sampled for bathing. The lack of bathing and toenail care could lead residents to experience embarrassment, isolation, decreased sense of self-worth, skin breakdown, pain, or otherwise compromise their physical and/or psychosocial well-being. Findings include: 1. On 2/7/17 at 10:00 am, the facility provided "Resident Bathing Type by Day" records, from 1/23/17 through 2/7/17 [16 days], for each of the 85 residents in the facility. Fifty-six of the 85 residents' records showed a bath had not been provided for greater than 5 consecutive days, including the records of Residents #8, #26, #27, #28, #29, #30, and #32. On 2/7/17 at 1:30 pm, one of the residents in the Resident Group meeting stated s/he had missed a bath in the past week because a CNA was sent home sick, and there was no one else to provide bathing. The group unanimously agreed they would feel more confident their baths would be provided regularly if the facility resurrected a delegated bath team, as they had in the past. The residents stated when the aides assigned to provide baths and showers were assigned other duties, there was a greater likelihood	{F 312}	Corrective actions that will be accomplished for those residents found to have been affected by the deficient practice; Residents #8, #26, #27, ##28, #29, #30, and #32 have received bathing and nail care per schedule of choice. Other residents who have the potential to be affected by the same deficient practice and what corrective actions will be taken; Residents residing at the facility have the potential to be affected by this deficient practice. Bathing is occurring per resident choice and schedule. Measures in place and systemic changes made to ensure that the deficient practice does not recur; Bathing records will be reviewed daily during the Nurse Manager/DON meeting. There are bathing/shower schedules in place for the residents. Facility is reinstating the bath team per resident request. RCM'S will view bathing of cognitively impaired residents three times per week for one month then once per week for two months. Regional staff will review records to insure bathing is occurring per care plan weekly for three months. Residents will be interviewed weekly during Caring Partner rounds regarding their bathing. Monitor performance to ensure the corrective actions are effective and	

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{F 312}	Continued From page 25 baths/showers would not be completed. On 2/7/17 at 11:15 pm, CNA #12 stated the facility's current system for showering residents was that the showers were assigned to day shift, then passed on to evening shift, and ultimately to night shift if they were not completed. CNA #12 stated there was a resident who was going to be showered that night, not because it was the resident's preference to bathe on the night shift, but because the day and evening shift had not been able to "get to" the resident, and when the night shift offered a shower "they [the resident] didn't say no." On 2/8/17 at 11:30 am, the DNS stated residents' showers and baths were assigned to direct care staff, with no staff dedicated solely to bathing. The DNS stated she had been made aware in January that the residents wanted dedicated bathing staff, but had not yet figured out the "logistics" of such an action yet. The DNS stated the LNs handed out shower or bathing assignments each morning to the CNAs, who then hand it off to the next shift if it did not get done. The DNS stated if a resident refused a bath or shower, the CNA was to tell the LN. The LN should then assess the resident, and if the resident continued to refuse, the refusal was documented in the resident's record. The DNS stated if a resident went for "72 hours or a week" without bathing it would "flag a report" and be re-assigned. The DNS stated she did not have a system to know for sure the baths were given, however, said she was sure they were being done. The DNS stated the only problems noticed with bathing over the past "couple of weeks" were CNAs providing showers but not	{F 312}	compliance is sustained; Bathing/shower records will be monitored daily Monday through Friday X 30 days then 2 X a week X 8 weeks during the morning Nurse Manager/DON meeting for completion. Each nurse manager will follow up with their line staff. Findings will be corrected and then presented at QAPI monthly X 3 for further corrective opportunities. Date corrective action will be done and who is responsible to ensure compliance; 3/27/17_____Director of Nursing	

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{F 312}	Continued From page 26 documenting, and the same core group of residents refusing baths repeatedly. The DNS stated if a CNA forgot to document a bath, they were called back in to make a late entry within 24 hours, so the bathing records were accurate and up to date. The DNS stated the same core group of residents who refused showers would receive a referral to the social worker to schedule a family conference. On 2/8/17 at 1:50 pm, the DNS provided a "Group Bathing" record, which documented how many showers or baths each resident had received since 1/23/17. The Group Bathing record did not document when the showers were provided, only the number each resident received. The DNS could not tell, by looking at the Group Bathing record, if a resident documented as having 2 showers since 1/23/17, had those 2 showers on the same day or a week apart. The DNS clarified her "report" would only flag for her attention if a resident had gone for 7 days or more without a bath. The DNS was asked to provide documentation from any of the residents' individual records which would show the facility had attempted to provide bathing, and what was being done to identify and overcome resident objections. No further information was provided. 2. On 2/7/17 at 5:30 pm, Resident #25 was laying in bed awaiting his dinner meal. The entrance to Resident #25's right ear canal was filled with a crusted whitish yellow substance, which was built up in his ear so as to create a level surface between the entrance to the ear canal and the upper tip of the ear lobe. Resident #25's hair had a greasy sheen, and was speckled with chunks	{F 312}		

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{F 312}	Continued From page 27 of a dandruff-like substance approximately 1 mm in size. Resident #25 stated he was to be on a bathing schedule, and he was not sure what was being documented in his record, but he had gone for over a week without a bath. 3. On 2/9/17 at 9:10 am, Resident #23 was laying in her bed. Resident #23 stated, "It always smells in this room." The room was noted with a lingering stale odor of urine and body odor. Resident #23 stated, "My roommate does not get bathed properly. They give her a bed bath, but they just do from her neck to her knees. Her hair is greasy and her feet are nasty with scales and it always smells in here." Resident #23's roommate was laying in bed. Her hair had a greasy sheen and was flattened against her head. There were scales of dry skin on the toes of both of her feet, and her toenails were thick and approximately 1/2 inch beyond the end of her toes. Resident #23's roommate was not able to recall when or if she had last received assistance with a bed bath or foot care. 4. Resident #8 was admitted to the facility with diagnoses which included quadriplegia and chronic respiratory failure. Resident #8 had chronic pressure ulcers on his sacrum and the small toe on his left foot. Resident #8's Annual MDS assessment, dated 1/7/17, documented he was dependent on staff for all ADLs. Resident #8's 1/18/17 Skin Integrity Care Plan documented he required frequent lotion application to protect his skin. The Skin Hygiene and Inspection section of Resident #8's care plan	{F 312}		

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{F 312}	Continued From page 28 was blank. Resident #8's Bathing Record by Day, from 1/23/17 through 2/7/17, documented he received assistance to bathe one time every 7 days, on 1/24/17, 1/31/17, and 2/7/17. On 1/7/17 at 2:10 pm, the skin on Resident #8's foot was observed to be dry and scaly, and his toenails were overgrown. 5. Resident #26 was admitted to the facility on 10/21/16, with diagnoses which included chronic respiratory failure, type 2 diabetes, and anemia. Resident #26 had a chronic pressure ulcer on her right heel. Resident #26's 1/17/17 Mood and Behavior care plan documented she rejected cares, but did not offer further specifics as to which cares she rejected, or the frequency with which she may reject cares. Resident #26's Quarterly MDS assessment, dated 1/22/17, documented she required extensive assistance from two people for most ADLs, and hygiene and bathing activities did not occur during the previous 7 days. The MDS documented Resident #26 had not rejected care during this time. Resident #26's Bathing Record by Day, from 1/23/17 through 2/7/17, documented she received one shower, on 2/6/17. On 2/7/17 at 1:15 pm, RN #8 performed a dressing change to the pressure ulcer on Resident #26's right heel. The skin on both of	{F 312}		

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{F 312}	Continued From page 29 Resident #26's feet was noted to be dry and scaly, and her toe nails were thick and overgrown. RN #8 did not know when Resident #26 had been bathed last, or had lotion applied to her feet. 6. On 2/7/17 a 1:50 pm, RN #9 was observed changing a dressing to a wound on Resident #34's coccyx. Resident #34's bare feet were exposed and visible as the dressing was changed. Resident #34's toenails were overgrown and thick, with a fungus-type growth visible. On 2/8/17 at 1:50 pm, the DNS stated if a resident had dry, scaly feet or overgrown toenails, there should be a related disease process documented in the resident's record. The DNS also said there should be notation on each resident's care plan as to what the facility was doing to monitor and resolve the issue.	{F 312}		
{F 314} SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record	{F 314}	Corrective actions that will be	3/27/17

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{F 314}	Continued From page 30 review, it was determined the facility failed to ensure pressure ulcers did not develop in the facility and services were provided to promote healing of pressure ulcers. This was true for 1 of 4 sampled residents reviewed for pressure ulcers (#28). This failure resulted in harm when Resident #28's coccyx wound reopened after being healed and she developed a fluid-filled blister on her right heel. Findings include: Resident #28 was readmitted to the facility on 11/21/16, with multiple diagnoses including a pressure ulcer on her coccyx, chronic pain, and diabetes. Resident #28's Admission Skin Integrity care plan, dated 11/21/16, documented Resident #28 was on bed rest and was to be turned and repositioned every 2 hours. a. Resident #28's Admision Skin Grid and Weekly Pressure Ulcer Healing Chart, dated 11/21/16, documented Resident #28 had a Stage III pressure ulcer to her coccyx. Resident #28's Skin Grid and Weekly Pressure Ulcer Healing Chart, dated 12/19/16, documented Resident #28's coccyx wound was healed. In addition, the entry documented the facility's licensed staff was to apply and change an Allevyn dressing to her coccyx every seven days for protection. Resident #28's weekly skin assessments on the January TAR, dated 1/23/17 and 1/30/17, documented with a signature the skin assessment was completed, but did not indicate with a "+" or "-" as to whether there was a	{F 314}	accomplished for those residents found to have been affected by the deficient practice; Resident #28 has weekly skin assessments as per policy and procedure. Resident #28 has pressure ulcer staging and monitoring documentation in place. Other residents who have the potential to be affected by the same deficient practice and what corrective actions will be taken; Residents residing at the facility with pressure ulcers have the potential to be affected by this deficient practice. Residents residing at the facility have had the risk for pressure areas assessed using the Braden tool. Documentation is current re: weekly skin assessments and associated pressure areas documentation. Turning and repositioning schedules are current as per assessment and care plan for residents at risk for pressure areas. Measures in place and systemic changes made to ensure that the deficient practice does not recur; Licensed Nurses have been enrolled in and have completed through Relias the pressure area learning module. This module is an extensive education on pressure area assessment, management, prevention and documentation related to pressure area management. Unit managers have also been re-educated on skin management through facility QAPI process to ensure proper	

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{F 314}	Continued From page 31 concerning skin area. Resident #28's Nurse's Note, dated 1/26/17, documented a dressing was changed on her sacrum wound and no drainage was noted. Resident #28's Skin Grid and Weekly Pressure Ulcer Healing Chart, dated 1/30/17, documented Resident #28 had an unstageable coccyx pressure ulcer. The measurements were 1.2 x 1.2 and the depth could not be determined as the wound bed was covered with yellow serosanqineous drainage. A fax to the physician, dated 1/30/17, documented Resident #28's coccyx wound had reopened. The measurements were 1.2 x 1.2 with depth undetermined due to slough [dead tissue] in the wound bed. Resident #28's physician's order, dated 1/30/17, documented staff were to cleanse the coccyx wound with normal saline, apply skin prep to the peri-wound, apply Santyl medication to the wound bed, and change the dressing every other day, and as needed. An undated entry on Resident #28's Skin Integrity Care Plan documented an unstageable coccyx wound. Goals were not documented. The interventions in place were for the staff to monitor the wound weekly and PRN and to see the Skin Grid for pressure/venous insufficiency ulcer/other. The next Nurse's Note pertaining to Resident #28's coccyx wound, dated 2/6/17, documented the dressing on the wound was clean, dry, and	{F 314}	application of policy and procedure. Monitor performance to ensure the corrective actions are effective and compliance is sustained; Residents at high risk for pressure areas and residents with pressure areas will be monitored daily X 30 to ensure turning and repositioning and documentation is current and accurate per facility policy and procedure. Findings will be corrected and then presented at QAPI monthly X 3 for further corrective action. Who is responsible to ensure compliance; _____Director of Nursing	

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{F 314}	Continued From page 32 intact. On 2/9/17 at 9:30 am, RN #7 stated licensed staff completed weekly skin assessments and documented a "+" on the TAR, if there was a new area observed, and notified the physician with concerns. RN #7 stated a licensed nurse notified her of the wound on Resident #28's coccyx and she filled out the Skin Grid and Weekly Pressure Ulcer Healing Chart. RN #7 stated only the Unit Managers documented open areas to be followed, but the licensed staff did the wound care per physician orders. On 2/9/17 at 11:25 am, Resident #28 was observed in bed waiting for staff to assist her up for lunch. Resident #28 stated she got up for all the meals and doctor appointments, otherwise she stayed in bed since her coccyx reopened again a week ago. Resident #28 stated she was up in her electric wheelchair all the time after her wound healed back in December. Resident #28 stated she had no feeling from her waist down for about four months and did not feel pain at the coccyx area to know that it reopened again. On 2/9/17 at 11:30 am, LPN #3 was observed as she removed the soiled dressing from the coccyx wound. The coccyx wound had a small amount of serous drainage, granulation tissue in the wound bed, and no redness around the peri-wound. b. Resident #28's Nurse's Notes, dated 1/21/17 at 1:00 pm, documented Resident #28's right heel had a discolored dark area the size of a nickel. The skin was intact, and staff were to float Resident #28's right heel.	{F 314}		

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{F 314}	Continued From page 33 Resident #28's physician order, dated 1/23/17, documented an unstageable fluid filled blister on her right heel. The licensed staff was to apply skin prep to her right heel every shift and Resident #28 to wear sage [heel protector] boots on both feet. Resident #28's Skin Integrity Care Plan, dated 1/23/17, documented an unstageable right heel blister. The interventions included skin prep to Resident #28's right heel, no shoes, sage boots, and off-loading her right heel with pillows when she was in bed. Resident #28's Skin Grid Assessment, dated 1/23/17, documented an unstageable right heel wound, measurements were 1.5 x 3 and the depth could not be determined. The wound was described as having no drainage and pink in color. Resident #28's weekly skin assessment on the TAR, dated 1/16/17 and 1/23/17, documented with a signature the skin assessment was completed, but did not indicate with a "+" or "-" if there was a skin area of concern. Resident #28's TAR, dated 1/23/17, documented licensed staff were to apply skin prep every shift to the unstageable fluid-filled blister on her right heel. The next Nurse's Notes, dated 1/23/17 at 6:38 pm, documented Resident #28's right heel had an intact fluid filled blister and the facility received physician orders for treatment to the right heel wound.	{F 314}		

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{F 314}	Continued From page 34 On 2/9/17 at 11:30 am, LN #3 was observed removing the sage boot on the right heel while Resident #28 was in bed. Resident #28's right heel was observed with a reabsorbed dark brown intact area. Resident #28 stated she had to wear the sage boots when the blister formed on her right heel. On 2/9/17 at 9:30 am, RN #7 stated Resident #28's diabetic shoes created the blister on her right heel. When Resident #28's coccyx wound healed in December, Resident #28 was up in a wheelchair all the time wearing shoes. RN #7 was unaware of why the Physician was not notified of the discoloration of the right heel discovered on 1/21/17, until 1/23/17, when the right heel had a fluid filled intact blister.	{F 314}		
{F 323} SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, family member and staff interview, and record review, it was determined the facility failed to ensure adequate supervision was provided to prevent injury to a resident. This was true for 1 of 3 residents (Resident # 29) sampled for adequate supervision. The deficient practice created the potential for harm when the	{F 323}	Corrective actions that will be accomplished for those residents found to have been affected by the deficient practice; Resident #29 has facility staff supervision as per MD order. Residents' family member was	3/27/17

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{F 323}	Continued From page 35 facility failed to provide 1:1 supervision for a resident as ordered by the physician. Findings include: Resident # 29 was admitted to the facility on 1/25/17, with diagnoses which included mental disability, cerebral palsy, difficulty communicating, and left lower leg (tibia and fibia) fractures. Resident # 29's physician's order, dated 1/25/17 documented, "Partial weight bearing [less than] 50%..." On 1/26/17, a Physician's Telephone Order documented, "[Resident] must be one on one at all times, no exceptions." On 1/26/17, Resident #29's care plan documented he was at risk of falls related to a history of falls with a tibia/fibia fracture, and cerebral palsy. One of the interventions was documented as, "Family hired a 1:1 sitter [at night]." On 2/7/17 at 1:30 pm, Resident # 29 was observed in his wheelchair. He had an attendant who was talking with him and pushing him down the 100 hall to the activity room, then into the facility dining room where he waited for a bingo game to start. The attendant remained with Resident #29 throughout this time. On 2/7/17 at 11:15 pm, Resident #29 was observed asleep in bed. His Family Member was in his room, sitting in a camp chair, and stated she would be staying with him through the night. On 2/8/17 at 9:30 am, Resident #29's Family Member stated that prior to his recent fractures,	{F 323}	reimbursed any out of pocket funds for cares required at the facility. Other residents who have the potential to be affected by the same deficient practice and what corrective actions will be taken; Residents residing at the facility have the potential to be affected by this deficient practice. There are no other residents identified. Measures in place and systemic changes made to ensure that the deficient practice does not recur; Management team has been re-educated by the Regional Director of Operations on facility responsibility to provide 1/1 staffing for residents utilizing 1/1 as ordered per MD. Monitor performance to ensure the corrective actions are effective and compliance is sustained; Residents with MD orders for 1/1 supervision will be monitored daily X 30 and then weekly X 8 to ensure facility has delivered care as per order. Any findings will be corrected immediately and reported to the Regional Director of Operations for further corrective action. Date corrective action will be done and who is responsible to ensure compliance; Administrator	

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{F 323}	Continued From page 36 Resident #29 had been physically active, even participating in cross country skiing with the Special Olympics. Resident #29's Family Member stated at present, he required 1:1 supervision to remind him not to put all of his weight on his fractured leg. Resident #29's Family Member stated the facility was aware of the need for this level of supervision, and the physician had provided an order for 1:1 supervision, but the facility informed her that was not a service available to Resident #29. Resident #29's Family Member stated the facility Administrator informed her the facility would bill her between $20 and $25 per hour for a 1:1 attendant. Resident #29's Family Member stated when she told the Administrator neither she nor Resident #29 could afford to pay that amount, she was provided with a list of people's names she may be able to hire privately for a lesser amount. Resident #29's Family Member stated she made contact with the people on the list, who were employees of the facility and agreed to also work on a private basis for $9 per hour. Resident #29's Family Member stated she was thankful for her friends and neighbors who provided financial assistance to help her pay for the 1:1 providers. Resident #29's Family Member stated she had enough money to cover approximately 8 hours per day, so provided the remaining hours of coverage herself. Resident #29's Family Member stated she had brought in a camp chair so she had somewhere to rest while Resident #29 was sleeping. On 2/8/17 at 11:00 am, E #2 stated she had been approached by Resident #29's Family Member asking how much she would charge to provide 1:1 supervision for Resident #29 to remind him to	{F 323}		

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{F 323}	Continued From page 37 ask for help prior to putting weight on his leg. E #2 stated she had initially quoted a higher rate than $9 per hour, but when Resident #29's Family Member stated she could not afford that rate, she felt sorry for the Family Member and stated she would accept whatever the Family Member could afford to pay. E #2 stated she contacted some other employees of the facility, and arranged a schedule for as much coverage as they could provide. E #2 stated Resident #29's Family Member handed whoever had worked with Resident #29 an envelope of cash at the end of the day, which contained $72. On 2/9/17 at 9:50 am, the Administrator stated he was aware Resident #29 had a 1:1. The Administrator stated he believed the 1:1 was arranged by Resident #29's Family Member as she was afraid of Resident #29 being unattended. The Administrator stated the facility would not have admitted Resident #29 if it had known a 1:1 attendant was required by a physician and not simply the preference of Resident #29's family. The Administrator said he was unaware there was a physician's order for the 1:1, and if he had known the facility would have provided that service or sought alternate placement for Resident #29.	{F 323}		
{F 329} SS=E	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	{F 329}		3/27/17

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{F 329}	Continued From page 38 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 drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and record review, it was determined the facility failed to ensure residents had adequate monitoring for the use of psychotropic medications. This was true for 4 of 11 residents (#23, #28, #31, and #32) sampled for indication for use and monitoring for medications. The deficient practice created the potential for residents to receive medications they may not need, or not receive sufficient doses to treat target symptoms. Findings include: 1. Resident #23 was admitted to the facility on 3/13/15, with diagnoses which included bipolar disorder, anxiety, and borderline personality disorder.	{F 329}	Corrective actions that will be accomplished for those residents found to have been affected by the deficient practice; Resident #23 has identified target behaviors identified and monitored related to the use of her ordered psychotropic medications. Resident #31 has identified target behaviors and monitors related to the use of his ordered psychotropic medications Resident #32 has a care plan that includes resident-specific target behaviors. Resident #28 has had his mood and behavior care plan updated to reflect resident's depression.	

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{F 329}	Continued From page 39 Resident #23's February 2017 MAR documented she received clonazepam 1 mg twice daily for anxiety, beginning 9/17/16, and fluoxetine HCl 20 mg daily for depression, beginning 9/13/16. On 2/7/17 at 12:55 pm, Resident #23 was sitting in her wheelchair in her room. Resident #23 agreed to an interview. Within 5 minutes, her tone became terse and dismissive, and she ended the interview. On 2/7/17 at 4:20 pm, E #1 stated one of her duties was to review behavior documentation and report the findings to the facility's IDT and the psychologist. E #1 stated she did not know what the physician identified as the target behaviors for Resident #23's psychotropic medications. Resident #23's care plan and behavior monitoring sheets did not include specific target behaviors for use of the psychotropic medication. On 2/8/17 at 3:30 pm, Resident #23's psychologist stated he had been treating Resident #23 for her mental health issues for a number of years. Resident #23's psychologist stated Resident #23 tended to fluctuate between crisis and minimization when something upsetting happened. Resident #23's psychologist stated Resident #23 did not seem to interact with other residents a great deal, but did not feel that was a recent development. Resident #23's psychologist stated he was not sure how the facility monitored Resident #23's behaviors, or the effectiveness of non-pharmacological interventions to alter those behaviors. On 2/9/17 at 9:10 am, Resident #23 was	{F 329}	Other residents who have the potential to be affected by the same deficient practice and what corrective actions will be taken; Residents residing at the facility utilizing psychotropic medications have the potential to be affected by this deficient practice. Residents residing at the facility, utilizing psychotropic medications have been evaluated by social services and LSW. Appropriate target behaviors and care planning is in place to support resident diagnoses/condition for identified residents. Measures in place and systemic changes made to ensure that the deficient practice does not recur; Social Services Department and Nursing Managers have been re-educated on target behavior monitoring and care planning for psychotropic medications. Monitor performance to ensure the corrective actions are effective and compliance is sustained; Documentation on target behaviors will be reviewed daily Monday-Friday X 30 days morning stand up meeting. Care planning for residents using psychotropic medications will be reviewed in accordance with the MDS schedule weekly X 12 to ensure accuracy and completeness. Findings will be presented at QAPI for further corrective action Responsible to ensure compliance; _____Director of Nursing	

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{F 329}	Continued From page 40 apologetic for her demeanor during the 2/7/17 interview. Resident #23 stated she was troubled because she had filed a complaint with the facility, and felt the facility's response had been retaliatory in nature. Resident #23 stated she had an experience at the facility the past summer which had caused her a great deal of distress, and afterward she had experienced self-isolation. Resident #23 stated she was "slowly returning to normal" but had not completely resumed her baseline patterns for interactions with others. 2. Resident #31 was readmitted to the facility on 12/17/16, with muliple diagnoses including dementia with behaviors and developmental delay. The 12/24/16 quarterly MDS assessment documented Resident #31 was severely cognitively impaired and did not experience hallucinations, delusions, or behaviors. The Physician's Recapitulation Orders for February 2017, documented Resident #31 was receiving Depakote 125 mg, 2 capsules in the morning and Depakote 125 mg, 1 capsule at lunch and dinner, initiated 12/19/16, for a diagnosis of impulse control. Impulse control was not further defined. The Physician Orders did not specify how Resident #31's impulse control affected the resident and/or others. Resident #31's Psychotropic Care Plan, dated 1/16/17, documented Resident #31 used psychotropic medication, Depakote, for impulse control. The interventions included:	{F 329}		

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{F 329}	Continued From page 41 * Staff was to monitor for side effects and monitor for drug-related cognitive/behavioral impairments: delirium/disordered thinking. The care plan did not include resident-specific target behaviors staff were to monitor. Resident #31's Hallucination, Delusions, or Paranoia Care Plan, dated February 2017, documented Resident #31 was having hallucinations with no description or triggers to monitor noted. Resident #31 was having suspiciousness/paranoia behavior with a description of being physically abusive. There were no interventions or goals documented. The behavior chart detail report, dated 1/23/17 to 2/8/17, documented Resident #31 had one episode of physically abusive, socially inappropriate behavior, and was resistant to care on 2/5/17 at 4:15 am. A Nurse's Note, dated 2/5/17 at 9:00 pm, documented Resident #31 was having a poor appetite and multiple episodes of loose stool. The note did not include documentation regarding Resident #31's behaviors. A social service progress note, dated 2/8/17, documented Resident #31 was hallucinating, wandering, physically abusive, and resisting cares. There was no further documentation in the Resident #31's clinical record of these behaviors. On 2/7/17 at 4:20 pm, E #1 stated she reviewed the clinical behavior report that CNA's documented the day before on general behaviors	{F 329}		

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{F 329}	Continued From page 42 for every resident. If a resident triggered for a behavior, she discussed the behavior with the Unit Managers in the daily meeting. E #1 thought the nurses documented, as well. E #1 stated the facility documented general behaviors, not resident-specific target behaviors. 3. Resident #32 was admitted to the facility on 8/13/12, with multiple diagnoses including paranoid schizophrenia, anxiety, and Parkinson's disease. The 1/14/17 quarterly MDS assessment documented Resident #32 did not experience hallucinations, delusions, or behaviors. Resident #32's February 2017 MAR documented orders, dated 1/3/17, for Zyprexa 5 mg in the morning and at bedtime for delusional episodes. The nurses documented Resident #32 did not have side effects related to the use Zyprexa, from 2/1/17 through 2/8/17. A Nurse's Note, dated 2/4/17, documented Resident #32 had thoughts of cutting her wrist. The facility notified the physician, implemented 15 minute checks, and initiated alert charting by the nursing staff. The behavior chart detail report, dated 2/3/17 to 2/6/17, documented Resident #32 did not experience behaviors. Resident #32's Psychotropic Care Plan, dated 1/18/17, documented Resident #32 used the psychotropic medication, Zyprexa for schizophrenia. The behavioral symptoms were delusions and hallucinations. The interventions	{F 329}		

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{F 329}	Continued From page 43 included: * Staff was to monitor for side effects and monitor for drug-related cognitive/behavioral impairments: delirium/disordered thinking. The care plan did not include resident-specific target behaviors staff were to monitor. On 2/7/17 at 4:25 pm, E #1 stated the facility documented general behaviors, not resident-specific target behaviors. E #1 stated the behavior chart report should have documented Resident #32's thought of self-harm on 2/4/17. 4. Resident #28 was readmitted to the facility on 11/21/16, with multiple diagnoses including a pressure ulcer on the coccyx, chronic pain, and depression. The 11/28/16 admission MDS assessment documented Resident #28 did not experience depression or behaviors. A Physician's Recapitulation Orders, dated February 2017, documented Resident #28 was receiving Lexapro 10 mg daily in the morning, initiated 11/21/16. On 1/24/17, the Lexapro was discontinued and Zoloft 25 mg daily in the morning for depression was initiated. A Physician's Order, dated 1/30/17, documented Resident #28's mood-severity score for depression had increased and included an order for a psychology consult. Resident #28's Psychosocial Well-Being Care	{F 329}		

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{F 329}	Continued From page 44 Plan, dated November 2016, documented Resident #28's mood-severity score showed she was at no risk for depression. The Psychosocial Well-Being Care Plan was not updated to reflect the increase of Resident #28's mood-severity score for depression, medication changes, and/or resident-specific interventions. Resident #28's Psychotropic Medication Care Plan, dated 1/25/17, documented Resident #28 used Zoloft, for depression. Interventions included: * Staff was to monitor for drug-related cognitive/behavioral impairment for depression. Specific target behaviors were not identified. On 2/7/17 at 4:20 pm, E #1 said the facility documented general behaviors, not resident-specific target behaviors.	{F 329}		
{F 353} SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:	{F 353}		3/27/17

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{F 353}	Continued From page 45 Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and review of residents' records and facility grievances, it was determined the facility failed to ensure adequate numbers of staff were available to provide bathing services and ADL assistance. This was true for 8 of 11 sampled residents (#8, #25, #26, #27, #28, #29, #30, and #32) and total of 56 of the 85 residents residing in the facility sampled for bathing. The deficient practice created the potential for residents to experience a delay in the provision of care, or not to receive care. Findings include: Facility grievances filed between 1/23/17 and 2/7/17 documented: * 1/25/17 - Not enough showers. Resolution: Showers would be assigned on Tuesday and Friday evenings. *1/26/17 - "Not enough Staff." Resolution: The resident was referred to physical therapy, and, "assigned staff need to be chosen based on their physical size to be able to handle the resident's weight and girth. *1/27/17 - Delayed call light response times on evening and night shift. Resolution: The resident	{F 353}	Corrective actions that will be accomplished for those residents found to have been affected by the deficient practice; Residents #8, #25, #26, #27, #28, #29, and #32 have and will continue to receive bathing/showers as per care plan. Resident #25 is receiving cares according to care plan Other residents who have the potential to be affected by the same deficient practice and what corrective actions will be taken; All residents residing at the facility have the potential to be affected by this deficient practice. ADL cares are being given as per care plan. Measures in place and systemic changes made to ensure that the deficient practice does not recur; The bath team has been re-instated and this team will comply with shower schedules. They will follow resident preferences for type and frequency. The bath will not be re-assigned to the floor. The facility call-off policy and procedure	

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{F 353}	Continued From page 46 agreed she may have fallen asleep, and had told her counselor she had been happy with the care. The facility planned to do call light audits. *2/7/17 - A resident complained that her roommate's hair and feet were not being cleaned. Resolution: The resident's roommate, who was cognitively impaired, had no concerns with the quality of her bed baths. On 2/7/17 at 10:00 am, the facility provided "Resident Bathing Type by Day" records, from 1/23/17 through 2/7/17 [16 days], for each of the 85 residents in the facility. Fifty-six of the 85 residents' records showed a bath had not been provided for greater than 5 consecutive days, including the records of Residents #8, #26, #27, #28, #29, #30, and #32. On 2/7/17 at 5:30 pm, Resident #25 stated the nursing care in the facility was "so-so," primarily due to a lack of nursing staff. Resident #25, who resided on the facility's specialized unit for residents requiring ventilators and tracheostomies, stated there were often plenty of nurses and aides scheduled, but often times the facility experienced call-ins. Resident #25 stated this resulted in him having to "sit on the bedpan for up to an hour and a half." Resident #25 stated the acuity of the residents on the respiratory care unit meant the nurses and aides had to spend "most of their time managing the paperwork" instead of providing direct resident care. Resident #25 stated, "They need at least one more nurse and one more aide so we can get the basic things we need." Resident #25 was observed with flakes of dandruff in his hair and a waxy build-up in his outer right ear during this conversation. When asked the reason for this,	{F 353}	has been re-educated to nursing staff. Care concerns brought forward will be reviewed related to staffing ratios with follow up as indicated Monitor performance to ensure the corrective actions are effective and compliance is sustained; Resident actual bathing will be compared to resident schedule to ensure bathing occurred. Resident interviews daily X 30 will be done to monitor bathing/showers have been provided as per care plan. Caring partners will complete daily questionnaires Monday through Friday for 12 weeks, through facility caring partner program, to ensure ADL care is being provided to the residents' satisfaction. Any findings will generate a concern report to be followed up by the Administrator related to staffing. Responsible to ensure compliance; _____Administrator Responsible to ensure compliance; _____Director of Nursing	

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{F 353}	Continued From page 47 Resident #25 stated he was to be on a bathing schedule, but it had been more than a week since his last bath, and going a week or more without a bath was not an unusual occurrence. Additionally, on 2/7/17 at 1:30 pm, one of the residents in the Resident Group meeting stated s/he had missed a bath in the past week because a CNA was sent home sick, and there was no one else to provide bathing. On 2/7/17 at 11:15 pm, CNA #12 stated the facility usually scheduled plenty of nursing staff for night shift, but it was not unusual for staff to call in, leaving fewer staff than were actually scheduled. CNA #12 stated if everyone who was scheduled did show up, it was not unusual for someone to be sent home. CNA #12 stated the person scheduled as the "float" CNA for that shift had been sent home at 10:00 pm. CNA #12 stated he understood the facility had determined the float CNA was not necessary if the facility's census was under 92, and the current census was 85. However, CNA #12 stated that resident care would be impacted with the loss of the float CNA because of the high acuity of the resident population as a whole. CNA #12 stated that day shift and evening shift had not been able to complete all of the assigned showers for that day, so night shift was to try to get them done. CNA #12 stated the staff planned to shower a resident that shift, not because late night showers were the resident's preference, but "because we asked earlier and they didn't say no." CNA #12 also stated because the float CNA had been sent home, residents on the 500 hall who required 2-person assist to get out of bed would have to wait until the day shift arrived at	{F 353}		

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{F 353}	Continued From page 48 6:00 am, even if they requested to get up earlier. Review of the facility's nursing schedule for the 10:00 pm - 6:00 am shift documented the float CNA had been sent home on 2/7/17. On 2/10/17 at 10:10 am, the Regional Administrator and Regional Nurse Consultant stated the facility's Administrator and DNS were new to the facility and the corporation, and had not utilized the corporate QA and tracking tools to determined care was being provided per regulatory requirements. The Regional Administrator and Regional Nurse Consultant stated they had become aware late the previous week that care outcomes were inconsistent with the data being reviewed, and were implementing corrective measures.	{F 353}		
{F 441} SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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 The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection	{F 441}		3/27/17

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{F 441}	Continued From page 49 (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (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. (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure a) staff performed hand hygiene [HH] to reduce the risk of infection, and b) aseptic technique was practiced during dressing changes. This was true for 1 of 11 sample residents (#31) and 6 random residents who were observed during mid-day and evening meals (#12 and #35-39), as well as, 2 random residents whose dressing changes were observed (#10 and #34). This failure created the potential for residents to develop infection from cross-contamination. Findings include: 1. CNA staff did not perform HH between contact with residents during assistance with meals in the Rehab Dining Room.	{F 441}	Corrective actions that will be accomplished for those residents found to have been affected by the deficient practice; Proper HH is being performed in the restorative and dining room. RN #9 has been re-educated on proper equipment cleaning and infection control during dressing changes. Other residents who have the potential to be affected by the same deficient practice and what corrective actions will be taken; Residents residing at the facility have the potential to be affected by this deficient practice. There are no other residents identified.	

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{F 441}	Continued From page 50 a. On 2/7/17, at 5:30 pm, the evening meal in the Rehab Dining Room was observed. * CNA #15 wheeled Resident #12 to her position at the table, then left the room. HH was not performed. She returned to the room at 5:37 pm, placed Resident #12's dinner tray on the table and put a clothing protector on her. * At 5:45 pm, CNA #16 was assisting Resident #37 with her meal. She assist her with cutting her food, then touch Resident #37's chair and table area. CNA #16 returned to Resident #12 and offered her bites of food. At 6:00 pm, CNA #16 was moving her wheeled stool back and forth to offer both Resident #12 and #37 bites of food. * CNA #15 was assisting Resident #36 with eating, then at 6:05 pm asked Resident #31 if he was done. She went to get a wet washcloth and returned to the room and assisted Resident #31 with wiping his face. Her keys dropped onto the floor, and she picked them up. HH was not performed until she picked the keys off the floor. b. On 2/8/17, at 11:30 am, the mid-day meal in the Rehab Dining Room was observed. * CNA #16 was seated between Residents #12 and #35. She scooted her wheeled stool to assist Resident #38. At 11:35 am, CNA #16 assisted Residents #37, #38 and #12, all while standing. CNA #16 walked over to Resident #31, fed him a bite, then returned to sit beside Resident #12 and feed her. She did not perform HH between contact with each resident.	{F 441}	Measures in place and systemic changes made to ensure that the deficient practice does not recur; Facility staff will be re-educated on proper handwashing related to dining service and equipment cleaning related to dressing changes by the facility educator. Monitor performance to ensure the corrective actions are effective and compliance is sustained; Hand washing will be monitored in the dining room daily during random times for all three meals by the Field Director of Education and Training Monday through Friday X 30 days. Random nurses performing dressing changes will be monitored by the RCM 2x week for 3 months. Findings will be corrected as identified, reported to the Director of Nursing and then presented at QAPI monthly X 3 for further corrective opportunities. Date corrective action will be done and who will be responsible to ensure compliance; Director of Nursing	

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{F 441}	Continued From page 51 * At 11:43 am, CNA #7 wheeled Resident #39 into the room. He placed a clothing protector on her, set up the tray of food, then went to assist Resident #37 with feeding. No HH was performed between contact with the residents. * At 11:48 am CNA #16 walked over to Resident #38 and helped cut up her food. She returned to offer Resident #12 a spoonful of pudding, then offer Resident #31 a bite of food. She was observed leaving the Rehab Dining Room without performing HH. * CNA #16 returned to the Rehab Dining Room at 11:50 am, and sat down to feed Resident #12. At 11:52 am, CNA #16 stood up and offered Resident #38 tissues. She returned to feed Resident #12. At 11:54 am, CNA #16 walked to a cabinet and put on a pair of gloves, took the soiled tissues from Resident #38, removed the gloves and discarded gloves and tissues in the trash. She did not perform HH before donning the gloves, removing the gloves or before returning to assist Resident #12. * At 12:12 pm, CNA #7 was sitting by Resident #31. He walked over to assist resident #39 to help her with eating, then went to Resident #37 to offer her a bite of food. HH was not performed between resident contact. On 2/8/17 at 12:30 pm, CNA #16 was interviewed about the dinner and lunch observations. She confirmed she did not wear gloves or perform hand hygiene between resident contact. She stated she thought gloves and hand hygiene were not required if her hands did not get dirty. She stated she was only touching the utensils.	{F 441}		

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{F 441}	Continued From page 52 2. Wound care and dressing changes of 2 residents were observed on 2/7/17. Breaches in aseptic technique were noted as follows: * 2/7/17 at 1:15 pm, RN #8 was observed as she provided wound care for Resident #10. She performed the wound care, applied the dressing, then with soiled gloves, reached into her right pocket for a pen. Directly after the procedure was completed, RN #8 was interviewed regarding the observation. She stated she knew she contaminated her pocket with the soiled gloves when she reached in for a pen. She stated she should have removed her soiled gloves and performed hand hygiene. She stated that she should have had the pen out and ready before starting the procedure. * 2/7/17 at 1:50 pm, RN #9 was observed as she provided wound care for Resident #34. Her supplies for the wound care were gathered on a medication cart in the hallway. Included with the dressing change supplies was a pair of scissors. RN #9 brought the supplies into the room and performed the dressing change. The scissors were not cleaned prior to coming into the room. After the new dressing was placed on his lower back, it was noted to have a gap on the lower edge. RN #9 used the scissors to clip the middle of the lower part of the dressing to allow it to fit Resident #34's contours. The scissors were placed between the cleft of his buttocks to cut the dressing. Directly after the procedure was completed, RN #9 was interviewed about the use of the scissors. She stated she cleaned her scissors after each time they were used. She confirmed she did not cleanse the scissors	{F 441}		

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{F 441}	Continued From page 53 directly before Resident #34's dressing change. RN #9 stated the residents in the facility did not have dedicated supplies such as scissors for their care.	{F 441}		
{F 490} SS=F	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, resident, staff, and resident group interviews, and review of facility staffing records, resident clinical records, and the facility's grievances, it was determined the facility was not administered in a manner to effectively use its resources to assist residents attain or maintain their highest practicable well being. The facility's administration failed to ensure prior deficient practices were corrected and facility sustained substantial compliance. Findings include: During a recertification and complaint survey on 11/7/16, the facility was cited for deficient practices at F166 (Grievances), F250 (Social Services), F280 (Care Plan Revisions), F312 (ADL Assistance), F314 (Pressure Ulcer Prevention), F323 (Supervision), F329 (Unnecessary Medications), F353 (Nursing Staffing), and F441 (Infection Control). During a follow-up survey on 2/10/17, the facility	{F 490}	Corrective actions that will be accomplished for those residents found to have been affected by the deficient practice; There are no further residents identified Other residents who have the potential to be affected by the same deficient practice and what corrective actions will be taken; Residents residing at the facility have the potential to be affected by the identified citations. Measures in place and systemic changes made to ensure that the deficient practice does not recur; Refer to F-tags 166, 250, 290, 312, 314, 323, 329, 353, 441, 252, 284 and 520 for corrections to ensure federal/state compliance. Facility will complete outlined measures and system changes for the above citations to prevent recurrence. Management team will be re-educated on	3/27/17

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{F 490}	Continued From page 54 was found to have deficient practices in those same areas, and new deficiencies were identified at F252 (Clean, Comfortable, and Homelike Environment) and F284 (Discharge Planning). Specifically, residents expressed that they feared retribution when filing a grievance, or felt that grievances were not resolved; medically related social services were not provided; they lacked input on the development and revision of their care plans; and they were not receiving assistance with bathing or nail care; On 2/10/17 at10:10 am, the Regional Administator stated the facility underwent a number of leadership changes in key positions in the past 2 to 3 months, including Administrator, DNS, and Social Services. The Regional Administrator stated these changes made it challenging for the facility to attain and maintain compliance.	{F 490}	policy and procedure by Field Educator, Director of Clinical Services and Executive Director of Business Administration to effectively use its resources to ensure residents attain or maintain their highest practicable level of well being. The Regional Executive Director will meet with the management team every 2 weeks x3 months to discuss this centers effective and efficient use of our resources. Monitor performance to ensure the corrective actions are effective and compliance is sustained; See citations, 166, 250, 280, 312, 314, 323, 329, 441, 252, 284 and 520 for monitoring plan for compliance. Date corrective action will be done and who is responsible to ensure compliance; Administrator	
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.	F 520		3/27/17

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LACROSSE HEALTH & REHABILITATION CENTER	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 520	Continued From page 55 A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to develop, implement, and monitor an effective Quality Assurance program. This deficiency created the potential for all residents in the facility to experience physical, emotional, or psychosocial harm from continued deficient practices in Quality of Care and Quality of Life. Findings include: 1. The facility was cited with deficiencies at F166, F250, F280, F312, F314, F323, F329, F353, F441, and F490 during a recertification and complaint survey on 11/7/16. The facility's plan of correction to achieve and maintain substantial compliance in these areas included ongoing review by the facility's Quality Assurance program. During the resurvey on 2/10/17, continued deficiencies were cited in these areas, as well as new deficiencies at F252 and F284. 2. On 2/10/17 at 10:10 am, the Regional Vice President (RVP) stated the facility's Administrator	F 520	Corrective actions that will be accomplished for those residents found to have been affected by the deficient practice; There are no further residents identified Other residents who have the potential to be affected by the same deficient practice and what corrective actions will be taken; Residents residing at the facility have the potential to be affected by the identified citations. Measures in place and systemic changes made to ensure that the deficient practice does not recur; Facility has employed a new Administrator and Director of Nursing to the facility. Area Director of Business Administration and/or Regional Director of Operations have re-educated the management team on the Quality Assurance Performance Improvement process. Monitor performance to ensure the corrective actions are effective and	

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	135042		R **02/10/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LACROSSE HEALTH & REHABILITATION CENTER	**210 WEST LACROSSE AVENUE** **COEUR D'ALENE, ID 83814**

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F 520	Continued From page 56 was new to the facility and the state, and unfamiliar with the corporate audit process for Quality Assurance. The RVP stated the facility's corporate consultants had identified the facility "wasn't getting where they needed to be" in terms of sustaining substantial regulatory compliance, and had come to the facility the previous week to review the implementation of the QA process. The RVP stated after review of the audits being used as data for QA, it became apparent that resident outcomes were inconsistent with that data. The RVP stated the organization identified the audits were not being done per corporate policy, and what information was being gathered was not being dispersed properly to the apprpriate channels. The RVP stated implementing the corporate QA process would be a crucial part of the facility's ability to achieve and sustain regulatory compliance.	F 520	compliance is sustained; Director of Clinical Services and/or Regional Director of Nursing will provide oversight to the facility weekly to ensure effective process for QAPI and Plan of Care completion 3X a week for 1 month and then weekly X 8 weeks. Findings will be communicated to management team and corrected as identified. Responsible to ensure compliance; _____Administrator	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	MDS001350		R **02/10/2017**

NAME OF PROVIDER OR SUPPLIER
LACROSSE HEALTH & REHABILITATION CENT

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) COMPLETE DATE
C 000	16.03.02 INITIAL COMMENTS The following deficiencies were cited during the licensure on-site follow-up and complaint investigation survey conducted at the facility on February 7, 2017 through February 10, 2017. The surveyors conducting the survey were: Jenny Walker, RN, Team Coordinator Nina Sanderson, LSW Susan Costa, RN Abbreviation: E = Employee	C 000		
C 703	02.152,03,a,i Idaho Licensed Social Worker i. Is a social worker licensed by the state of Idaho as a social worker or who receives regular consultation from such a qualified social worker. This Rule is not met as evidenced by: Based on interview and employee file review, it was determined the facility did not have the services of a Licensed Social Worker. This deficiency had the potential to effect all residents in the facility if they did not receive medically related social services. Findings include: On 2/7/17 at 9:10 am, the Administrator was asked to provide evidence the facility either employed, or had a contract for consultation with, a Licensed Social Worker. On 2/7/17 at 4:20 pm, E #1 stated she was the "social worker" for the facility. E #1 stated she had completed her master's degree in social work in another state, but had not taken a	C 703	Corrective actions that will be accomplished for those residents found to have been affected by the deficient practice; All residents residing in the facility have the potential to be affected by not having a LSW available. A LSW from our sister facility will consult at least weekly until our own MSW has completed the LSW testing process. Measures in place and systemic changes made to ensure that the deficient practice does not recur; Facility social services designee will register for and complete LSW testing or be replaced with a LSW.	3/27/17

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Electronically Signed — 03/10/17

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MDS001350	A. BUILDING: _____ B. WING _____	R **02/10/2017**

NAME OF PROVIDER OR SUPPLIER

LACROSSE HEALTH & REHABILITATION CENT

STREET ADDRESS, CITY, STATE, ZIP CODE

210 WEST LACROSSE AVENUE
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C 703	Continued From page 1 licensing exam and was not aware she needed to be licensed in the state of Idaho. On 2/8/17 at 4:30 pm, the Administrator stated he had not realized there was a state requirement for social workers to be licensed, or for the facility to employ or contract with a licensed social worker. The Administrator stated E #1 had downloaded an application to take the social work exam, and if she was eligible would do so at the earliest opportunity. On 2/10/17 at 10:30 am, the Regional Nurse Consultant stated the facility planned to have a Licensed Social Worker from another facility provide consultation services beginning that day.	C 703	A LSW from our sister facility will consult at least weekly until our MSW receives her licensure. Monitor performance to ensure the corrective actions are effective and compliance is maintained; The administrator will meet weekly with the LSW and MSW to discuss any residents that are at high risk for requiring medically related social services and the plan that is in place to meet the residents needs until our MSW is licensed. Responsible to maintain compliance; _____Administrator	

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSSELL S. BARRON– Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

May 23, 2018

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

Provider #: 135042

Dear Mr. Littman:

On **February 10, 2017**, an unannounced on-site complaint survey was conducted at Lacrosse Health & Rehabilitation Center. This complaint was investigated in conjunction with the onsite follow-up survey in the facility between February 7, 2017 and February 10, 2017.

Eleven resident records were reviewed, including the record of the identified resident. Record reviews included diagnoses and medications; physician visits and assessments; and diet orders.

Observations were made of call light response times; overall cleanlienss of the building; and portion sizes, appearance, and palatability of the food.

Individual and group grievances were reviewed.

Several individual resident interviews and resident family interviews were conducted, including an interview with the identified resident. A resident group interview was conducted. Multiple Licensed Nurses, Certified Nurse Aides, and Hospitality Aides were interviewed. Facility management interviews were conducted, including the Administrator, the Chief of Operations, the Director of Nursing, Nurse Case Manager, and Regional Nurse Consultant.

Menus were reviewed, including standardized portion sizes, and bread items were sampled.
The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007429

ALLEGATION #1:

The facility had delayed call light response times.

FINDINGS #1:

Call light response times were observed for a period of three days in the facility, at various times of the day and evening. There were no observations of resident call lights on for extended periods of time. However, multiple resident grievances had been filed citing a lack of available staff for bathing and provision of basic cares. Resident interviews confirmed these grievances had not been fully resolved by the facility. Several residents appeared unclean and complained of a lack of assistance with bathing.

This portion of the complaint was substantiated and cited at F 353.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #2:

The complainant stated an identified resident received injections which caused the resident to become overly sedated, and caused the resident to have seizures. The seizures were severe enough to cause the resident to be hospitalized.

FINDINGS #2:

The identified resident's medical record was reviewed, including medication orders. The only injections ordered by the physician for the identified resident were insulin and an anti-coagulation medication. The identified resident's blood sugar readings documented the resident rarely required insulin coverage, and when the resident did the readings were neither critically or critically low. There was no seizure activity documented in conjunction with either the blood sugar readings or the administration of insulin.

The anti-coagulation medication did not have seizures documented as a potential adverse reaction by the Food and Drug Administration.

The oral medications received by the identified resident were also reviewed. None of those medications had seizures documented as a potential adverse reaction by the Food and Drug Administration.

The identified resident did experience seizure activity which did require treatment in the hospital.

Hospital records documented the seizures were likely the result of an infection, which the resident had contracted before admission to the facility, and which was being treated at the facility.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant stated insects were noted in the facility during a visit to an identified resident.

FINDINGS #3:

No insects were observed in the facility during the survey. Pest control contracts documented an exterminator provided preventive services monthly, and was available as needed if insects or other pests were noted to be problematic. The facility stated they had had no reason to utilize "as needed" pest control services.

All interviews with individual residents and resident group were negative for concerns about insects in the facility. The identified resident was interviewed, and stated while s/he did not have a concern about insects in the facility, there were other cleanlienss issues that were concerning, including air return vents, window blinds, and the presence of odors in the facility.

No deficiencies were cited directly related to pest control, but the facility was cited at F 252 for overall cleanlienss and upkeep of the premesis.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The complaintant states the facility packed an identified resident's belongings while the resident was in the hospital, after which it was discovered that the resident's cell phone was missing.

FINDINGS #4:

The identified resident and review of the facility's grievance file confirmed that the event occurred as described by the complainant. However, at the time of the complaint, the facility had already been identified as out of compliance with the federal regulatory requirements for grievance resolution and investigation of resident incidents. The facility had not yet alleged they were in compliance with these

regulatory requirements at the time the identified resident was admitted to the hospital, and his/her complaint was received regarding the missing cell phone. As part of their Quality Assurance process to show substantial compliance with the regulatory requirements, the facility discovered that the resident's grievance had not been addressed, and took steps to rectify the situation.

During the February 2016 complaint investigation, the identified resident stated s/he was aware of the facility's efforts to resolve the concern of the missing cell phone, and was satisfied with those efforts. However, the resident stated that s/he had expressed other grievances with the facility, had not had a response after the grievances were filed, and stated those grievances were not resolved. Other residents interviewed also indicated their grievances were not resolved, and/or they feared retaliation should they express a grievance.

CONCLUSIONS:

The allegation was substantiated and the facility was cited at F211 during a recertification and complaint survey completed on November 7, 2016. No deficiencies related to the allegation are cited during the February 10, 2017 survey.

ALLEGATION #5:

The complainant stated an identified resident did not receive palatable food or adequate food portions at meals.

FINDINGS #5:

The identified resident was interviewed, and stated he was satisfied with both the palatability and portion sizes of the food served by the facility.

No other individual residents complained about the portion sizes or quantities of food served.

The survey team conducted observations of breakfast, lunch, and dinner during the survey, and residents were asked about their dining experience during the meals. Residents stated they were satisfied with the quality and quantity of the food served. Residents who were not eating or had concerns about the food were offered, and quickly provided, an alternative meal.

The facility's menus were signed as nutritionally adequate by a Registered Dietician, and consistent with regulatory requirements.

The Resident Group stated the facility's food was flavorful and sufficient, with their only concern being occasional "hard biscuits." The survey team sampled the biscuits during the breakfast meal observation, with no palatability issues noted.

This portion of the complaint could not be substantiated due to a lack of sufficient evidence.

ALLEGATION #6:

The complainant reported the family of an identified resident was "under distress" during the admissions process, and did not sign all the documents presented by the facility.

FINDINGS #6:

The Admission Agreement for the identified resident was reviewed, and it was discovered that not all of the documents were signed. The facility's documentation stated the resident was too ill at the time of admission to sign his/her own Admission Agreement, and had designated another individual to sign on his/her behalf. The surrogate decision maker for the resident had indeed not signed all of the documents presented. However, when this occurred, the facility recognized the resident or surrogate decision maker's right to refuse to sign the documents until they were comfortable doing so. In the time the surrogate decision maker was reviewing the documents, the resident had an acute change in their medical condition and required emergent hospitalization. Therefore, at the time the survey team investigated this complaint the documents remained unsigned.

This portion of the complaint could not be substantiated due to insufficient evidence.

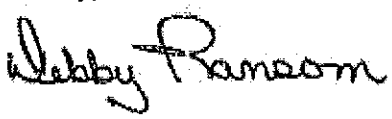
CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this 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 Debby Ransom, RN, RHIT at (208) 334-6626, option 5. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,



Debby Ransom, RN, RHIT, Chief
Bureau of Facility Standards

DR/lj