



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
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September 1, 2017

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

Provider #: 135042

Dear Mr. Lloyd:

On **August 25, 2017**, a survey was conducted at Lacrosse Health & Rehabilitation Center by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

Matthew Lloyd, Administrator
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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 **September 11, 2017**. Failure to submit an acceptable PoC by **September 11, 2017**, may result in the imposition of penalties by **October 2, 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; and
- 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*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **September 29, 2017 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **November 23, 2017**. A change in the seriousness of the deficiencies on **October 9, 2017**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **November 23, 2017** includes the following:

Denial of payment for new admissions effective **November 23, 2017**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying non-compliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **February 21, 2018**, 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, CMS will provide you with a separate formal notification of that determination.

If you believe these 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, 83720-0009; phone number: (208) 334-6626, option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **November 23, 2017** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

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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 **September 11, 2017**. If your request for informal dispute resolution is received after **September 11, 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,

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

David Scott, RN, Supervisor
Long Term Care

DS/lj
Enclosures

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

PRINTED: 10/23/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/25/2017
NAME OF PROVIDER OR SUPPLIER LACROSSE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 210 WEST LACROSSE AVENUE COEUR D'ALENE, ID 83814		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS The following deficiencies were cited during a complaint survey conducted at the facility from August 22, 2017 through August 25, 2017. The surveyors conducting the survey were: Edith Cecil, RN, Team Coordinator Brad Perry, LSW Juanita Stemen, RN Wendy Birch, RN Survey Abbreviations: ADLs = Activities of Daily Living CNA = Certified Nurse Assistant DCS = Director of Clinical Services DON = Director of Nursing EHR = Electronic Health Record LPN = Licensed Practical Nurse RN = Registered Nurse r/t = related to SSA = Social Service Assistant UTI = Urinary Tract Infection	F 000			
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State	F 225		9/26/17	

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

TITLE

(X6) DATE

Electronically Signed

09/11/2017

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 225	<p>Continued From page 1</p> <p>nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or</p> <p>(iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.</p> <p>(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.</p> <p>(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:</p> <p>(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.</p> <p>(2) Have evidence that all alleged violations are thoroughly investigated.</p>	F 225			

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F 225	Continued From page 2 (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the facility failed to ensure an allegation of abuse and neglect was thoroughly investigated. This was true for 1 of 4 (#6) residents sampled for abuse and neglect and created the potential for harm if residents were left exposed to neglectful and/or abusive treatment without the facility's knowledge or protection. Findings include: The facility's December 2016 abuse and neglect policy documented, "Thoroughly investigate all alleged violations and retain documents showing that all alleged violations are thoroughly investigated." Resident #6 was admitted to the facility on 6/23/17 with multiple diagnoses, including quadriplegia. A hospital discharge summary, dated 6/23/17, documented Resident #6 "has the ability to lift his arms to about 90 degrees at the shoulders and as [sic] active elbow flexion and wrist dorsiflexion	F 225	"This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. The submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the department's inspection report" Deficiencies related to F225 will be corrected as follows: 1) Correction/s as it relates to the resident's: Resident #6 no longer resides in the facility. 2) Action/s taken to protect residents in similar situations: The incident and accident log for the past 30 days will be reviewed by the Director of Operations to identify other instances of unresolved abuse or neglect.		

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F 225	<p>Continued From page 3 (bending backwards)."</p> <p>The initial and revised care plans, dated 6/24/17 and 7/6/17 respectively, documented Resident #6 had quadriplegia, but neither care plan documented the resident's physical level of assistance required for eating, food and time of meal preferences, range of motion ability, emotional triggers, or the personal value the resident placed on his computer.</p> <p>Resident #6's Nutrition Progress note, dated 6/29/17, documented, "Spoke with Resident about food preferences multiple times over the last several days, he requests to only have certain food items and then gets agitated after receiving items 2 days in a row. Will continue to speak with resident on a daily basis to ensure his satisfaction. Resident's main food preference is no pork, no other issues noted at this time."</p> <p>An admission Minimum Data Set assessment, dated 6/30/17, documented Resident #6 required the extensive assistance of one staff to eat and had bilateral limited range of motion to the upper extremities.</p> <p>A nurse progress note, dated 7/6/17, documented, "He spends much time on his computer..."</p> <p>A 7/12/17 facility abuse investigation documented an incident on 7/9/17 with the following Witness Investigation Statements:</p> <p>* CNA #8 - "I was sitting out with the smokers and I heard [CNA #7] and [Resident #6] yelling at each other ... I heard [CNA #7] tell [Resident #6]</p>	F 225	<p>3) Measures taken or systems altered to ensure that solutions are sustained: The interdisciplinary team will be re-educated on the policy and procedure of conducting thorough investigations to rule out abuse and/or neglect allegations. A new checklist has been implemented for allegations of abuse and neglect for management involved in the process. Education has occurred related to the new checklist. Staff will be re-educated to the abuse, neglect prevention and reporting and investigation policy.</p> <p>4) Plans to monitor performance to ensure solutions are sustained and person responsible: Beginning the week of 9/26/17 the Director of Operations or designee will review all allegations of abuse and neglect weekly to ensure all components of investigations are thoroughly investigated. Findings of the reviews will be brought to the QAPI committee monthly x 6 months for opportunities of continued quality improvement.</p> <p>Administrator will monitor compliance</p>		

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F 225	<p>Continued From page 4</p> <p>that she could not take care of him and everyone else. I went in [to Resident #6's room in response to his call light having been activated] and he told me that [CNA #7] had left a hot cup of coffee on his chest and left his sandwich on the table and [he] want[ed] to be fed. He said [CNA #7 left for 30 min[utes]."</p> <p>* CNA #7 - "I told [Resident #6] what was on his [breakfast] tray and he stated, 'I don't eat bacon, I do not want my tray.' I then asked him if [he] wanted anything else and he stated, 'No.' Later, my college [sic] told me he was hungry so I went in there to help him. I made him a sandwich [and] feed [sic] him half of it before realizing [she needed to leave the resident's room] ... and got sidetracked by the nurse ... I came back [about 10 minutes later] and [Resident #6 started yelling at me for leaving him. He stated, 'You left the coffee in my hands [and] I was afraid I was going to spill it.' I apologized and tried to explain, but he was to [sic] upset to hear me. I told him that we both needed a minute to cool down and he stated, 'Just leave and don't come back.'"</p> <p>* Resident #6 (written for the resident by a staff member) - "[CNA #7] took breakfast into me. (She brought bacon [and] eggs), sat the tray on the bedside table [and] said she would be back. [CNA #7] didn't come back for about 30 min[utes]. When she came back I was upset [and] hungry. I told her that I don't eat pork. [CNA #7 got me a cup of coffee and and put it in my hands, and left me again [for] 30-45 min[utes]. (I can't move my hands) was scared he was going to drop the coffee on my computer and burn myself. [CNA #7] mad [sic] me a sandwich with old bread. It was hard. I was upset and raised my</p>	F 225			

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F 225	<p>Continued From page 5</p> <p>voice. [CNA #7] said that they were short handed and she can't take care of him and everyone else."</p> <p>During survey, the facility provided statements from five other residents in the same hall as Resident #6 that documented they had no concerns with staff and that their needs were met.</p> <p>The facility's Alleged Verbal Abuse summary, dated 7/9/17, documented, "The resident reported that he did not feel he was verbally assaulted, but instead he and the staff member became upset."</p> <p>A Patient Representative Note, dated 7/10/17, documented, "Res[ident] reported over the weekend that him [sic] and a CNA got into a verbal argument. After talking with res today he states he feels that staff member was frustrated and got upset. Res states he was just upset that coffee was left in his hand due to it's hard for him to hold cup. Res shows no signs of psych[ological] harm ... Res has no concerns at this time."</p> <p>On 8/23/17 at 12:15 pm, CNA #8 said that on the morning of 7/9/17 she was outside in the courtyard where the resident's room window was and heard "bits and pieces" of an argument. CNA #8 said she heard CNA #7 say she had a hard time caring for the resident. CNA #8 said CNA #7's statement to Resident #6 sounded as if it was said more out of frustration than as a threat of neglect or verbal abuse.</p> <p>On 8/24/17 at 3:45 pm, the Director of Nursing</p>	F 225			

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F 225	<p>Continued From page 6</p> <p>said Resident #6 would often decline facility-prepared meals, but was "always" offered an alternative.</p> <p>On 8/24/17 at 3:45 pm and 8/25/17 at 3:25 pm, the facility's Patient Representative said Resident #6 had some mobility in both arms and could use his right arm to lift a coffee to his lips or to the bedside table in front of him. He said when he checked with Resident #6 the day after the incident and thereafter, the resident stated he did not feel abused or neglected.</p> <p>On 8/25/17 at 9:55 am, RN #3 said she visited Resident #6 "every" weekday, that he "usually refused breakfast," and that he did not mention the incident to her during their visits.</p> <p>On 8/25/17 at 3:00 pm and 4:15 pm, the Administrator said Resident #6 could move a coffee cup from his hand and place it to his lips or onto the tray table in front of him. He said the facility ruled out verbal abuse and neglect based on the resident's abilities, interviews with other staff, and follow-up interviews with the resident. The Administrator stated CNA #7 should not have left the room while assisting the resident to eat, and that the investigation should have been more thorough and account of the discrepancies in the differing timelines provided by Resident #6 and CNA #7.</p> <p>On 8/25/17 at 3:40 pm, CNA #7 said she felt the resident was safe with the cup of coffee "near his hip" because he could raise it to his lips by himself or put it on the bedside table. CNA #7 stated she was out of the room for "about 10 minutes" and that Resident #6 was upset when</p>	F 225			

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F 225	Continued From page 7 she returned to his room, where he "yelled" at her for leaving him alone with the cup of hot coffee in his hand. CNA #7 denied telling Resident #6 she could not take care of him. She said she felt there were enough staff at the time of the incident to meet the resident's needs, but that she should not have left the resident's room to retrieve her charting device. The investigation did not explain how the facility ruled out neglect based on the resident's physical limitations and eating assistance requirements, or the difference between the 2 timelines provided by Resident #6 and CNA #7.	F 225			
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure assistance at meals was provided in a manner that maintained or enhanced a resident's dignity when a staff member stopped assisting the resident and left mid-meal to retrieve a charting phone device. This was true for 1 of 3 residents (#6) sampled for dining and had the potential for harm if the resident experienced a sense of decreased self-worth. Findings include: A written statement for Resident #6, dated 7/12/17 as part of the facility's abuse	F 241	"This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with deficiencies or conclusions contained in the Department's inspection report." Deficiencies related to F241 will be corrected as follows 1) Correction/s as it relates to the resident:	9/26/17	

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F 241	<p>Continued From page 8</p> <p>investigation, documented, "[Certified Nursing Aide - CNA #7] took breakfast into me. (She brought bacon [and] eggs), sat the tray on the bedside table [and] said she would be back. [CNA #7] didn't come back for about 30 min[utes]. When she came back I was upset [and] hungry. I told her that I don't eat pork. [CNA #7] got me a cup of coffee and and put it in my hands, and left me again [for] 30-45 min[utes]. (I can't move my hands) was scared he was going to drop the coffee on my computer and burn myself. [CNA #7] mad [sic] me a sandwich with old bread. It was hard. I was upset and raised my voice. [CNA #7] said that they were short handed and she can't take care of him and everyone else."</p> <p>The investigation included a written statement from CNA #7 that documented, "I made him a sandwich [and] feed [sic] him half of it before realizing [she needed to leave the resident's room] ... and got sidetracked by the nurse ... I came back [about 10 minutes later] and [Resident #6] started yelling at me for leaving him. He stated, 'You left the coffee in my hands [and] I was afraid I was going to spill it.' I apologized and tried to explain, but he was to [sic] upset to hear me. I told him that we both needed a minute to cool down and he stated, 'Just leave and don't come back.'"</p> <p>On 8/24/17 at 3:45 pm, the Director of Nursing (DON) said CNA #7 should not have interrupted Resident #6's meal to retrieve her charting device. The DON stated CNA #7 had been suspended at the time and received education regarding the incident.</p>	F 241	<p>Resident #6 no longer resides in facility</p> <p>2) Action/s taken to protect residents in similar situations: Education has been provided to staff that if assisting a resident with a meal to not interrupt meal time to prevent resident from experiencing a sense of decreased self worth</p> <p>3) Measures taken or systems altered to ensure that solutions are sustained: LNs and CNA's will be re-educated to dignified assistance to resident requiring assistance with dining including directly engaging with residents and not allowing interruptions until residents have completed their meals. Caring partners will interview residents who requiring assistance to eat for any negative encounters.</p> <p>4) Plans to monitor performance to ensure solutions are sustained and person responsible: Beginning the week of 9/26/17 round and audits will be conducted daily by the ADONs or manager on duty for observation of 2 meal service to dependent diners re-education will occur at the time of discovery. Findings will be forwarded to QAPI for review and recommendations for continued monitoring and opportunity of continued quality improvement.</p> <p>The DON will monitor continued compliance</p>		
F 279	483.20(d);483.21(b)(1) DEVELOP	F 279		9/26/17	

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F 279 SS=D	Continued From page 9 COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR	F 279			

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F 279	<p>Continued From page 10 recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative (s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure resident care plans accurately reflected the initial and current status for 2 of 3 residents (#3 & #6) reviewed for the development of initial care plans. Failure to develop accurate, individualized care plans placed residents at risk for harm if they received inappropriate or inadequate care to meet their individualized needs. Findings include:</p> <p>1. Resident #3 was admitted to the facility on 6/2/17 with diagnoses that included paraplegia, neurogenic bladder, and benign prostate hypertrophy (BPH).</p>	F 279	<p>"This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report"</p> <p>Deficiencies related to F279 will be corrected as follows:</p> <p>1) Correction/s as it relates to the resident/s: Resident's #3 care plan has been updated to include suprabuc catheter,</p>		

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F 279	<p>Continued From page 11</p> <p>A 6/2/17 physician order directed staff to irrigate Resident #3's suprapubic catheter with acetic acid.</p> <p>An admission Minimum Data Set assessment, dated 6/9/17, documented Resident #3 had an indwelling catheter.</p> <p>A Care Delivery Guide for Certified Nurse Assistants (CNAs), initiated 6/2/17, did not provide direction for care of the resident's suprapubic catheter.</p> <p>An 8/9/17 Care Plan did not direct staff to monitor the suprapubic catheter site for signs and symptoms of infection or how care, such as cleansing of the site, was to be provided.</p> <p>On 8/24/17 at 11:50 am, CNA #5 stated Resident #3's catheter site was usually cleansed twice per shift. CNA #5 said the Care Delivery Guide for Resident #3 did not provide direction for the cleansing of the catheter and stated, "We just kind of wing it."</p> <p>On 8/24/17 at 4:15 pm, the Director of Nursing stated Resident #3 had a supra pubic catheter and that she did not know why the resident's care plan was written for an indwelling urethral catheter.</p> <p>2. Resident #6 was admitted to the facility on 6/23/17 with multiple diagnoses, including quadriplegia.</p> <p>Resident #6's hospital discharge summary, dated 6/23/17, documented, the resident "has the ability</p>	F 279	<p>monitor for s/sx of infection including redness, warmth and drainage from the site as well as the appropriate was to cleanse the suprapubic site with warm soapy water or incontinent wipes.</p> <p>Resident #6 no longer resides at the facility.</p> <p>2) Action/s taken to protect residents in similar situations.</p> <p>Resident's with urinary catheters either indwelling or suprapubic have new care plans specifying type of catheter including s/sx of infection and correct method for cleaning the site of insertion. This information will also be on the Care Delivery Guide, in POC and in PCC</p> <p>3) Measures taken or systems altered to ensure that solutions are sustained:</p> <p>LN staff including the Assistant Directors of Nursing will be re-educated on the facility's policy and procedure related to assessment and care planning. The IDT will review residents for appropriated care planning during facility's CCPR meeting and facility's clinical meeting process M-F to validate appropriate care planning is occurring for residents to include but not limited to urinary status, assistance to eat status and dietary preferences.</p> <p>4) Beginning the week of 9/26/17 the DON/Designee will audit weekly the completion of the CCPR that includes to urinary status, assistance to eat status and dietary preferences for 3 months the</p>		

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F 279	<p>Continued From page 12</p> <p>to lift his arms to to [sic] about 90 degrees at the shoulders and as [sic] active elbow flexion and wrist dorsiflexion (bending backwards). He has limited ability to move his ankles and feet."</p> <p>Initial and revised care plans, dated 6/24/17 and 7/6/17 respectively, documented Resident #6 had quadriplegia, but neither care plan documented the resident's required level of physical level of assistance for eating, food and meal time preferences, range-of-motion ability, emotional triggers, or the importance of his computer.</p> <p>A Nutrition Progress Note, dated 6/29/17, documented, the Certified Dietary Manager had spoken to Resident #6 "multiple times over the last several days," he requests to only have certain food items and then gets agitated after receiving items 2 days in a row. Will continue to speak with resident on a daily basis to ensure his satisfaction. Resident's main food preference is no pork, no other issues noted at this time."</p> <p>An admission Minimum Data Set assessment, dated 6/30/17, documented Resident #6 required the extensive assistance of 1 staff to eat and had bilateral limited range of motion to the upper extremities.</p> <p>A Nurse Progress Note, dated 7/5/17, documented, the resident became upset after hearing his roommate's rough evening with family members. The nurse listened to Resident #6's concerns and frustrations since it was a "situation that closely resembles his condition." The nurse offered to schedule a psychological consultation, but the resident refused.</p>	F 279	<p>monthly for 3 months. Trends of reviews identified will be forwarded to QAPI committee monthly for review and recommendations for continued monitoring.</p> <p>The DON will monitor continued compliance</p>		

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

PRINTED: 10/23/2017
FORM APPROVED
OMB NO. 0938-0391

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F 279	Continued From page 13 A Nurse Progress Note, dated 7/6/17, documented, "He spends much time on his computer..." An Allegation of Abuse form documented Resident #6 was served bacon as part of breakfast on 7/9/17, which upset Resident #6 as he did not eat pork. On 8/24/17 at 3:45 pm, the Director of Nursing said Resident #6 would often decline facility-prepared meals, but was "always" offered an alternative. She said the resident's care plans should be more accurate to meet his needs and reflect his behaviors. On 8/24/17 at 3:45 pm and 8/25/17 at 3:25 pm, the facility's Patient Representative said Resident #6 had some range-of-motion in both arms and could perform some eating tasks. On 8/25/17 at 9:55 am, RN #3 said she visited Resident #6 "every" weekday, and that he "usually refused breakfast." RN #3 said his computer was his "lifeline" and he spent considerable time using it. On 8/25/17 at 3:00 pm and 4:15 pm, the Administrator said Resident #6 could move a coffee cup from his hand and place it to his lips or onto the tray table in front of him. On 8/25/17 at 3:40 pm, CNA #7 said the resident could assist staff with self-feeding and raise a coffee cup to his lips or put it on the bedside table in front of him.	F 279			
F 323	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT	F 323			9/26/17

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F 323 SS=D	Continued From page 14 HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure a resident received sufficient supervision when self-transporting himself to a local hospital emergency room via motorized wheelchair. This was true for 1 of 4 (#6) residents reviewed for supervision and had the potential for harm if the resident were injured or became lost while self-transporting out of the facility without staff	F 323	"This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report" Deficiencies related to F323 will be		

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F 323	<p>Continued From page 15 supervision. Findings include:</p> <p>Resident #6 was admitted to the facility on 6/23/17 with multiple diagnoses, including quadriplegia.</p> <p>An admission Minimum Data Set assessment, dated 6/30/17, documented Resident #6 required setup assistance from staff for locomotion, was cognitively intact, had bilateral limited range of motion to the upper and lower extremities, and used a wheelchair.</p> <p>A 6/23/17 Progress Note documented, "Resident [#6] returned from [family member's] house [with] wound to L[eft] foot after dragging foot."</p> <p>Physician Orders, dated 7/3/17, documented Resident #6 was not to leave the facility without a responsible party due to the prior 6/23/17 injury while in his wheelchair.</p> <p>Resident #6's 7/6/17 care plan documented, "May leave facility with responsible adult only."</p> <p>The facility's 8/15/17 investigative documentation included the following:</p> <p>* A written statement from Certified Nurse Aide (CNA) #9, dated 8/14/17, documented she saw the resident talking to the front desk receptionist before leaving the building.</p> <p>* A written statement from the Director of Nursing (DON), dated 8/15/17, documented she was notified the resident was taking himself to a hospital. The statement documented the DON called the hospital and then exited the facility to</p>	F 323	<p>corrected as follows:</p> <p>1) Correction/s as it relates to the resident/s: Resident #6 no longer resides in the facility</p> <p>2) Action/s taken to protect residents in similar situations: Residents who are unsafe to leave the center independently will be assessed for elopement with care plans updated for appropriate interventions. MD, residents and familiea will be notified of any new interventions.</p> <p>3) Measures taken or systems altered to ensure that solutions are sustained: Staff will be re-educated to the elopement prevention and management policy including the resident missing action plan. Elopement education and drills will be conducted monthly for 3 months. Audits will be conducted with in 3 days of new admit charts via the daily clinical review meeting and quarterly via the comprehensive care plan review meeting there after.</p> <p>4) Plans to monitor performance to ensure solutions are sustained and person responsible: Beginning the week of 9/26/17 the Social Services Director/designee will audit the resident sign out log daily Monday-Friday for residence adherence to signing out of facility to include</p>		

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F 323	<p>Continued From page 16 look for Resident #6 in the immediate area.</p> <p>* A Social Services Note, dated 8/8/17, documented Resident #6 left the facility for the hospital because he was not satisfied with the wound treatment he received at the facility.</p> <p>*A conclusion statement documented the Interdisciplinary Team (IDT) was notified by the receptionist that Resident #6 left the facility for wound care evaluation at the hospital, reviewed the resident's clinical record, the DON searched for the resident outside the facility, and a Nurse Practitioner order documented Resident #6 should not leave the facility without a responsible party due to "poor safety awareness."</p> <p>On 8/24/17 at 3:45 pm, the Administrator, with the DON present, said the facility's receptionist interrupted an IDT meeting on 8/8/17 to say Resident #6 had left the facility to go to the local hospital for wound treatment. The Administrator said the resident would not wait for staff to transport him to the hospital and instead transported himself in a motorized wheelchair. The Administrator said facility staff did not accompany the resident to the hospital. The DON said she left the IDT meeting to look for Resident #6 in the immediate area, but could not find him.</p> <p>On 8/25/17 at 9:30 am, RN #3 said CNA #10 reported to her on 8/8/17 that Resident #6 was leaving the building without staff supervision to go to the hospital. RN #3 then "immediately" went to find the DON and relayed the information to her. RN#3 said neither she nor CNA #10 attempted to accompany the resident when he left the facility.</p>	F 323	<p>residents who are unsafe to leave the center alone are not signing out of center independently, for 8 weeks then 2 times per week for 6 months. Beginning the week of 9/26/17 the Life Enrichment Director will audit the Elopement binder 2 times per week and with new admits to ensure resident as risk for elopement have an identification sheet in binder for 12 months. Findings will be forwarded to QAPI for review and recommendations for opportunities of continued monitoring.</p> <p>The ED will monitor continued compliance</p>		

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F 366 SS=D	<p>483.60(d)(4)-(6) SUBSTITUTES OF SIMILAR NUTRITIVE VALUE</p> <p>(d)(4) Food that accommodates resident allergies, intolerances, and preferences;</p> <p>(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; and</p> <p>(d)(6) Drinks, including water and other liquids consistent with resident needs and preferences and sufficient to maintain resident hydration. This REQUIREMENT is not met as evidenced by: Based on record review, facility menus, and staff interview, it was determined the facility failed to honor residents' food preferences. This was true for 1 of 3 residents (#6) reviewed for dietary preferences and had the potential for harm if residents experienced frustration, hunger, and/or weight loss from being served meal items they did not want or like. Findings include:</p> <p>Resident #6 was admitted to the facility on 6/23/17 with multiple diagnoses, including quadriplegia.</p> <p>A Meal Preferences Card used by dietary staff documented Resident #6 disliked pork.</p> <p>Resident #6's 6/29/17 Nutritional Progress Note documented, "Resident's main food preference is no pork..."</p> <p>The facility's menu for 7/9/17 documented that day's breakfast meal included bacon.</p>	F 366	<p>"This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report"</p> <p>Deficiencies related to F366 will be corrected as follows:</p> <p>1) Correction/s as it relates to the resident/s: Resident #6 no longer resides in the facility</p> <p>2) Action/s taken to protect residents in similar situations: Resident food preferences will be audited by the dietary manager and the dietary card and care plans will be update to current preferences.</p>	9/26/17	

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F 366	Continued From page 18 An Allegation of Abuse form documented Resident #6 was served bacon as part of breakfast on 7/9/17, which upset Resident #6 as he did not eat pork. On 8/23/17 at 2:25 pm, the Certified Dietary Manager said he did not know why Resident #6 received bacon on his 7/9/17 breakfast tray. He said dietary and CNA staff should have checked the resident's meal ticket prior to delivering the meal. On 8/25/17 at 3:40 pm, CNA #7 said Resident #6's breakfast contained bacon and the resident became upset, declined the meal, and refused an alternate breakfast at that time.	F 366	3) Measures taken or systems altered to ensure that solutions are sustained: Dietary staff will be re-educated on reading and following meal preferences card. Dietary will offer alternative choices when disliked item is being served. CNA's will be re-educated to check the trays accuracy against the diet card. 4) Plans to monitor performance to ensure solutions are sustained and person responsible: Beginning the week of 9/26/17 resident food preferences will be assessed by the dietary manager or designee during the admission process and will be reviewed by the IDT team via the daily clinical meeting on the next business day and quarterly during the comprehensive care plan review process. Dietary manager or designee will audit tray line 3 times per week time 3 weeks and 1 time per week on going. The RD will audit the tray line and a test tray monthly on an ongoing basis. Findings will be forwarded to QAPI for review and recommendations for opportunities of continued quality improvement and monitoring The Nutrition Service Manager will monitor continued compliance		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention	F 441		9/26/17	

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F 441	<p>Continued From page 19 and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);</p> <p>(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under</p>	F 441			

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F 441	<p>Continued From page 20 the circumstances.</p> <p>(v) The circumstances under which 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; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review, it was determined the facility failed to ensure medical equipment used for multiple residents was cleaned and sanitized between each resident use. This was true for 2 of 10 residents (#9 and #10) reviewed for infection control practices and had the potential for harm through the spread of contagions between residents using the same equipment. The facility also failed to ensure staff did not expose residents to potential infections related to backflow of urine. This was true for 2 of 2 residents (#9 and #10) reviewed for indwelling catheter care and created the potential for harm if</p>	F 441	<p>"This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report"</p> <p>Deficiencies related to F441 will be corrected as follows:</p> <p>1) Correction/s as it relates to the resident/s: CNA's 1,5 and SSA were in-serviced</p>		

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F 441	<p>Continued From page 21</p> <p>residents developed urinary tract infections associated with improper catheter care. Findings include:</p> <p>1. On 8/24/17 at 10:35 am, Certified Nurse Aide (CNA) #1 and the Social Services Assistant (SSA), who was also a CNA, were observed positioning a mechanical lift into Resident #10's room from the hallway. The mechanical lift was not cleaned prior to its transfer into the resident's room. During the transfer, Resident #10 clutched the hand grips as the aides transferred him into the lift and onto the bed. After adjusting the resident's position on the bed, the aides moved the lift away from the bed and assisted the resident onto a bedpan.</p> <p>Following the transfer and repositioning, CNA #1 and the SSA pushed the mechanical lift out of the room without cleaning or sanitizing it, and then pushed the lift into Resident #9's room.</p> <p>2. On 8/24/17 at 10:50 am, CNA #1 and CNA #5, without first sanitizing the lift or sling, were observed transferring Resident #9, via the mechanical lift just utilized to transfer Resident #10 onto a bed pan, into a shower chair.</p> <p>On 8/24/17 at 11:00 am, CNA #5 stated the mechanical lift was used to transfer several residents without cleansing between residents.</p> <p>On 8/24/17 at 12:00 pm, when asked if mechanical lifts were cleaned between uses for multiple residents, CNA #1 stated staff cleaned the mechanical lifts between residents in the past, but they were not cleaned between resident transfers after the facility "ran out" of cleansing</p>	F 441	<p>immediately regarding sanitation of lifts in between residents and the appropriate placement of a catheter bag during a lift transfer.</p> <p>2) Action/s taken to protect resident's in similar situations: Nursing staff including CNAs have been re-educated on the need to sanitize mechanical lifts between resident uses. Nursing staff has been re-educated on appropriate placement of a catheter drain bag when moving a resident. Mechanical lifts in the facility will be cleaned between each resident use.</p> <p>3) Measures taken or systems altered to ensure that solutions are sustained: Nursing staff including CNAs will be re-educated including return demonstration on the proper way to sanitize equipment between residents. CNAs will be re-educated on the use of mechanical lifts not limited to but including catheter bag placement during transfer.</p> <p>4) Plans to monitor performance to ensure solutions are sustained and person responsible: Beginning the week of 9/26/17 the Maintenance Director or the Central Supply Coordinator when designated by the Maintenance Director will audit mechanical lifts for cleanliness daily Monday-Friday for 6 months.</p>		

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F 441	<p>Continued From page 22 wiper.</p> <p>The facility's Equipment - Cleaning/Disinfecting/Sterilizing policy/procedure, revised January 2017, documented, "All used equipment and supplies are considered contaminated with potentially infectious material and will be cleaned and disinfected as applicable before use with another resident."</p> <p>3. Resident #10 was admitted to the facility on 7/7/17 with diagnoses that included infection, inflammatory reaction due to an indwelling urethral stent, and chronic kidney disease.</p> <p>A 7/26/17 Nursing Progress Note documented Resident #10 was diagnosed with a urinary tract infection (UTI) and had a history of bladder infections.</p> <p>On 8/24/17 at 10:35 am, Certified Nurse Aide (CNA) #1 and the Social Services Assistant (SSA), who was also a CNA, were observed transferring Resident #10 from a wheelchair to his bed via a mechanical lift. During the transfer, the SSA held the indwelling catheter above the resident's lap, exposing the resident to potential backflow and infection. When the resident was positioned onto the bed and the catheter collection bag and tubing were lowered, a moderate amount of urine was observed draining into the bag.</p> <p>Resident 10's care plan, dated 8/22/17, documented staff was to ensure the catheter tubing and drainage bag were positioned "below the level of the bladder."</p>	F 441	<p>Beginning the week of 9/26/17 the DON/FDET or designee will audit staff performance of cleaning mechanical lifts between resident uses 2 times per shift on day and evening shifts for 3 weeks then weekly for 3 months. Findings will be forwarded to QAPI for review, recommendations and for opportunities of continued quality improvement.</p> <p>Beginning the week of 9/26/17 the DON/FDET or designee will audit mechanical lift transfers of residents with catheters for placement of catheter bag on 3 residents Monday through Friday daily x 4 weeks. Then audit 5 resident's per week x 2 weeks Monday through Friday and then 3 resident's weekly x 2 weeks. Continued auditing/monitoring will be completed with CNA competency updates.</p> <p>The DON will monitor continued compliance.</p>		

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F 441	Continued From page 23 On 8/24/17 at 11:05 am, the SSA stated he held the catheter above Resident #10's bladder out of concern the tubing was not long enough to prevent it from pulling on the resident during the mechanical lift transfer. 4. Resident #9 was admitted to the facility on 7/13/17 with diagnoses that included neurogenic bladder. On 8/24/17 at 10:50 am, CNA #1 and CNA #5 were observed transferring Resident #9 into a shower chair via mechanical lift. After positioning the resident onto the mechanical lift's cloth sling, CNA #5 was observed holding the resident's indwelling catheter above the level of the bladder, exposing Resident #9 to potential backflow and infection. Resident #9's care plan, dated 8/22/17, directed staff to "ensure catheter tubing and drainage bag are below the level of the bladder." The facility's Indwelling Urinary Catheters policy and procedure, effective July 2015, did not include procedures related to catheter care, or correct positioning/handling of an indwelling urinary catheter. On 8/25/17 at 5:00 pm, the Director of Nursing stated staff were to ensure the urinary collection bag and tubing were kept below the level of the bladder at all times, including during transfers.	F 441			
F 498 SS=D	483.35(c); 483.95(g)(1)(2)(4) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS 483.35 (c) Proficiency of Nurse Aides	F 498		9/26/17	

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F 498	Continued From page 24 The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. 483.95 (g) Required in-service training for nurse aides. In-service training must- (g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. (g)(2) Include dementia management training and resident abuse prevention training. (g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, it was determined the facility failed to ensure staff applied assistive devices for safe and comfortable transfers. This was true for 2 of 6 (#1 and #2) residents reviewed for use of assistive devices and created the potential for harm if residents were injured while receiving cares that did not meet their needs. Findings include: 1. Resident #1 was admitted to the facility on 4/20/16, and readmitted on 6/29/16, with diagnoses that included respiratory failure, tracheotomy, and myotonic muscular dystrophy.	F 498	"This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report" Deficiencies related to F498 will be corrected as follows: 1) Correction/s as it relates to the resident/s: CNA #4,#6 & LPN #4 were in-serviced regarding use of gait belt and appropriate		

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F 498	<p>Continued From page 25</p> <p>An ADL (Activities of Daily Living) care plan, dated 6/28/17, documented Resident #1 was able to bear weight, stand, and pivot with a front wheel walker.</p> <p>On 8/24/16 at 8:55 am, CNA #6 was observed leaving the facility to retrieve a gait belt. When she returned, CNA #6 made three attempts before she was successful securing the gait belt, which partially covered the resident's left breast. Resident #1, in a frustrated manner, swiftly pulled at the gait belt and pointed to the bedside commode. CNA #6 grasped the back of the gait belt as Resident #1 used the walker to ambulate to the bedside commode. The gait belt was loose and provided no support for the transfer</p> <p>2. Resident #2 was admitted to the facility on 1/3/17, and readmitted on 5/9/17, with diagnoses that included chronic respiratory failure, chronic obstructive pulmonary disease, and obstructive sleep apnea.</p> <p>A 6/27/17 care plan documented Resident #2 required supervision of one staff for transfers, and had a history of falls related to falling asleep in inappropriate locations.</p> <p>On 8/24/17 at 4:20 pm, CNA #4 and Licensed Practical Nurse (LPN) #4 were observed preparing to assist the resident to the bedside commode following an episode of urinary incontinence in bed. Prior to transferring Resident #2, CNA #4 and LPN #4 applied a gait belt to the resident by wrapping it around the resident's upper chest, including both breasts and her oxygen tubing. The resident removed her breasts from the belt, however the two staff</p>	F 498	<p>placement of gait belt on residents.</p> <p>2) Action/s taken to protect residents in similar situations: Nursing staff has been in-serviced on appropriate use and placement of gait belts per policy. All CNA staff will have gait belts provided as part of the uniform. An audit will be conducted of the new hires from the past 90 days for presence of new hire orientation skill check list.</p> <p>3) Measures taken or systems altered to ensure that solutions are sustained: Nursing staff has been re-educated on appropriate use and placement of gait belts per policy. Gait belts are a required part of the uniform and CNA staff will be monitored daily each shift for appropriate uniform. Newly hired nursing staff including CNA's will complete a skills check list monitored by the Field director of Education and Training.</p> <p>4) Plans to monitor performance to ensure solutions are sustained and person responsible: Beginning the week of 9/26/17 audits will be performed by the DON or designee each shift daily for the presence of gait belts for CNA. Beginning the week of 9/26/17 audits will be completed of 5 resident transfers a week x 4weeks for appropriate use and placement of gait belts during transfers. Then will be 3 residents per week x2 weeks.</p>		

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F 498	<p>Continued From page 26</p> <p>continued the transfer with the oxygen tubing captured within the gait belt. After the transfer, the resident stated her oxygen tubing had been "caught in" the gait belt.</p> <p>The facility's Applying a Transfer (Gait) Belt policy and procedure, documented staff were to "...check [the gait belt] for fit. When applying a transfer belt to a woman, make sure that her breasts are not trapped underneath the belt."</p> <p>On 8/25/17 at 3:00 pm, the Director of Nursing (DON) stated CNA #4 was newly hired and had not yet received training on the proper use of a gait belt and gait belt training was not part of LPN #4's nursing skills checklist.</p> <p>A CNA Skills Competency Checklist documented CNA #6 was evaluated for gait belt application and use and that he/she met the facility's standard as of 5/6/17.</p>	F 498	<p>Beginning the week of 9/26/17 the HR director will audit new hire records for skills checks with in 7 days from staff completing floor orientation ongoing.</p> <p>Findings will be forwarded to QAPI for review, recommendations, and for opportunities of continued quality improvement.</p> <p>The ED monitor continued compliance</p>		



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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September 20, 2017

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

Provider #: 135042

Dear Mr. Lloyd:

On **August 25, 2017**, an unannounced on-site complaint survey was conducted at Lacrosse Health & Rehabilitation Center. An on-site complaint investigation was conducted at the facility from August 21, 2017 through August 25, 2017. Observations were conducted throughout the facility of resident transfers via mechanical lift. Interviews were conducted with residents, staff, and family members.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007538

ALLEGATION#1:

The Reporting Party stated staff have been trained to perform transfers via Hoyer mechanical lift without the assistance of a second staff member because of an inadequate number of staff.

FINDINGS:

The investigation determined current residents were safely transferred via mechanical lifts by the appropriate number of aides.

The allegation could not be substantiated for lack of sufficient evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION # 2:

The Reporting Party stated an identified resident, who the facility has labeled as being "combative," is often left sitting at the edge of the bed, where he/she slumps forward and falls asleep. The Reporting Party stated the identified resident looks uncomfortable and as if he is about to fall. The Reporting Party was told not to approach the resident because he/she is combative, but the resident was grateful to have someone's help to lay down.

FINDINGS:

Observations, including several of the identified resident, and interviews with residents, staff, and family members were conducted throughout the facility and throughout the survey.

The identified resident denied needing staff assistance to reposition in bed and claimed he/she slept in positions that were comfortable. The resident's clinical record documented that only staff supervision was required for bed mobility.

There were no concerns regarding the identified resident or other residents being left in uncomfortable or unsafe positions for extended periods of time.

The allegation could not be substantiated due to a lack of sufficient evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The Reporting Party stated many female residents have their breasts pinched under their bodies or in a Hoyer mechanical lift when they are assisted from bed in the morning and when these female residents call out or strike out at staff they are immediately labeled as "combative."

FINDINGS:

The investigation determined staff inappropriately applied gait belts to residents during transfers and were observed capturing residents' breasts under the gait belts and during transfers. The allegation was substantiated and the facility was cited at F498. Please refer to Federal 2567 report for details.

Matthew Lloyd, Administrator
September 20, 2017
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CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #4:

The Reporting Party stated oral care is documented as refused when it is not offered and residents' rooms are malodorous from residents' bad breath.

FINDINGS:

Observations of multiple resident and resident rooms were conducted throughout the facility. Interviews were conducted with residents, staff, and family members.

Observations of residents' rooms in the general population areas, as well as within the ventilator unit and of those residents receiving nutrition via gastrostomy tube without foul odors being detected. Residents were observed with clean teeth.

The allegation could not be substantiated for lack of 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 David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

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

David Scott, R.N., Supervisor
Long Term Care

Matthew Lloyd, Administrator
September 20, 2017
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DS/lj



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September 20, 2017

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

Provider #: 135042

Dear Mr. Lloyd:

On **August 25, 2017**, an unannounced on-site complaint survey was conducted at Lacrosse Health & Rehabilitation Center. An on-site complaint investigation was conducted at the facility from August 21, 2017 through August 25, 2017. Staff were observed bathing residents throughout the facility as well as on the ventilator unit. Multiple interviews were conducted with residents, staff members, and the Reporting Party. The clinical records of nineteen residents were reviewed.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007546

ALLEGATION #1:

The Reporting Party (RP) stated an identified resident on the ventilator unit has not had a shower or a bath in three weeks. He requires the assistance of two Certified Nurse Aides (CNA) and one Licensed Nurse for approximately one hour to be bathed. This would leave one Licensed Nurse and one CNA on the floor to care for the remaining residents, which would not be safe, so staff simply chose not to bathe the identified resident.

FINDINGS:

The identified resident's clinical record and interviews with staff indicated staff had provided bed baths for the identified resident. The investigation determined current residents received at least two baths a week or more based on their bathing preference.

The allegation that the facility failed to have an adequate number of staff to provide care for residents on the ventilator unit could not be substantiated due to insufficient evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The Reporting Party stated an identified resident expressed a preference to arise at 6:00 am daily, but an inadequate number of staff requires him to wait at least an hour or two after that time to receive the assistance he needs to get out of bed.

FINDINGS:

The identified resident stated she does not always get up early, but can do so when she chooses. Other residents interviewed during the investigation stated the facility honored their preferences regarding getting out of bed at specific times.

None of the residents interviewed during the investigation, including the identified resident, expressed concerns with the facility's ability to honor their preferences and the allegation was not substantiated for lack of evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The Reporting Party stated that only one CNA worked the night shift in the ventilator unit on June 8, 2017.

Matthew Lloyd, Administrator
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FINDINGS:

Staffing schedules were reviewed for a two-week period from June 4, 2017 through June 17, 2017. Employee time cards were compared to the staff schedule for all shifts and all scheduled staff were present. There was no shift during this two-week period where one CNA worked alone on the ventilator- or any other unit within the facility.

The investigation revealed the facility had adequate staff to meet the needs of the residents on all units and shifts.

The allegation could not be substantiated due to insufficient evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The Reporting Party stated all residents require two-person assistance from staff for showers. The facility's "shower team" does not shower residents on the ventilator unit. The facility expects non-ventilator unit CNAs to shower four residents each day shift, but because each resident on the ventilator unit require two staff for bathing, each resident takes two-to-three hours to bathe; CNAs working an eight hour shift must therefore choose either to care for residents not on the ventilator unit or bathe ventilator unit residents, but there is not enough time or manpower available to do both.

FINDINGS:

The facility's 600 hall at the time of the investigation included a census of twenty residents, nine of whom were dependent on a ventilator for breathing. The 600 hall was staffed with three CNAs and two Licensed Nurses on the day and evening shift, and two CNAs and two Licensed Nurses on night shift. Not all residents on the 600 hall required the assistance of two staff for bathing.

The investigation determined the facility provided showers to those 600 hall residents on a regular and acceptable schedule per a shower schedule developed in July 2017.

This allegation could not be substantiated due to insufficient evidence.

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ALLEGATION #5:

The Reporting Party stated resident care is not consistently provided for most residents on the ventilator unit, including range of motion (ROM), repositioning every two hours, application and removal of splinting devices and providing these residents with the opportunity to participate in the facility's activities program.

FINDINGS:

Residents were observed throughout the investigation survey as they received ROM exercises during cares, and one resident was noted with a splinting device, which was applied and removed per physician orders and care plan. Residents were observed being repositioned in bed, wheelchairs, and chairs, both in their private rooms as well as in dining rooms and other common areas. Activities staff were observed visiting resident rooms, encouraging residents to attend activities, and offering different types of in-room activities. Some residents chose not to attend and were offered an activity or entertainment opportunity in their rooms.

This allegation could not be substantiated for lack of evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

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

David Scott, R.N., Supervisor
Long Term Care

DS/lj



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
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Boise, Idaho 83720-0009
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September 20, 2017

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

Provider #: 135042

Dear Mr. Lloyd:

On **August 25, 2017**, an unannounced on-site complaint survey was conducted at Lacrosse Health & Rehabilitation Center. This complaint was investigated from August 22, 2017 through August 25, 2017. During the complaint survey, eight residents were reviewed, including the identified resident, for quality of care issues.

Residents were observed throughout the survey for soiled briefs and/or beds and incontinence care. The facility was monitored for odors.

Residents were interviewed for staff response and provision of cares. The staff response time to call lights were monitored throughout the survey.

The identified resident's clinical record, and those of seven other residents, were reviewed and included physician orders, medication administration records, the provision of treatments, care plans.

Direct care staff were interviewed.

The complaint allegations or entity-reported incidents, findings and conclusions are as follows:

Complaint #ID00007596

ALLEGATION #1:

The Reporting Party stated an identified resident was discovered sitting in his own feces for several hours on July 30, 2017. It was thought that the identified resident had been sitting in this condition since the previous day, if not longer.

FINDINGS:

During observations of, and interaction with, the identified resident on each day of the complaint survey, the resident exhibited the ability to use the call light and access staff for assistance. Staff response to the identified resident's call light averaged between five to eight minutes. The identified resident's skin was observed to be intact.

Based on observation, record review, and resident and staff interviews, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The identified resident was taken to the hospital for evaluation and assessed with a fractured vertebra.

FINDINGS:

The identified resident's clinical record from the facility and hospital reports were reviewed and facility staff were interviewed. Documentation revealed that the resident fell during an independent slider board transfer on July 29, 2017. The identified resident complained of pain in his lower back but did not think he was injured.

The identified resident was assessed in an emergency room on July 30, 2017 with an acute to subacute mild grade compression fracture.

An x-ray report, dated July 8, 2017, was obtained for lower back pain and decreased range of motion. The x-ray report documented osteoporosis, and chronic thoracic and lumbar compression fractures.

The identified resident did not experience any falls from the date of admission to the facility until July 29, 2017.

The allegation of fractured vertebra was substantiated, but not cited as no facility practice deficiencies were identified.

Matthew Lloyd, Administrator
September 20, 2017
Page 3 of 3

CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

One of the allegations was substantiated, but not cited. Therefore, no response is necessary.
Thank you for the courtesies and assistance extended to us during our visit.

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

Sincerely,

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

David Scott, R.N., Supervisor
Long Term Care

DS/lj



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September 21, 2017

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

Provider #: 135042

Dear Mr. Lloyd:

On **August 25, 2017**, an unannounced on-site complaint survey was conducted at Lacrosse Health & Rehabilitation Center. This complaint was investigated from August 22, 2017 through August 25, 2017. During the complaint survey, eight residents were reviewed, including the identified resident.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007605

ALLEGATION #1:

The identified resident was left on a bedpan for hours.

FINDINGS:

The identified resident's clinical record, and those of seven other residents, were reviewed and included physician orders, medication administration records, the provision of treatments, and care plans.

Matthew Lloyd, Administrator
September 21, 2017
Page 2 of 3

The identified resident was no longer in the facility at the time of survey.

The facility's Grievance files and Incident and Accident reports from April 2017 through August 2017 were reviewed. Abuse investigations were reviewed and resident interviews were completed during this complaint survey.

Residents were interviewed for staff response and provision of cares. The staff response time to call lights were monitored throughout survey.

Nursing staff who provided care for the identified resident were interviewed.

Based on observation, record review, and resident and staff interviews, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The identified resident's catheter was left unattended.

FINDINGS:

The identified resident was no longer in the facility at the time of the survey.

The identified resident's clinical record was reviewed for physician orders, provision of treatments, and care plans. There was one resident in the facility with a catheter who was observed throughout survey for catheter care.

The identified resident's clinical record documented an alteration in urinary elimination care plan that directed staff in the management of the catheter and drainage system.

The identified resident's clinical record contained physician orders for catheter care and treatment sheets documented the completion of catheter care twice daily for the months of May, June, and July 2017. The treatment sheet for July documented the catheter was changed on the 15th. The treatment sheet for the month of August 2017 documented catheter care was provided from the first through the sixth. There was no evidence that the identified resident's catheter was left unattended.

This allegation was not substantiated.

Matthew Lloyd, Administrator
September 21, 2017
Page 3 of 3

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The identified resident fell in the shower and was not receive attention from staff.

FINDINGS:

The identified resident was no longer in the facility at the time of the survey.

The facility's Incident and Accident reports completed from April 2017 through August 2017 were reviewed. Abuse investigations completed from April 2017 through August 22, 2017 were reviewed.

Interviews were conducted with the licensed nurse identified in the complaint, the shower aide who provided showers for the identified resident, and the Resident Care manager. The Physical Therapist identified in the complaint was not known to staff.

Based on the record review and staff interview, it was determined the allegation could not be substantiated for lack of evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

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

David Scott, R.N., Supervisor
Long Term Care

DS/lj

Matthew Lloyd, Administrator
September 21, 2017
Page 4 of 3



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September 26, 2017

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

Provider #: 135042

Dear Mr. Lloyd:

On **August 25, 2017**, an unannounced on-site complaint survey was conducted at Lacrosse Health & Rehabilitation Center. The complaint was investigated during an on-site Complaint survey conducted August 22, 2017 through August 25, 2017.

Resident meals were observed throughout the survey for accuracy, for alternative meal requests, and for assistance with meals. Staff and resident interactions were observed throughout the survey for potential dignity and abuse and neglect. Call light response times and staff assistance was observed throughout the survey.

The clinical record of the identified resident and seven other residents' records were reviewed for Quality of Care concerns. The facility's meal menus, as well as alternative meal choices, staffing records, Grievance file, Resident Council minutes, Incident and Accident reports and allegations of abuse and neglect were also reviewed.

Several residents, Certified Nurse Aides (CNAs) and nurses were interviewed regarding Quality of Care concerns. The Certified Dietary Manager, Director of Nursing, and Administrator were interviewed regarding various issues.

The complaint allegations or entity-reported incidents, findings and conclusions are as follows:

Complaint #ID00007609

ALLEGATION #1:

The Reporting Party said an identified resident received bacon, although he had already informed the facility that he did not eat pork.

FINDINGS:

The identified resident no longer resided in the facility at the time the complaint was investigated.

Based on record review and staff interview, it was determined the allegation was substantiated and the facility was cited at F366. See federal 2567 report for details.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #2:

An identified resident was not offered an alternative meal and was hungry for a long period of time.

FINDINGS:

Several resident meals were observed throughout the survey and staff were observed offering alternative meals to residents.

The clinical record of the identified resident and one other resident's records were reviewed for alternative meal requests. The facility's Grievance file and Resident Council minutes did not document an issue with alternative meal requests. The facility's menus and alternative meals documented the facility provided options for residents.

Several residents said staff offered alternative meals when they did not like the main meal. Several CNAs, nurses, and the Certified Dietary Manager said residents were offered alternatives to the main menu.

Based on observation, record review, and resident and staff interview, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

A Certified Nurse Aide left an identified resident, who needed assistance with eating, during the middle of a meal to retrieve a charting device.

FINDINGS :

Based on record review and staff interview, it was determined the allegation was substantiated and the facility was cited at F241. Refer to federal 2567 report for details.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #4:

An allegation of verbal abuse and/or neglect was not thoroughly investigated.

FINDINGS:

Based on record review and staff interview, it was determined the allegation was substantiated and the facility was cited at F225. Refer to federal 2567 report for details.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #5:

Facility staff could not take care of an identified resident's needs.

FINDINGS:

Call light response times and staff assistance was observed throughout the survey and no concerns were identified.

The clinical record of the identified resident and five other residents' records were reviewed for residents' needs being met. The facility's Grievance file and Resident Council minutes did not

Matthew Lloyd, Administrator
September 26, 2017
Page 4 of 4

document a concern regarding staffing. Staffing records were reviewed and lack of staff was not identified as a concern.

Several residents, Certified Nurse Aides and nurses said staffing levels were appropriate to meet the residents' needs and call lights were answered in a timely manner. The Director of Nursing and Administrator said the facility had the appropriate staffing levels to meet the residents' needs.

Based on observation, record review, and resident and staff interview, it was determined the allegation could not be substantiated.

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 David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

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

David Scott, R.N., Supervisor
Long Term Care

DS/lj