



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSS 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
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February 27, 2018

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

Provider #: 135042

Dear Mr. Bolen:

On **February 22, 2018**, 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.

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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 **March 9, 2018**. Failure to submit an acceptable PoC by **March 9, 2018**, may result in the imposition of penalties by **March 29, 2018**.

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 **March 29, 2018 (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 **May 23, 2018**. A change in the seriousness of the deficiencies on **April 8, 2018**, 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 **May 23, 2018** includes the following:

Denial of payment for new admissions effective **May 23, 2018**. [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 **August 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 Debby Ransom, RN, RHIT, Bureau Chief, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 5; 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 **May 23, 2018** 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>

Gregory Bolen, Administrator
February 27, 2018
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Go to the middle of the page to **Information Letters** section and click on **State** and select the following:

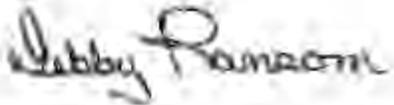
- BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process
2001-10 IDR Request Form

This request must be received by **March 9, 2018**. If your request for informal dispute resolution is received after **March 9, 2018**, 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 Debby Ransom, RN, RHIT, Bureau Chief at (208) 334-6626, option 5.

Sincerely,



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

dr/lj
Enclosures

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

PRINTED: 03/26/2018
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 02/22/2018
NAME OF PROVIDER OR SUPPLIER LACROSSE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 210 WEST LACROSSE AVENUE COEUR D'ALENE, ID 83814		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS The following deficiencies were cited during the complaint survey conducted at the facility from February 21, 2018 to February 22, 2018. The surveyors conducting the survey were: Brad Perry, LSW, Team Coordinator Jenny Walker, RN Cecelia Stockdill, RN	F 000			
F 559 SS=D	Choose/Be Notified of Room/Roommate Change CFR(s): 483.10(e)(4)-(6) §483.10(e)(4) The right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement. §483.10(e)(5) The right to share a room with his or her roommate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement. §483.10(e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interview, it was determined the facility failed to provide residents the opportunity to make informed choices regarding room moves. This was true for 1 of 3 (#1) residents sampled for room moves. The deficient practice created the potential for harm if Resident #1 experienced anxiety or a lack of self-worth due to the lack of control over room changes. Findings included:	F 559	The corrective action that was accomplished for residents found to have been affected by the deficient practice; Resident #1 has been interviewed and is satisfied with his current room at the facility. Identify other residents who have the potential to be affected by the deficient	3/5/18	

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

TITLE

(X6) DATE

Electronically Signed

03/02/2018

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 559	<p>Continued From page 1</p> <p>Resident #1 was admitted to the facility on 12/29/16 with multiple diagnoses including ventilator dependence.</p> <p>Resident #1's care plan, dated 9/22/17, directed staff to increase communication between the resident and caregivers regarding his living environment.</p> <p>Resident #1's annual Minimum Data Set assessment, dated 12/3/17, documented the resident was cognitively intact.</p> <p>Resident #1's clinical record documented the resident changed rooms 3 times from 12/27/17 to 1/9/18. There was no documentation found regarding why the resident was moved on 12/27/17.</p> <p>Resident #1's progress notes documented: *12/29/17-Resident #1 was having adjustment issues with having a roommate. *12/30/17-"Adjusting to room change, but having some difficulty adjusting to roommate. Does not appear to be a good match at this time, however situation is new and will continue to monitor through adjustment period." *1/1/18-Resident #1's family member called demanding a different room because the resident "was forced to move rooms." *1/2/18-Resident #1 was moved to a new room. *1/3/18-Resident #1 was having problems with the newest roommate. *1/9/18-Resident #1 and a family member had concerns with latest roommate and Resident #1 was moved to a new room.</p> <p>On 2/21/18 at 2:50 PM and 2/22/18 at 7:55 AM,</p>	F 559	<p>practice and what corrective actions will be taken;</p> <p>Residents residing at the facility have the potential to be affected by this deficiency. Residents were reviewed that had a room change considered or in progress and facility obtained a signed agreemnet from the resident prior to the room change.</p> <p>Measures that will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;</p> <p>Interdepartmental managers will be in-serviced on F-tag 559 and related components of citation. the managment team will also be in-sericed on the use of the "notification of room change" form and its use to ensure residents written consent prior to a room change.</p> <p>Indicate how the facility plans to monitor performance to ensure the corrective actions are effective and compliance is sustained;</p> <p>Resident room changes will be reviewed daily Monday through Friday in interdepartmental morning meeting to ensure written consent was obtained prior to the room changes 3 times a week for 12 weeks. Findings will be reviewed monthly in QAPI x 3 further educational opportunities.</p> <p>Director of nursing will monitor</p>		

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

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F 559	<p>Continued From page 2</p> <p>Resident #1 said he was not informed in writing and did not know the reason for his room change on 12/27/17. He said he was "not real happy" with having to move multiple times to find a good roommate match. He said he had difficulty with his last two roommates because one had a traumatic brain injury and would swear and yell out, and the other liked to keep the room dark and didn't always like Resident #1's TV turned on during certain hours of the day.</p> <p>On 2/22/18 at 9:20 AM, Certified Nursing Assistant #1 said Resident #1 and his second roommate did not get along.</p> <p>On 2/22/18 at 9:25 AM, Registered Nurse #1 said she was not sure why Resident #1 was moved on 12/27/17.</p> <p>On 2/22/18 at 9:55 AM, the Social Service Director said she would normally provide residents with written notification, but she was on leave at the time of the room change and said that nursing staff should have provided the resident with written notification.</p> <p>On 2/22/18 at 10:10 AM, the Assistant Director of Nursing said she thought the resident was verbally informed of the room change, but the facility did not provide the resident a written notification. She said the resident was moved because the ventilator unit had a limited number of rooms and they needed Resident #1's room for another resident who was more susceptible to infections and needed a private room.</p>	F 559	Compliance		

BRAD LITTLE – Governor
DAVE JEPPESEN – 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
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February 25, 2019

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

Provider #: 135042

Dear Mr. Littman:

On **February 22, 2018**, an unannounced on-site complaint survey was conducted at Lacrosse Health & Rehabilitation Center. The complaint was investigated during an on-site complaint survey February 21, 2018 and February 22, 2018.

During the survey resident records were reviewed for Quality of Life and Care concerns. The facility's Grievance file was reviewed, as well as Incident and Accident reports and facility staffing records. Residents and staff were interviewed also.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007710

ALLEGATION #1:

A resident was moved to a different room without proper notification and was placed with a roommate who was verbally inappropriate.

FINDINGS #1:

One resident's record documented the resident changed rooms three times during a period of 13 days. The resident's record documented they were moved twice and both times there were issues with the new roommate. Progress notes in the resident's record documented at the request of a family member the resident was moved twice because of issues with their roommates.

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The resident was interviewed and stated he was not informed in writing and did not know the reason for one of the moves. He said he was not "real happy" with having to move multiple times.

Based on record review, resident and staff interview, it was determined the allegation was substantiated and the facility was cited at F559.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #2:

The facility was insufficiently staffed.

FINDINGS #2:

Call lights, staff levels, and staff assistance were observed throughout the survey and no concerns were identified.

The records of four residents were reviewed for Quality of Care and lack of staffing and no concerns were identified. The facility's Grievance file and facility staffing records were reviewed and no concerns were identified.

Several residents said the facility had adequate staff to meet their needs. Several staff members said there were enough staff to meet the residents' needs. The Director of Nursing and the Administrator said they had worked on increasing staff levels and were meeting the residents' needs.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The daily nurse staffing was not posted.

Michael Littman, Administrator
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FINDINGS #3:

The daily nurse postings were observed throughout the survey.

The receptionist and a nurse said the nurse staff postings were placed in the front lobby each day.

Based on observation 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 any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,



Laura Thompson, RN, Supervisor
Long Term Care Program

LT/lj