



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

August 17, 2018

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

Provider #: 135042

**RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER
LETTER**

Dear Mr. Littman:

On **August 9, 2018**, a Facility Fire Safety and Construction survey was conducted at **Lacrosse Health & Rehabilitation Center** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies. 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. Please provide **ONLY ONE** completion date for each federal and state tag in column (X5) Completion Date to signify when

Michael Littman, Administrator
August 17, 2018
Page 2 of 4

you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office. If a State Form with deficiencies was issued, it should be signed, dated and returned along with the CMS-2567 Form.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **August 30, 2018**. Failure to submit an acceptable PoC by **August 30, 2018**, may result in the imposition of civil monetary penalties by **September 21, 2018**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.
- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567. If a State Form was issued as well, it should also be signed, dated and returned.

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

Remedies may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **September 13, 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 **September 13, 2018**. A change in the seriousness of the deficiencies on **September 13, 2018**, may result in a change in the remedy.

Michael Littman, Administrator
August 17, 2018
Page 3 of 4

The remedy, which will be recommended if substantial compliance has not been achieved by **September 13, 2018**, includes the following:

Denial of payment for new admissions effective **November 9, 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 noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **February 9, 2019**, if substantial compliance is not achieved by that time.

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

If you believe these deficiencies have been corrected, you may contact Nate Elkins, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, option 3; Fax #: (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 **August 9, 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:

Michael Littman, Administrator
August 17, 2018
Page 4 of 4

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

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

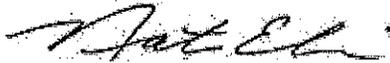
BFS Letters (06/30/11)

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

This request must be received by **August 30, 2018**. If your request for informal dispute resolution is received after **August 30, 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, please contact us at (208) 334-6626, option 3.

Sincerely,



Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosures

Printed: 08/17/2018
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135042	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE FACILITY BUILDINGS 1 & 2 B. WING _____	(X3) DATE SURVEY COMPLETED 08/09/2018
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NAME OF PROVIDER OR SUPPLIER LACROSSE HEALTH & REHABILITATION CEN	STREET ADDRESS, CITY, STATE, ZIP CODE 210 WEST LACROSSE AVENUE COEUR D'ALENE, ID 83814
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	<p>INITIAL COMMENTS</p> <p>The facility is a single story, type V(111) structure, comprised of 7 smoke compartments, originally constructed in 1967. The structure is fully sprinklered and equipped with an interconnected fire alarm system, which includes smoke detection in corridors and open spaces.</p> <p>The 300 hall and the 600 hall have additional smoke detection in each resident sleeping room. The facility is equipped with a ventilator unit wing, which was approved in November of 2011, and has a Type 1 Emergency Electrical System, diesel-fired generator and 96 hour fuel supply. The facility is currently is licensed for 100 SNF/NF beds and had a census of 89 on the date of the survey.</p> <p>The following deficiencies were cited during the annual Fire/Life Safety survey conducted on August 8 and 9, 2018. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy in accordance with 42 CFR 483.70 and 483.80 (Infection Control).</p> <p>The survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	K 000	<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 style="text-align: center;">RECEIVED SEP 06 2018 FACILITY STANDARDS</p>	10/9/18
K 100 SS=F	<p>General Requirements - Other CFR(s): NFPA 101</p> <p>General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard</p>	K 100		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Michael Altman* TITLE *E.D.* (X6) DATE *8/30/18*

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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K 100	<p>Continued From page 1 citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to demonstrate implementation of a water management program for waterborne pathogens such as Legionella, in accordance with 42 CFR 483.80. Failure to conduct a facility based risk assessment, or defined applicable control measures, has the potential to limit relevant facility awareness and expose residents to Legionella and other water source bacterium based on inconclusive data. This deficient practice affected 89 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During review of provided water management documentation conducted on 8/8/18 from 2:30 - 3:30 PM and 8/9/18 from 3:30 - 4:00 PM, page 1 of documentation provided indicated the facility was to establish a Water Management Plan, but no plan had been implemented as of the date of the survey. Further review of the information presented did not reveal the facility had conducted a risk assessment for water borne bacterium, or established control measures based on any such findings.</p> <p>CFR standard: 42 CFR 483.80</p> <p>§ 483.80 Infection control. The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection.</p>	K 100	<p>What corrective action will be accomplished For those residents found to have been affected By the deficient practice.</p> <p>There were no residents identified.</p> <p>How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken.</p> <p>Residents residing at the facility have the potential to be affected by this deficient practice. Infection control nurse evaluated monthly listings and there are no identified residents.</p> <p>Measures in place and what systemic changes will be made to ensure that the deficient practice does not recur.</p> <p>A facility based water management program For risk management of legionella and other Water quality issues has been implemented. Staff has been inserviced on the water Management program.</p> <p>How the facility plans to monitor performance to ensure the corrective actions are effective and compliance is sustained.</p> <p>A full review of the water management Program will be reviewed for compliance Monthly X 3 through QAPI process for further educational opportunities.</p> <p>Person responsible for compliance. Maintenance Director</p>	10/9/18
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K 100	Continued From page 2	K 100		
K 324 SS=D	<p>Additional reference: Center for Medicaid/Medicare Services S&C 17-30</p> <p>Cooking Facilities CFR(s): NFPA 101</p> <p>Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.6, 9.2.3, TIA 12-2</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure that cooking facilities were maintained in accordance with NFPA 96 and NFPA 17A. Failure to ensure semi-annual inspections and protection of</p>	K 324	<p>What corrective action will be accomplished For those residents found to have been affected By the deficient practice.</p> <p>There were no residents identified.</p> <p>How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken.</p> <p>Residents residing at the facility have the potential to be affected by this deficient practice. A hood inspection has been completed.</p> <p>Measures in place and what systemic changes will be made to ensure that the deficient practice does not recur.</p> <p>Bi-annual hood suppression inspection has been added to TELS to correlate with the Months that facility requires inspection. Inspections will be on the hood on a bi-Annual basis as they are flagged on TELS System to alert facility and ensure compliance.</p> <p>How the facility plans to monitor performance to ensure the corrective actions are effective and compliance is sustained.</p> <p>TELS task will alert vendor and maintenance Director to ensure inspection of hood is completed Bi-annually to ensure compliance. TELS will be Reviewed monthly through QAPI to ensure Compliance.</p> <p>Person responsible for compliance, Maintenance Director</p>	10/9/18

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K 324	<p>Continued From page 3</p> <p>suppression system equipment for cooking ventilation systems, has the potential to increase the risk of fires associated with grease-laden vapors during cooking procedures. This deficient practice affected staff and vendors of the main Kitchen on the date of the survey.</p> <p>Findings include:</p> <p>1) During review of inspection and maintenance documentation conducted on 8/8/18 from 2:30 - 3:30 PM, no records were provided for semi-annual inspections for the Kitchen hood fire suppression system within the previous twelve months.</p> <p>2) During review of inspection and maintenance documentation conducted on 8/8/18 from 2:30 - 3:30 PM, records provided indicated only 1 of 2 semi-annual hood inspection/cleaning reports were completed in the previous twelve months.</p> <p>Asked about the missing documentation, the Maintenance Director stated that a change in vendors created a gap in the timing for getting the inspection(s) completed.</p> <p>3) During the facility tour conducted on 8/9/18 from 1:00 - 3:00 PM, observation of the fire suppression system in the main Kitchen hood, revealed 1 of 3 protective caps for the suppression system pendants was hanging down and coated with grease.</p> <p>Actual NFPA standard:</p> <p>NFPA 96</p> <p>Chapter 10 Fire-Extinguishing Equipment</p>	K 324		

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K 324	<p>Continued From page 4</p> <p>10.2.6 Automatic fire-extinguishing systems shall be installed in accordance with the terms of their listing, the manufacturer's instructions, and the following standards where applicable:</p> <p>(1) NFPA 12 (2) NFPA 13 (3) NFPA 17 (4) NFPA 17A</p> <p>11.2 Inspection, Testing, and Maintenance of Fire-Extinguishing Systems.</p> <p>11.2.1* Maintenance of the fire-extinguishing systems and listed exhaust hoods containing a constant or fire-activated water system that is listed to extinguish a fire in the grease removal devices, hood exhaust plenums, and exhaust ducts shall be made by properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction at least every 6 months.</p> <p>11.4* Inspection for Grease Buildup. The entire exhaust system shall be inspected for grease buildup by a properly trained, qualified and certified person(s) acceptable to the authority having jurisdiction and in accordance with Table 11.4.</p> <p>11.6 Cleaning of Exhaust Systems.</p> <p>11.6.1 Upon inspection, if the exhaust system is found to be contaminated with deposits from grease-laden vapors, the contaminated portions of the exhaust system shall be cleaned by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction.</p> <p>NFPA 17A</p> <p>4.3.1.5 All discharge nozzles shall be provided with caps or other suitable devices to prevent the</p>	K 324		
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K 324	Continued From page 5 entrance of grease vapors, moisture, or other foreign materials into the piping.	K 324		
K 325 SS=F	Alcohol Based Hand Rub Dispenser (ABHR) CFR(s): NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure manually operated Alcohol Based Hand Rub Dispensers (ABHR), were maintained in accordance with NFPA 101. Failure to install, test and document operation of ABHR dispensers under manufacturer's recommendations and in accordance with the standard, has the potential of	K 325	What corrective action will be accomplished For those residents found to have been affected By the deficient practice. There were no residents identified. How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken. There are no residents identified. Residents at The facility have the potential to be affected by This deficient practice. Measures in place and what systemic changes will be made to ensure that the deficient practice does not recur. Alcohol based hand sanitizer have been replaced with foam hand sanitizer and in accordance with manufacturers guidelines. Staff have been in serviced on the change from alcohol gel based hand sanitizer to foam hand sanitizer. How the facility plans to monitor performance to ensure the corrective actions are effective and compliance is sustained. Hand sanitizer dispensers will be audited weekly X 12 to ensure foam sanitizer is in use instead of alcohol gel sanitizer. Findings will be reviewed monthly at QAPI for further correction as indicated. Person responsible for compliance. Maintenance Director	10/9/18

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K 325	<p>Continued From page 6</p> <p>Increasing the risk of fires from flammable liquids. This deficient practice affected 89 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>1) During review of facility maintenance and inspection records conducted on 8/8/18 from approximately 2:30 - 3:30 PM, maintenance records provided for the facility failed to indicate what procedures were performed during the refill process for ABHR dispensers. When interviewed on the ABHR dispenser refilling procedure, the Maintenance Director stated the facility had a procedure for documentation, but had not yet implemented it.</p> <p>2) During the facility tour conducted on 8/9/18 from 11:00 AM - 3:00 PM, observation of the facility revealed manually activated ABHR dispensers installed throughout the building.</p> <p>Actual NFPA standard:</p> <p>NFPA 101</p> <p>19.3.2.6* Alcohol-Based Hand-Rub Dispensers. Alcohol-based hand-rub dispensers shall be protected in accordance with 8.7.3.1, unless all of the following conditions are met:</p> <p>(1) Where dispensers are installed in a corridor, the corridor shall have a minimum width of 6 ft (1830 mm).</p> <p>(2) The maximum individual dispenser fluid capacity shall be as follows:</p> <p>(a) 0.32 gal (1.2 L) for dispensers in rooms, corridors, and areas open to corridors</p>	K 325		

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K 325	Continued From page 7 (b) 0.53 gal (2.0 L) for dispensers in suites of rooms (3) Where aerosol containers are used, the maximum capacity of the aerosol dispenser shall be 18 oz. (0.51 kg) and shall be limited to Level 1 aerosols as defined in NFPA30B, Code for the Manufacture and Storage of Aerosol Products. (4) Dispensers shall be separated from each other by horizontal spacing of not less than 48 in. (1220 mm). (5) Not more than an aggregate 10 gal (37.8 L) of alcohol-based hand-rub solution or 1135 oz (32.2 kg) of Level 1 aerosols, or a combination of liquids and Level 1 aerosols not to exceed, in total, the equivalent of 10 gal (37.8 L) or 1135 oz (32.2 kg), shall be in use outside of a storage cabinet in a single smoke compartment, except as otherwise provided in 19.3.2.6(8). (6) One dispenser complying with 19.3.2.6 (2) or (3) per room and located in that room shall not be included in the aggregated quantity addressed in 19.3.2.6(5). (7) Storage of quantities greater than 5 gal (18.9 L) in a single smoke compartment shall meet the requirements of NFPA 30, Flammable and Combustible Liquids Code. (8) Dispensers shall not be installed in the following locations: (a) Above an ignition source within a 1 in. (25 mm) horizontal distance from each side of the ignition source (b) To the side of an ignition source within a 1 in. (25mm) horizontal distance from the ignition source (c) Beneath an ignition source within a 1 in. (25 mm) vertical distance from the ignition source (9) Dispensers installed directly over carpeted floors shall be permitted only in sprinklered	K 325		

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

Printed: 08/17/2018
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 01 - ENTIRE FACILITY BUILDINGS 1 & 2 B. WING _____	(X3) DATE SURVEY COMPLETED 08/09/2018
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NAME OF PROVIDER OR SUPPLIER LACROSSE HEALTH & REHABILITATION CEN	STREET ADDRESS, CITY, STATE, ZIP CODE 210 WEST LACROSSE AVENUE COEUR D'ALENE, ID 83814
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K 325	<p>Continued From page 8 smoke compartments. (10) The alcohol-based hand-rub solution shall not exceed 95 percent alcohol content by volume. (11) Operation of the dispenser shall comply with the following criteria: (a) The dispenser shall not release its contents except when the dispenser is activated, either manually or automatically by touch-free activation. (b) Any activation of the dispenser shall occur only when an object is placed within 4 in. (100 mm) of the sensing device. (c) An object placed within the activation zone and left in place shall not cause more than one activation. (d) The dispenser shall not dispense more solution than the amount required for hand hygiene consistent with label instructions. (e) The dispenser shall be designed, constructed, and operated in a manner that ensures that accidental or malicious activation of the dispensing device is minimized. (f) The dispenser shall be tested in accordance with the manufacturer's care and use instructions each time a new refill is installed.</p>	K 325		
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IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

August 17, 2018

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

Provider #: 135042

RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER

Dear Mr. Littman:

On **August 9, 2018**, an Emergency Preparedness survey was conducted at **Lacrosse Health & Rehabilitation Center** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with 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 Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. Please provide **ONLY ONE** completion date for each federal and state tag in column (X5) Completion Date to signify when you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **August 30, 2018**. Failure to submit an acceptable PoC by **August 30, 2018**, may result in the imposition of civil monetary penalties by **September 21, 2018**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.
- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567. If a State Form was issued as well, it should also be signed, dated and returned.

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

Remedies may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **September 13, 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 **September 13, 2018**. A change in the seriousness of the deficiencies on **September 13, 2018**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **September 13, 2018**, includes the following:

Denial of payment for new admissions effective **November 9, 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 noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **February 9, 2019**, if substantial compliance is not achieved by that time.

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

If you believe these deficiencies have been corrected, you may contact Nate Elkins, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, option 3; Fax #: (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 **August 9, 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>

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 **August 30, 2018**. If your request for informal dispute resolution is received after **August 30, 2018**, the request will not be granted. An incomplete

Michael Littman, Administrator
August 17, 2018
Page 4 of 4

informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626, option 3.

Sincerely,

A handwritten signature in black ink, appearing to read "Nate Elkins". The signature is fluid and cursive, with a prominent initial "N" and "E".

Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosures

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

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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 08/09/2018
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NAME OF PROVIDER OR SUPPLIER LACROSSE HEALTH & REHABILITATION CEN	STREET ADDRESS, CITY, STATE, ZIP CODE 210 WEST LACROSSE AVENUE COEUR D'ALENE, ID 83814
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E 000	<p>Initial Comments</p> <p>The facility is a single story, type V(111) structure, comprised of 7 smoke compartments, originally constructed in 1967. It is located within a municipal fire district, with both county and state EMS services available. The structure is fully sprinklered and equipped with an interconnected fire alarm system, which includes smoke detection in corridors and open spaces.</p> <p>The 300 hall and the 600 hall have additional smoke detection in each resident sleeping room. The facility is equipped with a ventilator unit wing, which was approved in November of 2011, and has a Type 1 Emergency Electrical System, diesel-fired generator and 96 hour fuel supply. The facility is currently licensed for 100 SNF/NF beds and had a census of 89 on the date of the survey.</p> <p>The following deficiencies were cited during the annual Emergency Preparedness survey conducted on August 8 and 9, 2018. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73.</p> <p>The survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	E 000	<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>	
E 004 SS=D	<p>Develop EP Plan, Review and Update Annually CFR(s): 483.73(a)</p> <p>[The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the</p>	E 004		

RECEIVED
AUG 30 2018
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Michael E. D.* TITLE _____ (X6) DATE *8/30/18*

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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E 004	<p>Continued From page 1 requirements of this section.]</p> <p>* [For hospitals at §482.15 and CAHs at §485.625(a):] The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach.</p> <p>The emergency preparedness program must include, but not be limited to, the following elements:] (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least annually.</p> <p>* [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least annually.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure the EP (Emergency Preparedness) Program was reviewed on an annual basis. Failure to review the EP program, policies and procedures annually has the potential to perform training and exercises on outdated information, leaving the facility residents and staff vulnerable during emergencies. This deficient practice affected 89 residents, staff and visitors on the date of the survey.</p> <p>Findings include: During review of the facility EP plan, policies and</p>	E 004	<p>What corrective action will be accomplished For those residents found to have been affected By the deficient practice.</p> <p>There were no residents identified.</p> <p>How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken.</p> <p>There are no residents identified. Residents at the facility have the potential to be affected by this deficient practice.</p> <p>Measures in place and what systemic changes will be made to ensure that the deficient practice does not recur.</p> <p>A alert task has been set up in TELS to ensure Review is completed annually.</p> <p>How the facility plans to monitor performance to ensure the corrective actions are effective and compliance is sustained.</p> <p>Maintenance Director will review and report on The emergency preparedness program for Compliance and report findings to QAPI Monthly X 3 for educational opportunities.</p> <p>Person responsible for compliance. Maintenance Director</p>	10/9/18
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NAME OF PROVIDER OR SUPPLIER LACROSSE HEALTH & REHABILITATION CEN		STREET ADDRESS, CITY, STATE, ZIP CODE 210 WEST LACROSSE AVENUE COEUR D'ALENE, ID 83814		
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E 004	Continued From page 2 procedures conducted on 8/8/18 from 2:30 - 3:30 PM, the page provided in Section 1 for the facility annual review, was not signed or dated by the three (3) designated facility officials as prescribed. Interview of the Administrator, Maintenance Director and the Director of Nursing established the facility plan was recently updated and no formal review of its contents in its entirety had been completed.	E 004		
E 006 SS=F	Reference: 42 CFR 483.73 (a) Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* *[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. *[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events	E 006		

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(X4) ID PREFIX TAG E 006	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG E 006	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Continued From page 3</p> <p>Identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, it was determined the facility failed to develop an EP plan that included a geographically relevant facility based and community based risk assessment. Failure to provide a relevant facility and community based risk assessment, has the potential to focus staff training and resources on hazards that are not consistent with the facility location. This deficient practice affected 89 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>1) On 8/8/18 from 2:30 - 3:30 PM, review of the provided emergency plan, policies and procedures, revealed the facility HVA (Hazard Vulnerability Analysis) provided information of the probability and impact of Hurricanes and Tidal waves, which are not geographically relevant to the facility. Review of the current county all-hazard mitigation plan for the area published in 2015, found no indication Hurricanes or Tidal waves, pose a likely hazard or threat to the area.</p> <p>2) On 8/9/18 from 1:00 - 3:30 PM, interviews with the both the Administrator and the Maintenance Director stated they were not aware Hurricanes or Tidal waves had been included in the facility risk assessment and the available county information had not been used in developing the HVA.</p> <p>Reference:</p>		<p>What corrective action will be accomplished For those residents found to have been affected By the deficient practice.</p> <p>There were no residents identified.</p> <p>How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken.</p> <p>There are no residents identified. Residents at the facility have the potential to be affected by this deficient practice.</p> <p>Measures in place and what systemic changes will be made to ensure that the deficient practice does not recur.</p> <p>Maintenance Director and leadership team will Review the regions hazardous vulnerability Assessment and ensure that LaCrosse Health & Rehabilitation's hazardous vulnerability Assessment coincides with regional threats.</p> <p>How the facility plans to monitor performance to ensure the corrective actions are effective and compliance is sustained.</p> <p>The hazardous vulnerability assessment will be Reviewed annually through QAPI to ensure Information is updated and does not include non-Regional hazards.</p> <p>Person responsible for compliance. Maintenance Director</p>	10/9/18

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E 008	Continued From page 4 42 CFR 483.73 (a) (1) - (2)	E 008		
E 009 SS=F	Local, State, Tribal Collaboration Process CFR(s): 483.73(a)(4) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. * [For ESRD facilities only at §494.62(a)(4): (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the dialysis facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency. This REQUIREMENT is not met as evidenced by: Based on record review, it was determined the facility failed to document collaboration with local, tribal, regional, State and Federal EP officials and integrated emergency response efforts. Failure to develop a collaborative planning effort with	E 009	What corrective action will be accomplished For those residents found to have been affected By the deficient practice. There were no residents identified. How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken. There are no residents identified. Residents at the facility have the potential to be affected by this deficient practice. Measures in place and what systemic changes will be made to ensure that the deficient practice does not recur. Staff was in serviced on the facility emergency Plan. LaCrosse Health and Rehabilitation will be Actively involved in collaboration with local, State and tribal entities on a scheduled basis to Establish contact and dialog between facility and Other agencies during a disaster. How the facility plans to monitor performance to ensure the corrective actions are effective and compliance is sustained. The emergency plan will be reviewed annually to Ensure compliance through QAPI and findings Assessed for corrective actions if necessary. Person responsible for compliance. Maintenance Director	10/9/18

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E 009	Continued From page 5 multi-jurisdictional entities, has the potential to limit the facilities options during a disaster. This deficient practice affected 89 residents, staff and visitors on the date of the survey. Findings include: On 8/8/18 from 2:30 - 3:30 PM, review of provided policies, procedures and the emergency plan, failed to establish documentation indicating collaborative involvement with local, tribal, regional State and Federal EP officials, including such involvement as participation in county EMS or regional healthcare coalition meetings. Reference: 42 CFR 483.73 (a) (4)	E 009		
E 031 SS=D	Emergency Officials Contact Information CFR(s): 483.73(c)(2) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, or local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance.	E 031	What corrective action will be accomplished for those residents found to have been affected by the deficient practice. There were no residents identified. How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken. There are no residents identified. Residents at the facility have the potential to be affected by this deficient practice.	

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NAME OF PROVIDER OR SUPPLIER LACROSSE HEALTH & REHABILITATION CEN		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
E 031	Continued From page 6 *[For ICF/IIDs at §483.475(c):] (2) Contact Information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to ensure current contact information for emergency management officials and other resources of assistance was provided in the emergency communication plan. Failure to provide updated information for resources available to the facility has the potential to hinder facility response and continuity of care for the 89 residents, staff and visitors in the facility on the date of the survey. Findings include: On 8/8/18 from 2:30 - 3:30 PM, review of the emergency plan, policies and procedures, revealed the plan did not include contact information for State Licensing and Certification Agency. Reference: 42 CFR 483.73 (c) (2)	E 031	Measures in place and what systemic changes will be made to ensure that the deficient practice does not recur. LaCrosse Health and Rehabilitation will schedule collaborative efforts with local, state and tribal entities and have contact and dialog between facility and other agencies during a disaster. during annual review facility will insure all information and contacts are updated for contacting agencies. How the facility plans to monitor performance to ensure the corrective actions are effective and compliance is sustained. The emergency plan will be reviewed annually to Ensure compliance through QAPI and findings Assessed for corrective actions if necessary. Person responsible for compliance. Maintenance Director	10/9/18
E 039 SS=F	EP Testing Requirements CFR(s): 483.73(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing.	E 039		

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

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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 08/09/2018
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NAME OF PROVIDER OR SUPPLIER LACROSSE HEALTH & REHABILITATION CEN	STREET ADDRESS, CITY, STATE, ZIP CODE 210 WEST LACROSSE AVENUE COEUR D'ALENE, ID 83814
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E 039	<p>Continued From page 7</p> <p>The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:</p> <p>(i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event.</p> <p>(ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.</p> <p>*[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set</p>	E 039	<p>What corrective action will be accomplished For those residents found to have been affected By the deficient practice.</p> <p>There were no residents identified.</p> <p>How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken.</p> <p>There are no residents identified. Residents/ Staff at the facility have the potential to be Affected by this deficient practice.</p> <p>Measures in place and what systemic changes will be made to ensure that the deficient practice does not recur.</p> <p>LaCrosse Health and Rehabilitation will participate in a scheduled community based disaster drill and or a facility table top drill with the completion time.</p> <p>How the facility plans to monitor performance to ensure the corrective actions are effective and compliance is sustained.</p> <p>TELS task system will alert all responsible parties That community and table top drills are to be Reviewed annually through QAPI.</p> <p>Person responsible for compliance. Maintenance Director</p>	10/9/18
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E 039	<p>Continued From page 8 of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to complete two full-scale exercises which tested the emergency preparedness plan and the overall readiness of the facility. Failure to participate in full-scale or tabletop exercise events has the potential to reduce the facility's effectiveness in providing continuity of care to residents during an emergency. This deficient practice affected 89 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>On 8/8/18 from 2:30 - 3:30 PM, review of provided emergency plan inservice and training documentation, failed to demonstrate completion of two (2) full-scale exercises, testing the effectiveness of the emergency preparedness plan, policies and procedures.</p> <p>Interview of the Administrator, SDC and Maintenance Director, confirmed the facility had yet to complete these exercises.</p> <p>Reference: 42 CFR 483.73 (d) (1)</p>	E 039		
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