



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR  
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P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: (208) 334-6626  
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July 3, 2019

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

Provider #: 135042

Dear Mr. Littman:

On **June 21, 2019**, 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 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. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3.) **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

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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 **July 15, 2109**. Failure to submit an acceptable PoC by **July 15, 2109** , may result in the imposition of additional civil monetary penalties by August 5, 2019 .

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

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

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

- The administrator must sign and date the first page of the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

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

This agency is required to notify Centers for Medicare & Medicaid Services (CMS) Regional Office of the results of this survey. We are recommending to the CMS Regional Office that the following remedy(ies) be imposed:

- Denial of payment for new admission effective **September 21, 2019**.

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We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **December 21, 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 and Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.**

Your facility's noncompliance with the following:

- **F0883 -- S/S: F -- 483.80(d)(1)(2) -- Influenza And Pneumococcal Immunizations**

has been determined to constitute substandard quality of care (SQC) as defined at 42 CFR §488.301. Sections 1819 (g)(5)(c) and 1919 (g)(5)(c) of the Social Security Act and 42 CFR §488.325 (h) requires the attending physician of each resident who was found to have received substandard quality of care, as well as the state board responsible for licensing the facility's administrator be notified of the substandard quality of care. In order for us to satisfy these notification requirements, and in accordance with 42 CFR §488.325(g), you are required to provide the following information to this agency within ten (10) working days of your receipt of this letter:

The name and address of the attending physician of each resident found to have received substandard quality of care, as identified below:

Residents # **#1, #7, #13, #16, #18, and #39** as identified on the enclosed Resident Identifier List.

Please note that in accordance with 42 CFR §488.325(g), your failure to provide this information timely will result in termination of participation or imposition of additional remedies.

If you believe the deficiencies have been corrected, you may contact Belinda Day, RN or Laura Thompson, RN, 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.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy.

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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:

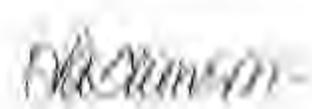
- BFS Letters (06/30/11)

[2001-10 Long Term Care Informal Dispute Resolution Process](#)  
[2001-10 IDR Request Form](#)

This request must be received by **July 15, 2109** . If your request for informal dispute resolution is received after **July 15, 2109**, 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 Belinda Day, RN, or Laura Thompson, RN, at (208) 334-6626, option 2.

Sincerely,



Laura Thompson, RN, Supervisor  
Bureau of Facility Standards

lt/lj

c: Chairman, Board of Examiners - Nursing Home Administrators

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135042</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/21/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>LACROSSE HEALTH &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>210 WEST LACROSSE AVENUE COEUR D'ALENE, ID 83814</b>		
(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 federal recertification and complaint survey conducted June 17, 2019 to June 24, 2019.  The surveyors conducting the survey were:  Jenny Walker, RN, Team Coordinator Brad Perry, LSW Sallie Schwartzkopf, LCSW Karen George, RN Patricia Hinson, RN  Abbreviations:  MDS = Minimum Data Set UM = Unit Manager	F 000			
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v)  §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.  §483.10(g)(18) The facility must inform each	F 582		7/26/19	

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

TITLE

(X6) DATE

Electronically Signed

07/05/2019

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 582	<p>Continued From page 1</p> <p>resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.</p> <p>(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.</p> <p>(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.</p> <p>(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.</p> <p>(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.</p> <p>(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.</p> <p>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 residents were provided with an Advanced Beneficiary Notice at the termination of</p>	F 582	<p>Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p>		

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F 582	<p>Continued From page 2</p> <p>their Medicare Part A benefits. This was true for 1 of 3 residents (Resident #227) reviewed for Advance Beneficiary Notice (ABN). This failure created the potential for residents to experience financial and psychological distress when residents were not informed of their potential liability for payment. Findings include:</p> <p>The facility's Advanced Beneficiary Notice policy, dated 2018, directed facility staff to issue an ABN before services were delivered to inform the Medicare beneficiary that services may not be paid for by Medicare and they, the resident, may assume the financial responsibility.</p> <p>This policy was not followed.</p> <p>Resident #227 was admitted to the facility on 1/19/19, with multiple diagnosis including urinary tract infection.</p> <p>Resident #227's record included a Census List (list of admission, payer change, and discharge dates) which documented her Medicare Part A benefits ended on 4/6/19, and she remained in the facility. Her record did not include an ABN.</p> <p>On 6/21/19 at 9:31 AM, the MDS Coordinator stated she did not provide the ABN to Resident #227 before her Medicare coverage ended.</p>	F 582	<p>Resident #227 no longer resides at the facility.</p> <p>Address how facility will 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 receiving Medicare benefits in the facility have been reviewed and will be provided with an Advanced Beneficiary Notice at the time of the termination of their Medicare Part A benefits as per CMS guidelines.</p> <p>Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>Staff involved in the ABN process will be educated/trained on the procedure and tracking template utilized.</p> <p>The Advanced Beneficiary Notice will be initiated and provided to residents receiving Medicare benefits on admission by the Business Office Manager or designee.</p> <p>The RAIC Manager or designee will monitor Resident's eligibility of benefits through weekly medicare meeting processes.</p> <p>Social Service Director or designee will be responsible to provide all information</p>		

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F 582	Continued From page 3	F 582	related to the termination of benefits within CMS guidelines for Advanced Beneficiary Notice to resident or responsible party.  Indicate how the facility plans to monitor performance to ensure the corrective action are effective and compliance is sustained:  All residents receiving Advance Beneficiary Notices will be audited weekly X 8 and then monthly X 4 by the administrator or designee to ensure compliance. Findings will be reviewed monthly X 3 at QAPI/QAA to ensure effectiveness and compliance with CMS requirements.  Indicate date when corrective action will be completed:		
F 684 SS=D	Quality of Care CFR(s): 483.25  § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure staff completed neurological assessments as directed	F 684	Address what corrective action will be accomplished for those residents found to have been affected by the deficient	7/26/19	

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F 684	<p>Continued From page 4</p> <p>on their Neurological Assessment flowsheet. This was true for 1 of 2 residents (Resident #25) reviewed for falls. This failure created the potential for harm if changes in residents' neurological status went undetected and untreated after falls. Findings include:</p> <p>The facility's undated Neurological Assessment flowsheet documented:</p> <p>* Neurological evaluation included assessing residents' vital signs (blood pressure, temperature, pulse rate, and respirations), pupils, motor functions, level of consciousness, and pain response.</p> <p>* Neurological evaluations were to be completed every 15 minutes for 1 hour, then every 30 minutes for 2 hours, then every hour for 4 hours, then every 4 hours for 16 hours, then every 8 hours.</p> <p>On 6/20/19 at 2:35 PM, the DNS said the facility used the timelines on the Neurological Assessment flowsheet as the policy for neurological checks after an unwitnessed fall or a suspected head injury.</p> <p>This was not followed.</p> <p>Resident #25 was admitted to the facility on 3/15/19, with multiple diagnoses including stroke with right sided weakness and general muscle weakness.</p> <p>Resident #25 had 3 unwitnessed falls and the Neurological Assessment flowsheets were not completed as directed. Examples include:</p>	F 684	<p>practice:</p> <p>Resident #25 has been evaluated without negative findings related to neurological status post fall.</p> <p>Address how facility will 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. Residents with fall occurrences within the last 14 days have been evaluated to ensure neurological status is without negative findings.</p> <p>Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur:Un</p> <p>LN's have been educated on policy and procedure for completing neurological assessments post fall using the time lines as stated on the neurological form. Unit managers have been educated on the required monitoring to ensure completion of required neurological assessment form post fall occurrence.</p> <p>Unit managers will monitor neurological assessments required post fall occurrence. Unit Managers will ensure the neurological assessments are completed during the timeframe for over-all completion of the neurological</p>		

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F 684	<p>Continued From page 5</p> <p>a. An Incident Report, dated 3/22/19, documented Resident #25 had an unwitnessed fall in his room that morning. The Incident Report documented neurological assessments were started. Neurological assessments were not completed every hour for 4 hours, or every 4 hours for 16 hours.</p> <p>Resident #25's Neurological Assessment flowsheet documented assessments were started at 8:45 AM on 3/22/19 and ended at 1:30 PM on 3/22/19, a period of 4 hours and 45 minutes. Neurological assessments were not completed as directed at 2:30 PM, 3:30 PM, 7:30 PM, 11:30 PM, 3:30 AM, or 7:30 AM on 3/22/19 and 3/23/19, respectively.</p> <p>b. An Incident Report, dated 4/27/19, documented Resident #25 had an unwitnessed fall in his room at 1:30 PM that day. He was found on the floor of his room lying on his back. The Incident Report documented neurological assessments were started.</p> <p>Resident #25's Neurological Assessment flowsheet documented vital signs were started on 4/27/19 at 1:30 PM and were stopped on 4/28/19 at 4:00 AM, a period of 14 hours and 30 minutes. There was no documentation Resident #25's pupils, motor function, level of consciousness, and pain response were assessed after 2:00 PM on 4/27/19. The flowsheet also documented the times neurological assessments were to be completed on 4/28/19, at 8:00 AM, 12:00 PM, and 8:00 PM, these areas were blank.</p> <p>c. An Incident Report, dated 5/10/19,</p>	F 684	<p>assessments required.</p> <p>Indicate how the facility plans to monitor performance to ensure the corrective action are effective and compliance is sustained:</p> <p>Director of Nursing or designee will do weekly audits of neurological assessments post fall occurrence to ensure completion X 3. Findings will be reviewed at QAPI/QAA monthly X3 for further identified training needs.</p> <p>Indicate date when corrective action will be completed:</p>		

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F 684	Continued From page 6 documented Resident #25 had an unwitnessed fall in his room at 10:30 AM that day and was found on the floor of his room in a sitting position. The Incident Report documented neurological assessments were started.  Resident #25's Neurological Assessment flowsheet documented neurological assessments were started on 5/10/19 at 10:30 AM and were stopped on 5/11/19 at 8:15 AM. Neurological assessments were not completed every 30 minutes for for 2 hours as directed and were not completed every 8 hours as directed.  On 6/20/19 at 4:36 PM, the DNS said Resident #25's neurological assessments were not completed. She said staff were expected to complete the neurological checks for 72 hours.	F 684			
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)  §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and  §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure a resident's environment was free from accident hazards when an anti-tip wheel was missing from the resident's wheelchair. This was true for 1 of 19 residents (Resident #25) reviewed for accident hazards. This created the	F 689	Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice:  For Resident #25, the anti-tip bars were removed from the w/c post evaluation for	7/26/19	

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F 689	<p>Continued From page 7</p> <p>potential for harm if the resident's wheelchair tipped backward and the resident was injured. Findings include:</p> <p>Resident #25 was admitted to the facility on 3/15/19, with multiple diagnoses including stroke with right-sided weakness.</p> <p>Resident #25's admission MDS assessment, dated 3/22/19, documented he was severely cognitively impaired and used a wheelchair for mobility.</p> <p>Resident #25's Fall Risk Evaluation, dated 5/10/19, documented he was at risk for falls and had poor trunk control.</p> <p>Resident #25's care plan documented he was at risk for falls due to his history of a stroke with right-sided weakness.</p> <p>Resident #25's wheelchair was missing an anti-tip wheel, on the right side, while he was in it or when it was at his bedside on 6/18/19 at 8:26 AM, 10:39 AM, 12:30 PM, 2:57 PM, and 3:24 PM and on 6/19/19 at 8:44 AM, 10:05 AM, 2:00 PM and 2:10 PM.</p> <p>On 6/19/19 at 3:39 PM, UM #1 was shown the missing anti-tip wheel and she said if Resident #25 tipped backwards, he could fall out of his wheelchair because the anti-tip device was "broken."</p> <p>On 6/20/19 at 10:38 AM, the Maintenance Director said he was unaware Resident #25's wheelchair was missing an anti-tip wheel because he had never received a work order to</p>	F 689	<p>use and there were no negative findings.</p> <p>Address how facility will 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 and utilizing anti-tip bars were evaluated to ensure equipment was in good repair and safe.</p> <p>Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>Staff at the facility have been inserviced on safe equipment use and process for removing broken equipment from service. Staff have been inserviced on how to complete repair requests.</p> <p>Unit managers will add daily monitoring for safety devices used related to resident care to the Treatment Administration Record for monitoring and ensuring equipment is not broken and it is functioning properly.</p> <p>Indicate how the facility plans to monitor performance to ensure the corrective action are effective and compliance is sustained:</p> <p>Unit Managers will audit safety device monitoring weekly X 12 to ensure</p>		

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F 689	Continued From page 8 fix it.	F 689	completed from the Treatment Administration Record. Maintenance will audit work orders weekly X 12 and both will present at QAPI/QAA monthly X3 to ensure completion of documentation and completion of any work orders submitted related to safety device use.  Indicate date when corrective action will be completed: 09/26/2019		
F 691 SS=D	Colostomy, Urostomy, or Ileostomy Care CFR(s): 483.25(f)  §483.25(f) Colostomy, urostomy,, or ileostomy care. The facility must ensure that residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and resident and staff interview, it was determined the facility failed to ensure an order was in place for care of a urostomy for 1 of 1 resident (Resident #71) reviewed for urostomy management. This created the potential for harm if the resident experienced skin breakdown due to the lack of direction for urostomy care. Findings include:  The facility's Admission Orders policy, undated, documented staff were to ensure admission orders contain routine care orders to maintain or improve functional abilities.	F 691	Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice:  Resident #71 has a current MD order in place for urostomy care  Address how facility will identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken:  Residents residing at the facility with urostomies have current MD orders for	7/26/19	

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F 691	<p>Continued From page 9</p> <p>Resident #71 was admitted to the facility on 4/1/19, with multiple diagnoses including peritoneal abscess (a pocket of infected fluid and pus located inside the abdominal cavity) and severe protein-calorie malnutrition.</p> <p>Resident #71's admission assessment, dated 4/1/19, documented he had a urostomy (a surgical procedure that creates a stoma [artificial opening] for the urinary system). Resident #71's admission orders, dated 4/1/19, did not include an order for urostomy care.</p> <p>Resident #71's Medication Administration Record (MAR) and Treatment Administration Record (TAR), dated 4/1/19 to 6/20/19, did not include direction to staff to provide care or management of his urostomy.</p> <p>Resident #71's care plan directed staff to change the urostomy appliance as needed, monitor urine, and report leakage to the nurse. The care plan did not include who provided urostomy care, including assessment for potential skin breakdown and when to use a catheter drainage bag.</p> <p>On 6/17/19 at 9:15 AM, on 6/18/19 at 8:40 AM, and on 6/20/19 at 10:45 AM, Resident #71 was in bed and his urine drained from the urostomy into a catheter tubing to a catheter bag attached to the side of his bed.</p> <p>On 6/19/19 at 9:00 AM, Resident #71 was transported from his room to the therapy room with his wheelchair. There was no catheter tubing visible at that time.</p>	F 691	<p>care in place</p> <p>Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>LN's have been inserviced on urostomy orders to be obtained upon admission and updated as indicated.</p> <p>Urostomy orders will be monitored on the Treatment Administration Record by Licensed Nurses and documented daily.</p> <p>Indicate how the facility plans to monitor performance to ensure the corrective action are effective and compliance is sustained:</p> <p>Urostomy orders and care will be audited 3X a week for 8 weeks and then monthly X3 by the unit managers. Findings will be presented to QAPI/QAA monthly X 3 for compliance review and further educational opportunities.</p> <p>Indicate date when corrective action will be completed:</p>		

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F 691	<p>Continued From page 10</p> <p>On 6/19/19 at 11:25 AM, Resident #71 was on his bed with his urostomy bag visible on the outside of his clothes. The bag had urine in it and was not attached to catheter tubing. Resident #71 said he had recently come back from therapy and said one of the staff had unhooked his urostomy bag from the catheter tubing prior to going to therapy. Resident #71 said it was easier to participate in therapy when his urostomy bag was not attached to the catheter tubing. He said staff cleaned around his urostomy and changed the bag as needed.</p> <p>On 6/20/19 at 1:38 PM, RN #1 said she did not need to provide urostomy care for Resident #71 during her shift because she followed the electronic TAR and his TAR did not document direction for urostomy care for her shift that day. RN #1 said urostomy care directions were probably on the TAR for a different shift.</p> <p>On 6/20/19 at 1:48 PM, CNA #1 said she had worked with Resident #71 and transferred his catheter tubing and drainage bag when he left his room in his wheelchair. CNA #1 said CNAs were responsible to drain the urine from the drainage bag and check for any leaks from the urostomy. CNA #1 said the nurses were responsible for changing the urostomy bag.</p> <p>On 6/20/19 at 2:50 PM, the DNS said she could not find a physician order for Resident #71's urostomy care and/or management. The DNS said she expected to find directions on when he used the urostomy bag versus the catheter tubing and drainage bag, who provided urostomy care, and what supplies were needed to care for the urostomy. The DNS said there were no</p>	F 691			

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F 691	Continued From page 11 directions in Resident #71's record for the care and management she described.  A nurse's progress note, dated 6/20/19 at 4:20 PM, documented Resident #71's spouse had taken care of his urostomy for the past 5 years and wanted to keep providing care and supplies, with the facility staff as a back-up. The progress note documented Resident #71's spouse verbalized and demonstrated sufficient knowledge and skills to manage the urostomy.  On 6/20/19 at 4:32 PM, the DNS said Resident #71 had the urostomy for 5 years and his spouse had been managing the urostomy care at home and in the facility. The DNS said staff had assessed Resident #71's spouse's knowledge and skills to manage his urostomy that day.	F 691			
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)  §483.60(i) Food safety requirements. The facility must -  §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812		7/26/19	

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F 812	<p>Continued From page 12</p> <p>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, policy review, and staff interview, it was determined the facility failed to prepare and distribute food under sanitary conditions when staff members were observed in the kitchen without facial hair restraints and fully contained hair. This was true for 19 of 19 residents (#1, #6, #7, #10, #13, #16, #17, #20, #25, #35, #50, #51, #65, #66, #68, #69, #71, #72, and #73) who dined in the facility and the other 55 residents who dined in the facility. This placed residents at risk for potential contamination of food and adverse health outcomes. Findings include:</p> <p>The facility Sanitation policy, dated July 2015, directed staff who worked in the kitchen to always wear hair restraints to cover all hair, including facial hair.</p> <p>On 6/17/19 at 8:44 AM, Dietary Staff #1 (DS) was at a food prep counter in the kitchen with a bag of cut vegetables. DS #1 had a mustache and beard that were not contained in a facial hair restraint.</p> <p>On 6/18/19 at 10:55 AM, DS #1 removed a container of food from one of the ovens in the kitchen. He did was not wearing a facial hair restraint to cover his mustache and beard.</p> <p>On 6/19/19 at 11:15 AM, DS #1 measured temperatures of the prepared food at the tray line in the kitchen. After measuring the food</p>	F 812	<p>Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>Residents (#1, #6, #7, #13, #16, #17, #20, #25, #35, #50, #51, #65, #66, #68, #69, #71, #72, and #73) were evaluated and are without negative outcome.</p> <p>Resident #10 is no longer at the facility.</p> <p>Address how facility will 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 the deficient practice. There are no residents with negative findings.</p> <p>Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>DS Employees with facial hair were inserviced on using gacial hair restraints while preparing or distributing food</p>		

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F 812	<p>Continued From page 13</p> <p>temperatures, DS #1 proceeded to plate the food which was served to the residents. DS #1 was not wearing a facial hair restraint to cover his beard and mustache.</p> <p>On 6/19/19 at 11:20 AM, DS #2 entered the food service area and assisted with placing the residents' plated food on trays. DS #2 had facial hair that was not contained with a beard restraint. At 11:44 AM, during the same meal service, DS #3 entered the kitchen and stood near the food preparation table. DS #3 was wearing a head covering that allowed three inches of his hair to be exposed. DS #3 was also not wearing a facial hair restraint to cover his mustache.</p> <p>On 6/20/19 at 9:30 AM, DS #1 and DS #2 were in the kitchen and were not wearing facial hair restraints.</p> <p>On 6/20/19 at 9:30 AM, DS #1 stated, "I know I am supposed to wear a beard cover."</p> <p>On 6/20/19 at 9:33 AM, DS #2 stated he was instructed to wear a beard restraint to prevent possible contamination of the food and equipment with facial hair.</p> <p>On 6/20/19 at 9:35 AM, the Dietary Manager said she expected all dietary staff to wear facial hair restraints and hair restraints on their heads which completely covered their hair to prevent contamination of the residents' food.</p>	F 812	<p>Beard and facial hair restraints are available in the dietary department for use when staff are preparing or distributing food</p> <p>Dietary Staff with facial hair have been inserviced on the use of facial hair restraints during preparing or distributing food</p> <p>Indicate how the facility plans to monitor performance to ensure the corrective action are effective and compliance is sustained:</p> <p>Dietary Manager will do random audits 2X a day Monday-Friday X 12 weeks to ensure facial air restraints are being used as in accordance with professional standards. Findings will be presented at QAPI/QAA monthly X 3 to evaluate and ensure compliance.</p> <p>Indicate date when corrective action will be completed:</p>		
F 883 SS=F	<p>Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2)</p> <p>§483.80(d) Influenza and pneumococcal immunizations</p>	F 883		7/26/19	

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F 883	<p>Continued From page 14</p> <p>§483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that-</p> <p>(i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;</p> <p>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-</p> <p>(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's representative</p>	F 883			

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F 883	<p>Continued From page 15</p> <p>has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview, policy review, and record review, it was determined the facility failed to ensure a process for tracking each residents' pneumococcal vaccination status was developed and implemented following the Centers for Disease Control and Prevention (CDC) recommendations, residents received a pneumococcal vaccination when requested or consented, or documentation which pneumococcal vaccination was given. This was true for 6 of 9 residents (#1, #7, #13, #16, #18, and #39) reviewed for pneumococcal vaccinations. This failed practice represented a systemic failure which increased residents' risk for contracting pneumonia with its associated complications of infection of the blood which could cause death or brain damage. Findings include:</p> <p>The CDC website, updated 11/22/16, included recommendations for the Pneumococcal vaccination (PCV13 or Prevnar13®, and PPSV23 or Pneumovax23®) for all adults 65 years or older included the following:</p>	F 883	<p>Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>Residents #1, #7, #13,#16,#18,and #39 have been given the pneumovac 13 or 23 as per indicated/ordered.</p> <p>Address how facility will 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 or admitting to the facility have the potential to be affected by the deficient practice.</p> <p>Residents residing at the facility have received the pneumovac 13 or 23 as indicated unless refused by the resident. Information related to risks and benefits are completed and present in the medical record for residents refusing the</p>		

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F 883	<p>Continued From page 16</p> <p>* Adults 65 years or older who have not previously received PCV13, should receive a dose of PCV13 first, followed 1 year later by a dose of PPSV23.</p> <p>* If the patient already received one or more doses of PPSV23, the dose of PCV13 should be given at least 1 year after they received the most recent dose of PPSV23.</p> <p>The facility's policy for Immunization--Standing Orders, dated July 2015, documented all adults 65 years and older receive both the Pneumococcal Conjugate Vaccine (PCV13) followed by the Pneumococcal Polysaccharide Vaccine (PPSV23) at least one year later. The facility's policy also included guidelines for offering the vaccines to persons ages 19-64 who are immunocompromised.</p> <p>a. Resident records did not include documentation the pneumococcal vaccine was offered or given for those who had not received it. Examples include:</p> <p>- Resident #1 was admitted to the facility on 8/31/18, with multiple diagnoses including a femur (thigh bone) fracture and dementia.</p> <p>The quarterly MDS assessment, dated 6/3/19, documented Resident #1 was not up to date or not offered the pneumococcal vaccinations.</p> <p>Resident #1's record did not include documentation he was offered or educated on the pneumococcal vaccination.</p>	F 883	<p>pneumovac 13 or 23 as offered.</p> <p>Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>Unit Managers/Infection Control Preventionist have been inserviced by the Regional Director of Clinical Services and the Director of Nursing on the CDC guidelines for the immunization related to pneumovac 13 and pneumovac 23.</p> <p>A facility tracking tool has been established to ensure immunizations are offered and given as per CDC guidelines and infection control policy.</p> <p>Indicate how the facility plans to monitor performance to ensure the corrective action are effective and compliance is sustained:</p> <p>Director of Nursing/esignee will audit the tracking logs weekly X 12 to ensure compliance. Findings will be presented by the Infection Control Preventionist monthly to QAPI/QAA for review with the Medical Director included to maintain compliance.</p> <p>Indicate date when corrective action will be completed:</p>		

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F 883	<p>Continued From page 17</p> <p>- Resident #7 was admitted to the facility on 12/3/18, with multiple diagnoses including hypoxia (lack of oxygen to the tissues) and respiratory failure.</p> <p>The quarterly MDS assessment, dated 6/12/19, documented Resident #7 was not up to date or not offered the pneumococcal vaccinations.</p> <p>Resident #7's record did not include documentation he was offered or educated on the pneumococcal vaccinations.</p> <p>b. Residents signed a consent form to receive the pneumococcal vaccination and it was not given by the facility. Examples include:</p> <p>- Resident #16 was admitted to the facility on 6/20/18, with multiple diagnoses including hypoxia, respiratory failure, and a traumatic brain injury.</p> <p>A quarterly MDS assessment, dated 3/30/19, documented he was not up to date or not offered the pneumococcal vaccinations.</p> <p>Resident #16's record included a Pneumococcal and Annual Influenza Information consent form, dated 6/20/18. The consent documented Resident #16 requested to have the pneumococcal vaccine administered.</p> <p>On 6/20/19 at 2:26 PM, the Infection Control Nurse stated Resident #16 did not receive the pneumococcal vaccine and his record did not include which vaccine he was offered, the PCV13 or the PPSV23.</p>	F 883			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135042</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/21/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>LACROSSE HEALTH &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>210 WEST LACROSSE AVENUE COEUR D'ALENE, ID 83814</b>		
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F 883	<p>Continued From page 18</p> <p>- Resident #18 was admitted to the facility on 2/23/16, with multiple diagnoses including a traumatic subdural hemorrhage (bleeding into the brain due to a severe head injury).</p> <p>An annual MDS assessment, dated 2/11/19, documented Resident #18 was not up to date or not offered the pneumococcal vaccinations.</p> <p>Resident #18's record included a Pneumococcal and Annual Influenza Information consent form, dated 10/3/18, which documented his representative requested to have Resident #18 receive the pneumococcal vaccine.</p> <p>On 6/20/19 at 2:26 PM, the Infection Control Nurse stated Resident #18 did not receive the pneumococcal vaccine and his record did not include which vaccine he was offered the PCV13 or the PPSV23.</p> <p>c. Resident's who had documentation they received a pneumococcal vaccine did not include which vaccination they received, the PCV13 or PPSV23. Examples include:</p> <p>- Resident #39 was admitted to the facility on 8/28/09, with multiple diagnoses including diabetes and a traumatic brain injury.</p> <p>A quarterly MDS assessment, dated 5/7/19, documented Resident #39 was not up to date with the pneumococcal vaccine.</p> <p>Resident #39's Immunization Record documented he received the pneumococcal vaccine on 8/28/09. The record did not include if the pneumococcal vaccine was the PCV13 or the</p>	F 883			

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

PRINTED: 08/08/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135042</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/21/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>LACROSSE HEALTH &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>210 WEST LACROSSE AVENUE COEUR D'ALENE, ID 83814</b>		
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F 883	<p>Continued From page 19 PPSV23.</p> <p>- Resident #13 was admitted to the facility on 12/7/16, with multiple diagnoses including a stroke.</p> <p>A quarterly MDS assessment, dated 3/24/19, documented Resident #13 was up to date on pneumococcal vaccinations.</p> <p>Resident #13's Immunization Record, dated 3/16/17, documented he received the pneumococcal vaccination. The record did not include documentation which pneumococcal vaccine, the PCV13 or the PPSV23, was given.</p> <p>On 6/20/19 at 2:30 PM, the Infection Control Nurse stated she was not tracking the pneumococcal vaccinations. The Infection Control Nurse stated she identified three weeks ago the facility did not have a tracking system in place, but had not implemented a system to track resident vaccination status. She stated most of the resident population in the facility were 65 years or older with comorbidities that increased their risk for pneumococcal infection.</p> <p>On 6/20/19 at 3:55 PM, the DNS said she was not aware the facility was not tracking pneumococcal vaccinations.</p>	F 883			



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

BRAD LITTLE – Governor  
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR  
LICENSING & CERTIFICATION  
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BUREAU OF FACILITY STANDARDS  
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August 6, 2019

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

Provider #: 135042

Dear Mr. Littman:

On **June 21, 2019**, an unannounced on-site complaint survey was conducted at Lacrosse Health & Rehabilitation Center. The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00008084**

**ALLEGATION #1:**

The facility did not monitor and implement bowel care protocols.

**FINDINGS #1:**

An unannounced recertification and complaint survey was conducted from 6/17/19 to 6/21/19. During the survey 19 resident records were reviewed, facility grievances were reviewed, and the facility's bowel care protocols were reviewed.

A review of one resident's record, admitted in August 2018, documented bowel care was monitored by the facility and interventions were implemented as needed and ordered. The resident's record documented the resident had bowel movements on a regular basis, every one to three days. The resident was sent to the Emergency Department in March 2019 for evaluation of a change in condition. At the Emergency Department the resident was found to have a fecal

Michael Littman, Administrator  
August 6, 2019  
Page 2 of 3

impaction, a condition related to constant constipation. The resident had co-morbid health conditions and used narcotic pain relievers which may have contributed to his condition. The Emergency Department documentation stated the resident was given an enema which was effective and was sent back to the facility. Bowel management records after return from the hospital documented the resident had regular bowel movements, was seen by his physician 2 days later for a follow-up, and new interventions were implemented for bowel care.

Bowel management records were reviewed for the other 18 residents and no concerns were identified.

Based on the investigative findings, the allegation could not be substantiated.

#### CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

#### ALLEGATION #2:

The facility failed to properly care for a wound.

#### FINDINGS #2:

During the investigation 19 resident records were reviewed, observations were conducted, and residents were interviewed.

One resident, admitted in August 2018, developed a blister on his inner forearm in April 2019. The record documented nursing staff contacted the physician, the wound was assessed, and dressings were applied. Care of the wound was referred to an outside wound care clinic and the clinic documented the wound had healed after a little more than 3 weeks. The wound was addressed in physician notes and treatments were ordered and modified by the physician. Nursing staff documented in the record care and treatment of the wound and descriptions of the wound, as well as, when orders or treatment was changed.

Observations were made of resident care and positioning related to skin care with no concerns identified. Wound care was observed for four patients with no concerns.

Based on the investigation findings, the allegation could not be substantiated.

#### CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Michael Littman, Administrator  
August 6, 2019  
Page 3 of 3

ALLEGATION #3:

The facility did not have enough staff to address all the needs of the residents.

FINDINGS #3:

During the investigation observations were conducted, staff schedules were reviewed, staff were interviewed, and residents were interviewed.

Throughout the survey, call lights were monitored and were responded to in less than five minutes. Interviews with residents at the facility yielded no reports of delayed response or of adverse outcomes related to slow response by staff.

Review of the nursing staff schedules for the two weeks prior to the survey showed staff were scheduled based on the facility's annual needs assessment. In interviews the Care Manager, CNA staff, and the residents on the floor showed no concerns with staffing levels.

Based on the investigation findings, the allegation could not be substantiated

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.

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/slj



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

BRAD LITTLE – Governor  
DAVE JEPPESEN – Director

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September 30, 2019

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

Provider #: 135042

Dear Mr. Littman:

On **June 17, 2019** through **June 21, 2019**, an unannounced on-site complaint survey was conducted at Lacrosse Health & Rehabilitation Center. The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00008123**

**ALLEGATION #1:**

One resident was neglected by staff at the facility and not appropriately groomed.

**FINDINGS #1:**

During the recertification survey, the team made observations of the residents, showering schedules were reviewed, residents were interviewed, and staff were interviewed.

On the first day of the survey, Restorative Nursing Staff was observed assisting one resident while he/she was ambulating in the hallway near the 100 Hall Nurses' Station. The staff member was using a gait belt to support the resident during the ambulation activity. The resident's clothes looked clean, non-stained, and in good repair. Four other residents were observed who looked neatly dressed and were observed wearing clothing that looked clean, and in good repair. Three of the four residents had beards, but their beards did not look dirty or unkempt. Review of the shower documentation for the four residents included documentation whether it was completed and/or residents' refused. There were no residents identified as not receiving showers/bathing per the planned schedules.

During an interview with one resident, they stated they did not want staff to clean their finger nails, and they personally took care of that. The resident said his/her feet were sort of "touchy, like ticklish" and he/she did not want staff to trim his/her toenails.

Two Certified Nursing Assistants (CNA) were interviewed and one of the two shower aides for the 200/300 hallways stated each resident had a scheduled bath and/or shower days for up to two showers/baths per week. However, the CNA stated if a resident requested additional showers, and if another shower/bath was needed anytime during a week, the bathing would be provided. One CNA stated the facility had recently added an additional shower aide onto the day shift to ensure residents received their showers timely, as planned.

Continued interview with the two CNAs and the two unit nurses, revealed one resident frequently refused offers for showers and grooming. They said the resident became verbally aggressive when showers were offered. One CNA interviewed said since that particular resident was known to frequently refuse showers, the direct care staff had been instructed to ask the resident daily if he/she wanted to take a shower. On shower days, staff were to offer a shower three times before documenting the resident refused the offer for a shower. The CNA said they were to also offer to give the resident a shower on days other than his/her scheduled shower days, to give the resident many opportunities to accept bathing care. The CNAs were to also inform the unit nurse when the resident refused a shower three times on a scheduled shower day.

Another CNA that worked with the resident said the resident often refused showers, and would say things like, "let me go smoke first" or "I'm already dressed and ready for the day." The CNA said when the resident's family member (a daughter) visited, she could usually convince the resident to change clothes. She said the resident usually changed clothes about once per week.

One resident's record documented the resident was assessed as needing only minimal assistance with personal hygiene and dressing. The resident's Interdisciplinary (IDT) care plan included a component for Activities of Daily Living with a revision date of 1/29/19. It was documented in the care plan the resident had a history of not showering when he/she lived at home with family. The care plan noted one of the resident's typical comments was "I don't do anything to get dirty." Also, the care plan documented the resident was offered showers and washing of clothes, daily, but the resident often refused the care. The CNA care instructions documented the resident was independent with dressing and grooming, and would ask for assistance, as needed. The care plan also documented, with cueing, the resident was independent with oral care. In addition, direct care staff were to honor and respect the resident's choices for life routines. The resident's record included nursing and skin assessments and there was no documentation of rashes, skin infections, or skin breakdown.

The Unit Manager (UM) was interviewed and stated facility staff had a meeting with the family (two daughters) of one resident. She said the resident also attended the meeting. The UM said during the meeting, the resident verbally agreed to allow staff to assist with showers. However, the UM stated after the meeting, when staff offered a shower the resident repeated the pattern of refusing the bathing. The UM stated on occasion, the resident would allow a family member to trim and clean his/her finger nails. The UM stated at the 3/12/19 meeting, the staff learned that infrequent bathing had been part of the resident's lifestyle before admission to the facility.

The Director of Nursing Services (DNS) was interviewed and stated she was aware one resident frequently refused most attempts by staff to provide bathing and grooming care. She said the resident would become very agitated with staff when they asked if they could provide the care. If the resident refused care, the direct care staff had been instructed to re-approach later and ask again. She said the resident did accept footcare recently, including some toe nail trimming from the UM, but only after a very long conversation and much encouragement. The DNS said it was important to provide nail care if the resident allowed it. She said she would want staff to monitor the condition of the nails and to inspect the condition of the skin around the nails and document any changes to the integrity of the resident's skin.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

A resident's room, bed, and wheelchair had an odor of urine.

FINDINGS #2:

During the survey observations were conducted of the facility and residents' rooms.

Upon a comprehensive initial tour of all the facility's nursing units by survey team members, there were no offensive odors identified. Observations during the five days of the survey, revealed there were no odors noted in one resident's room. One resident 's room, bed, and wheelchair were all odor free, and appeared clean.

There were no lingering malodorous smells identified on the units in the facility for the five days of the survey.

Based on the investigative findings, the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

Personal laundry was not done by the facility for a resident and family had to take care of it.

FINDINGS #3:

During the survey observations were conducted and staff were interviewed.

Observations of the living spaces, clothing closets, and drawers in four residents' rooms showed an

Michael Littman, Administrator  
September 30, 2019  
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adequate supply of clean clothing hanging neatly in the closets, and other articles of clean clothing folded in drawers and available for use. Observations of residents throughout the facility revealed residents were dressed in clean looking clothing and they were neatly groomed.

Observation of the Facility's Laundry Suite, revealed clean bed linen, towels, and wash cloths had been processed, folded, and were ready to be delivered to the nursing units. Interview with the Housekeeping Manager revealed staff stocked clean linen and towels in closets on the nursing units at least two times daily, early morning and then later on the afternoon shift once the heavier morning care for residents had been completed. Interview with the laundry staff revealed a system was in place to ensure residents' personal clothing was laundered regularly, and the plan was to try to return a resident ' s clothing within twenty-four hours of processing. Residents' clothing was to be labeled with a marker for identification.

During an interview with the UM for the 100/200 hall she said a family member did one resident's laundry at home maybe a couple of times, but most of the time the resident ' s laundry was processed by the facility.

Based on the investigative findings, the allegation could not be substantiated.

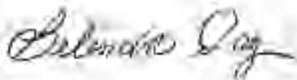
#### CONCLUSIONS:

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.

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,



Belinda Day, RN, Supervisor  
Long Term Care Program

BD/lj